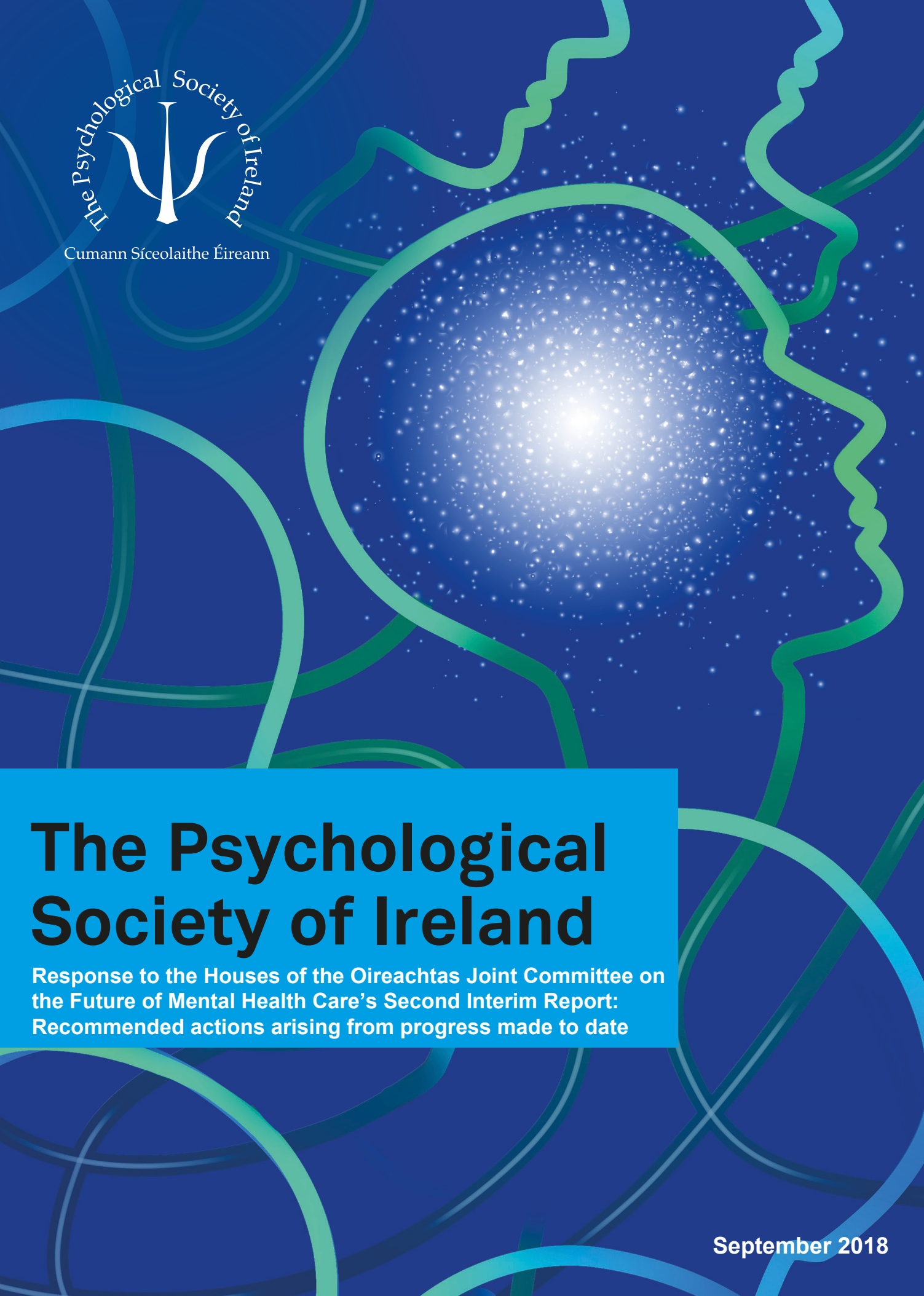

The Psychological Society of Ireland

Response to the Houses of the Oireachtas Joint Committee on the Future of Mental Health Care's Second Interim Report: Recommended actions arising from progress made to date

September 2018

Executive Summary

The Psychological Society of Ireland (PSI) is the learned and learning professional body for Psychology in the Republic of Ireland. The Society is committed to maintaining high standards of practice in Psychology and also to exploring new and innovative ways of furthering Psychology as a real and applied science. The PSI broadly welcomes the second interim report of the Oireachtas Joint Committee on the Future of Mental Health Care.

