The College

Response of the Irish Division to 'Planning for the Future'*

Summary

In 1981, the Labour Minister for Health in a coalition government, Mrs Eileen Desmond, set up a study group 'to examine the main components, both institutional and community, of the psychiatric services; to assess the existing services, to clarify their objectives and to draw up planning guidelines for future development of the service with due regard to cost implications; to carry out such studies and to take part in such consultations as are necessary to assist this examination'. The result appeared in December 1984 in the form of a report *The Psychiatric Services: Planning for the Future*. The text of the response of the Irish Division of the College, reproduced in full here, was sent to the current Minister for Health, Mr Barry Desmond, (also a Labour Minister in a coalition government) in October 1985. Meanwhile, in February 1986, Mr Desmond caused widespread alarm in political circles by the sudden announcement of the closure of two of the 22 psychiatric hospitals in the Republic without prior provision of alternative community services. British readers will detect a close parallel between this Irish report and the series of DHSS reports exemplified by *Better Services for the Mentally Ill* (HMSO, 1975). Perhaps the only significant difference between these two reports is that sectorisation (a mental health team headed by a psychiatrist and assigned to a 'sector' of 25,000 to 30,000 persons) is advocated rather more firmly in *Planning for the Future*. It is also worth remembering that the Republic of Ireland, in its population size and urban-rural distribution is comparable to the whole of Yorkshire. Half the population lives in Dublin. Elsewhere, psychiatric services must cope with widely scattered rural populations, with a minority only of working adults. There is a large private sector in Irish medicine and 20% of psychiatric admissions are to one or other of five private psychiatric hospitals. Despite these social differences from the UK, several comparative studies have shown a remarkable similarity in declared attitudes and practice amongst Irish compared with British psychiatrists. Finally, the method of remuneration of Irish family doctors differs from the UK: Irish GP's are paid, not on a capitation basis, but on a 'fee-per-item-of-service' basis with a majority of the population availing of this service free: patients tend to move from doctor to doctor and many use private health insurance to opt for private care. Psychiatric referral rates from general practice are low as in Britain.

Planning for the Future, as the Minister notes in his Foreword, 'contains a detailed analysis of our psychiatric service and provides guidelines for its future development as a community based service meeting in the most effective ways the psychiatric needs of the population. It is in accordance with a major objective of health policy which has been identified in the Government's National Plan *Building on Reality* which is the shifting of resources from institutional services to community services.

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(1) Introduction

We welcome this Report as a badly needed stimulus to the provision of better services for the mentally ill in this country. We note this is the first time in the history of the State that an attempt has been made to provide a written Departmental policy for psychiatric services.

We endorse the following general principles contained in the Report:

(i) Comprehensiveness of psychiatric care to include all cases of psychiatric disorder in the community irrespective of severity;

(ii) continuity of professional responsibility for patient care extending from in-patient through out-patient, day-patient and emergency services to community care;

(iii) a multidisciplinary team approach;

(iv) integration of psychiatric with general health care;

(v) the need for special psychiatric services for the elderly mentally ill, alcohol and drug related disorders and special groups including the deaf, the mentally handicapped and the homeless;

(vi) the particular importance of the psychiatry of general practice.

These principles and many of the recommendations in the Report are endorsements of existing practice. Certain aspects require special comment.

We open on a note of criticism directed at *the process* by which the Report was formulated: our comments thereafter deal exclusively with *the content* of the Report.

(2) Authorship

The study group comprised civil servants, health administrators, psychiatrists and one senior administrative

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https://doi.org/10.1192/pb.10.6.130 Published online by Cambridge University Press

nurse, all chosen by the Department of Health without consultation with professional bodies. In a Report which emphasises the importance of multi-disciplinary team work, the omission of representative nurses, social workers, psychologists and occupational therapists does little to reassure these disciplines that their views are sufficiently represented. Irish psychiatry, in common with these cognate disciplines, remained ignorant of the contents of the Report until its publication (December 1984): this has delayed our response.

(3) Consultation

The claim at the beginning of the Report that there was consultation with professionals working the service is only partly true. Visits by the study group to Health Boards were not conducted so as to encourage free expression of views. No opinion surveys were done and submissions from individuals or professional bodies were not invited. Consensual approval of the Report will therefore emerge in spite of, and not because of, the breadth of consultation which assisted its preparation. It is our hope that the Report will signal the beginning of real consultation, not only with professionals but with the whole community.

(4) The general nature of the report

The Report may be fairly characterised as a social and political document which reduces the complexity of modern psychiatry to the problem of accelerating the demise of the Victorian mental hospital in favour of 'community care'.

