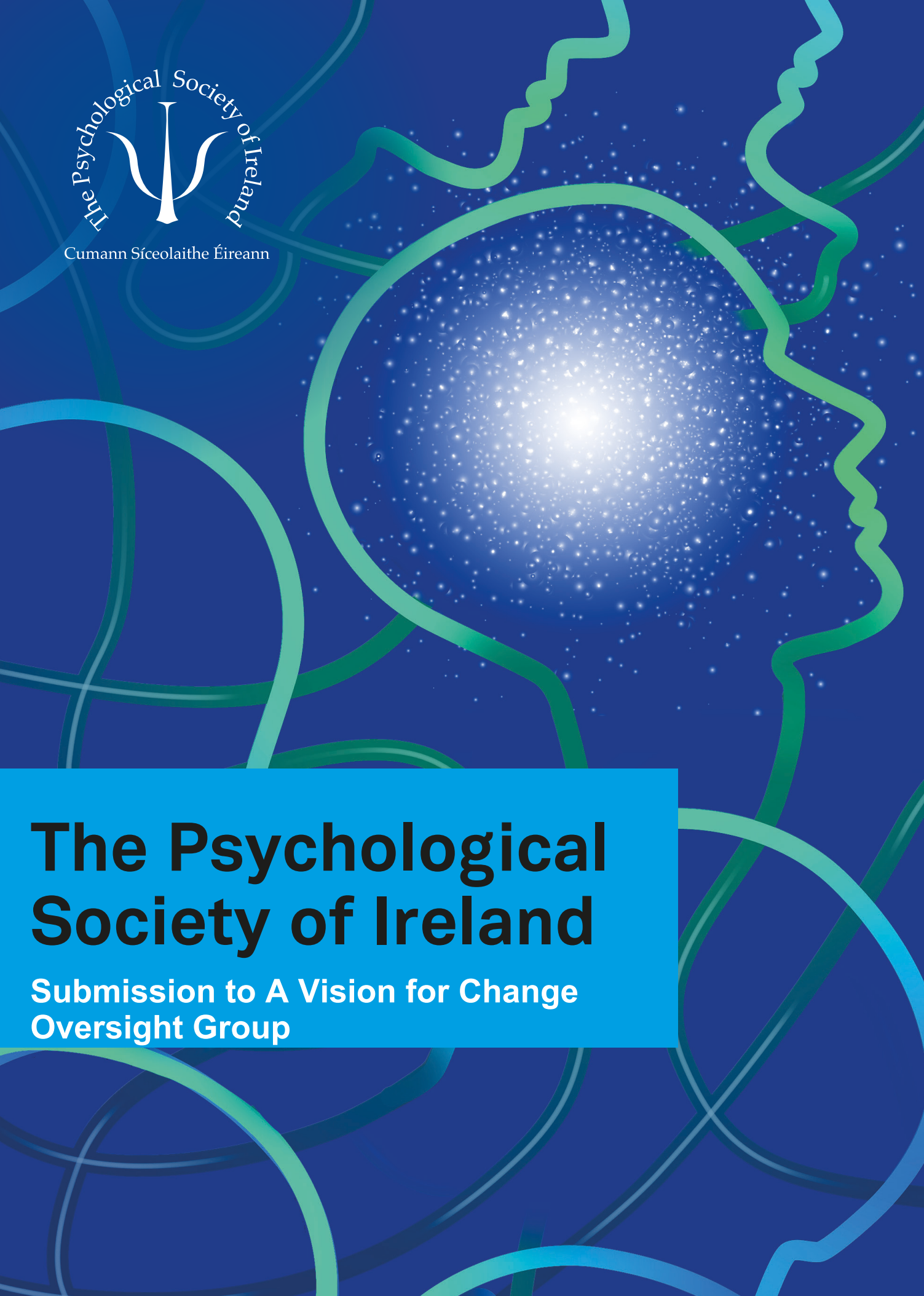

The Psychological Society of Ireland

Submission to A Vision for Change Oversight Group

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The Psychological Society of Ireland (PSI) is the learned and professional body for Psychology in the Republic of Ireland. Established in 1970, the Society currently has almost 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.

This statement outlines concerns held by the Council of the PSI regarding the process currently being implemented by the Department of Health to review A Vision for Change, as an important document for the provision of mental health service in Ireland. In particular, the PSI has concerns about the current composition of the departmental Vision for Change Oversight Group operating within the Department of Health.

