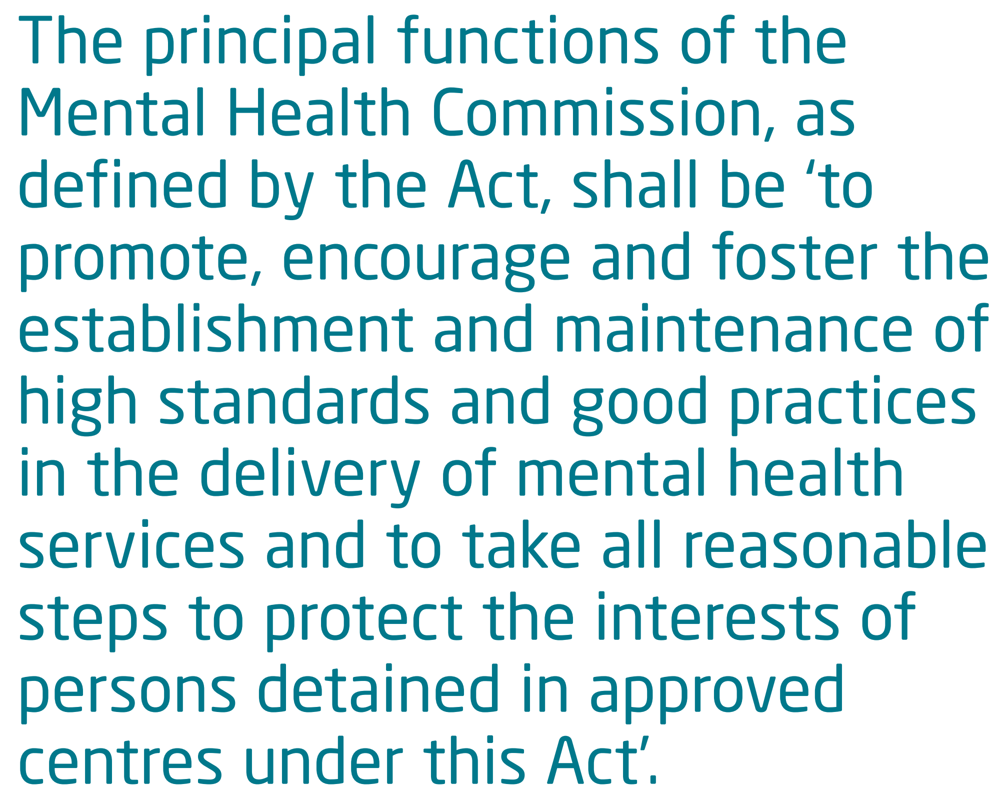
Mental Health Commission
Coimisiún Meabhair-Shláinte

ANNUAL REPORT | TUARASCÁIL BHLIANTÚIL

including the Report of the Inspector
of Mental Health Services 2005

2005

Book One (of Six)



The principal functions of the Mental Health Commission, as defined by the Act, shall be ‘to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act’.

Mental Health Act 2001 Section 33 (1)

Vision

Working together for quality mental health services.

Mission

The Mental Health Commission is committed to fostering and promoting high standards in the delivery of mental health services, to promoting and enhancing the well-being of all people with a mental illness and ensuring the interests of those involuntarily admitted under the provisions of the Mental Health Act 2001 are protected.

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Chairman's Introduction

The year 2005 can be characterised as being one of major preparation for the long awaited modernisation of the Irish mental health services. The Expert Body completed its work in the elaboration of a new mental health policy. The policy document "A Vision for Change" was published in January 2006. This policy will guide the development of mental health services for the next seven to ten years. The Mental Health Commission made a submission to the Expert Group and is pleased to note that its major recommendations have been included.

For the Mental Health Commission this has been a year of truly hectic activity. The concerns of consultant psychiatrists in relation to commencing Part 2 of the Mental Health Act 2001 were resolved after prolonged discussions with the HSE in which the Commission was intimately involved. It is hard to overestimate the amount of work required to ensure that all procedures are fully in place for the commencement of the Act. A reference guide to the Mental Health Act was published is August 2005. Arrangements were completed to ensure adequate accommodation for Mental Health Tribunals. Appointments of second examining consultants and Tribunal members were well advanced. A truly prodigious amount of educational work was undertaken with all those who will be involved in the implementation of the Act. The situation has now been reached whereby the commencement of the Act can be anticipated in 2006.

In its approach to the quality agenda the Mental Health Commission published "Quality in Mental Health – Your Views" in January 2005. This followed an in-depth assessment of the views of all those involved in the mental health services, not least the users. Not surprisingly perhaps there was broad agreement on what constitutes quality in the delivery of mental health services. What everybody wants is a service that is user friendly, allows user participation, is community based, provides a high standard of care, is easy to access, is efficient and accountable. In pursuit of these goals the Mental Health Commission has published a range of discussion documents to guide the evolution of high quality services and these documents, when finalised, will be very helpful in improving quality and in providing a template for the implementation of the range of reforms recommended in the new policy document "Vision for Change". Indeed, the Commission, through its Inspectorate, sees itself as the prime agency in overseeing the implementation of this policy.

The report of the Inspector of Mental Health Services follows a much more comprehensive inspection of all inpatients units than was possible in 2004. Inspections also involved all 24-hour nurse staffed community residences. The findings confirmed, in some areas, a picture of services inappropriately institutionally-based, lacking true multidisciplinary community mental health teams with limited user involvement and poorly structured inadequate management systems. A major concern of the Inspectorate and of the Commission relates to the quality of services provided for individuals with severe and enduring illness. These people still make up the majority of inpatients and while many have been discharged to alternative community residences this has often been an exercise in relocation, serving the priority of closing mental hospitals rather than a treatment and rehabilitation exercise in its own right. There are now in the region of 3,000 people living in community residences. Many of these individuals lack personal care plans and regular clinical review. The treatment of these people is all too often restricted to a narrow medication-based model. The impression is of an inappropriate lack of optimism regarding the possibility of improvement and the potential for return to meaningful community life. The Mental Health Commission has published a discussion document "A Vision for a recovery model in Irish Mental Health Services". This document emphasises the importance of broadly-based collaborative approaches in mental health care and should be helpful in designing more appropriate care models. The Mental Health Commission sees those with severe and enduring mental illness as having a special priority in mental health service improvement and accepts fully the recommendations of the policy

document " Vision for Change" to establish a specialist service where the rights of these individuals can be recognised and their potential for recovery realised. Other priorities for the Commission are services for children and for those with intellectual disability who have a mental illness and committees of the Commission have been set up to address these priorities.

The Commission strives all the time to advance the quality of service delivery within the mental health services. While it may seem, on occasions, that the Commission is being overly critical, it sees itself as advancing its aims by working collaboratively with both users and providers. There are some areas of high quality practice in this country, which could provide useful national models. There has been very little emphasis on mental health service research whereby new service models can be scientifically evaluated. With this in mind, the Commission has established a committee on research with the emphasis on mental health service research. It is hoped that a mental health service research centre can be established, perhaps on an all-Ireland basis and in this way interest in service models stimulated.

The members of the Commission are very conscious of the amount of work undertaken by the executive particularly in these formative years and continue to be impressed and very appreciative of the professionalism and commitment of its CEO, Ms. Bríd Clarke and the other members of the executive in advancing the aims of the Commission. The Commission also appreciates the work of the Mental Heath Service Inspectorate which continues to provide the Commission with detailed knowledge of the structures and quality of service provision.

Finally, I would like to thank all the members of the Commission for their contributions and continuing support.

Dr. John Owens
Chairman

Introduction - Chief Executive Officer

It is with pleasure that I introduce the fourth Annual Report of the Mental Health Commission, for the year ending 31st December 2005, including the report of the Inspector of Mental Health Services as per the provisions of Section 42, Mental Health Act 2001.

The Mental Health Act 2001 defines the statutory mandate of the Mental Health Commission. The overarching statutory functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres (Section 33 (1)). During 2005, the Mental Health Commission undertook an extensive programme of work in fulfilment of its statutory functions.

The Mental Health Act 2001 introduces an automatic independent review system for all patients admitted involuntarily to a psychiatric hospital/unit. During 2005, work was advanced on the different elements of this review system e.g. recruitment of mental health tribunal panels, preparation and piloting of the new prescribed forms, preparation and approval of mental health legal aid scheme, reviewing and funding facilities for mental health tribunal hearings.

Two publications were issued by the Mental Health Commission in early 2005 which will underpin the strategic direction of the Mental Health Commission over the coming years. In January 2005 the Commission published its research strategy. The publication of this strategy gives expression to the importance of high quality research in mental health services and the Commission's commitment to supporting mental health service research in Ireland.

The report of the consultation process undertaken in 2004 with the various stakeholders in mental health services on what constitutes a quality mental health service was published also in January 2005. This report – 'Quality in Mental Health Services – Your Views' will inform the development of the quality framework for mental health services, thereby supporting and guiding continuous improvements in the quality of mental health services in Ireland.

In recognition of the importance of training and information on the Mental Health Act 2001, the Commission, in 2005, developed an extensive training programme for those involved in mental health services. The training programme will continue during 2006. Information prepared by the Mental Health Commission on the Mental Health Act ranges from the Reference Guide to information booklets and leaflets.

The reports of the inspections undertaken by the Inspectorate of Mental Health Services in 2005 and the national review of mental health services provide comprehensive information and insight into the delivery of mental health services in Ireland. The Commission is also committed to expanding the range of mental health information and data. The data gathered from the annual census of inpatient units and the monthly census of involuntary admissions is reported in the Annual Report.

Since its establishment the Mental Health Commission has been supported in its work by a wide range of organisations and individuals. I wish to thank all those who have assisted and supported the Commission in its work during 2005. I also wish to acknowledge the support of the Department of Health and Children, in particular the Mental Health Division during 2005.

I wish to thank the members of the Commission for their continued support and guidance in the past year.

I wish to express my sincerest gratitude and appreciation to all the staff in the Commission. The extensive work programme undertaken in 2005 was achieved through the unstinting commitment and dedication of the staff in the Commission.

Bríd Clarke
Chief Executive Officer

Commission Members

AT TIME OF APPOINTMENT

Dr. **John Owens**
CHAIRMAN
Consultant Psychiatrist, North Eastern Health Board

Dr. **Anne Byrne-Lynch**
Principal Clinical Psychologist, South Tipperary Mental Health Services

Mr. **Joe Casey**
Mental Health Ireland

Mr. **Gerry Coone**
Psychiatric Nurse, East Galway Mental Health Services

Mr. **Padraig Heverin**
Clinical Nurse Manager II, Mayo Mental Health Services

Mr. **Diarmaid McGuinness**
Senior Counsel

Dr. **Deirdre Murphy**
General Practitioner

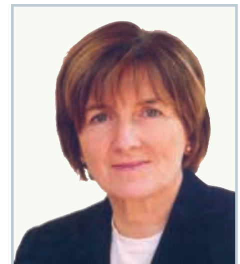
Dr. **Finbarr O'Leary**
Consultant Child & Adolescent Psychiatrist, Child and Adolescent Mental Health Services Southern Health Board

Mr. **Diarmuid Ring**
Lecturer on mental health issues and service user

Ms. **Annie Ryan**
Campaigner on mental health issues

Ms. **Vicki Somers**
Principal Social Worker, Dublin West/South West Mental Health Services

Mr. **Mike Watts**
National Co-ordinator, GROW and former service user


Ms. **Maureen Windle**
CEO, Northern Area Health Board

Part One

Chapter 1
Mental Health Commission

Functions & Structures

Mental Health Commission: Functions & Structures

1.1. Mental Health Commission

The Mental Health Commission, an independent statutory body, was established in April 2002 under the provisions of the Mental Health Act, 2001.

The principal functions of the Commission, as specified in the Mental Health Act, 2001 are to promote, encourage, and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres (Section 33 (1)).

The remit of the Commission incorporates the broad spectrum of mental health services including general adult mental health services, mental health services for children and adolescents, older people, people with learning disabilities and forensic mental health services.

The Commission consists of 13 people, including the Chairman, who are appointed by the Minister for Health and Children. The composition of the Commission is as follows:

- A person who has had not less than 10 years experience as a practising barrister or solicitor in the State ending immediately before his or her appointment to the Commission.
- Three shall be representative of registered medical practitioners (of which two shall be consultant psychiatrists) with a special interest in or expertise in relation to the provision of mental health services.
- Two shall be representative of registered nurses whose names are entered in the division applicable to psychiatric nurses in the register of nurses maintained by An Bord Altranais under section 27 of the Nurses Act, 1985.
- One shall be representative of social workers with a special interest in or expertise in relation to the provision of mental health services.
- One shall be representative of psychologists with a special interest in or expertise in relation to the provision of mental health services.
- One shall be representative of the interest of the general public.
- Three shall be representative of voluntary bodies promoting the interest of persons suffering from mental illness (at least two of whom shall be a person suffering from or who has suffered from mental illness).
- One shall be representative of the chief executives of the health boards.
- Not less than four shall be woman and not less than four shall be men.