The PSI notes the concerns of the Joint Oireachtas Committee in relation to engagement with the Department of Health, and indeed shares similar concerns explicated in our submission to the A Vision for Change (AVFC) Oversight group (which can be found on our website: www.psychologicalsociety.ie) and is attached for convenience.

A fundamental policy shift is necessary within the Health Service Executive (HSE), if the AVFC's vision of a transition from a medical model of mental health care to one that is predominantly psychosocial in nature is to be achieved. This additionally requires changes to 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/mental health difficulties. Improved, more cost-effective health outcomes are being achieved internationally (Harvey, 2018), where: the centrality of psychological and social issues in the development and maintenance of mental health difficulties are meaningfully acknowledged (including trauma, poverty, family problems, relationships, social inequality and exclusion for example); psycho-social, collaborative, person-centred, evidence-based interventions are provided very early, ideally initially from the first contact with health services.

In 2006, AVFC highlighted the importance of a biopsychosocial model of mental health and the need for multi-disciplinary teams to support individuals with mental health difficulties. Mental health care within the health service, however, is still predominantly grounded in the medical model with approximately €400 million per year still being spent on psychotropic medication alone. To move towards a trauma-informed, recovery focused and psychosocial model of mental healthcare, a significant increase in funding for psychological therapies far beyond what was previously recommended is required. It is estimated that approximately one third of General Practitioner (GP) consultations in Ireland pertain to mental health difficulties. Yet spending in mental health is only a fraction of the overall health budget. Furthermore, whilst psychological therapies are evidenced and recognised as the treatment of choice for many mental health difficulties, the distribution of spending is inequitable across different disciplines within mental health, with pharmacological interventions accounting for a large proportion of spending.

The PSI makes further recommendations, as to how referral, clinical governance and out-of-hours structures and processes should be evolved, to reflect and align with international best practice and the *actual* rather than *oft-misperceived* legal context. This will help to ensure the right people,

get the right intervention and at the right time, from a broad range of health and social care professionals, whatever the time of day.

Bio-psycho-social, rather than solely medical / disease model, formulation and assessment from the first point of contact with mental health services, and removed from their current location in hospital Emergency Departments (EDs), are necessary to facilitate implementation and sustainability of AVFC's goal of a recovery rather than medical model of support to people.

The PSI asserts that this evidence-based paradigm shift will necessitate a move from diagnostic/illness-based language, to transdiagnostic, psychological formulation in simple language and in accordance with progress internationally.

An expansion of primary care to ensure greater access for individuals across the lifespan to psychological therapies is welcomed and supported by the PSI. Given the breadth and depth of expertise Psychologists bring to mental health services, access to Psychology in primary care (as well as secondary and tertiary care) should be considered central to the proposed reforms. This will require increased recruitment and the addressing of barriers to retention. Barriers to retention are not simply fiscal. Others include, for example, inequitable access to continuing professional development budgets for Psychologists, relative to Consultant Psychiatrist colleagues.

Inclusion is one of our five core values in the PSI and to that end we welcome the Committee's focus on improving access to mental health services for marginalised groups in Ireland. In addition to the three groups the Committee references, the PSI wishes to highlight that people in, or who have experience of custody, consistently evidence significantly poorer health outcomes in Ireland, as in other countries. Many of these are contributed to by stigma and other barriers to re-entering our communities in ways that promote personal and community health.

Below, we have outlined our twenty recommendations in response to the Committee's second interim report. The PSI looks forward to continuing to work effectively with members of both Houses of the Oireachtas as we strive to achieve our shared goal of healthier lives and communities for all members of Irish society.

Summary Recommendations

1. A fundamental policy shift is necessary within the HSE, if the AVFC's vision of a transition from a medical model of mental health care to one that is predominantly psychosocial in nature is to be achieved.