As set out in its terms of reference, the priorities of the Oversight Group have been established to include, but were not be limited to, the following[1]:

a) primary prevention, early intervention and positive mental health;
b) integration of care and delivery systems between primary and secondary services;
c) development of E mental health responses;
d) workforce planning, forecasting and skill-mix including mechanisms to attract and retain staff;
e) emerging needs of vulnerable groups, people with co-morbidities and specialist needs informed by the relevant clinical programme; and
f) development of research, data and evaluation capability to ensure achievement of best mental health outcomes can be demonstrated with the resources available.

The scope of these terms of reference is very much welcomed by the PSI and it is of note that there are multiple points of overlap between the work of the Oversight Group and the mission and aims of the PSI. Furthermore, the areas of concerns for the Oversight Group fall directly within the areas of competence and expertise of professionally qualified psychologists, including many PSI members. As such, the PSI looks forward to the possibility of being able to collaborate directly with the Department of Health in progressing its work within the terms of reference for the Oversight Group.

At this point in time, however, the PSI is greatly concerned at the composition of the Oversight Group itself. Whereas the PSI notes and welcomes a commitment to incorporating a wide range of perspectives, including those of mental health advocacy groups and experts by experience, it is

[1] Hugh Kane. Opening address. JC on the F of MHC, 19 Oct

concerning that there is no representation of Health and Social Care Professionals (HSCPs) at the level of the Oversight Group. This is particularly worrying in the case of psychologists, given the above-noted relevance of psychological expertise to the work of the Group.

The PSI is aware that our colleagues in the Irish College of General Practitioners had noted similar concerns regarding the omission of General Practitioners (GPs) from the original make-up of the Oversight Group and that this has since been rectified. In an attempt to address the matter of the omission of appropriate psychological representation within the Oversight Group, the PSI wrote to the chair of the group but, as yet, has received no response. The PSI continues to believe that the lack of inclusion of a psychological perspective at the highest level of the review of *A Vision for Change* will ultimately fail to appropriately initiate the review according to the terms of reference.

In recent stakeholder consultations the Oversight Group stated that 'membership of the committee was considered with the view of keeping the group small, efficient and to include thought leaders in the area'. The Oversight Group also indicated that membership of the Oversight Group was based upon 'expertise in policy', not professional background. The PSI asserts that quality should supersede the priority being placed on efficiency, given the importance of this document to the future of mental healthcare in Ireland. The PSI believes that representation of non-medical professionals at the level of the Oversight Group is of paramount importance, given the acknowledged need to move toward a less-medically dominated approach to mental healthcare, which is the central concern of *A Vision for Change*.

Psychologists play a central role in mental healthcare across primary, secondary and tertiary services. They are typically trained to Doctoral level with expertise in working with mental health difficulties across the lifespan. Psychologists possess a breadth and depth of knowledge that enables them to deliver a wide variety of evidence-based interventions that are tailored to the unique needs of the individual. In view of this and their research expertise, many psychologists can be considered as 'thought leaders' in the area of mental health. Furthermore, many PSI members have quite significant expertise in policy development in the area of mental health. The PSI will welcome an opportunity to recommend suitable representation from psychology for membership of the Oversight Group.

Internationally, mental health care provision has progressed beyond a primarily medical-led and disease/disorder-based understanding of distress. There is ample indication within the relevant professional literature of the importance of more holistic views of human distress that are informed by research and clinical experience from multiple professional perspectives. The PSI strongly queries whether there is any justification for the fact that the current Oversight Group retains a primarily medical focus. Indeed, the generally accepted value of the multidisciplinary model of mental health care serves to highlight what is to be gained from ensuring that multiple perspectives are considered in an integrated way from the outset. In this regard, it is also important to note that the group leading the current review process deviates substantially in its makeup from the group

that developed the original A Vision for Change document. Notably, the current group appears different in that there are:

- No Health and Social Care Professional inputs to the Oversight Group;
- No open and transparent publication of submissions to the review;
- No indication of use of advisory sub-groups as used in the in original document or composition of same.