Members of the Commission shall hold office for a period not exceeding 5 years.

1.2 Mental Health Commission Committees 2005

The Mental Health Commission has established a number of committees to advise on a range of issues:-

Audit Committee

Mr. Gavin Maguire (External Chair), Ms. Maureen Windle, Ms. Annie Ryan, Dr. Finbarr O'Leary, Mr. Padraig Heverin.

Criminal Law (Insanity) Bill 2002

Dr. John Owens (Chair), Dr. Anne Byrne-Lynch, Mr. Diarmaid McGuinness, Dr. Finbarr O'Leary, Mr. Padraig Heverin, Ms. Bríd Clarke.

World Mental Health Day 2005

Ms. Vicki Somers, Mr. Padraig Heverin, Dr. Anne Byrne Lynch, Ms. Bríd Clarke, Ms. Marina Duffy.

Child & Adolescent Mental Health Services Committee

Dr. Finbarr O'Leary (Chair), Ms. Annie Ryan, Ms. Bríd Clarke, Ms. Patricia Gilheaney, Dr. Susan Finnerty, Ms. Vicki Somers

Multidisciplinary Team Working Committee

Mr. Diarmuid Ring (Chair), Ms. Vicki Somers, Mr. Gerry Coone, Dr. Fiona Keogh, Mr. Gerard Perry, Dr. Teresa Carey, Ms. Rhona Jennings, Dr. John Owens.

Recovery Model in Irish Mental Health Services

Mr. Mike Watts (Chair), Dr. Anne Byrne-Lynch, Mr. Diarmuid Ring, Dr. Deirdre Murphy, Ms. Rhona Jennings, Ms. Bríd Clarke.

Forensic Mental Health Services Committee

Dr. Anne Byrne-Lynch (Chair), Mr. Joe Casey, Mr. Padraig Heverin.

Dr. Gerry Cunningham, Dr. Pauline Twomey, Mr. Des McMorrow.

Intellectual Disability and Mental Health Services Committee

Ms. Bríd Clarke (Chair), Dr. Anne Byrne-Lynch, Ms. Annie Ryan, Mr. Joe Casey,

Dr. Deirdre Murphy, Ms. Marina Duffy, Ms. Patricia Gilheaney

Mental Health Commission Research Committee

Professor Patrick Wall (Chair), Dr. Jim Campbell, Dr. John Owens, Ms. Elizabeth Brosnan, Dr. Patricia Clarke, Dr. Elizabeth McKay, Dr. Eadbhard O'Callaghan, Professor Tom O'Dowd, Professor Anne Scott, Dr. Dermot Walsh, Dr. John McCarthy, Dr. Fiona Keogh.

Mental Health Commission Committee on Service User Involvement and Inspectorate

Mr. Mike Watts (Chair), Mr. Diarmuid Ring, Dr. John Owens, Mr. Gerry Coone, Dr. Anne Byrne Lynch.

Other committees established during 2005 to address specific areas are outlined in the relevant sections of the Annual Report.

1.3 Organisational Structure

The Mental Health Act 2001 provides for the appointment of a Chief Executive Officer for the Commission and the Inspector of Mental Health Services.

The Chief Executive Officer (CEO), appointed by the Commission, has responsibility for the overall management and control of the administration and business of the Commission. The Chief Executive Officer is the accountable officer for the organisation.

The Inspector of Mental Health Services, a consultant psychiatrist, is appointed by the Commission. The principal responsibilities of the Inspector of Mental Health Services include:

- The inspection of each approved centre at least once a year.
- The inspection, as appropriate, of any other premises where mental health services are being provided.
- The preparation of an annual report of the inspections which were completed and on the quality of care and treatment received by people availing of mental health services.

The Mental Health Act also provides for the appointment of Assistant Inspectors of Mental Health Services.

Mental Health Commission Staff 2005

CHIEF EXECUTIVE OFFICER

Ms. Bríd Clarke

INSPECTOR OF MENTAL HEALTH SERVICES

Dr. Teresa Carey

DIRECTOR STANDARDS AND QUALITY ASSURANCE

Ms. Patricia Gilheaney

DIRECTOR MENTAL HEALTH TRIBUNALS

Dr. Gerry Cunningham

RESEARCH CONSULTANT

Dr. Fiona Keogh

DIRECTOR CORPORATE SERVICES

Mr. Ray Mooney

TRAINING AND INFORMATION OFFICER

Ms. Rosemary Smyth

HEALTH INFORMATION OFFICER

Mr. David O'Regan

POLICY OFFICERS

Mr. Tony Keating

Ms. Lisa O'Farrell

ASSISTANT INSPECTORS

Dr. Susan Finnerty

Mr. Tom Flanagan

Ms. Rhona Jennings

Mr. Des McMorrow

Dr. Pauline Twomey

Mr. Gerard Perry

ADMINISTRATION

Ms. Melissa Alexander

Mr. Conor Carroll

Ms. Sandra Curran

Ms. Marina Duffy

Mr. Kevin Foley

Ms. Esther Gerrard

Ms. Gale Gilbert

Ms. Marie Higgins

Mr. Noel Kirwan

Ms. Máire McLoughlin

Ms. Maura-Jane Nulty

Ms. Colette Ryan

Ms. Deirdre Hyland

Chapter 2
Mental Health Commission

Strategic Plan 2004 - 2005

Strategic Plan 2004 - 2005

The Mental Health Commission published its first Strategic Plan in March 2004, covering the period 2004 – 2005.

The Strategic Priorities identified in the Strategic Plan are based on the statutory functions of the Mental Health Commission as specified in the Mental Health Act 2001 and informed by international human rights conventions. The strategic plan mapped out the direction and focus of the Mental Health Commission during this two year period.

The six strategic priorities identified in the 2004 - 2005 plan were:

Strategic Priority No. 1

To establish the management, professional and organisational systems and infrastructure which will enable the Commission to fulfil its statutory responsibilities.

Strategic Priority No. 2

To promote and implement best standards of care within the mental health services.

Strategic Priority No. 3

To promote and protect the rights and welfare of persons availing of mental health services, as defined in the Mental Health Act 2001.

Strategic Priority No. 4

To promote and enhance knowledge and research on mental health services and treatment interventions.

Strategic Priority No. 5

To increase public awareness and interest in mental health services

Strategic Priority No. 6

To provide an efficient, responsible, quality service to our customers.

Strategic Plan 2004 - 2005

Guiding Principles and Values of the Mental Health Commission

The Commission is guided in particular by the principles enunciated in the Mental Health Act, 2001, the UN Universal Declaration of Human Rights, International Covenants on Civil and Policital Rights and on Economic, Social and Cultural Rights, Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms and the UN Principals for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

The core values which define the Commission's ethos and culture include:

EQUITY:

This value is manifested by the prioritisation of activities of greatest need and in accordance with the Commission's mandate.

ACCOUNTABILITY AND INTEGRITY:

These values are expressed through the work of the Commission by operating at all times in a professional and transparent manner.

QUALITY:

The Commission is committed to striving for continuous improvement of its activities.

DIGNITY AND RESPECT:

It is a core value of the Commission to treat all those in contact with the organisation with dignity and respect. The Commission is committed to providing services that are culturally and linguistically appropriate.

EMPOWERMENT AND ADVOCACY:

The Commission is committed to facilitating the realisation of the full potential of those availing of mental health services and promoting their best interests.

CONFIDENTIALITY:

This value underpins the work and activity of the Commission. The Commission is committed to handling confidential and personal information with the highest level of professionalism and takes due care not to release or disclose information outside the course of that necessary to fulfil our legal and professional requirements.

ACHIEVING TOGETHER:

It is our commitment to collaborate for improvement through ongoing partnership, consultation and teamwork.

EVALUATION:

The Commission is committed to ongoing review and monitoring of its activities and incorporating the required change.

Chapter 3

Mental Health Commission

Progressing the Strategic Plan in 2005

Progressing the Strategic Plan in 2005

STRATEGIC PRIORITY:

To promote and implement best standards of care within the mental health services.

INTRODUCTION

The Mental Health Commission, in accordance with the provisions of the Mental Health Act, 2001 has the statutory function to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services. This responsibility encompasses the broad spectrum of mental health services from childhood to adulthood to later life. Achieving this mandate is a continuous, evolving and multifaceted process.

INSPECTORATE OF MENTAL HEALTH SERVICES

The Inspectorate of Mental Health Services visited and inspected all registered inpatient psychiatric units and hospitals in 2005. In addition the Inspectorate visited all 24 hour staffed community residences and met with local and regional service user advocates throughout the country. The Inspector of Mental Health Services reprorts on her review of mental health services in Ireland in Part 2. Individual Inspection reports are available in books 2 - 6 on CD ROM.

INQUIRY

Section 55, Mental Health Act 2001, provides for the establishment of an inquiry by the Commission into any approved centre or the care and treatment of a specific patient. The Commission decided in April 2005 to establish an inquiry with the following terms of reference:-

> *"To review current care and treatment practices in the Central Mental Hospital and to report to the Commission."*.

The inquiry is ongoing.

QUALITY IN MENTAL HEALTH SERVICES – YOUR VIEWS

Extensive consultations with all the stakeholders involved in mental health services was undertaken by the Commission in 2004 to ascertain their views on what constitutes a quality mental health service. This culminated in the publication by the Commission on 22nd February 2005 of the report "Quality in Mental Health - Your Views" (available on our website).

There was a high degree of consensus among the stakeholders on what are the determinants of a quality mental health service. A quality mental health service is a service which encompasses eight items. These are a mental health service which:

- Facilitates respectful and empathetic relationships between people using the service and those providing it;
- Empowers people who use mental health services and their families, parents and carers;
- Provides a holistic seamless service and encompasses the full continuum of care;
- Is equitable and accessible;
- Is provided in a high quality environment, which respects the dignity of the individual, his/her carers and family;
- Has effective management and leadership;
- Is delivered by highly skilled multidisciplinary teams;
- Is based on best practice and incorporates systems for evaluation and review.

During 2005, work was undertaken on the development of the quality framework for mental health services. Standards for each of the key themes are being developed as well as defining criteria

Progressing the Strategic Plan in 2005

against which attainment and outcome will be measured.

An international Expert Group to quality assure the process in developing the quality framework has been formed. The membership represents key people with extensive and international expertise in mental health and quality:-

- Dr. Michelle Funk, Coordinator Mental Health Policy and Services, Department of Mental Health and Substance Abuse, World Health Organisation (WHO);
- Dr. Mike Shooter, Consultant Child & Adolescent Psychiatrist, Past President of the Royal College of Psychiatrists.
- Dr. John Øvretveit, Director of Research, Medical Management Centre, The Karolinske Institute, Stockholm and Professor of Health Management, Bergen University, Norway

The Commission will be engaging in further consultation with stakeholders on the quality framework in 2006.

TRAINING AND INFORMATION

The acquisition and application of knowledge is one element of a quality system. Training and information for those who will be involved in implementing the Mental Health Act 2001 had been identified as critical factors in facilitating the effective implementation of the Mental Health Act 2001. During the year, this was reflected by the priority given to this area of the work programme of the Mental Health Commission.

During 2005, in order to create conditions to support mental health professionals to provide quality mental health services, the Commission embarked upon an extensive multifaceted training and information programme. The overall objective of the programme was to equip mental health care professionals, families, carers, advocates and the general public with knowledge of the Mental Health Act 2001. From the outset, it was the Commission's intent to develop, deliver and evaluate a programme that would incorporate a local approach to sustainability. The approach adopted included the following key elements:-

- Train the Trainers Programme. This programme - four days duration - trained over 200 people within the Health Service Executive and independent sector as trainers, thereby facilitating the roll out of the training programme on the Mental Health Act, 2001 within the mental health services and latterly within the wider health services e.g. A & E Departments. Certificates were awarded to 225 people who completed the training programme and these were presented by the Mental Health Commission to the participants on 8th September 2005.

  The roll-out of the training programme within the mental health services has now covered over 3,000 people and by mid 2006 over 7,000 people will have been trained on the provisions of the Mental Health Act, 2001.

  The Commission transferred €2.2m to the Health Service Executive to fund this training programme, including the costs of locum cover.

- A joint training programme organized by the Mental Health Commission and the Irish College of Psychiatrists commenced in November 2005 and will continue during the early months of 2006.
- Training commenced for members of the Mental Health Tribunals. This will be expanded in 2006.
- The Mental Health Commission and the Irish College of General Practitioners (ICGP) agreed on an information exchange programme for general practitioners. This included the development of a customized e-mail address for mental health queries on the ICGP website, participation by the Mental Health Commission in the ICGP Mental Health Awareness Week, participation in workshops at the ICGP winter meeting and Annual General Meeting and the dissemination of the Reference Guide and other literature.
- Meetings have also been held with An Garda Síochána in relation to training on the Mental Health Act, 2001. Training is provided by An Garda Síochána both for probationers and as part of their ongoing in-service training programme.