2. A review of referral practices from primary to secondary care is necessary. We suggest that referrals to Community Mental Health Teams (CMHTs) should be accepted from any member of the Primary Care Team, not only the GP.

3. A psychiatric diagnosis should not be a prerequisite for referral to CMHTs. A psychiatric diagnosis is only necessary for psychiatric / pharmacological treatment. CMHTs are multidisciplinary teams, not *psychiatric* teams, and as such, individuals with moderate to severe mental health difficulties should be able to access care from any of the professionals on a CMHT (Psychology, Social Work, Occupational Therapy, Nursing).

4. The PSI strongly asserts that in moving forward with quality mental health care in Ireland it is essential that the concepts of leadership and clinical leadership in mental health are brought into line with international best practice.

5. Consequently, the PSI recommends the development of a competency framework for clinical leadership and leadership development programmes that are equally open to all suitable clinicians with the requisite competencies.

6. The PSI asserts that the evidence-based paradigm shift will necessitate a move from diagnostic / illness-based language, to transdiagnostic, psychological formulation in simple language and in accordance with progress internationally.

7. The PSI supports the identified need for 24/7 mental health services in the community. We are concerned that the nature of the services provided should 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 a treatment plan and ongoing intervention to address the psychosocial difficulties that led to their crisis and psychological distress. It is also important that 24/7 mental health services are embedded within community settings as opposed to hospital EDs.

8. Currently all crisis care is provided by medical staff (Psychiatry, Nursing, GPs) which is perpetuating the dominance of the medical model within mental health. The PSI asserts that it is crucial that 24/7 teams are multi-disciplinary in nature, to ensure implementation of the shift in culture and practise required in achieving a psychosocial model of mental health care. 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.

9. The PSI agrees with the view held in the Joint Oireachtas Committee's report that there needs to be greater access to counselling, psychotherapy and family therapy at primary care level. Given the breadth and depth of expertise Psychologists bring to mental health services, access to Psychology in primary care (as well as secondary and tertiary care) should be considered central to the proposed reforms.

10. The PSI recommends that the cap on the maximum number of therapy sessions that can be offered in primary care be removed and, as such, aligned with evidence-based best practice and the AVFC's stated goal of 'recovery'. Increasing the maximum number of sessions that can be provided will reduce the need for referral to secondary care services and reduce long-term dependency on psychiatric medications.

11. The PSI asserts that there is a need for more Psychologists on CMHTs if Service Users are to have equal access to both psychological and pharmacological interventions. The PSI recommends a minimum number of Whole Time Equivalent (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 and derived in consultation with the PSI and other stakeholders.

12. The PSI recommends equity in and parity of Continuing Professional Development (CPD) funding across HSCPs. In CMHTs, Psychiatry currently have individual CPD budgets allocated annually which they can use for CPD events / training. However, HSCPs including Psychologists, do not have individual CPD budgets and have to typically self-fund any training they take part in to further their professional development.

13. In light of the evidenced adverse impact of minority stress on health, including mental health, the PSI welcomes the acknowledgement of the need to give special consideration to minority groups and service design for these groups. Given consistently evidenced poorer health markers, the PSI is concerned at the absence of people in custody from the minority groups focussed upon in the report and recommends that people in custody be explicitly included in the final report.

14. The PSI recommends the development of an ethnic identifier, with associated staff training, is expedited without delay in order to quantify health trends and outcomes to inform service planning and design.

15. The PSI agrees with the assertion of BelongTo that the requirement for young people aged 16-17 to have parental consent to access mental health services can block access to needed care for such young people who are Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) but who have not come out to their parents. The PSI recommends priority is given to addressing this barrier, which may require legislative reform, with meaningful collaboration with community stakeholders to ensure a young peoples' rights-based approach is consistently taken to addressing this barrier.

16. The PSI endorses the Joint Oireachtas Committee's view that specific mental health supports should be integrated into and added to the physical health supports currently available to victims of trafficking. These should be developed in collaborative and culturally responsive ways, in recognition of the diversity that exists both within and between migrant

communities in Ireland. These supports should be equality-proofed to ensure equality of access to services.