The PSI is aware that reference-group and stakeholder consultations on the current review have recently been completed by the Oversight Group. While the PSI, in principle, welcomed these consultations, the Society Council does not believe that, given the importance of A Vision for Change as a blueprint for future mental healthcare provision in Ireland and the complexities of the issues being discussed, this was an appropriate or sufficient level of consultation. The PSI asserts that the principles established by *A Vision for Change* and the terms of reference of the review cannot reliably be addressed without the review being jointly led by medical and non-medical colleagues in mental healthcare. In particular, the quality of the consideration that can be given to stakeholder considerations will be benefitted by the integration of multiple perspectives from the outset. The acceptance of written submissions from members of the Mental Health Reform group is also welcomed. However, the PSI is aware that the nature and extent of the submissions were somewhat limited by the Oversight Group. This PSI asserts that an extensive review of current policy requires a greater scope of review than has been conducted to date.

The application of best practice in mental health care is an ever-evolving process that necessitates constant revision and updating of knowledge and skills. Blueprint documents such as A Vision for Change that establish standards for how such a process will be supported and guided should not be produced without significant consideration. Furthermore, the documents themselves need to account for changes in best practice. The PSI is aware that the Oversight Group had indicated that it is a 'refresh' rather than a thorough review of A Vision for Change that is being conducted. This is considered by the PSI to be wholly insufficient. The central tenets of A Vision for Change were that there was a need for a significant shift away from an illness-based model of mental healthcare. Unfortunately, the achievements in this direction have to date been limited. It is now essential, in order to develop a modern mental healthcare system that will address the needs of service-users in the medium to long-term, that a comprehensive policy is developed in line with international best practice, such that services are coordinated and delivered as both trauma-informed and recovery-focused.

The PSI is also aware that, at stakeholder consultations, representatives of the Oversight Group indicated that they would not be making recommendations regarding a number of issues including drug, alcohol and dual diagnosis services as these services were not covered within the original *A Vision for Change* policy. This is a very significant omission in the work of the Group. It is crucial that in developing a policy that will inform the future of mental healthcare in our country, we ensure

that it is inclusive, holistic and can accommodate the mental health needs of all individuals, including those with complex needs including addiction.

The dominance of the illness model of mental healthcare in Ireland is historical and is to some extent associated with imbalances of power within medically-led multi-disciplinary teams. At present, psychiatrists are automatically assumed to be the leaders of Community Mental Health Teams (CMHTs), although it is our understanding that this has no substantive legal basis. Rather, it is a policy based on historical assumptions regarding medico-legal responsibility and contract based position. In many instances, this structure has the potential to defer decisions about understandings of and responses to people's difficulties to one particular powerful societal group, and can effectively sideline the potential influence of other groups. In the experience of many PSI members, this situation has the potential to result in a further continuation of the medical disease model in developing understandings of mental health difficulties. An important step forward toward a more holistic and balanced view of mental health problems will be importantly aided by the distribution of responsibility for mental healthcare among all members of multidisciplinary teams.

It is of note that *A Vision for Change* (2006) states 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. The document rather recommended a "*shared governance model,*" which has yet to be implemented.

The following statement from the Mental Health Commission (2010; Section 4.4.1) is also of relevance:

'*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)*'.

The legal and contractual rationale for psychiatry automatically assuming the role of "clinical lead" is questionable. The model that has been traditionally used in multidisciplinary teams is one where the team's most senior medical practitioner assumes case-coordinating responsibility for all other professional casework. However, there is no actual clarity in relation to the role and responsibility of the "clinical lead" as no agreed definitions or role descriptions currently exist. As psychologists working in mental healthcare, PSI members have their own legal, contractual, professional, and ethical responsibilities, for which they are recognised to be competent through the completion of extensive training. We do not regard it as appropriate that any one particular professional should be held accountable for another professional's actions except in part by negligent delegation or inappropriate referral.

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 clear inferences in the media have been that in the absence of a Consultant Psychiatrist being available on a CAMHS team, it is not possible for other professionals to work safely and effectively. Whereas psychiatrists may have a lot to offer within CAMHS, the PSI asserts that it is inappropriate to regard their contribution as superordinate or even a prerequisite for the services offered by other professionals. In the UK, CAMHS have moved away from such 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.

The PSI strongly advocates for the development of concepts of leadership and clinical leadership in mental health care in Ireland, so as to be brought into line with international practice. This requires developing a competency framework for clinical leadership and leadership development programmes that are open to all suitable clinicians with the requisite competencies. It is important that there is an understanding that all professionals in mental healthcare will be expected to work together to progress recovery-oriented services as specified in A Vision for Change. This will include addressing problematic current arrangements, in which the clinical opinion of an individual psychiatrist can potentially override policy.

