Dr Edel McGinnity
Dr Angela Shortall
Dr Catherine Mullen
Dr Nicola Cronin

Riverside Medical Centre
Mulhuddart
Dublin 15
Tel: 6467888
Fax: 6467571
email: edelmcg@outlook.ie

SEANAD PUBLIC CONSULTATION COMMITTEE CHILDREN'S MENTAL HEALTH IN IRELAND

27/05/2017

I have been working as a GP in a disadvantaged area of Dublin since 1995.

I am a partner in a large group practice with a GMS list of 3000 patients, of whom more than 1000 (33%) are under 18 (much higher than average). I write on behalf of my colleagues.

I am also a founder member of Deep End Ireland, a group of GPs advocating for improved services to patients living in areas of disadvantage, where mortality and morbidity is much higher than average.

I have 3 important observations about the provision of CAMHs services that I wish to draw to your attention.

The first relates to the distribution of resources.
I attach the statement of Deep End Ireland presented to the Oireachteas Committee on the Future of Healthcare in September 2016 which provides important background on the reality and challenges of providing care to disadvantaged populations.
The most important of these is a concept called The Inverse Care Law, which outlines how those most in need of services are least likely to get them.
There are a number of reasons for this but in terms of access the core problem **is providing services according to numbers and not needs.**
At the moment in this country services are distributed according to numbers – one service such as CAMHS, for X number of people.
In areas like our however the volume of people within a given population with illnesses, in this case childhood mental health problems, **is more than twice as high as the national average.**
By having only one CAMHs team for a given population in this situation we are effectively providing half the service.
This one of the reasons why waiting times are much longer in some areas than others.
It is also why allied mental health services have similar problems.
At this time there are 2 family therapy services in this area for children with mental health and family problems – Aistear Beo and Barnardos. **Both are closed to referrals at the moment** (except from Tusla, in the case of Aistear Beo).
Child psychology waiting times in this area are currently 18 months (vs 4 months in Lucan).
This means that when a referral is rejected by CAMHs with the suggestion that the child is referred to another service they get **no service at all.**

One easy and accessible way to deal with this inequality in access is to weight resources (in the form of staffing) according to deprivation levels.

The HSE has ready access to levels of disadvantage in the country via Pobal which has detained information on this. A system comparable to the DEIS schools system could be adopted, whereby if the population served has X% in very or extremely disadvantaged areas, then this warrants increased staffing – in the case of CAMHs I would suggest at least 1.5 or 2 full extra teams per group of population. This should also apply to PHNs, psychology and all the other primary care services.
Even within current staffing levels teams and staff could be removed from existing areas where waiting times are low and relocated in these very high needs areas.

My second observation relates to the CAMHS referral process from other health professionals especially GPs.
CAMHs is the only service in the country that **routinely refuses referrals** from a GP who has specialist training, including in mental health, and may have many years of experience in mental health problems. Often such a referral will have been made in comsultation with the rest of the primary Care Team such as PHNs, social workers and community mental health nurse.
This is obviously a way to try and manage waiting lists but it is highly dysfunctional.
Often we are advised to refer to another service which as outlined above, often does not exist.
I have had experience of being told to refer a child to psychology. They have waited for more than a year for this, only to be advised by psychology that they need CAMHs anyway, which I knew all along.

No other service refuses referrals from GPs and this is unacceptable.
A very easy way to address this would be to offer an initial assessment within a short time and decide after that if the referral is or is not appropriate.
This is what happens at the moment in the PCT psychology service for adults for example, where a person is assessed within 2-3 months then a letter is sent advising that they have been listed for individual therapy, group therapy, reading materials, or referred to another service.

My final observation relates to very vulnerable families. These families often function in a chaotic way which is not the fault of the child with the problem. As a result they can be slow to engage with services and unreliable in relation to appointments. My experience with CAMHs is that instead of viewing missed appointments as a red flag and intensifying efforts, the child is discharged.

I have many heartbreaking stories of children for whom I spent years trying to get a CAMHS service without success, in particular this group who were discharged for non attendance despite having been diagnosed with problems. (Tusla were rarely interested unless there was overt parental abuse).
Those children are now young adults with grave mental health and addiction problems, many involved in criminality. I firmly believe much of this could have been prevented.
Its important to note that a prison place costs over 70 000 euro a year, when decisions are taken about the level of resourcing in disadvantaged areas.

Please again accept my apologies for the lateness of this submission.
Perhaps if information about it had been given to the ICGP I would have heard about it sooner, and you would have heard more from one of the groups of health professionals most likely to refer to CAMHs.

Yours Sincerely

_____

Dr Edel McGinnity MRCGP DCH DObs Medical Council No 9931