17. The PSI recommends that the State prioritises increasing the number of forensic mental health in-patient beds, including expediting the development of planned regional forensic in-patient units, to reflect norms across comparable Western democracies.

18. The PSI recommends a cross-departmental working group is established to develop a prisoner mental health action plan that recognises many people will access services through both the Irish Prison Service (IPS) and the HSE at differing times in their lives. The PSI is particularly concerned that throughcare between both service providers is optimised and also that those serving sentences of significant length have equitable access to primary, secondary and tertiary mental health care when required.

19. The PSI recognises the IPS Psychology Service as an 'appropriate healthcare setting' for gaining experience in adult mental health for the reckoning of experience of Assistant Psychologists, Psychologists in Training and for the reckoning of experience of Qualified Psychologists of all grades, when assessing eligibility for recruitment to adult mental health care settings within the IPS and the HSE. The PSI recommends the HSE immediately similarly recognises experience in the IPS. Such mutual recognition will help to foster a culture of collaboration and knowledge transfer between both State agencies, ultimately benefiting Service Users and our broader communities.

20. The PSI recommends the IPS and the HSE explore opportunities for Psychologists to avail of secondment and/or innovative opportunities for knowledge transfer between both State agencies.

1. Introduction

1.1 The Psychological Society of Ireland (PSI) is the learned and learning professional body for Psychology in the Republic of Ireland. Established in 1970, the Society currently has approximately 3,000 members. The PSI is committed to maintaining high standards of practice in Psychology and also to exploring new and innovative ways of furthering Psychology as a real and applied science.

1.2 The PSI broadly welcomes the second interim report of the Oireachtas Joint Committee on the Future of Mental Health. In particular, the Society welcomes both:

I. the acknowledgement of a lack of parity of esteem for mental health care funding during the past period of de-hospitalisation;
II. the recognition and focus on recruitment and retention as a block to efforts at implementation of reform since 2006.

1.3 We would like to highlight the central role Psychologists can, and do, play in various domains of evidence-based mental health services such as:

I. Advisory / consultancy to national and local State and Non-Governmental Organisation (NGO) stakeholders;
II. Policy development and implementation;
III. Service development, audit and evaluation;
IV. Senior management and clinical governance;
V. Service delivery across primary, secondary and tertiary services;
VI. Training and development of non-Psychologist and Psychologist healthcare staff.

2. Engagement with the Department of Health

2.1 The PSI notes the concerns of the Joint Oireachtas Committee in relation to engagement with the Department of Health, and indeed shares similar concerns. These significant concerns are explicated in detail in the Society's submission to the Department of Health AVFC Oversight Group.

3. Overcoming barriers to moving from a medical to a recovery model

3.1. *Psychosocial model of mental health*

3.1.1. A fundamental policy shift is necessary within the HSE, if the AVFC's vision of a transition from a medical model of mental health care to one that is predominantly psychosocial in nature is to be achieved.

3.1.2. This additionally requires changes to 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/mental health difficulties. Improved, more cost-effective health outcomes are being achieved internationally (Harvey, 2018), where:

I. The centrality of psychological and social issues in the development and maintenance of mental health difficulties are meaningfully acknowledged (including trauma, poverty, family problems, relationships, social inequality and exclusion for example);
II. Psycho-social, collaborative, person-centred, evidence-based interventions are provided very early, ideally initially from the first contact with health services.

3.1.3. In 2006, AVFC highlighted the importance of a biopsychosocial model of mental health and the need for multi-disciplinary teams to support individuals with mental health difficulties. Mental health care within the health service, however, is still predominantly grounded in the medical model with approximately €400 million per year still being spent on psychotropic medication alone. To move towards a trauma-informed, recovery focused and psychosocial model of mental healthcare, a significant increase in funding for psychological therapies far beyond what was previously recommended is required.

3.1.4. It is estimated that approximately one third of GP consultations in Ireland pertain to mental health difficulties. Yet spending in mental health is only a fraction of the overall health budget. Furthermore, whilst psychological therapies are recognised as the treatment of choice for many mental health difficulties, the distribution of spending is inequitable across different disciplines within mental health, with pharmacological interventions accounting for a large proportion of spending.