- The commissioning and development of an e-learning programme on the Mental Health Act, 2001, which will be ready in March 2006. The e-learning programme is being translated for sign language. Both these developments are unique to the Irish health system.

Feedback from the training programme has been very positive – some of the comments were:-

"Well run, huge content to be covered. Good discussion facilitated. Excellent presentations, well prepared, clear and well delivered. Overheads and material very useful."

"Excellent, well organised and stimulating."

"Excellent experiential/hands on working through the relevant sections of the Mental Health Act, 2001. Good balance between the terms of the Act and the various guidance and the forms."

"Overall the two days were very worthwhile and I have gained a much greater understanding of the Act. Good clarity provided in questions posed and all expectations covered."

"Good presentations, a lot of information, questions and discussion well facilitated. The course was excellent, good practical information and guidance."

Information on the Mental Health Act, 2001 is considered to be the second critical factor to the effective implementation of the Act. In August 2005, the Mental Health Commission published A Reference Guide on the Mental Health Act, 2001. The Reference Guide is in two parts - Part One for Adults and Part 2 for Children.

The Reference Guide, the first such publication in Ireland, will assist all those whose work may bring them into contact with persons who have a mental illness or a mental disorder to provide the best possible care and treatment in the best interest of the person or patient.

It is written to provide mental health professionals, and all those whose work may bring them into contact with persons with a mental illness or a mental disorder, with a clear and practical understanding of the major objectives and requirement of the Mental Health Act, 2001.

The Reference Guide is not intended to be a complete or authoritative statement of the law and is not intended as legal advice or advice of any type, rather it is a general reference guide that should be read in association with the Mental Health Act 2001. Legal advice, if required should be sought from the appropriate source i.e. Solicitors / Barristers.

Over 7,000 copies and CD Rom have been produced and circulated.

Information booklets for service users and the public on the provisions of the Mental Health Act, 2001 were prepared during 2005 and referred to the National Adult Literacy Agency (NALA) for plain English proofing. These will be published nearer to the commencement date for the remaining sections of the Mental Health Act, 2001.

REGISTRATION OF APPROVED CENTRES

Parts 5 of the Mental Health Act, 2001 provide for the registration of approved centres by the Mental Health Commission and regulations issued by the Minister ensuring proper standards in approved centres.

An approved centre, according to the Act "means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" (S.62). During 2005 the Mental Health Commission advanced the preparatory work for the establishment of the Register and preparing advice for the Minister on the regulations.

DISCUSSION PAPERS

During 2005, the committees established to examine key areas of service delivery progressed the development of the proposed discussion papers. The discussion papers will be circulated for comment and feedback and the Commission will then issue a position paper/statement on these issues. At the end of 2005, the discussion papers on "A Vision for a Recovery Model in Irish Mental Health Services"; "Multidisciplinary Team Working: From Theory to Practice" and "Forensic Mental Health Service in Ireland" were finalised and preparations were well advanced for publication in early 2006. The discussion papers on intellectual disability and mental

health services and on child and adolescent mental health services, it is anticipated, will issue later in 2006. The committee on intellectual disability and mental health services met with Professor Nick Bouras and Dr. Geraldine Holt, Estia Centre, Kings College London and South London and Maudsley NHS on 8th November 2005 to discuss models of mental health care for adults with intellectual disabilities. The committee on child and adolescent mental health services focused in particular, on the sections of the Mental Health Act, 2001 that relate to children (Sections 23, 25, 26, 27 and 61).

RULES PURSUANT TO THE MENTAL HEALTH ACT 2001

The Commission established a working group in June 2005 to prepare rules providing for the use of electro-convulsive therapy (ECT) as per section 59 of the Mental Health Act, 2001. The terms of reference are:-

1. To review international standards of best practice in relation to the use of electro-convulsive therapy.
2. To prepare the draft rules for the use of electro-convulsive therapy.

The members are:-

- Dr. Eamon Tierney, Consultant Anaesthetist, Wexford General Hospital.
- Dr. Breda McLeavey, Principal Clinical Psychologist and Clinical Neuropsychologist, HSE, Cork University Hospital.
- Ms. Madge Conboy Browne, Clinical Nurse Manager (CNM) 3, HSE, East Coast Mental Health Services.
- Ms. Antoinette Barry, Senior Manager, HSE, South Western Area.
- Dr. Aisling Denihan, Consultant Psychiatrist, HSE, Our Lady's Hospital, Navan.
- Dr. Jim Lucey, Consultant Psychiatrist, St. Patrick's Hospital, Dublin.
- Mr. John Redican, Irish Advocacy Network.
- Dr. John Cooney, Clinical Director, HSE Our Lady's Hospital, Cork.
- Ms. Patricia Gilheaney, Director Standards & Quality Assurance, Mental Health Commission.
- Dr. Susan Finnerty, Assistant Inspector of Mental Health Services, Mental Health Commission.

Work was also advanced on the preparation of rules for the use of seclusion and mechanical means of bodily restraint as per section 69, Mental Health Act, 2001. It is planned to issue these in 2006.

POLICE AND MENTAL HEALTH SERVICES

The Mental Health Commission had discussions with the Garda Commissioner, Commissioner Noel Conroy, in mid 2004, to discuss the contact and interface between the police and those with a mental illness. A review of the international literature and practices in other jurisdictions indicates that close collaboration and formal liaison systems between the police and mental health systems facilitate a more effective response to mental health emergencies in the community.

The Garda Commissioner and the Mental Health Commission agreed to set up a joint working group to examine this issue. The terms of reference of this joint working group on mental health services and the police are:

> *"To review current national and international best practice models of joint working between police and mental health services and to make recommendations in relation to enhanced liaison and joint working systems between An Garda Síochána and the mental health services in Ireland. The joint working group, will in particular identify operational boundaries, which will facilitate the establishment of liaison committees and regionally based fora, which will promote and review joint working arrangements."*

The membership of the group, chaired by Dr. John Owens, Chairman, Mental Health Commission, is:

- Dr. John Owens, Chairman, Mental Health Commission.

- Mr. Martin Connor, Director of Nursing, HSE Nominee.
- Dr. Mary McGuire, Clinical Director, HSE Nominee.
- Dr. Philip Wiehe, General Practitioner, ICGP Nominee.
- Superintendent John Shanahan, Crime Policy Unit, Garda Commission Nominee.
- Ms. Vicki Somers, Mental Health Commission Member.
- Mr. Diarmuid McGuinness, Mental Health Commission Member.
- Mr. Gerry Coone, Mental Health Commission Member.

The first meeting of this working group took place on 25th May 2005. The working group had a number of meetings in 2005 and will continue to meet in 2006.

Progressing the Strategic Plan in 2005

STRATEGIC PRIORITY:

To promote and protect the rights and welfare of persons availing of mental health services as defined in the Mental Health Act, 2001

INTRODUCTION

The statutory function of the Commission place an obligation on the Commission *"to take all reasonable steps to protect the interests of persons detained in approved centres under this Act"* (Section 33(1), Mental Health Act, 2001).

The commencement of Parts 2, 4, 5 and 6 of the Mental Health Act, 2001 will introduce new procedures and practices in relation, in particular, to involuntary admissions, thereby enhancing and protecting the rights of the individual service user. The Mental Health Act, 2001 also brings the Irish mental health legislative provisions into conformity with the European Convention on Human Rights and Fundamental Freedoms.

The Mental Health Act, 2001 provides for the automatic independent review of all involuntary admissions. Within 21 days of an admission, a three person mental health tribunal, consisting of a lawyer as chair, a consultant psychiatrist and a lay person will review the admission order. Prior to this review a legal representative is appointed by the Mental Health Commission for each person (patient) admitted involuntarily, (unless s/he proposes to engage one) and an independent medical examination by a consultant psychiatrist, appointed by the Commission, will have been completed.

The Commission advanced the preparatory work on the independent review system as far as was feasible during 2005.

PART 2, MENTAL HEALTH ACT, 2001

Advertisements for members of the mental health tribunals were placed in the national newspapers in September 2004. Following advice issued by the medical representative organisations an insufficient number of applications were received from consultant psychiatrists.

Discussions involving the Irish Hospital Consultants Association and the Irish Medical Organisation, continued throughout 2005 initially with the Mental Health Commission and subsequently joined with the Health Service Executive, Department of Health and Children and Health Service Executive Employers' Agency. By the end of 2005, agreement was imminent.

The interviewing, selection and vetting of applicants for membership of the chairpersons' panel (lawyer) and lay persons' panels were finalised in the early part of the year. In late 2005 the members of these panels attended a one-day training programme on understanding mental illness and increasing awareness of the service users' perspectives. Mandatory training for all mental health tribunal panels will be rolled out in 2006 on a team basis i.e. involving all members of the mental health tribunals. This together with training for the legal representatives will involve more than 40 days training by the Mental Health Commission.

The Mental Health Commission advertised for mental health tribunal clerks in 2005 and the interviewing and selection took place during the year.

The consent of the Minister for Finance to the mental health legal aid scheme prepared by the Mental Health Commission, issued in September 2005, and the Mental Health Commission proceeded with advertising and selecting legal representatives to operate the scheme. Training for the legal representatives (a mandatory three day training programme) commences in 2006.

The Mental Health Act, 2001 introduces a new suite of prescribed forms issued by the Mental Health Commission in relation to provisions in the Act.

During 2005, four mental health services, providing a mix of urban/rural and public/private, piloted the relevant forms for all involuntary admissions and regrading of people from voluntary to involuntary status admitted under the Mental Treatment Act 1945. The feedback from these pilots informed the final design and content of the prescribed forms. Clinical practice forms to facilitate consistency in recording certain aspects of the procedures associated with involuntary admissions and treatments have also been prepared by the Mental Health Commission.

The Mental Health Commission visited all registered psychiatric units/hospitals where it is proposed to hold mental health tribunals. The Mental Health Commission had previously issued a template advising on appropriate facilities. The majority of the arrangements for mental health tribunals were satisfactory. A minority required some minor refurbishment and a very small number required more remedial works or alternative facilities. In 2004 the Mental Health Commission had transferred €0.45m to the Health Service Executive for furnishings for mental health tribunals and in 2005, the Mental Health Commission transferred a further €0.5m to complete this. All mental health services have indicated that the facilities are now ready.

NATIONAL IMPLEMENTATION GROUP

The Mental Health Commission established a National Implementation Group with representation from the Mental Health Commission, Health Service Executive, Irish College of General Practitioners, Independent Sector, Irish Advocacy Network and the Federation of Voluntary Bodies in late 2004. The terms of reference of the group are *"to plan and coordinate the implementation of the Mental Health Act as directed by the Mental Health Commission"*. The National Implementation Group met on six occasions during 2005 and monthly meetings are planned to continue in 2006. The group provides an opportunity to review the state of readiness of mental health services for the commencement of the Mental Health Act, 2001 (Parts 2, 4, 5 and 6) and to exchange information and expertise on the procedures and provisions which will flow from this.

MONTHLY RETURNS ON INVOLUNTARY ADMISSIONS

In July 2004, the Mental Health Commission commenced the collection of monthly returns from service providers detailing their levels of involuntary admissions. This monthly census continued in 2005. The census was introduced to provide data to assist the planning process required for implementation of the Mental Health Act 2001. Further details of this are outlined in Chapter 4.

AUTHORISED OFFICER

At the end of the year (December 2005) the Mental Health Commission established a multidisciplinary, interagency working group on the Authorised Officer (as per section 9, Mental Health Act, 2001). This resulted from the feedback received on an earlier discussion document issued by the Mental Health Commission on the Authorised Officer. The consultation had indicated support for more detailed information on the proposed role of the Authorised Officer and models of best practice in other jurisdictions.

The Authorised Officer will be an officer of the Health Service Executive of a prescribed rank or grade. Prescribed means prescribed by regulations made by the Minister for Health and Children. It is anticipated that the working group will complete its work in a three/four month period. Following consideration by the Mental Health Commission the recommendations will be forwarded to the Minister for Health and Children.

Progressing the Strategic Plan in 2005

STRATEGIC PRIORITY:

To promote and enhance knowledge and research on mental health services and treatment interventions

INTRODUCTION

It is widely acknowledged that high quality research enhances strategic planning and service delivery. It is of equal importance to the policymaker, the practitioner and the service user. The publication of the Mental Health Commission's research strategy was identified as an integral objective in furthering and broadening the research agenda in mental health in Ireland.

RESEARCH STRATEGY

The Research Strategy was launched on 10th March 2005. The strategy addressed the importance of mental health research, the mental health research infrastructure, the absence of a national policy on mental health research, the international context and the funding and infrastructure to support mental health research.