In common with ethical psychiatrists everywhere, we welcome *any* new development which encourages progress towards the twin ideals of:

(a) the best possible quality of life for the individual sufferer from psychiatric illness and, *at the same time;*
(b) the betterment of the mental health of the community as a whole.

We respect and share current, widespread concern to liberate psychiatric patients from all unnecessary restraint. However, in keeping with our independent ethical role we support no political or social ideology for its own sake.

The Report, as presented, superficially appears to share these aims. We note that it is simplistic in the way it denies, ignores or otherwise omits references to the current state of scientific psychiatric knowledge except insofar as the latter strengthens the view that deinstitutionalisation is desirable for all but a few psychiatric patients.

(5) The mental hospital and its future: deinstitutionalisation

Other countries in Europe and elsewhere have proposed to dispense with psychiatric hospitals altogether and to replace them with systems of community care which, hopefully, would not only be superior in efficacy but also cheaper. The most recent evidence available to us suggests that no country has yet achieved these ideals. Psychiatric research, as the Report indicates (3.3), has shown that many patients with chronic and severe mental illness can be managed successfully in the community. But the corollary of this statement is that the *same* psychiatric research indicates that not all psychiatric patients can be successfully managed outside some kind of residential institution.

High support hostels

The concept of these hostels as the principal location for 'new long stay' patients of all ages is a novel and interesting suggestion. We know of no established value of such units and are unaware of typical examples in operation although a few units may resemble the concept. We suspect that the study group, when confronted with the dilemma of placing refractory patients without the option of hospital admission, invented such units as inevitable. Thus, we view this concept with some reserve.

As this concept is central to the idea of dismantling traditional psychiatric hospitals we suggest detailed examination is needed before 'high support hostels' become part of national policy. We wish to participate in further discussions under such headings as staffing, level and quality of care, physical structure, support services, community acceptance, the legal status and responsibility, respectively, of residents and of staff.

We recommend that as a matter of urgency, carefully controlled and intensively studied pilot projects be undertaken of 'high support hostels' in at least three representative catchment areas.

Good and bad hospitals

Contrary to the tone of the Report, which implies that all psychiatric hospitals are bad hospitals, we urge discrimination between good and bad hospitals. Small hospitals, strategically located near towns and general hospitals and held in high regard by the community, should be retained with suitable structural modification where necessary. *No* hospital should be closed until community facilities of at least equivalent quality have been made available to replace it.

The Report (3.2) noted the following cautionary statement by WHO with regard to deinstitutionalisation but failed to reproduce this quotation in its recommendations: 'In no case should the chronically ill or handicapped person be discharged from hospital until or unless adequate supporting services are provided in the community'. *We strongly endorse* this statement and we call upon the Minister to adopt it formally.

(6) Expectations of 'community care'

The purpose of the Report is in line with trends worldwide to decentralise health services and, in the case of psychiatry, to dismantle old-fashioned and expensive mental hospitals. The general tone of the Report is one of euphoric optimism in this regard. References throughout the Report are highly selective in choosing only those comments which are favourable, and ignoring those which are adverse. Thus, a growing contemporary literature on the disadvantage of deinstitutionalisation is omitted. There is, therefore, a real danger of creating unrealistic

expectations of what 'community care' can achieve, particularly in a time of economic recession.

The public have a right to know that the status of 'community psychiatry' is still that of a philosophy or slogan: there is little in the way of scientific evidence either for or against it. No major psychiatric disorder can be expected to recover in response to social therapy alone and it is not to be expected that patients will lose their symptoms solely by virtue of being relocated in the community. Because of world population growth, generally increased expectation of life and better medical care, deinstitutionalisation in 1985 is dealing with much larger numbers of severely mentally ill persons than at any time in the past. Secondly, modern society is of such complexity that it is more difficult to provide an environment in the community which can match the low levels of stress to which patients have been exposed in traditional mental hospitals. We welcome, therefore, the several notes of caution in the Report which emphasise that the psychiatric hospital will be the principal basis of Irish psychiatry for some time to come and that the proposed policy of total community care will require phasing in over a number of years.

(7) Existing rehabilitation services

A major defect of the Report, considering the scope of its remit, is that it does not address the adequacy or otherwise of existing arrangements for psychiatric rehabilitation services in our community. By modern standards, such services are virtually non-existent in many areas. We have noted the criticisms by our colleagues in psychiatric social work with respect to this issue and their comments have our support. As these colleagues have pointed out, the existing situation in relation to rehabilitation services is piecemeal and confusing. Several different organisations are involved including the Rehabilitation Institute, the National Rehabilitation Board, ANCO and various voluntary bodies. These bodies are poorly co-ordinated at the present time. The virtual monopoly by the Rehabilitation Institute in the field is a particular problem: the understanding of this and similar bodies of the nature of psychiatric handicap and their commitment to psychiatric rehabilitation is unsatisfactory. The orientation of rehabilitation bodies generally is towards training for open work employment as opposed to provision of a sheltered work environment which is genuinely therapeutic and respects the severity and chronicity of psychiatric disability. The Report fails to address these issues directly but indirectly admits the problem in suggesting the National Rehabilitation Board review the needs of the mentally ill (10.22).

