Draft Deep End Ireland Submission:

August 2018

Deep End Ireland

We are a group of GPs who practice in disadvantaged areas (www.deepend.ie), many of us for over 15 years. GPs in our areas have a particular interest in mental health care given the higher prevalence of mental health issues in our patient population. We are extremely concerned about the current state of specialist and community based services for adults and children with mental health problems. A major continuing constraint is the inverse care law, which results in less consultation time being available in general practices in deprived areas for patients with mental health problems. The flat distribution of funding means that the only way GPs in disadvantaged areas can meet increased needs is to have shorter consultation times which is particularly problematic when dealing with mental health issues.

Mental health difficulties in disadvantaged areas

There is limited data on mental health illness prevalence in Ireland that specifically focuses on socio-economic differences. The available evidence from Ireland and Scotland suggests the following:

- Mental health problems are more than twice as prevalent in the most deprived areas compared to the most affluent areas
- General practices in most deprived areas have 38% more patients with multimorbidity [228/1000 vs 161/1000] and over 120% more mental-physical health multimorbidity [113/1000 vs 52/1000]
- Mental health illnesses occur in combination with physical health problems more commonly in the most deprived areas and about a sixth of patients with a chronic medical condition also have depression
- Addiction is more common and alcohol use is more harmful with higher proportions of binge drinking compared to more affluent areas
- Unemployment is more prevalent and unemployed people have lower self-reported health than employed people and higher rates of diagnosed mental health problems
- The All-Ireland Report on Tackling Health Inequalities noted that “living in poor material circumstances or being faced with discrimination or exclusion is a stressful experience. People living in poverty tend to experience poorer mental health and have a higher dependency on mental health services than people in higher socioeconomic groups.”

Deep End Ireland Perspective

The neglect of children and adults suffering mental illness and distress leads to untold damage in terms of education, employment, criminality and long-term mental health. There is a totally unacceptable level of services and our experience is

that services for children, in particular, i.e CAMHS, have deteriorated significantly in recent years.

These are a few core issues that we wish to highlight that apply to adult, adolescent and children's mental health services:

- **Available services and waiting lists**
  For children, referrals are commonly declined but for all ages, waiting lists can be extremely long. While this may be a resource issue, we strongly recommend *the distribution of resources to match need within the population served.* In other words, in disadvantaged areas where there is a higher prevalence of mental health problems there should be proportionately more services available to address these needs. There is no recognition of the need for resources to match the needs of local populations, leading to marked health inequalities. Even within current budget constraints we suggest moving personnel from areas with less demand and shorter waiting lists to areas with higher demand to ensure equitable provision of care.

- **Barriers to Assessment and lack of integration of different elements of mental health services**
  A GP referral of a patient with mental illness is a carefully considered decision in the context of significant distress. Our experience is that the referral criteria are needlessly restrictive with particular challenges relating to co-existing addiction and personality disorder. Children and adults with Autistic Spectrum Disorders (ASD), learning problems or behavioural problems can develop co-morbid mental health problems but referrals in this context are frequently rejected.

- **Dual Diagnosis (i.e., mental illness and addiction)**
  This is so frequently present in the homeless and hostel residents in many Deep End practice that it is quite unusual for a person in these services to present without this combination of diagnoses. Our experience is that psychiatric services are very reluctant to treat people with addiction and addiction services are often unable to cope with serious psychiatric illness. Therefore, many of these very vulnerable people, who are at high risk of harm, are not being treated for either problem with resultant severe suffering.

- **Early discharge**
  Many GPs in our group have experienced situations where adequate time is not being taken for therapeutic intervention. This likely reflects poor resourcing and we would strongly support resourcing for the full range of therapeutic interventions based on population need.

- **Automatic discharge when appointments are missed**
  Although we understand the reason for this policy, we are very concerned that patients in a deprived populations are particularly vulnerable as they may be dealing with multiple other social stressors and chronic physical and

mental health problems. There are often changes of address and mobile phone numbers that mean patients do not receive appointments. In particular, for CAMHS, when a child does not attend (or more accurately, was not brought), this should be regarded as a "red flag" situation where efforts are intensified, rather than the child being discharged, which is what usually happens.

- **Communication between mental health services and GPs**
  This is a very challenging area, which is compounded by the fact that for many of us, our practice population is split geographically between services, which operate strict catchment area policies.

- **Lack of non-pharmaceutical treatment options**
  While the relatively recent Counseling in Primary Care Service can be very useful there are now substantial waiting lists, particularly in areas with high demand. Referrals are often refused based on the nature of the mental health problem and the service is only available for those with current GMS cards.

- **Referral to community services for children, which don't exist.**
  Many of us have had referrals for children with mental health problems refused on the basis that a child should be referred to community psychology services instead. In many disadvantaged areas the waiting time for child psychology is excessive. For example in the South Inner City area, the waiting time is currently about 1 year and in Dublin 15 it is 18 months, and it is the only service available for children under 12. In the case of an acutely distressed child this is completely unsafe/unacceptable. In the context of limited CAMHS, community services need to be vastly improved and easily accessible.

Conclusions and Recommendations

It is important to note that over 90% of all mental health problems are dealt with in primary care, and GPs are therefore very skilled at managing common mental health conditions and determining when a specialist service is required. In order for GPs in deprived areas to address the ever-growing mental health caseload we need to be adequately resourced. In many cases, if community mental services were adequate and waiting times shorter, psychiatry services would not need to be involved. This is currently not the case. Resourcing of adult and child psychiatry services in areas of deprivation needs to reflect the complexity and volume of work. Flexibility, responsiveness and communication between professionals needs to be enhanced. Counselling and other community support services are vital and attached mental health workers and/or link workers could help us to provide more integrated care.

A major continuing constraint is the inverse care law, which results in less consultation time being available in general practices in deprived areas for patients with mental health problems, despite the increased prevalence. It is critical that GPs

in these areas are resourced to manage these problems. This could be achieved by additional capitation based on patient's socioeconomic status, or a grant for extra staff for general practices in these areas. The principle of matching resources to needs, and not to population numbers, should be applied to all mental health services, whether secondary or primary care services. This basic principle, which for example is well established within the education service (Deis schools) has to date not been applied in the health service. This has contributed hugely to the enormous disparities in health outcomes based on where you live in Ireland.

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