An action plan to progress mental health research in Ireland was prepared and adopted by the Mental Health Commission. This encompasses four broad areas - capacity for mental health research, systems for recording and dissemination knowledge on best practice in the mental health services, creating links in mental health research and setting the mental health research agenda.

Mental Health Research Committee

The Research Strategy recommended the establishment of a mental health research committee by the Mental Health Commission. Professor Patrick Wall, University College Dublin agreed to chair this all-Ireland research committee. The terms of reference of the Mental Health Research Committee are:-

- to make recommendations on the research to be commissioned or carried out by the Mental Health Commission;
- to review research projects commissioned or carried out by the Mental Health Commission;
- to make recommendations on the number, location and preferred research interests of the Mental Health research fellows;
- to make recommendations in relation to the establishment of mental health research centres;
- to review appropriate sources of funding for mental health research; and
- to give general advice on research to the Commission.

The committee held its first meeting on 13th April 2005 and held three further meetings during 2005. The committee has reviewed research commissioned by the Mental Health Commission, prior to its establishment, and in particular has focussed on the scheme for mental health research fellowships and the recommendations in the Research Strategy on the establishment of a mental health research centre.

Research fellowships focusing on mental health services research were advertised by the Mental Health Commission in July 2005. One fellowship was awarded.

The research strategy also identified the relative isolation of many of those involved in mental health research and the difficulties in establishing what research has been done in Ireland and in establishing contact and sharing of ideas. An Irish Mental Health Research Network Database was recommended to address these barriers to mental health research in Ireland. The network and database were developed

by the Mental Health Commission following the publication of the Research Strategy and were launched on World Mental Health Day, 10th October 2005.

Mental Health Research Network & Database

The Mental Health Research Network is designed to support and promote national and international research links. It aims to connect the mental health research community, to share the valuable resource of knowledge and to create an awareness of the skills and expertise which are available to all researchers. Stakeholders within the mental health sector with an interest in research, as well as international mental health researchers, are invited to register with the network www.mhcresearchnetwork.ie or through the Commission's website, www.mhcirl.ie.

The Mental Health Research Database aims to record all mental health research, published and unpublished, being carried out in Ireland. Currently, a great deal of research is undertaken that is not disseminated widely and so has limited impact on mental health services. All those involved in mental health research are invited to submit a summary of their research to the database at www.mhcresearchdatabase.ie or through the Commission's website, www.mhcirl.ie.

Research Studies

The research study, conducted on behalf of the Mental Health Commission, by the Health Research Board on community residences in the Irish mental health services continued in 2005. All the field work was completed in 2005. The report it is expected will be published in September/October 2006.

The research study conducted by Dr. Elizabeth Dunne, Department of Applied Psychology, University College Cork, on users' views of publicly funded mental health services was finalised and will be published in 2006.

The research study conducted by Dr. Eamon O'Shea and Dr. Brendan Kennelly, NUI Galway on "Economic Research on Mental Health in Ireland" is ongoing and is expected to be completed by early 2007.

The Mental Health Commission provided funding for a research study exploring the experiences of service users of a home-care team approach in Dublin. This study is conducted by Ms. Mary Fell, Department of Psychology, Trinity College, Dublin. This study will be available in early 2006.

MENTAL HEALTH INFORMATION

It is generally acknowledged that the absence of comprehensive, robust, computer based information systems within the Irish mental health services impedes service planning and evaluation. The Mental Health Commission, Health Research Board and individual mental health service providers have undertaken a number of initiatives to redress this deficit. The Annual Report 2005 again includes a specific section analysing information collected by the Mental Health Commission in 2005 relating to the activity within the mental health services. This includes the annual inpatient census data, community mental health services activity and data on involuntary admissions during 2005.

In August 2005 the Mental Health Commission sought tenders "to conduct a scoping exercise on current mental health information systems in use in Ireland and elsewhere with a view to recommending the requirements for a national mental health information system". This work was ongoing at the end of 2005, including consultation with the key stakeholders.

Progressing the Strategic Plan in 2005

STRATEGIC PRIORITY:

To increase public awareness and interest in mental health services

WORLD MENTAL HEALTH DAY

World Mental Health Day is viewed by the Mental Health Commission as an ideal opportunity to raise awareness and understanding of mental health services and mental health problems. World Mental Health Day takes place each year on 10th October. It is viewed as a global mental health education project which takes place in over 180 countries. Each year a theme is selected by the World Federation of Mental Health. The theme in 2005 was "Mental and Physical Health Across the Life Span".

For the last three years, the Mental Health Commission has marked World Mental Health through free public seminars in the National Concert Hall. This year over 200 people attended the public seminar which was addressed by two key note speakers. Dr. Tony Bates, Clinical Psychologist, spoke on "Arriving at your Door: Celebrating Advantage and Adversity in Later Life" and Ms. Sylvia Meehan, Senior Citizens Parliament and Board Member of Age and Opportunity spoke on "Life is for Living".

Very positive feedback was received from the participants at this event. The Mental Health Commission intends to enhance the profile of World Mental Health Day, thereby increasing public awareness and understanding of mental health problems.

NEWSLETTER

Four issues of the Mental Health Commission Newsletter issued during 2005. The newsletter provides the reader with a brief description of the ongoing work of the Commission and further information can then be accessed through the Mental Health Commission. The newsletter is distributed to over 13,000 people.

CONFERENCES AND SUBMISSIONS

Commission members and the executive attended and/or spoke at a number of conferences during 2005. Again these conferences provide an opportunity to raise awareness about mental health, the work of the Commission and the provisions of the Mental Health Act, 2001. The annual European HOPE Conference was held in Dublin in February 2005. The conference theme was "Quality and Choice in Mental Health". Dr. Teresa Carey, Inspector of Mental Health Services and Ms. Patricia Gilheaney, Director of Standards and Quality Assurance addressed the conference on the theme "Quality in Mental Health".

During 2005, the Commission reviewed legislative provisions impacting on mental health service users including the Criminal Law (Insanity) Bill 2002, Disability Bill 2004 and the consultation paper issued by the Law Reform Commission on "Vulnerable Adults and the Law: Capacity".

TRUST IN CARE

A working group was established in October 2003 by the Health Service Executive – Employers Agency to agree a policy document for the health services on the prevention of abuse of patients/clients by staff members and the management of allegations against staff members of patient/client abuse. The Mental Health Commission was represented on this working group. Trust in Care - policy for health service employers on upholding the dignity and welfare of patient/clients and the procedure for managing allegations of abuse against staff members was launched by the Minister for Health and Children, on 19th May 2005. The Mental Health Commission has endorsed this national policy thereby ensuring a consistent approach across all the health services.

Progressing the Strategic Plan in 2005

The Mental Health Commission Annual Report 2004 including the Report of the Inspector of Mental Health Services was launched on the 22nd July 2005. Over 100 people attended the launch of the report and over 2,500 copies of the report were distributed. This report was also made available on our website.

The Commission continues to meet with and develop contacts with statutory and non-statutory agencies to promote understanding and knowledge of mental health issues. This is an area the Commission intends to develop and expand in the future.

Progressing the Strategic Plan in 2005

STRATEGIC PRIORITIES:

To establish the management, professional and organisational systems and infrastructure which will enable the Commission to fulfil its statutory responsibilities

and

To provide an efficient, responsive, quality service to our customers.

As a relatively new organisation, the Commission's programme of infrastructure and systems development continued in 2005. Recruitment of staff proceeded for approved posts and vacancies. The Commission established a committee in April 2005 *"to examine the input of service users in the Inspectorate process and to make recommendations to the Mental Health Commission"*. The committee is expected to report to the Commission in 2006.

The non capital allocation to the Mental Health Commission for 2005 was €15.464m. The provisional out-turn for 2005 is €7m approx. The full allocation in 2005 was not utilised as Part 2 and other Sections of the Mental Health Act were not commenced for the reasons outlined earlier in the Annual Report. The Comptroller and Auditor General issued an audit certificate following completion of the audit for 2004. The accounts for 2005 have been furnished to the Comptroller and Auditor General as per Section 47 of the Mental Health Act, 2001.

AUDIT COMMITTEE

The Audit Committee met four times in 2005. Areas reviewed by the Audit Committee included the Internal Audit Review of Internal Financial Controls and compliance with Corporate Governance Code for State bodies.

The Mental Health Commission is now included in the list of organizations regulated by the provisions of the Ethics in Public Office (Prescribed Public Bodies, Designated Directorships of Public Bodies and Designated Positions in Public Bodies) Regulations 2004. The Mental Health Commission had introduced these provisions of governance on a voluntary basis prior to the enactment of the regulations.

Discussions continued with the Health Service Executive in relation to the complaints system for mental health service users. The Health Service Executive is currently finalizing its procedures for the management of complaints in accordance with the provisions of the Health Act 2004. It is expected that this matter will be finalized in mid 2006.

Work was advanced on the publication of a customer charter to be followed by a Customer Action Plan. The charter has been referred to NALA for plain English proofing and will be available by mid 2006.

The Mental Health Commission's website www.mhcirl.ie was redesigned and enhanced in 2005.

FREEDOM OF INFORMATION

Under the provisions of the Freedom of Information Acts (1997 and 2003) the Mental Health Commission received four direct requests for information during 2005. All of the requests were granted.

Analysis of information on Mental Health Services (AIMS)

Analysis of information on mental health services (AIMS)

INTRODUCTION

This part of the Annual Report presents two types of mental health information collected by the Mental Health Commission in 2005; an annual census of inpatients which was carried out on 4th November 2005 and a summary of monthly information on involuntary admissions throughout 2005.

WHY DOES THE MENTAL HEALTH COMMISSION COLLECT THIS INFORMATION?

Inpatient care is an important element of the mental health services in Ireland, but it is only one element in an increasingly complex system. For historical reasons, the inpatient centre (either hospital or psychiatric unit) has been the centre of data collection in the mental health services. It is also comparatively easy to collect data from inpatient facilities as the activity takes place in one location and an admission is relatively easily defined, with a discrete start and end point.

Community mental health services are a larger and arguably more important part of mental health service delivery in Ireland at this point. Current policy is that the bulk of mental health treatment and care should be delivered in the community by community mental health teams (CMHTs) (Department of Health and Children 2006). Unfortunately the means for collecting detailed information on the activity of community mental health services and the outcomes for individual service users, is not available to many mental health services. Ideally, the type of information reported here on inpatients should be available on all users of the mental health services, regardless of which part of the mental health service they are attending. Therefore the collection and reporting of inpatient data should not be taken as a reflection of the relative importance of this part of the mental health services. Data collection on inpatient services is well established and will continue. This information provides a detailed picture of an important element of the mental health services, and assists in the planning and monitoring of inpatient services. The challenge now is to roll out similar data collection systems and processes into community mental health services so that similar reports on the complete spectrum of mental health care will be available in the future.

ANNUAL INPATIENT CENSUS

This is the second year the Mental Health Commission has collected an annual inpatient census. The first census was reported in the Annual Report of the Mental Health Commission for 2004 (2005). There have been several changes in the way the data were collected for 2005. Firstly, the date of the census was changed from 31st December to 4th November. This date allows a more realistic representation of inpatient figures than the 31st December which had a strong seasonal influence. The annual inpatient census will be conducted in early November each year from now on. Secondly, a different form was used to collect the inpatient data for 2005. Individualised information was collected on each inpatient to provide a more accurate and detailed profile of inpatients. The Mental Health Commission has been included as a specified body under section 15, Social Welfare and Pensions Act, 2005 – personal public service number (PPSN) extension of provisions. This allows the Commission access to PPSN data (see sections 222 and 223, Social Welfare (Consolidated) Act, 1993 which allows for the sharing of information between specified bodies and ministerial departments). The use of the PPSN will enable record linkage over the years to build up a comprehensive database of inpatient use. The form was in spreadsheet format to facilitate as many services as possible in returning data in an electronic format, which most availed of. A detailed guidance document was issued with the census form which described the information governance activities relevant to the information collected and gave detailed definitions of the data to be collected. Feedback received by the Commission indicated that these efforts have helped improve the accuracy and completeness of the data. The form and guidance document can be seen in Appendix 1.

NUMBER OF INDIVIDUALS IN PSYCHIATRIC HOSPITALS AND UNITS

On 4th November 2005 there were 3,475 individuals resident in inpatient facilities. This gives a rate of 114.7 per 100,000 population over 16 years (and a rate of 88.7 per 100,000 total population). This represents a decrease on the number of inpatients in 2004 which was 3,556 – a decrease of 81 persons. This is in spite of the fact that the 2004 figure was

Analysis of information on mental health services (AIMS)

taken on 31st December which may have resulted in a slightly lower rate due to the seasonal factor. This decrease continues the decrease in inpatient figures which is evident over the last 42 years (see Figure 4.1).

Almost 20,000 people were resident in psychiatric hospitals in 1963. The 3,475 inpatients in 2005 represent an 82% decrease in inpatient figures over this time (Table 4.1).