3.1.5. Contrary to this practise, evidence suggests that medication should not be the first line treatment for many difficulties, such as mild to moderate depression. Research suggests that antidepressants are no more effective than placebo when treating mild to moderate depression (Kirsch, Deacon, Huedo-Medina, Scoboria, Moore & Johnson, 2008; Moncrief and Kirsch, 2015) and widely prescribed Selective Serotonin Reuptake Inhibitors (SSRIs) have been found to carry risk of serious adverse effects such as increased risk of suicide, sexual dysfunction and discontinuation syndrome/withdrawal effects (Fava, Gatti, Belaise, Guidi, Offidani, 2011). On the other hand, research evidence supports the effectiveness of psychological interventions in treating depression as well as other mental health difficulties. Furthermore, psychological interventions do not present the same risks of harmful side-effects and are less expensive than psychotropic medications in the long-term as they are time-limited and can result in long-term change/recovery (Spielmans, Berman, Usitalo, 2011).

4. The link between governance structures & implementation

4.1 Referral Practices

4.1.1. A review of referral practices from primary to secondary care is necessary.

4.1.2. We suggest that referrals to CMHTs should be accepted from any member of the Primary Care Team, not only the GP. In Child and Adolescent Mental Health Services (CAMHS), referral pathways have been expanded since the introduction of the CAMHS Standard Operating Procedures (SOPs) in June 2015, allowing other professionals to refer young people to the Service. Central to this evidence-based expansion of the referral pathways was keeping the GP at the centre of all referrals. The PSI recommends that Adult Mental Health Service (AMHS) referral pathways be reviewed to bring them in line with CAMHS pathways.

4.1.3. A psychiatric diagnosis should not be a prerequisite for referral to CMHTs.

4.1.4. A psychiatric diagnosis is only necessary for psychiatric/pharmacological treatment. CMHTs are multidisciplinary teams, not *psychiatric* teams, and as such, individuals with moderate to severe mental health difficulties should be able to access care from any of the professionals on a CMHT (Psychology, Social Work, Occupational Therapy, Nursing), even if they do not require or want pharmacological treatment. Individuals with moderate to severe mental health difficulties, who require Psychology/Occupational Therapy/Social Work support at secondary care level, should be referred to CMHTs just as readily as those who require referral to psychiatry. Furthermore, referrals should be made to the CMHT, not to the Psychiatrist, as the entire multi-disciplinary team are collectively responsible for the assessment and treatment of the individual, not just the psychiatrist on the team. In relation to this point, it has been claimed that Psychiatrists on CMHTs have to be the team clinical lead because of legislative requirements. However, when one examines the Mental Health Act, the necessity for Psychiatry to take the lead is only in regard to an involuntary detainment in an approved centre. There are no legislative requirements for Psychiatrists to be clinical leads in community mental health settings.

4.2. Clinical Governance / Leadership

4.2.1. AVFC (2006) notes that *'clinical accountability for all disciplines must be explicit within the team'* (Section 9.3), but makes no reference to psychiatrists holding ultimate clinical responsibility.

4.2.2. 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 (Royal College of Psychiatrists, 2006), or for all referrals received. Such a centralised or 'star' model of responsibility (Muijen, 1993) can be perceived as crossing professional boundaries and forcing team members into 'devalued, disempowered, hand-maiden' roles (Rosen, 2001, p.136)*'.

4.2.3. The legal and contractual rational for psychiatry automatically assuming the role of "clinical lead" is questionable. Also, there is no clarity in relation to the role and responsibility of the "clinical lead" as no agreed definitions or role descriptions currently exist.

4.2.4. The Vision for Change policy document (2006) recommends a "*shared governance model*". In the traditional model for Multi-Disciplinary Team (MDT) contexts, the terms 'overall' and 'ultimate' responsibility are used where the Team's most senior medical practitioner assumes case coordinating responsibility for coordinating the input of all other professional casework. This practice is described as the assumption of '*primacy*' where it is stated that where primacy operates the client is referred to and under the continuing care of the person with primacy and not to the team. This is an outdated practice which is not in line with Irish mental health guidance documents or international practice.