We recommend:

(a) that the orientation and co-ordination of different bodies concerned with Rehabilitation services be urgently examined as to their relevance for the mentally ill;

(b) that the boards of such bodies include representation from mental health professions, including psychiatry;

(c) that each Health Board reserve at least one consultant psychiatrist post for a consultant 'with a special interest' in rehabilitation.

(8) Financial implications

The attraction of 'community psychiatry' for governments has always been that it is ostensibly less expensive than maintaining old mental institutions to required modern standards. We share the views of other interested groups that *good community psychiatry is never cheap*. We would have wished for more emphasis in the Report on prospective cost-benefit analysis of new experiments in community services, controlled pilot projects and comparative studies of different types of catchment area. This approach would stimulate the development of innovative community care services particularly suited to the Irish context.

(9) 'Sectorisation'

We endorse the report's emphasis on continuity of professional responsibility linked to defined community populations. The concept of sectorisation as presented in the Report gives the impression of a rigid system of one psychiatrist (and 'his team') supplying single-handed all necessary services within a sector of 25–30,000 persons. We trust such an interpretation is incorrect, for the following reasons:

(i) such a style of service would offend against modern needs for psychiatrists to develop special interest training in such areas as addiction, psychotherapy, forensic psychiatry and rehabilitation;

(ii) a rigid sectorised structure may restrict the benefits to patients of a centralised professional base, recently aptly termed the 'bee-hive' model of service;

(iii) large conurbations may need a much larger 'sector' than 25,000 persons and remote rural areas may have quite different requirements;

(iv) referring doctors (and their patients) may resent interference with their traditional rights to refer patients (or to be referred) to the psychiatrist of their choice.

Thus, whilst we accept as a general principle the need for a community dimension to a consultant's responsibility, we have reservations about the 'sector' as a uniform model of service organisation in all types of catchment area.

(10) Integration of psychiatric with general medical services

We endorse the importance of guarding against the further alienation of the psychiatric patient from general medical care services. In this matter, we are in agreement with the Report. However, the Report fails to acknowledge the *non*-integrated state of Irish health services in general. By this omission the Report's exhortations to form effective working links between psychiatric and other services fail to convince. In the public sector, the tripartite organisation of services into Special Hospital, General Hospital and Community Care programmes offends the very principle of continuity of care which the Report seeks to espouse. Mental health care professionals may find it exasperating

to be expected to have 'good working links' with general hospital care, community care and general practitioner care when these elements have no shared commitment to catchment areas—let alone 'sectors' as proposed for psychiatrists. It is difficult to see how this disorganisation of health services will be reconciled with the 'sector' model without major reorganisation. Unfortunately, this nettle is never grasped in the Report.

(11) Psychiatry and general practice

We approve of the emphasis given to the importance of good working links with family doctors and the recognition of the major role of the family doctor in psychiatric care. However, it is not enough to encourage psychiatrists to work with family doctors without identifying the reasons for the present alienation of family practice from psychiatry in this country. These reasons include the absence of any incentive for family doctors to enjoy close working relationship with psychiatrists. Two examples will illustrate this important problem.

(i) Family doctors could free psychiatrists to become actively involved in expanding psychiatric services away from institutions if they were facilitated in providing medical care for the elderly and mentally handicapped patients in residual mental hospital populations and also in the community. In the United Kingdom, for example, it is usual for local family doctors to be part-time members of staff in psychiatric hospitals so that good working relationships are easily achieved within the ordinary professional work routine.

We recommend that appropriately structured part-time positions on the staff of psychiatric services be offered to local family doctors.

(ii) The Report (5.25) praises the idea of *domiciliary psychiatric consultation* but does not offer any incentive to psychiatrists or to family doctors to promote this practice. At this point the Report overlooks the fact that most psychiatric domiciliary care is presently carried out, not by psychiatrists or family doctors, but by psychiatric community nurses, albeit under the supervision of psychiatrists.

The ethical structure of medical practice makes it difficult for psychiatrists to initiate domiciliary visiting. This initiative lies with the family doctor to invite the psychiatrist to visit the home and carry out joint consultations.