Figure 4.1:Number of inpatients in Irish psychiatric hospitals and units. Census figures from 1963 - 2005

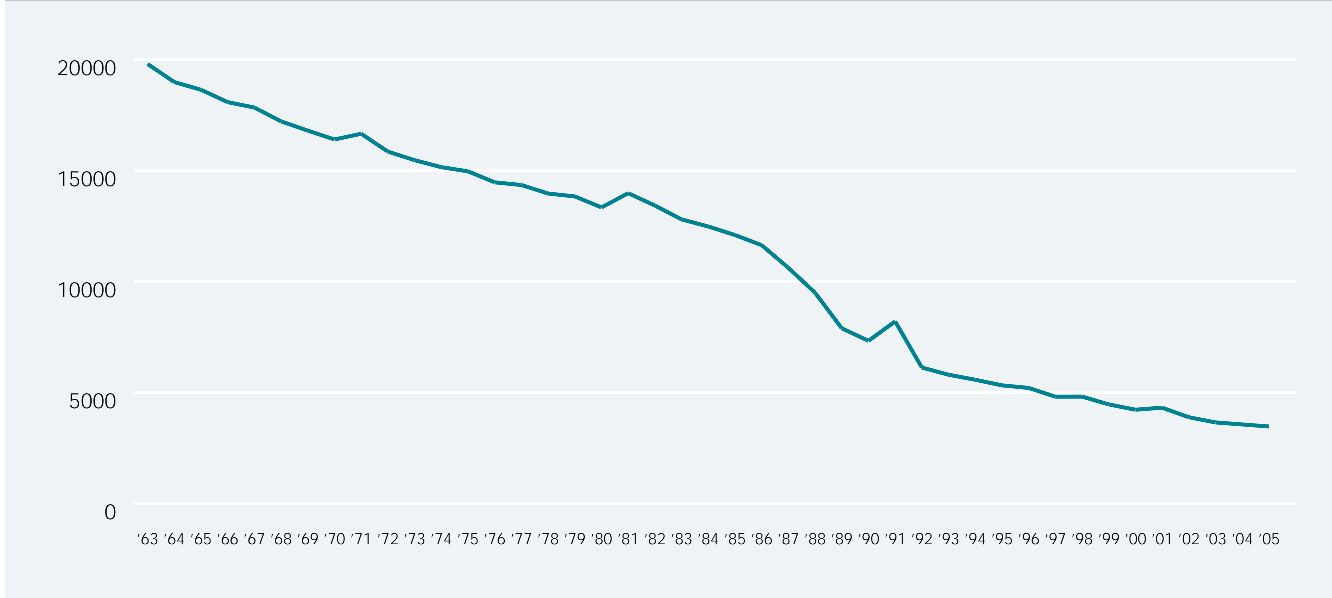


Table 4.1: Census of inpatients in psychiatric hospitals and units. 1963 to 2005

Year	Number	Year	Number	Year	Number	Year	Number
1963	19,801	1974	15,156	1985	12,097	1996	5,212
1964	18,989	1975	14,967	1986	11,643	1997	4,817
1965	18,641	1976	14,473	1987	10,621	1998	4,820
1966	18,084	1977	14,352	1988	9,500	1999	4,469
1967	17,841	1978	13,968	1989	7,897	2000	4,230
1968	17,218	1979	13,838	1990	7,334	2001*	4,321
1969	16,802	1980	13,342	1991*	8,207	2002	3,891
1970	16,403	1981*	13,984	1992	6,130	2003	3,658
1971*	16,661	1982	13,428	1993	5,806	2004	3,566
1972	15,856	1983	12,802	1994	5,581	2005	3,475
1973	15,471	1984	12,484	1995	5,327		

* MSRB/HRB Inpatient census completed on 31st March of these years. All other figures up to 2003 from Department of Health and Children inpatient census on 31st December of each year. 2004 figure from Mental Health Commission (2005)

MENTAL HEALTH CATCHMENT AREAS

There are 31 mental health catchment areas in Ireland. The Annual Report for 2004 included a list of all electoral divisions (EDs) in each mental health catchment area, with associated population breakdown by age. Figure 4.2 shows the mental health catchment areas for Ireland, with those for Dublin shown in Figure 4.2a. The location of psychiatric inpatient hospitals and units is also shown. A breakdown of census information by mental health catchment area provides a clearer picture of the differences and similarities throughout the country. In accordance with the reorganised health service, information is presented for mental health catchment areas and the four HSE administrative areas.

Figure 4.2: Mental health catchment areas in Ireland showing psychiatric hospitals and units.

Analysis of information on mental health services (AIMS)

Figure 4.2a: Mental health catchment areas in Dublin showing psychiatric hospitals and units.

MENTAL HEALTH CATCHMENT AREAS - RESIDENTS ON CENSUS NIGHT

Table 4.2 shows the number of resident inpatients in the 31 mental health catchment areas in Ireland. Rates are also shown for the population of the catchment area. However, these rates can present a skewed picture if there are residents from outside the catchment area on the census night. 'Outside catchment area' was one of the pieces of information collected for each resident as part of the census to determine the extent of this practice. These figures are also presented in Table 4.2. Catchment areas in Cork seem to have a considerable movement of inpatients across catchment areas with almost one third of the inpatients in the North Cork catchment area coming from outside the catchment area. East Galway and North Lee also reported a number of out-of-area residents, as did Area 2 and Area 6 in Dublin. Rates in other areas were relatively low or zero. Overall, five per cent of residents on census night were 'out of area'.

Interpretation of all the rates for residents in the inpatient census presented here should take this factor into account. It was not possible to assign a usual catchment area to all those who were outside catchment area on census night and for this reason the number of reported residents is rated to the catchment area population throughout this report.

Table 4.2: Inpatients by mental health catchment area. Census 2005. Numbers, rates per 100,000 population over 16 years and percentage from outside catchment area.

MENTAL HEALTH CATCHMENT AREAS	Number of inpatients	Rate of inpatients per 100,000 population over 16	Number of inpatients from outside catchment area	% of inpatients from outside catchment area
HSE Dublin North East	**490**	**76.4**	**46**	**9.4%**
Area 6 North West Dublin	133	119.5	39	29.3%
Area 7 North Inner City Dublin	87	78.5	4	4.6%
Area 8 North County Dublin	131	80.8	2	1.5%
Cavan/Monaghan Mental Health Catchment Area	51	62.5	0	-
Louth Meath Mental Health Catchment Area	88	50.1	1	1.1%
HSE Dublin Mid-Leinster	**498**	**56.0**	**24**	**4.8%**
Area 1 South East Coast Dublin	33	24.5	0	-
Area 2 South East Dublin *	41	46.7	16	39.0%
Area 3 South West Inner Dublin City *	47	42.1	1	2.1%
Area 4 & 5 South West Dublin	74	39.9	2	2.7%
Area 9 Kildare and West Wicklow	33	24.7	0	-
Area 10 Wicklow	48	63.1	0	-
Laois Offaly Mental Health Catchment Area	67	72.9	0	-
Longford Westmeath Mental Health Catchment Area	155	195.5	5	3.2%

Analysis of information on mental health services (AIMS)

Table 4.2: Inpatients by mental health catchment area. Census 2005. Numbers, rates per 100,000 population over 16 years and percentage from outside catchment area.

Mental health catchment areas	Number of inpatients	Rate of inpatients per 100,000 population over 16	Number of inpatients from outside catchment area	% of inpatients from outside catchment area
TABLE 2 CONTINUED				
HSE South	**1,144**	**147.9**	**63**	**6.0%**
Carlow/Kilkenny Mental Health Catchment Area *	135	140.6	0	-
Kerry Mental Health Catchment Area	136	131.1	1	0.7%
North Cork Mental Health Catchment Area	149	261.6	43	28.9%
North Lee Mental Health Catchment Area	129	107.4	15	12.0%
South Lee Mental Health Catchment Area	76	58.0	0	-
Tipperary (Tipperary South and North)	202	188.8	1	0.5%
Waterford Mental Health Catchment Area *	148	189.4	0	-
West Cork Mental Health Catchment Area	16	41.1	0	-
Wexford Mental Health Catchment Area	153	173.5	3	2.0%
HSE West	**593**	**81.8**	**56**	**9.4%**
Clare Mental Health Catchment Area	51	64.7	0	-
Donegal Mental Health Catchment Area	83	86.1	0	-
East Galway Mental Health Catchment Area	161	215.4	54	33.5%
Limerick Mental Health Catchment Area	127	92.8	0	-
Mayo Mental Health Catchment Area	75	83.3	1	1.3%
Roscommon Mental Health Catchment Area	25	60.2	1	4.0%
Sligo Leitrim Mental Health Catchment Area	34	46.9	0	-
West Galway Mental Health Catchment Area	37	42.3	0	-
Other Services Provided **	750	-	-	
National Total	**3,475**	**114.7**	**189**	**5.4%**

* There is a lack of clarity in the electoral divisions and therefore the population served by these mental health services.

** Independent providers (private hospitals), the Central Mental Hospital and St. Joseph's intellectual disability service which do not have a defined catchment area and have residents from the whole country. Therefore population rates cannot be given for these services.

PROFILE OF RESIDENT INPATIENTS

Gender and age

There were 1,565 females and 1,910 males in psychiatric hospitals and units on the census day in 2005, a breakdown of 45% and 55% respectively. Table 4.3 shows a breakdown of residents by age and gender. There were four residents aged under 16 years at the time of the census, and 17 aged 16-17 years.

Analysis of information on mental health services (AIMS)

Table 4.3: Resident inpatients. Census 2005. Gender and age. Numbers and column percentages.

	Male	Female	All residents
Less than 16 years	1 *(0.1%)*	3 *(0.2%)*	4 *(0.1%)*
16-17 years	9 *(0.5%)*	8 *(0.5%)*	17 *(0.5%)*
18-64 years	1,341 *(70.2%)*	932 *(59.6%)*	2,273 *(65.4%)*
65 years and over	557 *(29.2%)*	617 *(39.4%)*	1,174 *(33.8%)*
Missing data	2 *(0.1%)*	5 *(0.3%)*	7 *(0.2%)*
All ages	1,910 *55.0%*	1,565 *45.0%*	3,475 *100%*

Legal status

The majority of residents were voluntary admissions (80.3%) (Table 4.4). There were 519 (15%) residents who were involuntarily admitted (494 on 'temporary forms' and 25 who were 'PUM' or person of unsound mind) which gives a national rate of 17.1 per 100,000 population over 16 years. The 75 residents in the Central Mental Hospital are all admitted under a variety of court orders and there were three 'lodgers' on the night of the census. There were 87 (2.5%) residents who were wards of court.

Table 4.5 presents the number and rate of residents in the voluntary and involuntary categories by mental health catchment area. The highest rates of involuntary status of residents were in the Area 6 (44.0 per 100,000 population over 16), Longford/Westmeath (40.4) and East Galway (32.1) mental health catchment areas. However, 26 of the involuntary residents from Area 6 were from outside the catchment area, as were 5 of those from the East Galway service. The lowest rates were in Area 9 (6.0), South Lee (6.1) and Area 3 (6.3). There was a seven-fold difference in the involuntary resident rate between mental health catchment areas.

Table 4.4: Resident inpatients. Census 2005. Gender and legal status. Numbers and column percentages.