4.2.5. The PSI understands that no one professional can be held accountable for another professional's actions except in part by negligent delegation or inappropriate referral. Psychologists have their own legal, contractual and professional, and ethical responsibilities. Psychologists are accountable for those tasks for which they are recognised as competent as a result of their training.

4.2.6. The PSI strongly asserts that in moving forward with quality mental health care in Ireland it is essential that the concepts of leadership and clinical leadership in mental health are brought into line with international best practice.

4.2.7. There has been much media focus in recent years, and indeed months, on the difficulty in recruiting Consultant Psychiatrists for CAMHS teams in particular. The inferences have been that the absence of a Consultant Psychiatrist being available on a CAMHS team precludes the safe and effective work of all other disciplines. In the United Kingdom (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 emphasises leadership at all levels of CAMHS,

including service user and family leadership as well as clinical leadership. It also outlines specific programmes to develop CAMHS specific leadership skills and evaluation of the impact of leadership skills.

4.2.8. Consequently, the PSI recommends the development of a competency framework for clinical leadership and leadership development programmes that are equally open to all suitable clinicians with the requisite competencies.

4.2.9. The PSI asserts that the evidence-based paradigm shift will necessitate a move from diagnostic / illness-based language, to transdiagnostic, psychological formulation in simple language and in accordance with progress internationally.

4.2.10. Diagnosis is an overly simplistic way of assessing / describing complex mental health difficulties (Rotherham-Borus, 2018; Harvey 2018). Kinderman (2014) argues that mental health difficulties should be described in simple terms rather than using diagnostic/illness-based language. A mental health diagnosis does not typically provide reliable information regarding aetiology that can inform treatment planning. However, a psychological formulation will highlight the psychological, social and biological factors that contribute to the development and maintenance of a person's mental health difficulty and this information can then be used to inform their treatment/interventions.

5. Toward 24/7 access to services…

5.1. The PSI supports the identified need for 24/7 mental health services in the community.

5.2. Whilst the PSI supports the principle of 24/7 access to mental health services in the community, we are concerned that the nature of the services provided should 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 a treatment plan and ongoing intervention to address the psychosocial difficulties that led to their crisis and psychological distress.

5.3. Assessments, treatment plans and interventions should be both collaborative and evidence based. Staff need to be trained in evidence-based assessment and treatments 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.

5.4. It is also important that 24/7 mental health services are embedded within community settings as opposed to hospital EDs. Firstly, EDs are not a suitable environment for individuals who present in mental health crisis and situating these services in EDs is typically experienced as aversive by Service Users. Secondly, locating 24/7 services within a hospital setting, risks further medicalising psychological and social difficulties.

5.5. The PSI asserts that it is crucial that 24/7 teams are multi-disciplinary in nature, if the shift in culture and practise required to implement a psychosocial model of mental health care is to be achieved and sustained.

5.6. 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.

6. Primary Care

6.1. Psychology in Mental Health Care

6.1.1. An expansion of primary care to ensure greater access for individuals across the lifespan to psychological therapies is welcomed and supported by the PSI.

6.1.2. The PSI agrees with the view held in the Joint Oireachtas Committee's report that there needs to be greater access to counselling, psychotherapy and family therapy at primary care level. Given the breadth and depth of expertise Psychologists bring to mental health services, access to Psychology in primary care (as well as secondary and tertiary care) should be considered central to the proposed reforms.

6.1.3. The PSI recommends that the cap on the maximum number of therapy sessions that can be offered in primary care be removed and, as such, aligned with evidence-based best practice and the AVFC's stated goal of 'recovery'.

6.1.4. Increasing the maximum number of sessions that can be provided will reduce the need for referral to secondary care services and reduce long-term dependency on psychiatric medications.

6.1.5. In geographical areas that have access to 'Counselling in Primary Care' (CIPC), individuals with mental health difficulties who hold a medical card can be offered up to eight sessions of counselling. Whilst this support is incredibly valuable and the service has demonstrated good outcomes, the service provided by CIPC is not sufficient to meet the

needs of all individuals presenting to primary care with mental health difficulties. As well as the aforementioned barriers to accessing this service, the upper limit of eight sessions is likely to be insufficient to meet the needs of many individuals. Research suggests that a minimum of 20 sessions of psychological therapy is necessary for reliable change with individuals with moderate mental health difficulties, with a minimum of 23 sessions required for recovery (Harnett, O'Donovan, & Lambert, 2010). In line with AVFC, 'recovery', should be the ultimate goal of interventions in mental health.