The recent Mental Health Commission review report[2] has noted, as the Commission has done consistently for the past 10 years, we continue to offer sub-optimal standards of mental health care to the most vulnerable in our society. We cannot afford to continue to repeat the mistakes and misunderstandings of the past with regard to mental health service provision. There is quite significant concern that the continuance of arrangements that assign preferential responsibility to Consultant Psychiatrists will serve to maintain the status-quo in which medicalised understandings of distress predominate, and may undermine a shift in balance toward more genuinely psycho-social, recovery led, trauma informed and human rights-based approach. The 12 years since publication has demonstrated that without significant change in the philosophy, power structures and resourcing within mental health, little is likely to change.

Making this submission within the limits specified by the Oversight Group means that it is not possible to comment comprehensively on all aspects of mental healthcare that require reform. The PSI wish to note that this is unsatisfactory with regard to the scope of review it considers to be necessary. However, the PSI remains hopeful that the Oversight Group will recognise the

[2] Mental Health Commission Annual Report, 2017

importance of the involvement of psychologists and other Health and Social Care Professionals on the Oversight Group to produce a policy that will facilitate truly collaborative working among mental healthcare professionals so as to delivery best practice.

1. Social Inclusion and Recovery

- Reforms to the current *A Vision for Change Policy* should ensure that it is inclusive, holistic and can accommodate the mental health needs of all individuals, including those with complex needs such as addiction.
- All mental healthcare should be trauma-informed and recovery-focused to facilitate the development of compassionate services that address the underlying factors that contribute to mental health difficulties and provide sufficient intervention and support to facilitate recovery/long-term improvement in mental health.
- Research suggests that at the very minimum 20 sessions of psychological therapy is necessary for reliable change with individuals with mental health difficulties, with a minimum of 23 sessions required for recovery (Harnett, O'Donovan, & Lambert, 2010). However, some intensive therapeutic protocols require a greater number of sessions than this. It is strongly recommended that the number of sessions required by particular clients should not be presupposed or defined by an upper limit. Rather, clinicians should have the freedom to implement evidence-based protocols in their entirety, and flexibly, according to individual client needs. Reforms should ensure that mental healthcare is inclusive, holistic and can accommodate the mental health needs of all individuals, including those with complex needs. Individuals with addiction and mental health difficulties as well as those with mild intellectual disabilities and mental health difficulties, often require more specialist care than current mental healthcare provision provides. These groups of individuals have been neglected in mental health service planning and service provision.
- Individuals with addictions often use alcohol or drugs as means of self-medicating, to soothe or avoid psychological pain. A psychological assessment can help guide interventions that will help address both the addiction issues and the psychological traumas and social issues that often contribute to the person's addiction issues. Providing care that does not address the underlying psychological and social difficulties is unlikely to be successful in the long-term. Psychologists have expertise and skills in working from different therapeutic models which is necessary when working with individuals with complex needs such as this.
- Similarly, individuals with mild intellectual disability/other disabilities and mental health difficulties often require more intensive supports that are adapted to their individual needs. These individuals are particularly vulnerable and their unique needs have not been adequately considered in current service provision. It is important that service planning for this population considers the expertise and supports that these individuals are likely to require, and provides services that are staffed by mental health professionals with expertise and training in both disability and mental health. Psychology can play a key role in such services given that training spans disability and mental health.

2. Mental Health Promotion, Prevention and Early Intervention

- In line with *A Vision for Change*, 'recovery', should be the ultimate goal of interventions in mental health. Offering a sub-optimal number of therapy sessions is likely to result in a revolving door effect and/or the need to refer onwards to secondary/tertiary care services. Increasing resources in primary care so that a range of evidence-based psychological therapies can be provided and increasing the maximum number of sessions that can be provided can reduce the need for referral to secondary care services and reduce long-term dependency on psychiatric medications.
- An expansion of mental healthcare services to ensure greater access to psychological therapies to individuals across the lifespan is supported by the PSI. Given the breadth and depth of expertise psychologists bring to mental health services, improving access to psychology services across primary, secondary and tertiary care is recommended.