	Male	Female	All residents
Voluntary	1,482 *77.6%*	1,309 *83.6%*	2,791 *80.3%*
Temporary	298 *15.6%*	196 *12.5%*	494 *14.2%*
PUM	12 *0.6%*	13 *0.8%*	25 *0.7%*
Ward of Court	48 *2.5%*	39 *2.5%*	87 *2.5%*
Court Order	69 *3.6%*	6 *0.4%*	75 *2.2%*
Lodger*	1 *0.1%*	2 *0.1%*	3 *0.1%*
Total	1,910 *100%*	1,565 *100%*	3,475 *100%*

** Lodger is not a legal status*

Analysis of information on mental health services (AIMS)

Table 4.5: Selected legal status by mental health catchment area. Census 2005. Numbers and rates per 100,000 population over 16 years. (This table includes voluntary, tempory and pum stats only)

MENTAL HEALTH CATCHMENT AREAS	Voluntary residents	Rate of voluntary residents per 100,000 population over 16	Involuntary patients (Tempory and PUM)	Rate of involuntary patients per 100,000 population over 16
HSE Dublin North East	**351**	**54.7**	**124**	**19.3**
Area 6 North West Dublin	82	73.7	49	44.0
Area 7 North Inner City Dublin	59	53.2	26	23.5
Area 8 North County Dublin	107	66.0	19	11.7
Cavan/Monaghan Mental Health Catchment Area	38	46.6	12	14.7
Louth Meath Mental Health Catchment Area	65	37.0	18	10.2
HSE Dublin Mid-Leinster	**388**	**43.7**	**105**	**11.8**
Area 1 East Coast Dublin	21	15.6	12	8.9
Area 2 South East Dublin *	30	34.1	11	12.5
Area 3 South West Inner City Dublin *	40	35.8	7	6.3
Area 4 & 5 South West Dublin	53	28.6	21	11.3
Area 9 Kildare and West Wicklow	25	18.7	8	6.0
Area 10 Wicklow	39	51.3	6	7.9
Laois Offaly Mental Health Catchment Area	59	64.2	8	8.7
Longford Westmeath Mental Health Catchment Area	121	152.6	32	40.4
HSE South	**983**	**127.1**	**129**	**16.7**
Carlow/Kilkenny Mental Health Catchment Area	117	121.8	8	8.3
Kerry Mental Health Catchment Area	112	107.9	24	23.1
North Cork Mental Health Catchment Area	136	238.8	7	12.3
North Lee Mental Health Catchment Area	98	81.6	27	22.5
South Lee Mental Health Catchment Area	68	51.9	8	6.1
Tipperary (Tipperary South and North)	184	172.0	13	12.1
Waterford Mental Health Catchment Area	122	156.1	22	28.2
West Cork Mental Health Catchment Area	11	28.3	5	12.8
Wexford Mental Health Catchment Area	135	153.1	15	17.0
HSE Western	**466**	**64.3**	**120**	**16.6**
Clare Mental Health Catchment Area	41	52.0	10	12.7
Donegal Mental Health Catchment Area	62	64.3	21	21.8
East Galway Mental Health Catchment Area	133	177.9	24	32.1
Limerick Mental Health Catchment Area	106	77.5	19	13.9
Mayo Mental Health Catchment Area	63	70.0	11	12.2
Roscommon Mental Health Catchment Area	20	48.2	5	12.0
Sligo Leitrim Mental Health Catchment Area	15	20.7	19	26.2
West Galway Mental Health Catchment Area	26	29.7	11	12.6
Other Service Providers	**603**	**-**	**41**	**-**
St. Josephs Intellectual Disability Service	185	-	1	-
Independent Providers	418	-	40	-

* There is a lack of clarity in the electoral divisions and therefore the population served by these mental health services.

Diagnosis

The profile of residents by diagnostic group is shown in Table 4.6. As with previous years, the largest single diagnostic group for residents was schizophrenia, followed by depressive disorders and mental handicap. Unfortunately, 15% of residents had no diagnosis returned. This is due in large part to the practice in some inpatient facilities of not recording a diagnosis until discharge. As this is a census, the residents have not yet been discharged and therefore have no recorded diagnosis.

Length of stay

Table 4.7 shows the length of stay of residents by age groups. The largest proportion of residents had been in hospital for less than three months (40%). However, almost one third of residents were long-stay, having been in hospital for more than five years, and 17% were new-long stay (in hospital for 1-5 years). These figures represent a long-stay hospitalisation rate of 37.2 per 100,000 over 16 years, and a new long-stay hospitalisation rate of 19.2 per 100,000 population over 16.

Table 4.6: Diagnostic groups* for inpatients. Census 2005.
Numbers, percentages and rates per 100,000 population aged over 16 years.

	Numbers	%	Rates
Organic Psychosis	218	6.3	7.2
Schizophrenia	1,187	34.2	39.2
Other psychoses	26	0.7	0.9
Depressive disorders	449	12.9	14.8
Bipolar affective disorders (including manic episode)	283	8.1	9.3
Neuroses	55	1.6	1.8
Personality disorders	85	2.4	2.8
Alcoholic disorders	129	3.7	4.3
Drug dependence	40	1.2	1.3
Mental handicap	418	12.0	13.8
Diagnosis unspecified	51	1.5	1.7
Diagnosis not returned	534	15.4	17.6
Total	3,475	100	114.7

* ICD 10 codes were summarised into 12 categories for ease of presentation. Details of specific ICD 10 codes are available from the Commission if required.

Table 4.7: Length of stay and age groups. Census 2005. Numbers and row percentages.

	Less than 16 years	16-17 years	18-64 years	65 years and older	Date of Birth Not Given	Total (column %)
Less than three mths	4 *(0.3%)*	14 *(1.0%)*	1,116 *(80.6%)*	247 *(17.8%)*	4 *0.3%*	1,385 *(39.9%)*
3-12 mths	0 -	2 *(0.5%)*	252 *(67.2%)*	121 *(32.3%)*	0 -	375 *(10.8%)*
1-5 years	0 -	1 *(0.2%)*	327 *(56.1%)*	254 *(43.6%)*	1 *0.2%*	583 *(16.8%)*
More than 5 years	0 -	0 -	576 *(51.0%)*	551 *(48.8%)*	2 *0.2%*	1,129 *(32.5%)*
Date of admission not specified	0 -	0 -	2 *66.7%*	1 *33.3%*	0 -	3 *0.1%*
Total	4 *(0.1%)*	17 *(0.5%)*	2,273 *(65.4%)*	1,174 *(33.8%)*	7 *0.2%*	3,475 *(100%)*

Hospital type

The format of data collection for 2005 has allowed an analysis of residents in the different inpatient facilities (Table 4.8). The majority of beds and therefore residents were in psychiatric hospitals on census night 2005. There were 2,169 beds in psychiatric hospitals, 55% of all psychiatric beds, with 895 (23%) in general hospital psychiatric units and 626 (16%) in private hospitals (independent providers).

In 2004, 47% of psychiatric admissions were to beds in general hospital psychiatric units (Daly et al., 2005). Therefore, 23% of psychiatric beds cater for almost half of inpatient activity.

Ward type

Information was also collected on the type of wards in each inpatient facility (Table 4.9). On census night,

Table 4.8: Residents and beds by Hospital Type. Census 2005. Numbers and rates per 100,000 population over 16 years.

	Number of residents	Rate of inpatients 100,000 over 16 population	Number of beds	Rate of beds 100,000 over 16 population
General Hospital Psychiatric Units	817	27.0	895	29.5
Psychiatric Hospitals	1,908	63.0	2,169	71.6
Independent Providers	479	15.8	626	20.7
Central Mental Hospital	75	2.5	71	2.3
St. Joseph's intellectual disability service	196	6.5	214	7.1
Total	**3,475**	**114.7**	**3,975**	**131.2**

Table 4.9: Ward type* and age groups. Census 2005. Numbers and column percentages.

	Up to 17 years	18-64 years	65 years and older	Date of Birth Not Given	Total (column percentage)
Acute unit	20 *95.2%*	1,253 *55.1%*	211 *18.0%*	4 *57.1%*	1,488 *42.8%*
Old age acute unit	0 -	2 *0.1%*	39 *3.3%*	0 -	41 *1.2%*
Long-stay ward	1 *4.8%*	585 *25.7%*	532 *45.3%*	2 *28.6%*	1,120 *32.2%*
Old age long-stay ward	0 -	72 *3.2%*	337 *28.7%*	1 *14.3%*	410 *11.8%*
Rehabilitation ward	0 -	149 *6.6%*	43 *3.7%*	0 -	192 *5.5%*
Intensive care unit	0 -	123 *5.4%*	8 *0.7%*	0 -	131 *3.8%*
Central Mental Hospital	0 -	73 *3.2%*	2 *0.2%*	0 -	75 *2.2%*
Ward Type not Given	0 -	16 *0.7%*	2 *0.2%*	0 -	18 *0.5%*
Total	21 *100%*	2,273 *100%*	1,174 *100%*	7 *100.0%*	3,475 *100%*

* The definitions of wards are given in Appendix 1 – Instructions for completing the census form.

equal numbers of residents were in acute units and long-stay wards (44% on each, including old age acute units and old age long-stay). Just over one fifth (21%) of older people were in acute units on census night, with almost three quarters (74%) on long-stay wards. Over half (55%) of those aged 18-64 years were on acute units, although 29% were on long-stay wards.

Residents and beds by HSE administrative area and mental health catchment area

Table 4.10 shows resident and bed numbers and rates for each mental health catchment area in the country. Wide variation is seen with resident and beds rates across the 31 mental health catchment areas. Very high rates of residents are evident in the North Cork, East Galway, Longford/Westmeath and Waterford mental health catchment areas. These rates are closely related to the number of available beds and the presence of a psychiatric hospital. Areas 1, 9 and 4 & 5 have the lowest resident inpatient rates and the lowest rate of beds.

Inpatient beds

A total of 3,975 beds was available in psychiatric hospitals and units in November 2005, a rate of 131.2 beds per 100,000 population over 16 years (and a rate of 101.5 per 100,000 total population) (Table 4.10). This represents a reduction of 146 beds on 2004, when there were 4,121 beds reported, a rate of 136.1 per 100,000 population over 16. Wide variation in the availability of inpatient beds is still evident in the mental health system. The HSE Dublin Mid-Leinster area has 559 psychiatric beds, a rate of 63 per 100,000 population over 16 years. The HSE Southern area has more than double this with 163 beds per 100,000 population over 16.

Table 4.10: Inpatients and beds by mental health catchment area. Census 2005. Numbers and rates per 100,000 population over 16 years.

MENTAL HEALTH CATCHMENT AREAS	Number of inpatients	Rate of inpatients 100,000 over 16 population	Number of beds	Rate of beds 100,000 over 16 population
HSE Dublin North East	**490**	**76.4**	**539**	**84.0**
Area 6 North West Dublin	133	119.5	134	120.4
Area 7 North Inner City Dublin	87	78.5	102	92.0
Area 8 North County Dublin	131	80.8	141	87.0
Cavan/Monaghan Mental Health Catchment Area	51	62.5	70	85.8
Louth Meath Mental Health Catchment Area	88	50.1	92	52.4
HSE Dublin Mid-Leinster	**498**	**56.0**	**559**	**63.0**
Area 1 East Coast Dublin	33	24.5	42	31.2
Area 2 South East Dublin*	41	46.7	41	46.7
Area 3 South West Inner City Dublin*	47	42.1	51	45.7
Area 4 & 5 South West Dublin	74	39.9	74	39.9
Area 9 Kildare and West Wicklow	33	24.7	30	22.5
Area 10 Wicklow	48	63.1	60	78.9
Laois Offaly Mental Health Catchment Area	67	72.9	90	98.0
Longford Westmeath Mental Health Catchment Area	155	195.5	171	215.7
HSE South	**1,144**	**147.9**	**1,263**	**163.3**
Carlow/Kilkenny Mental Health Catchment Area*	135	140.6	167	173.9
Kerry Mental Health Catchment Area	136	131.1	133	128.2
North Cork Mental Health Catchment Area	149	261.6	180	316.1
North Lee Mental Health Catchment Area	129	107.4	124	103.2
South Lee Mental Health Catchment Area	76	58.0	83	63.3
Tipperary (Tipperary South and North)	202	188.8	210	196.3
Waterford Mental Health Catchment Area*	148	189.4	177	226.5
West Cork Mental Health Catchment Area	16	41.1	18	46.2
Wexford Mental Health Catchment Area	153	173.5	171	193.9
HSE West	**593**	**81.8**	**703**	**97.0**
Clare Mental Health Catchment Area	51	64.7	51	64.7
Donegal Mental Health Catchment Area	83	86.1	96	99.6
East Galway Mental Health Catchment Area	161	215.4	207	276.9
Limerick Mental Health Catchment Area	127	92.8	143	104.5
Mayo Mental Health Catchment Area	75	83.3	81	90.0
Roscommon Mental Health Catchment Area	25	60.2	30	72.2
Sligo Leitrim Mental Health Catchment Area	34	46.9	52	71.7
West Galway Mental Health Catchment Area	37	42.3	43	49.1
Other services**	750	-	911	-
National Total	**3,475**	**114.7**	**3,975**	**131.2**

* There is a lack of clarity in the electoral divisions and therefore the population served by these mental health services.

** Independent providers (private hospitals), the Central Mental Hospital and St. Joseph's intellectual disability service which do not have a defined catchment area and have residents from the whole country. Therefore population rates cannot be given for these services.

Analysis of information on mental health services (AIMS)

Comparison with Europe

Ireland has a relatively high rate of psychiatric beds per 100,000 total population (101.5) when compared with other European countries (Table 4.11). Only three of the selected countries had higher psychiatric beds rates; Belgium, Germany and the Netherlands.