6.1.6. Offering a sub-optimal number of therapy sessions is likely to result in: perceived individual failure amongst vulnerable populations; a revolving door effect; and/or the need to refer onwards to secondary care services.

6.2 Resourcing/funding across disciplines

6.2.1. The PSI asserts that there is a need for more Psychologists on CMHTs if Service Users are to have equal access to both psychological and pharmacological interventions. The PSI recommends a minimum number of 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 and derived in consultation with PSI and other stakeholders.

6.2.2. In addition to highlighting the lack of 'filled teams' across the Community Health Organisations (CHOs), it is necessary to examine where these gaps occur. It is crucial to understand how teams are currently resourced (WTEs across disciplines) in order to understand where exactly the limited funding that is allocated to mental health, is being spent.

6.2.3. Furthermore, understanding how different professionals on teams work, is essential to understanding differences in relation to the capacity different team members will have in terms of caseload. It is necessary to consider this when determining how many professionals from each discipline are required for teams to meet the needs of Service Users. Psychologists, for example, typically offer weekly appointments of 50-60 minutes duration for a number of months to individuals on their caseload, whereas psychiatrists typically offer 15-minute review appointments once every 3-6 months for an indefinite period of time to those on their caseload. The time commitment required for psychological interventions is greater, but the quality and depth of the interventions offered can result in long-term change/recovery (Spielmans, Berman & Usitalo 2011).

6.2.4. These metrics mean that psychiatrists have capacity to see significantly more patients per week than a Psychologist but the nature and depth of the interactions and interventions offered by these professions are qualitatively very different. This ultimately

means that there is a need for more Psychologists on a team than psychiatrists if Service Users are to have equal access to both psychological and pharmacological interventions.

6.2.5. Given the relative scarcity of Psychology resources on CMHTs, this resource is typically reserved for individuals who have the most complex needs. Consequently, the majority of Service Users attending CMHTs, will typically not be referred to Psychology and will only receive pharmacological treatment. It is not unusual therefore, for individuals to be prescribed psychotropic medications for 20+ years without referral for any other therapeutic interventions despite the fact that psychological therapies demonstrate better long-term outcomes than psychotropic medication (Spielmans, Berman & Usitalo, 2011).

6.2.6. In a system where €400 million per year is spent on psychotropic medication, it is imperative to ensure there is increased access to high quality psychosocial interventions and evidence-based psychological therapies as a first line of treatment if we are to begin to redress the imbalance in our system and move away from a medical model of mental health care and long-term dependence on pharmacological treatment. The PSI recommends a minimum number of 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.

6.2.7. The PSI recommends equity in, and parity of, CPD funding across HSCPs.

6.2.8. There is a need for equitable funding for CPD across all professions working within CMHTs and Primary Care Teams. In CMHTs, Psychiatry currently has individual CPD budgets allocated annually which they can use for CPD events / training. However, HSCPs including Psychologists, do not have individual CPD budgets and have to typically self-fund any training they take part in to further their professional development.

7. Mental Health Services and People from Minority Groups

7.1 In light of the evidenced adverse impact of minority stress on health, including mental health, the PSI welcomes the acknowledgement of the need to give special consideration to minority groups and service design for these groups. Given consistently evidenced poorer health markers, the PSI is concerned at the absence of people in custody from the minority groups focussed upon in the report and recommends that people in custody be explicitly included in the final report.

7.2 Travellers and Roma

7.2.1. The PSI recommends the development of an ethnic identifier, with associated staff training, is expedited without delay, in order to quantify health trends and outcomes to inform service planning and design.

7.2.2. The National Traveller Health Strategy (2002 – 2005) recommended the introduction of an ethnic identifier to track health trends and outcomes. The PSI notes the Committee's observation that 'progress does not seem to have been made' (p57). The PSI is aware, however, that significant progress has been made within some parts of the Public Service, for example, within the IPS and commends such exemplars, where an ethnic identifier, with associated staff training, has been implemented.