Referral of patients by family doctors. (5.6). Many new referrals to psychiatric services come to notice at the height of crisis and require a 24-hour emergency service. By contrast, rates of elective or 'cold' referral from other doctors to psychiatrists have always been low compared with the high levels of psychiatric morbidity both in general hospital and in family practice. An increased emphasis on general hospital psychiatric units may bring with it better liaison with hospital based non-psychiatric specialists. However, the answer to the regrettable separation of Irish psychiatry from family practice is more likely to stem from increased participation of psychiatrists in the 'Psychiatry of Primary Care', in close co-operation with our colleagues in general practice. Of British psychiatrists, one in five is now spending time in GP-based psychiatric clinics and in conducting mental health consultation procedures at health centres and/or group practices.

We recommend to the Department and to The Irish College of General Practitioners that family practice organisation should be encouraged to develop in such a way as to facilitate mental health consultation procedures. These procedures should be based firmly in the domain of family practice and should aim to strengthen the therapeutic role of family doctors *without recourse to specialist referral.*

We note with concern that the Report lays significant blame for low psychiatric referral rates from general practice on the *fee-per-item method of payment to family doctors.* We note also that no convincing evidence is offered for this view. Whilst conceding that economic factors may be relevant, we deny that they are crucial to the issue of referral. Otherwise, why is it that referral rates are also low in the United Kingdom, where fee-per-item does not apply and where efforts to increase referral rates have been ineffectual for a quarter of a century?

Reasons for non-referral. The reasons for non-referral advanced in the Report (5.6) are not representative of those established by scientific enquiry, particularly in the United Kingdom: these reasons include a dislike for psychiatric referral shared equally between the patient and the family doctor. There is evidence that much the same attitudes inspire our own low referral rates. In any case, there is little reason to expect that an increase of psychiatric referral rates from general practice would carry any guarantee of benefit to patients. On the contrary, the most predictable effect of any increase in psychiatric referral rates would be to overwhelm existing psychiatric services, at least in the public sector.

We recommend that the method of payment to family doctors should not be regarded as central to the issue of non-referral of psychiatric patients from general practice. The appropriate response to low rates of referral is to develop psychiatric consultation procedures which preserve and strengthen the therapeutic alliance between the family doctor and his patient.

Treatment of psychiatric disorders by general practitioners (5.9–5.12). These paragraphs criticise standards of treatment by family doctors and make proposals for undergraduate and postgraduate training in psychiatry for doctors entering general practice. (5.13–5.16). We regard the remarks in this part of the Report as unfortunate and out of place in a Report of this kind. They are not the views of our College. Professional standards are the responsibility of academic and professional bodies, subject to the Medical Council.

(12) Staffing norms

The value of the Report is diminished by its failure to attend to staffing norms apart from the suggestion of one consultant in adult psychiatry per 25,000 total population (staffing norms in respect to Child and Adolescent

https://doi.org/10.1192/pb.10.6.130 Published online by Cambridge University Press

Psychiatry are considered separately below). Staffing norms with respect to nurses, social workers, occupational therapists, clinical psychologists and clerical staff receive little attention. The Report merely recommends (14.3) that the consultant in each 'sector' should have 'access' to the services of social workers and psychologists. Unfortunately, this kind of vague statement provides no guidelines as to the appropriate composition of sector teams. Nor does it recognise that other specialised services will not be 'sectorised' and will need to be staffed separately.

We recommend that one consultant and two non-consultant hospitals doctors, two community psychiatric nurses, one psychiatric social worker, one clinical psychologist, one occupational therapist and one medical secretary be taken as the minimum staffing norm for mental health teams.

(13) The role of general hospital units

The Report indicates that in the future general hospital units throughout the country will function as reception centres for all kinds of psychiatric patients. No reference is made to the widespread disappointment experienced here and in other countries by the failure of general hospital units adequately to fill this role. There is a growing literature on the inadequacy of general hospital units to cater for all types of psychiatric admission. Particular shortcomings include:

(i) The small size and inadequate facilities of such units;
(ii) difficulties in accommodating socially disruptive patients in a mixed sex, open-plan design;
(iii) increased drug requirements of certain patients who might otherwise be contained with less medication in a less pressurised atmosphere;
(iv) a 'two-tier service' with the parent mental hospital being cast in a second-rate role;
(v) the consequent need for regional medium security units.

We recommend a detailed study of the design and staffing requirements of general hospital units which would make the latter capable of receiving all kinds of psychiatric admission without detriment to patient care.

(14) Forensic psychiatric services

The current and future role of the Forensic Psychiatric Service is not dealt with in the Report. Considering society's often expressed concern about criminality and mental illness, it becomes a curious omission, particularly since new mental health legislation is now pending.