Table 4.11: Census of psychiatric hospital beds in selected EU countries for 2004* (or most recently available year)

Country	Psychiatric beds per 100,000 total population
Austria	63.3* (2003)
Belgium	147.8
Denmark	70.3* (2003)
Finland	94.2
France	97.1* (2003)
Germany	150.4
Ireland	101.5 (2005)
Italy	13.4* (2003)
Netherlands	152.7* (2002)
Portugal	65.9* (2003)
Spain	50.3* (2002)
Sweden	50.1

Countries were included that were members of the EU in 2003 and have recently reported data.
Source: European Health for All Database (http://data.euro.who.int/hfadb)

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Monthly Returns on Involuntary Admissions

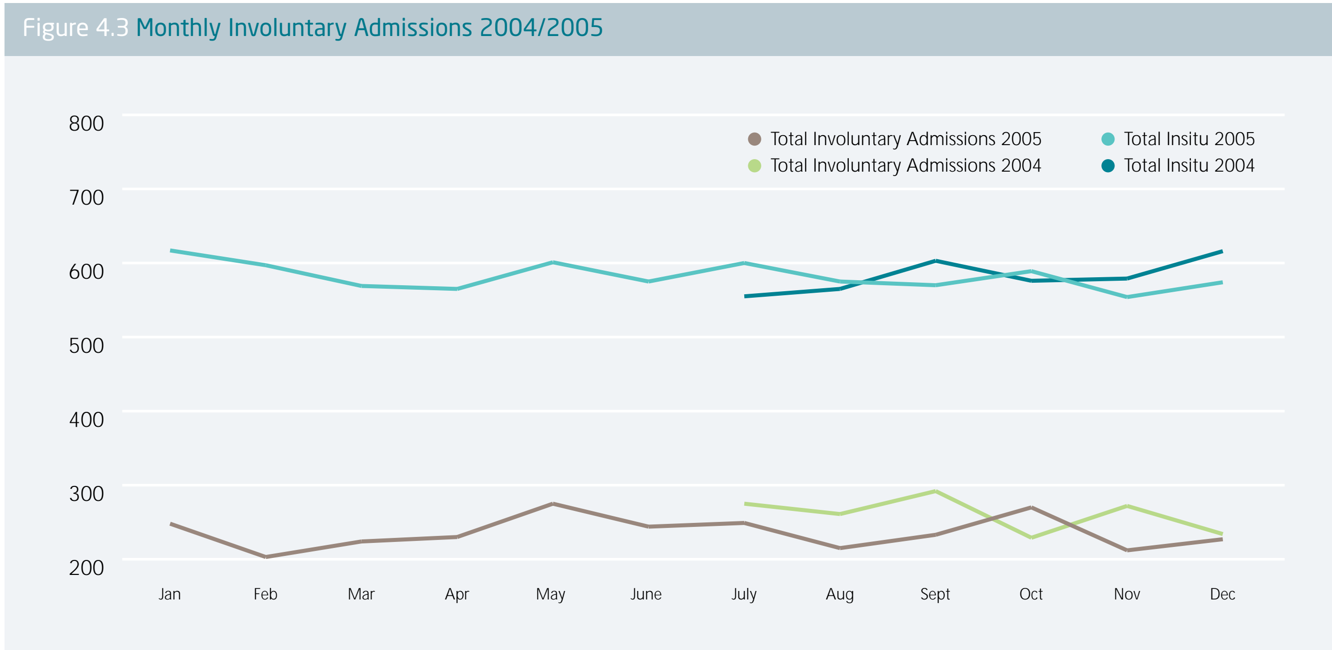
BACKGROUND

In July 2004 the Commission commenced the collection of monthly returns from service providers detailing their level of involuntary admissions to each facility and the number of patients subject to Person of Unsound Mind (PUM) or Temporary Reception Orders at the end of each calendar month. The returns were introduced by the Commission to provide data to assist the planning process required for implementation of the 2001 Act while also allowing service providers to prepare for the more detailed statutory notifications required in the Mental Health Act (2001). Upon implementation, Part 2 of the Act will require that the Commission receives individual notifications of every involuntary admission within 24 hours of an order being made. The Mental Health Commission began collecting monthly returns for involuntary admission at the end of July 2004. Fifty six facilities across all areas provide returns, however a number (range = 7 to 9) submit a zero return.

FINDINGS

Table 4.12 below summarises the monthly returns for each category of involuntary admission, (including patients re-graded after a voluntary admission) and Figure 4.3 below details overall trends.

Figure 4.3 Monthly Involuntary Admissions 2004/2005



Monthly Returns on Involuntary Admissions

Table 4.12: National Summary of Monthly Returns for Jan 2005 to Dec 2005

Involuntary Admissions and Re-grading to Involuntary Status

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Type of Involuntary Admissions													
Temporary order admissions	187	161	181	179	219	190	207	171	189	216	167	176	2243
Voluntary patients re graded to temporary order	57	40	36	43	51	51	39	42	41	49	44	48	541
Person of Unsound Mind (PUM) admissions	4	2	7	8	5	3	3	2	3	5	1	3	46
Voluntary patients regarded to PUM	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Involuntary Admissions	**248**	**203**	**224**	**230**	**275**	**244**	**249**	**215**	**233**	**270**	**212**	**227**	**2830**

Legal Category as of Midnight – At month end

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Temporary order admission	573	558	528	521	560	533	558	540	540	559	525	542	N/A
Person of Unsound Mind (PUM)	44	39	41	44	41	42	42	35	30	30	29	32	N/A
TOTAL (in-situ at month end '05)	**617**	**597**	**569**	**565**	**601**	**575**	**600**	**575**	**570**	**589**	**554**	**574**	**N/A**
No. of Approved Centres returned	56	56	56	56	56	56	56	56	56	56	56	56	N/A
No. of Centres with Nil returns	8	9	9	7	7	9	9	8	9	8	8	8	N/A

Excludes figures for Central Mental Hospital

The month with the highest number of involuntary admissions was May with 275 admissions while the month with the lowest is February with 203 involuntary admissions. The average number of involuntary admissions over the 12-month period of 2005 is 236.

The month with the highest number of patients detained at midnight on month end is January with 617 patients while November has the lowest number with 554 patients.

When the total number of involuntary admissions from the community (n= 2,289) in 2005 is compared with similar figures for 2004 from the report of the Activities of Irish Psychiatric Units and Hospitals (HRB, 2004) this shows a reduction of 7.22 % from 2004 when the figure was 2,467. It is important to note that figures for these comparisons do not include patients who were re-graded from voluntary to involuntary after their admission, which the monthly returns inform there were 541 in 2005.

Monthly Returns on Involuntary Admissions

From the monthly returns involuntary admission rates (per 100,000 of population over 16) were compared with similar figures for 2004 in the report of the Activities of Irish Psychiatric Units and Hospitals (HRB, 2004). Comparison shows a rate of 75.6 per 100,000 in the 2005 monthly returns compared to the Activities report for 2004 where the figure was 81.4 per 100,000. Population figures are based on the Central Statistics Office report for 2002.

DETAILS OF PATIENTS SUBJECT TO INVOLUNTARY ADMISSION ORDERS AT 31ST DECEMBER 2005

Table 4.13 below details the type of admission for all patients who were detained as at midnight on the 31st December 2005. Of the 574 patients detained 31.5% (n=181) were recorded as being on their first ever admission to an approved centre, while 68.5% (n=393) are recorded as having a previous admission.

Table 4.14 below shows the breakdown by gender for patients who were detained as at midnight on the 31st of December 2005. Of the 574 patients detained, almost 60% (n = 338) were male.

Table 4.15 below shows the age/gender categories of detained patients. The highest concentration of males detained is in the 21 to 65 category with 46.5% (n=267) patients. The age category with the highest concentration of females is in the 21 to 65 category with 26.13% (n=150) patients. There were 3 persons aged under 18 detained at 31st December 2005.

Table 4.13: Type of admission (First / Readmission) of Involuntary Patients at 31st December 2005

	Frequency	Percent
First ever admission	**181**	**31.5 %**
Readmission	**393**	**68.5 %**
Total	**574**	**100 %**

Table 4.14: Gender analysis of Involuntary Patients detained at the 31st December 2005

	Frequency	Percent
Male	**338**	**58.9 %**
Female	**236**	**41.1 %**
Total	**574**	**100 %**

Table 4.15: Age / Gender analysis of Involuntary Patients as at the 31st December 2005

AGE	MALE	*Male %*	FEMALE	*Female %*	TOTAL	*Total %*
Under 16	0	(0%)	0	(0%)	0	(0%)
16 to 17 (inclusive)	1	(0.2%)	2	(0.35%)	3	(0.55%)
18 and over and under 21	9	(1.6%)	8	(1.39%)	17	(2.99%)
21 and over and under 65	267	(46.5%)	150	(26.13%)	417	(72.63%)
65 and over and under 85	56	(9.7 %)	69	(12.01%)	125	(21.71%)
Over 85	5	(0.9%)	7	(1.22%)	12	(2.12%)
TOTAL	**338**	**(58.9%)**	**236**	**(41.1%)**	**574**	**(100%)**

Monthly Returns on Involuntary Admissions

Table 4.16 below shows length of detention. The category having the highest concentration of involuntary patients at the 31st December 2005 is patients detained between 4 weeks and 6 months. Within this category there were 234 (41%) patients detained. The second highest concentration is in the 1 week to 4 weeks category with 106 (18.47%) patients involuntarily detained. Of the 106 patients, 104 are on temporary orders while 2 are graded as PUM. When both of these categories are combined this shows that 59.25% (n=340) of all involuntary detained patients as at the 31st December 2005 were detained for six month or less. It should be noted that a Temporary Order lasts up to six months and can be extended by a further period not exceeding six months or by a series of orders the aggregate of which shall not exceed eighteen months. Patients detained on a Temporary Order for longer than two years require a new order to be signed.

The highest concentration of PUM patients fall within the length of detention category 20 years or more (n=14). This represents 2.44% of all patients involuntary detained as at 31st December 2005. The number of PUM patients detained for 10 years or more is 18 while in the same timeframe we have 13 patients who have been detained 10 years or more on temporary orders.

Table 4.16: Length of detention of Involuntary Patients as at the 31st December 2005

Length of time	Temporary	*Temp %*	PUM	*Pum %*	Total	Total (%)
Up to 1 week	37	6.45 %	1	0.17 %	38	6.62 %
More than 1 week - less than or equal to 4 weeks	104	18.12 %	2	0.35 %	106	18.47 %
More than 4 weeks - less than or equal to 6 months	230	40.08 %	4	0.70 %	234	40.78 %
More than 6 months - less than or equal to 12 months	53	9.23 %	0	0 %	53	9.23 %
More than 1 year - less than or equal to 2 years	48	8.36 %	1	0.17 %	49	8.53 %
More than 2 years - less than or equal to 5 years	38	6.62 %	3	0.52 %	41	7.14 %
More than 5 years - less than or equal to 10 years	19	3.31 %	3	0.52 %	22	3.8 %
More than 10 years - less than or equal to 15 years	7	1.22 %	1	0.17 %	8	1.39 %
More than 15 years - less than or equal to 20 years	2	0.35 %	3	0.52 %	5	0.9 %
20 years or more	4	0.70 %	14	2.44 %	18	3.14 %
TOTAL	**542**	**94.44 %**	**32**	**5.56 %**	**574**	**100 %**

DISCUSSION

This is the first full calendar year data from the monthly returns. The figures provide more detailed information relating to recent involuntary admission rates under the 1945 Act than has been previously available. All admitting units are now providing comprehensive returns within the required timeframes.

There is evidence of less frequent use of PUM orders for admission and these are occurring in a small number of areas. The figures for involuntary admissions from the community in 2005 (n= 2,289) are notable. The fact that this shows a reduction by 7.22% compared with similar figures for 2004 may suggest a trend and we will continue to monitor this. However, it is important to note that figures for these comparisons do not include patients who were re-graded from voluntary to involuntary status after their admission. The monthly returns indicate there were 541 such re-gradings in 2005. Analysis of the initial six month period of the returns, for July to December 2004, indicates there were 295 such re-gradings, again indicating there may be a downward trend in the re-grading of voluntary patients during 2005.

Analysis of the monthly returns will continue in 2006 and will assist in the planning process for commencement of Part 2 of the Act.

Part Two

Chapter 5

Report of the Inspector of Mental Health Services 2005

Review of Mental Health Services Nationally

Dr. Teresa Carey
Inspector of Mental Health Services

Irish mental health services are currently undergoing a major reformation. Up until now, services have been contained within the model described in the 1984 policy document "Planning for the Future" and within the legislative framework of the 1945 Mental Treatment Act. The way has finally been cleared to fully implement the Mental Health Act 2001, with its twin principles of patient rights and quality within the mental health services. The Mental Health Commission is actively engaged with service providers and people who use mental health services in defining what constitutes quality across a range of service provision.

The new mental health service policy document "Vision for Change" has been published. It has been accepted by Government as national policy, with a commitment to providing the necessary funding to implement its recommendations within a seven to ten year period. This reformation of services will involve a radical change in the way services are planned, managed, implemented and audited. This change will require fundamental reorientation in the minds of everyone involved in their approach to mental health services and how they are provided. The new services will have the needs of users at the centre. They will involve an even greater move towards community provision of mental health services, for both those with acute and enduring illness. The current preoccupation with beds will be replaced by home-based treatment for those with acute illness and assertive outreach services for those with enduring illness. Service user and carer inputs will be recognised and supported. The new services will all be based on a range of specialised community mental health teams, with a new concept of genuine multi-professional input and team functioning. Major changes in management systems will occur, with clinical managers and professional managers sharing management responsibilities. Larger catchment populations will be fashioned and, for the first time ever, there will be a national mental health service management directorate. These management changes will result in the necessary transparency and accountability that is lacking in the current system.