7.2.3. The PSI welcomes the consultation process on a National Traveller Health Action Plan. The PSI recommends that face to face consultation should also take place within all Irish prisons, as Community Members in these institutions are unable to attend community-based consultations. Additionally, literacy levels amongst Community Members in custody mean that a consultation process based on written submissions from those in custody would create a significant barrier to participation for these Community Members.

7.3. LGBTI People

7.3.1. The PSI agrees with the assertion of BelongTo that the requirement for young people aged 16-17 to have parental consent to access mental health services can block access to needed care for such young people who are LGBTI but who have not come out to their parents. The PSI recommends priority is given to addressing this barrier, which may require legislative reform, with meaningful collaboration with community stakeholders to ensure a young peoples' rights-based approach is consistently taken to addressing this barrier.

7.4. Migrants

7.4.1. The PSI endorses the Joint Oireachtas Committee's view that specific mental health supports should be integrated into and added to the physical health supports currently available to victims of trafficking. These should be developed in collaborative and culturally responsive ways, in recognition of the diversity that exists both within and between migrant communities in Ireland. These supports should be equality-proofed to ensure equality of access to services.

7.5. People with experience of detention in the IPS.

7.5.1. The Department of Health was intended to be the lead, rather than sole driver of AVFC. As with other aspects of AVFC, there remains significant potential to strengthen existing collaboration between the HSE, the Probation Service and the IPS. In any one

year, 17,000 people are committed to custody in the Republic of Ireland. Currently, there are approximately 3,700 people in custody in the care of IPS across 13 sites. This rate compares favourably with most other Western democracies. Those with experience of: mental health difficulties; personality disorders (emerging and more enduring); homelessness; State care as children; abuse (especially females); and membership of the Travelling Community are all over-represented in our prison population.

7.5.2. The International Covenant on Economic, Social and Cultural Rights provides a legally binding framework for the right to the highest attainable standard of mental health. Some obligations may be progressively realised, whereas others are immediate obligations. Core immediate obligations include the equitable distribution of services in the community and non-discriminatory access to services (WHO, 2000).

7.5.3. The PSI recommends that the State prioritises increasing the number of forensic mental health in-patient beds, including expediting the development of planned regional forensic in-patient units, to reflect norms across comparable Western democracies.

7.5.4. Currently, the State has two forensic mental health in-patient beds per 100,000 population. This compares to between 7.5 – 10 per 100,000 in Northern Ireland, Scotland, England and Germany. A national overview of forensic mental health services in Ireland (O'Neill, 2011) found that 80% of mentally ill people in custody are already known to local mental health services in the HSE.

7.5.5. In its 2016 Annual Report, the Mental Health Commission (MHC) observed that 'the majority of young people remanded to Irish prisons, with diagnoses of severe and enduring mental illnesses, are charged with very minor offences. These patients have fallen through the net of a public mental health system which is not designed to meet their needs' (MHC, 2017).

7.5.6. The PSI recommends a cross-departmental working group is established to develop a prisoner mental health action plan that recognises many people will access services through the IPS / Probation Service and the HSE at differing times in their lives. The PSI is particularly concerned that throughcare between service providers is optimised. Also that people with offence histories and those serving sentences of significant length have equitable access to primary, secondary and tertiary mental health care when required.

7.5.7. The PSI recognises the IPS Psychology Service as an 'appropriate healthcare setting' for gaining experience in adult mental health for the reckoning of experience of Assistant Psychologists, Psychologists in Training and for the reckoning of experience of Qualified Psychologists of all grades, when assessing eligibility for recruitment to adult mental health care settings within IPS and HSE. The PSI recommends the HSE immediately similarly recognise experience in the IPS. Such mutual recognition will help

to foster a culture of collaboration and knowledge transfer between both State agencies, ultimately benefiting Service Users and our broader communities.

7.5.8. The PSI recommends the IPS and the HSE explore opportunities for Psychologists to avail of secondment and/or innovative opportunities for knowledge transfer between both State agencies.

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