Even now, substantial numbers of de-institutionalised patients are living a precarious community existence. They are clearly visible on our streets, and they contribute substantially to the worrisome increase in the prison population. Without elaborate supports which include out-patient, in-patient and hostel locations, this group drifts inevitably into anti-social behaviour which can be trivial to serious. Often they need to be taken out of circulation for their own protection and the protection of society during a crisis. Patients of this kind can terrify and torment an open door system of psychiatric care: they need secure accommodation which raises the obvious question of where that accommodation will be located. Will it be part of the general hospital-located psychiatric unit, or will it be a retained function of the (now dismantling) psychiatric institution? Secure accommodation implies costly space and high staffing levels, and it certainly needs to be planned. A problem that has been highlighted in Britain already exists here. Large numbers of patients are held up in maximum security hospitals after they have been judged fit for discharge to less secure wards. The psychiatric institutions, under threat, seem to have lost their capacity to manage and contain disruptive illness and seem increasingly reluctant to accept transfers from security hospitals. As one part of the system, the general psychiatric hospital, disclaims responsibility for managing and treating disruption, another part of the system, namely the prisons and the security hospitals, fills up with illness surrounded by oppressive and unnecessary security. These difficulties must be addressed in any future planning.

Up to the mid-sixties follow-up studies on discharged psychiatric hospital patients showed a negative correlation between anti-social behaviour and mental illness. Since that time the correlation has become positive, and understandably so. The concept of 'involuntary communitisation' is a real one, and without meticulous planning will lead inevitably to the unnecessary labelling of the mentally ill as criminals.

The problems summarised here are particularly urgent in view of the imminence of new mental health legislation.

We recommend that a Study Group should immediately look at the Forensic Service, the overall problem of criminality and mental disorder and regional requirements for medium security units.

(15) Monitoring of services

The Report (16.11) recommends that the Department 'might consider' the setting up of an advisory body to evaluate and monitor 'the new service' as it develops. The intention here appears to be to exert continuing pressure on Health Boards to deinstitutionalise and develop sectors. Whilst the need for this kind of monitoring is understood, the Report does not anticipate that any such body might be regarded as an hostile inspectorate by professionals in the field. In this context we regret that the Report omits any reference to the submission of the Irish Division to the Department of Health (June, 1982) on the need for peer review to encourage the development of modern services and to maintain uniformly high standards of service nationally.

We therefore again recommend the setting up of an advisory body with a monitoring role under psychiatric leadership. It should have a multidisciplinary membership, should function by peer review and should include in its remit the obligation to publish regular reports on standards of services, which reports would be freely accessible to the public.

(16) The importance of morale: the question of leadership

Psychiatric services, more than any other services in health care, depend for their efficacy on a high standard of morale amongst the professionals providing the service. This need is acknowledged in the Report in terms of 'dynamic leadership' with reference to psychiatrists and administrators and senior nursing staff.

Insufficient attention is given to current problems of *industrial relations* particularly with respect to psychiatric nurses. We have previously detailed our views on this and related issues in a position paper on *The Future of Psychiatric Nursing'* submitted to the Department in June 1983 without response to date.

We are concerned that new developments in the service envisaged in the Report may be seen as threatening by the Trades Unions representing such groups as psychiatric nurses, social workers, occupational therapists and clinical psychologists. 'Dynamic leadership' can be maintained only if these several disciplines are able to work together in harmony towards the same goals. A multi-disciplinary approach which respects the experience and knowledge of each of the mental health professions under the leadership of the person legally responsible for the totality of interventions is the appropriate approach to these problems.

(17) The special needs of teaching units

The Report makes no reference to the special needs of units and services which have particular responsibility for teaching and training. Services attached to university centres have a heavy burden of responsibility as regional centres of training for medical students, psychiatrists and other staff. It is at these centres that centralised courses of teaching are located.

The Report recommends more extensive undergraduate and postgraduate teaching but with no acknowledgement of the time for preparation and teaching which this implies for the medical and para-medical staffs of teaching units.

It is in the teaching centres that most *research* is likely to be carried on. Although the Report supports the notion of research the concern appears to be only with health services research which evaluates the new services as it develops. There is no reference to scientific clinical research designed to elucidate the causes of psychiatric illness and to discover more effective methods of treatment.

The 'sector' model, rigidly applied, is not compatible with the responsibilities of teaching units without extra staffing. Such units have to take patients not only from within their 'sector' but also referrals from the Regional Hospitals to which they are attached, including, inevitably many patients from outside their catchment area. There is no provision in the Report for extra staffing to compensate for this increased pressure of admissions and referrals.

We recommend that area psychiatric services attached to teaching units and/or university centres be recognised as having extra staffing needs by virtue of their commitments to undergraduate and postgraduate teaching and to research.

(18) Chief psychiatrist/RMS/Clinical Director grade

The Report comes down firmly in favour of the retention of this grade (14.13) *on a permanent basis*. We share the view, implied here, *that medical leadership of the mental health team requires to be based firmly on statute law*. Only in this way can public accountability be guaranteed and the legal rights of patients be fully protected.