3. Service Access, Coordination and Continuity of Care

- It is important that there is a realistic understanding of caseload capacity for different professionals working across all levels of services. This is essential in determining how many professionals from each discipline are required for teams to meet the needs of service users and to ensure that service users have access to the full range of interventions offered by different disciplines. Psychologists, for example, typically offer weekly appointments of 50-60 minutes duration for a number of months to individuals or families 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 active caseload. The time commitment required for psychological interventions is greater in the short-term, but the quality and depth of the interventions offered can result in long-term change/recovery (Spielmans, Berman & Usitalo 2011).
- These metrics mean that psychiatrists have capacity to see significantly more clients 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 a greater number of psychologists than psychiatrists on a team if service users are to have equal access to both psychological and pharmacological interventions. Given the relative scarcity of psychology resources on CMHTs (for the reasons outlined above), psychology services are typically reserved for individuals who have the most complex needs. Consequently, the majority of service users attending CMHTs, will 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).

- In a system where €400 million 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 treatment 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 treatment.
- PSI recommends a minimum number of Whole Time Equivalents (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.
- A review of referral practices from primary to secondary care is necessary to improve access to secondary care services. We suggest that referrals to CMHTs should be accepted from any member of the primary care team, not only the GP. In CAMHS, referral pathways have been expanded since the introduction of the CAMHS Standard Operating Procedure of June 2015, allowing other professionals to refer young people to the service. Central to this expansion of the referral pathways was keeping the GP at the centre of all referrals. PSI recommends that CMHT referral pathways be reviewed to bring them in line with CAMHS pathways.
- A psychiatric diagnosis should not be a prerequisite for referral to CMHTs. A psychiatric diagnosis is primarily useful in the context of psychiatric/pharmacological treatment, and should be seen as necessity for access to other services. Community mental health teams 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, Speech and Language Therapy, Psychotherapy, 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.
- 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.

4. Quality Improvement and Innovation

- There needs to be a fundamental shift within the Irish health services 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/mental health difficulties. 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.

- The making of a psychiatric diagnosis should be seen as but one option in a multi-component model of assessing/describing complex mental health difficulties. The PSI concurs with Kinderman (2014) who argues that mental health difficulties should be described in simple terms rather than using diagnostic/illness-based language. A mental health diagnosis does not provide any information regarding aetiology that can inform treatment planning, whereas a psychological formulation will highlight the psychological, social and biological factors that contributed to the development and maintenance of a person's mental health difficulty. This information can then be used to inform their treatment/interventions.
- *A Vision for Change* 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.
- This will require a review of public funding used for psychological training, such that training programmes that provide graduates with expertise in the provision of psychological therapy. Such training currently includes programmes in Counselling Psychology and Clinical Psychology but may in future include other training programmes accredited by the PSI. It is important that such programmes receive active funding to promote the development and growth of the field of psychology in Ireland, and the availability of psychologists trained to deliver evidence-based therapies.
- 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.
- Contrary to this practice, evidence suggests that medication should not be the first line treatment for the majority of mental health difficulties. For example, with respect to 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).

- The PSI wishes to highlight 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 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. 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.
- It is also important that 24/7 mental health services are embedded within community settings as opposed to Emergency Departments (EDs). EDs are not suitable environments for individuals who present in mental health crisis and situating these services in A&E is typically experienced as aversive by service users. In addition to this, locating 24/7 services within a hospital setting risks further medicalising psychological and social difficulties, and contributing to a sense of stigma around mental health difficulties.
- To ensure the shift in culture and practice 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.
- There needs to be equitable funding for training across all professions working within CMHTs and primary care teams. In CMHTs Psychiatry currently have individual Continuous Professional Development (CPD) budgets allocated to them annually which they can use for CPD events/training. However, HSCPs including psychologists do not have individual CPD budgets and have to self-fund any training they take part in to further their professional development.

5. Accountability and transparency

- It has been claimed that psychiatrists on CMHTs have to be clinical leads on teams 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.
- The PSI strongly advocates that the concepts of leadership and clinical leadership in mental health are brought into line with international practice. This would take the shape

of developing a competency framework for clinical leadership and leadership development programmes that are open to all suitable clinicians with the requisite competencies.

- In addition to highlighting the lack of 'filled teams' across the Community Healthcare Organisations (CHOs), it is necessary to examine where these gaps lie. It is crucial to understand how teams are currently resourced (WTEs across disciplines) so we can understand where exactly the limited funding that is allocated to mental health, is being spent.

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