We recommend that the question of the *permanency* of the 'RMS' grade (or equivalent) be deferred until a clear statement becomes available from the profession and the future role and legal responsibilities of the psychiatric consultant are clarified in new Mental Health legislation, now pending.

(19) The role of psychiatric social workers

Further expansion of psychiatric services into the community will involve an increasing role for psychiatric social workers in helping patients avail of their rights and enabling them to survive in a complex society. Unfortunately the Report does not address this issue.

We have earlier recommended that minimum staffing for mental health teams include at least one psychiatric social worker. We choose one example of the need for PSW's as an illustration.

There is evidence that chronic mental illness, in particular chronic schizophrenia, leads to the non-utilisation of community services by many patients due to the behavioural defects caused by the illness itself (and not due to any secondary environmental effects). The Report reveals an awareness of this issue by making the suggestion that the disabled person's maintenance allowance (DPMA) should be paid out at support centres so as to encourage patients to attend.

We note that our colleague psychiatric social workers believe that DPMA is 'an inalienable right of the individual and should not be used as a means of motivating attendance at work-shops, day centres, etc., as this can lead to discrimination at times and can be open to abuse' (quoted from the Response to the Report by the Social Workers in Psychiatry Group, already submitted to the Department). We think this is an important ethical issue and needs further examination.

The grade of PSW is not sufficiently represented at present in our psychiatric services. One consequence has been that psychiatrists have had to rely exclusively on community psychiatric nurses.

We consider that psychiatric social workers and community psychiatric nurses are complementary in their roles and are equally necessary in a modern psychiatric service.

We recommend that social workers working with mentally ill patients should always be members of a mental health team under the direction of a consultant psychiatrist.

(20) Drug related problems (13.26–44)

Value of research

We find ourselves in broad agreement with the principles

https://doi.org/10.1192/pb.10.6.130 Published online by Cambridge University Press

set out in this section of the Report. In particular, we support the recommendation (13.30) that there should be reliable information on the drug problem. However, we do not consider that surveys of drug abuse to date have been completely satisfactory. Such surveys have been quantitatively insufficient and have not yet covered all of the Dublin area, where drug problems are for the moment mainly concentrated. More extensive epidemiological surveys are still required. Moreover, evaluation of this area should be on-going and not solely dependent on once-off studies whose findings quickly become out of date. Whilst we agree with the Report's view (13.14) that it is valuable to have continual statistics from the National Drugs Advisory and Treatment Centre, it should be kept in mind that statistics from this quarter do not reflect accurately the total situation in a city or region. Other indicators such as numbers of overdose cases in emergency departments, the incidence of hepatitis and other drug-related illnesses, forensic details of arrests by drug squads etc. are equally important indicators of the extent of the drug problem and should be taken into consideration.

Education programmes

The Report (13.36) seems ambivalent in its reluctance to advocate a commitment to substantial funds to drug education programmes. Yet, the contribution of teachers is viewed as important. We consider that education programmes are of great potential value if properly planned and directed to the right audience. Furthermore, it is essential that all such programmes be independently evaluated as to their cost effectiveness (13.37). The Report might have given more emphasis to the point that in-patient detoxification alone gives poor results. Treatment of hard drug abuse must be continuous, with in-patient detoxification but one initial element of care: this must be complemented by comprehensive follow-up care. The latter is necessarily an arduous procedure for the addict and relapses are to be expected. However, international experience suggests that about 30% of addicts will terminate their addiction irrespective of treatment of any kind. This last point highlights the importance of independent cost benefit analysis of any programmes to be instituted.

We agree that at present there is lack of justification for significantly increased residential facilities for the treatment of drug addiction.

Forensic aspects

The Report (13.38) does not refer to the forensic aspects of the management of alcohol or substance addiction. These issues, including that of compulsory treatment, are of great importance and should have been addressed.

We recommend that the legal aspects of drug addiction be urgently examined in the light of new legislation now pending, in consultation with us.

Finally, we agree with the view of the Report (13.41) that general practitioners should not treat drug addicts. Treatment of addicts needs a high degree of special training and experience and can and should be handled by special centres or programmes.

(21) Alcohol related disorders (Chapter 13)

We recognise, as does the Report, that alcohol related disorders form an important part of the general burden of psychiatric care. These disorders are potentially susceptible to effective prevention by adoption of a national alcohol policy. But this recognition of the role of prevention must not distract from the need to provide psychiatric care for those already addicted and for their families, as well as those who will inevitably become addicted despite preventive measures of unproven efficacy.

Historically, the private sector has been the mainstay of care in this field, mainly by provision of specialised in-patient treatment. Because of the expensive and 'separatist' character of this approach, there is now a trend, reflected in the Report, to favour more cost effective and community or family-orientated care for services in the public sector. This development has our wholehearted support. Already, there are examples of alcohol services in several Health Board areas which reflect the principles of 'Local Alcohol Services' described at 13.17: this reflects a greater appreciation of the role of social and economic factors in the initiation and spread of alcohol related disorders. Thus, there is increasing emphasis on a team approach to intervention centred on the alcoholic counsellor (frequently a psychiatric nurse). However, here, as elsewhere in the Report, there is a discernible tendency to dismiss one kind of treatment approach in favour of another, ostensibly cheaper one which fits in more closely with the 'sector' format.

Neither the 'specialised/residential' nor the 'local/community' approach has exclusive merit. Alcohol dependency is multifactorial in origin and a diversity of approaches is called for if all those in need of care are to benefit—irrespective of personal income. Patients at different stages of alcohol dependency need different types of intervention if these are to be effective. Dismissal of residential care for lack of evidence as to efficacy is therefore premature. The Report conceals the fact that there is as little evidence for efficacy of local services as for residential services. Finally, the value of specialist intensive models of intervention for training of counsellors should not be overlooked.

The need for a continuum of services

We believe that intensive specialist residential care is one facet only of a *continuum of services* extending from prevention and early intervention through local services to residential care. We would support a broadly based national alcohol policy which emphasises prevention but also seeks to develop local services along the lines recommended in the Report.

We recommend:

(i) That all services for alcohol related disorders in receipt of public funds be monitored as to their cost effectiveness.

(ii) That established 'intensive' services continue to both supported *and* monitored.

(iii) That private hospital services continue to develop closer links with public sector services on an agency basis, for both service provision and for training of alcoholic counsellors.

(iv) That a national alcohol policy as proposed in the Report be given high priority.

(22) The private sector in psychiatric care

A striking omission from the Report is any consideration of the substantial role of the private sector in the provision of psychiatric care in this country. Historically, the private hospitals have provided a very significant service to the community and continue to do so as indicated by figures quoted in the Report. In 1982, they dealt with 4,444 admissions (3,534 of these between the major hospitals, St Patrick's Hospital and St John of God's Hospital) representing about 20% of all admissions, or about 10% of beds. Even more striking is the figure of 24% of all first admissions (1,696 out of a total of 7,108).

The private hospitals also deal with large numbers of out-patients and day-patients. Each of the two major hospitals operates a community service on an agency basis from the Eastern Health Board and they are also important teaching centres at both undergraduate and postgraduate levels.

While many of the cases dealt with in private hospitals can be fully managed within their own resources, there should be full co-operation with public services in regard to long term patients who will have only part of their treatment on a private basis. The possibility of using certain specialised services such as those for alcoholism or certain forms of psychotherapy developed by the private hospitals should be further explored. They could possibly be provided on an agency basis.

We recommend that Irish psychiatric patients should have available to them the fullest possible range of facilities, irrespective of personal income. The integration and co-operation that already exists in certain catchment areas between the private and public sectors should be further developed along the lines suggested in the Report.

(23) Services for the elderly mentally infirm (Chapter 11)

This is an excellent resumé of the psychiatric needs of the elderly mentally infirm. We take particular satisfaction in the obvious contribution of our College to the content of this section. Our comments should be received as complementary to the Report's recommendations (11.29).

The contribution of the family doctor

The Report points out that the majority of the elderly mentally infirm already reside in the community.

Nevertheless, 4% of the population are both mentally infirm and residing in institutions. The number in psychiatric hospitals in 1981 was 4,601, most of whom must be expected to spend the rest of their lives as in-patients. This group comprises 40% of long stay psychiatric in-patients and makes considerable demands on the time of staff. Suitably structured part-time posts for family doctors would greatly improve standards of care for these elderly patients. This would free psychiatrists for more specialised work. Since the family doctor is the pivot of community health care, a further benefit would be the lessening of the isolation of these patients from their families and from general health services. A final benefit would be to foster closer ties between local family doctors and psychiatric services.

We recommend that the potential contribution of local family doctors to the care of elderly patients in psychiatric institutions be recognised and fully exploited.

An academic base for psychogeriatric care

We fully endorse the need to encourage recognition of psychiatric consultants with a 'special interest' in the elderly. This in fact has long been a policy of our College. However, there may be some reservations about the concept of psychiatrists whose concern would be *exclusively* with the care of aged patients. In a recent submission to a Comhairle na n-Ospideal (The Hospital Council, the body responsible for regulating medical manpower at consultant and senior registrar levels) working party on the aged, we have called for an academic base for psychogeriatric care in the shape of a specially funded University post. It is not sufficient to outline the structure of psychogeriatric services—which the Report admirably does—without addressing the need to foster teaching and research in this important and little understood area.

We recommend that a lectureship in psychogeriatric medicine be established at one of our medical schools.

Finally, we take issue with the Report's suggestion that initial establishments of psychogeriatric posts should be 'perhaps three in the Dublin area' (11.21). The implication here seems to be that few areas outside Dublin can expect to have the benefit of psychiatrists with special training in this field in the near future. The disadvantages of this kind of staffing policy for all but a very few areas are obvious and unacceptable to us.

We recommend

(i) The potential contribution of family doctors to psychogeriatric care should be formally recognised through the creation of part-time posts attached to area psychiatric services. The Irish College of General Practitioners should participate in further discussions on these posts;

(ii) a statutory academic post in Psychogeriatric Medicine should be established at one of our medical schools;

(iii) each Health Board area should be encouraged to have at least one consultant psychiatric post reserved for a consultant with a special interest in the care of the elderly. (Qualifications for such posts should follow the guidelines for higher professional training laid out by the Irish Psychiatric

https://doi.org/10.1192/pb.10.6.130 Published online by Cambridge University Press

Training Committee and by the Joint Committee for Higher Professional Training in Psychiatry. Such appointments should be given high priority where the opportunity already exists for collaboration with a consultant geriatrician). *Equal* priority should be accorded to such appointments in each of the University centres at Dublin, Cork and Galway.

(24) Hospital in-patient services (Chapter 7)

We accept the guidelines set out in this section for various categories of in-patients but we note that these are subject to the availability of a comprehensive range of community facilities. Our reservations regarding general hospital units and 'high support hostels' are detailed elsewhere.

We note and approve the Report's view that all general hospital units should related to a defined catchment area; *all* psychiatric treatment facilities in receipt of public funds should have a definite community commitment.

In this section as elsewhere in the Report, the study group is at pains to indicate a variety of residential placements other than psychiatric hospitals for various categories of in-patient including the 'new long stay' of all age groups. This strategy necessarily derives from the basic premise of the Report that the traditional mental hospital needs to be phased out. We have no quarrel with this. However, we must again express the fairly widespread scepticism amongst all mental health professions at the prospect of long term management of the more severe chronic mentally ill patients within community settings. The central issue here appears to be a widespread feeling amongst psychiatrists and administrators alike that *bridging funds* will be essential to effect such a massive transition from institutional to community care as is proposed in the Report. What is lacking here is a groundwork of careful appraisal of the extent of *existing* facilities, combined with a concentrated study of the actual process of deinstitutionalisation in at least three different kinds of catchment area. Work of this kind cannot be done by existing staff without additional injection of funds but this is an essential step if any of the proposals in this section of the Report are to be realised.

(25) Services for children and adolescents (Chapter 12)

These services are underprovided and the recommendations at the end of this section will need significant investment if they are to be implemented. The recommendations at 12.37 and the staffing norms at 12.14 are acceptable. We endorse the view of our College that there should be an 'irreducible minimum' of two child psychiatrists per 200,000 population with additional staffing for regional and supra-regional units.

School psychology services

Contrary to the view of the Report, we consider that these services should be provided by the Department of Education with careful provision for a system of consultation and early referral to Child Psychiatric Services of children with psychiatric disorders.

Walk-in centres for adolescents

These are probably not appropriate in an Irish context as they imply by-passing of primary care and general practitioner services. 'Walk-in' centres may have a place in the provision of services to adolescent drug abusers.

We recommend

(i) That each Health Board should move immediately to provide two child guidance teams per 200,000 population.

(ii) That School Psychology services be the responsibility of the Department of Education.

(iii) That walk-in centres not be part of national policy.

(26) Services for the mentally handicapped

Services for the mentally handicapped are not dealt with in any detail in the Report. This is a vulnerable sub-group in our community and deserves separate consideration.

We agree that the phasing out of long-stay mentally handicapped patients from psychiatric hospitals should be proceeded with. The deinstitutionalisation of such patients should not proceed at a pace which is greater than the provision of appropriate community support services.

Where mentally handicapped persons remain in the psychiatric facilities on a long term basis these facilities should be in separate accommodation which should be phased out as soon as possible.

We recommend

(i) Mentally handicapped individuals who contract psychiatric illnesses and who require hospitalisation should have the same right to treatment in their local psychiatric service as is enjoyed by non-handicapped persons.

(ii) Because of the limited mention in the Report of the psychiatry of mental handicap, we believe that it is now time that a new Government commission be set up to up-date the Report on mental handicap which was published in 1965.

(iii) To promote maximum standards of care in this area, each Health Board should have a post of Clinical Director of Mental Handicap Services and an academic post in the Medicine of Mental Handicap should be established at least one of our medical schools.