The implications of this mental health service reform are not yet fully recognised by heath service providers. The HSE has to respond by developing an implementation plan that will ensure that there is full implementation of all aspects of "Vision for Change" within the seven to ten year time frame. Clinical professionals must recognise the extent of change required in the way in which they plan and deliver care programmes. For some professional groups, particularly doctors and nurses, there will have to be a change in deeply ingrained ways of working. This will need courageous leadership from senior professionals and professional bodies.

The Inspectorate recognises fully the major challenges posed by the most radical reform of the mental health services that has taken place for many years. The Inspectorate is committed to the implementation of this long-awaited reform and will be supportive of services that respond adequately to the new mental health policy.

THE FUTURE SHAPE OF SERVICES

In last year's report the Inspectorate outlined the areas of service development that required urgent attention. These included the development of new management systems with larger catchments, the development of specialist community-based teams, the development of systems to enable meaningful service user and carer involvement and the

introduction of strong management and clinical governance systems. These themes have been given central focus in "Vision for Change" and the inspections of 2005 have confirmed that these remain the priorities.

SERVICE MANAGEMENT

Fundamental to real service reform is the reorganisation of mental health service management nationally. Under the new regime, mental health services are under the management of local health managers, who are responsible for all community based services in their area. These areas, as they relate to mental health services, are the same catchments that have, with a few exceptions, been in place for 150 years. To try to ensure some degree of wider planning vision, each HSE Region has a lead local health manager in mental health. However, these lead local health managers also carry responsibility as local health officers. The traditional catchment management system of clinical director, director of nursing and service administrator remains at traditional catchment level, with no system in place to allow true service planning and development at regional level. "Vision for Change" requires the setting up of regional management teams, made up of both clinical personnel and professional managers, taking responsibility for service developments and management for populations of approximately 350,000. Mirroring these regional management teams, it is proposed there would be a national mental health management team. Without these management changes, "Vision for Change" will remain aspirational.

These management changes will pose considerable challenges to all concerned. Traditional managers within the health service may not be accustomed to sharing management responsibility with clinical personnel, and may genuinely believe that it is their job to manage and the job of clinical personnel to treat. Others may believe that clinical personnel have no real management skills and will not be able to work in the practical world of limited resources and ever-increasing demand. Current catchment management teams, particularly the clinical personnel on these teams, may well interpret "Vision for Change" as depriving them of influence in their local service and the right to use the resources of their service as they think best. Yet the failures of the current mental health service management systems have been evident to the Inspectorate during the inspections of 2004 and again in 2005.

During inspections in 2004 the Inspectorate saw clear evidence of the failure of the old Health Board management system and during inspections in 2005 serious deficiencies remained. Management teams whose responsibility is restricted to small catchment areas are not in a position to plan and develop services for populations greater than those served by their catchment areas. Likewise, they are not well placed to audit objectively their own effectiveness as managers. In the opinion of the Inspectorate it is these two factors, planning and governance, that make a new management system essential. Members of the new broader management teams, as envisaged by "Vision for Change", will be appointed on the basis of their proven management competency, and central to this competency, will be their ability to think beyond the boundaries of their own traditional catchment services and professional group. A national management group, in turn, will be responsible for working out the details of the implementation of the new mental health policy, and will be in a position to ensure the rational development of speciality services that are currently under-developed or not available. With clear knowledge of what responsibilities lie at each level of management, the current situation where no group takes accountability for management failures will come to an end.

GOVERNANCE

The lack of governance in both management systems and clinical systems within the mental health service is both evident and disturbing. There are large tranches of "Planning for the Future", now over 20 years old, still not implemented, yet no one has ever been held accountable for the failure to fully implement this national policy. We still have large mental hospitals like St. Luke's Hospital in Clonmel, St. Loman's Hospital in Mullingar, St. Otteran's Hospital in Waterford, St. Sennan's Hospital in Wexford and St. Stephen's Hospital in Cork that are not only still open, but have significant numbers of remaining long stay beds which are still actively used. There is no accounting for the continued and

vigorous existence of these facilities 20 years after national policy dictated that they should be closed. The development of multi-professional teams as the cornerstone of service delivery was a central tenet of "Planning for the Future" yet, nowhere in the country have fully-staffed teams been delivered. Community-based care was another central tenet of "Planning for the Future", yet admission rates do not reflect any substantial shift in focus from beds to a community and readmission rates, in particular, are persistently high.

Governance systems, at their simplest, are systems to ensure the provision of quality services that are known to be safe, effective and efficient. Governance requires accurate, timely and accessible information but the mental health service nationally, as with the health service as a whole, has consistently failed to develop that capability. Yet even with the limited information available, it is evident that clinical practices that are clearly outside the norm occur time and time again, in the same services. Perhaps there is a valid reason why some services are yet again the highest admitting services nationally, admitting more than four times the lowest-admitting service. Perhaps there is a valid reason why some services have again generated rates of new long-stay patients that are in a different realm to the rest of services nationally. Perhaps there is a valid reason why certification rates still vary by a factor of four between catchments. Perhaps there is a valid clinical reason why admission rates for alcohol-related disorders vary by a factor of 10 between services. In the absence of adequate governance systems, the questions have never been answered.

The Irish public, as a result of recent controversies in the health service, are considerably more sensitive to issues relating to health care in recent years. Some health care facilities are better staffed, better equipped and better managed than others. Clinical practice can vary between clinicians and we have learned that it is not acceptable for individual clinicians to practice as they see fit, if this is in conflict with what is best practice. What is missing for many people is the essential information to allow them to choose their health-care provider. This is particularly the case for those who attend the public mental health services, where the less-well off are over-represented and where the system itself limits choice through the insistence that catchment boundaries are sacrosanct. For these reasons, robust clinical governance systems are essential within mental health services to ensure that every patient, no matter where they live and what service they access, can be confident of being able to avail of the best available standard of care. Governance systems are also essential so that the tax-payer can clearly see where their taxes are being spent and clearly see what services are giving value for money. Clinical and management governance systems must be both internal and external, so that systems can assess themselves internally and also be judged objectively in comparison to others.

The new management system, described in "A Vision for Change" will be in an ideal position to implement management and clinical governance systems locally and nationally and to bring badly needed visibility and clarity to activity within the Irish Mental Health Services. The Mental Health Commission, with its twin statutory obligations of promoting service quality and protecting patient rights, has a central role as an external governance agency, and will continue to develop systems and processes to fulfil these obligations.

THE INSPECTION PROCESS

A new era in the provision of mental health services requires a new type of inspection process. The statutory requirement on inspecting facilities will have to be matched by an emphasis on inspecting services and the powers given to the Inspectorate under the Act will be fully utilised to enable this. It is not acceptable to this Inspectorate, or to the Mental Health Commission, that annual reports of the Inspector should recount the same deficiencies year on year.

The Mental Health Commission is charged with developing various rules, regulations and guidelines relating to service quality. These are currently being developed and will be the objective measure by which mental health services are assessed. In 2005, the Inspectorate considered it important that service provision failures which, in the opinion of the Inspectorate team, fell significantly below an acceptable standard of patient care, should be notified immediately to the Mental Health Commission. The Mental Health Commission was subsequently alerted to issues in a number of services

that were considered in need of immediate action. These services were contacted, given clear details of the Inspectors' concerns and given clear recommendations on what actions were to be taken immediately to remedy the situation. Each service was informed that an unannounced follow-up visit would occur within three months, to assess progress, and where necessary further interaction between service managers and the Commission took place after these visits. This process of ongoing interaction will form an integral part of the inspection process, and as detailed knowledge of the services nationally is built up, services that consistently show evidence of poor management and clinical governance will be called to account.

INSPECTIONS 2005

The inspections of 2004, the first year of this Inspectorate's work, concentrated on fulfilling the statutory obligation of inspecting inpatient units and on obtaining a broad knowledge of services available nationally. Considerable detail was presented in the report of 2004 on general adult mental health services. The inspection of 2005 was extended in 2005 to cover all inpatient units and wards and all 24-hour nurse supervised residences. The details and recommendations on general adult catchment services given in the 2004 report still stand, as little changes in one year. Some facts from the 2005 inspection, relating to these services are worthy of note and these are highlighted below. During the inspections of 2005, mental health services for the elderly, for children and adolescents, for those with learning disability and for those with enduring mental illness were inspected in more detail.

GENERAL ADULT MENTAL HEALTH SERVICES

Table (5.1) gives information on a range of service indices for adult mental health services nationally. Information in the table has been gleaned from information returned to the Mental Health Commission and from the "Activities of Irish Psychiatric Hospitals 2004". Appendix 2 gives a breakdown of this information for the four HSE Areas. The Inspectorate must stress, however, that the accuracy of these figures is limited by the constraints of the information management capabilities of the mental health service nationally. The information in the Tables incorporates the services indices for general adult mental health services, rehabilitation mental health services and

Table 5.1: Range of service indices for adult mental health services (includes information on the Central Mental Hospital, St. Joseph's Intellectual Disability Service and Independent Providers)

National Population (census 2002)	3,917,203
National Over 16 Population (census 2002)	3,028,893
Funding € (2005)	€646,745,721.82
Beds (2005)	3,975
Admission Rate (2004)[1]	735.5
Involuntary Admission Rate (2005)[2]	93.4
Total New Long Stay Patients (2005)[3]	583
Patients Who Became New long Stay (2005)[4]	168

1 Daly et al (2005), Activities of Irish Psychiatric Units and Hospitals 2004, p.89, Table 4.1, Health Research Board.

2 Mental Health Commission (2006), Mental Health Commission Annual Report 2005, Including the Report of the Inspector of Mental Health Services, p.46, Table 4.12 National Summary of Monthly Returns for Jan 2005 to Dec 2005 - Involuntary Asmission and Re-grading to Involuntary Status.

3 New long stay patients on the night of the inpatient census, 4th November 2005 (see chapter 4 for details of the inpatient census).

4 Persons who became new long stay patients between 1st January 2005 and 4th November 2005, the night of the inpatient census (see chapter 4 for details of the inpatient census).

mental health services for the elderly. However, as the general adult mental health services are far and away the largest consumer of resources and the biggest user of beds, the services indices can be seen as relating predominantly to the general adult services.

The data highlights again the absence of management and clinical accountability. Some of these variations in service indices are clearly failures at catchment management level or higher and some are clearly the responsibility of individual clinicians or groups of clinicians. Many represent joint failures of both managers and clinicians. It can be seen how a lack of accurate information can be a protection for some. It can also be seen how a new management structure, with clear lines of accountability will be challenging for some. But if we are to move towards a quality mental health service, one that provides high standards of care to patients and one that provides value-for-money to the tax payer, these new management structures are essential. It is the Inspector's view that failure to implement these new structures will result in a failure to implement " A Vision for Change".

The Inspectorate was impressed at the difficulties facing some services due to lack of essential resources. Significant per capita variations in available funding for adult mental health services, continue to exist, see table 5.7 Appendix 2. The Inspectorate must again highlight that, in the absence of a uniform way to measure service resource, information can only be used as a general indicator. Accepting this constraint, funding varies six fold accross the Country. This variation relates in large part to the inequitable distribution of resources that are still tied to large institutions that previously served a far greater population. These difficulties are particularly evident in the Dublin and Cork/Kerry Services. In Dublin the bulk of resources, particularly the nursing resource, was tied up in the institutions of St. Ita's Hospital and St. Brendan's Hospital. While this resource has, to a considerable extent, been used to progress the process of deinstitutionalisation, funding of services in the capital has never kept pace with levels of deprivation and with the significant population growth that has occurred in the past decade. Similarly, in the South, the bulk of resource in the past was tied to the large institutions of Our Lady's Hospital in Cork, St. Finan's in Kerry, and more recently, to St. Stephen's Hospital in North Cork. As a result, the city services of South Lee, North Lee and the small rural service of West Cork are considerably less well off. Services in Kildare/West Wicklow and in Louth/Meath are disadvantaged historically, as adequate funding did not follow changes in catchment boundaries and populations. It is also acknowledged that some areas provide services for poeple outside their catchment area.

These funding issues highlight the long-term lack of an effective management system, particularly at national level. The catchment management system, localised as it is, has not allowed the equitable distribution of existing resources and in the absence of an effective national management system, there is no facility to match funding to population need. As a result, some of the most deprived urban areas are among the least well resourced.

REHABILITATION MENTAL HEALTH SERVICES

In the report of 2004 the Inspectorate identified two vulnerable groups of patients in need of specialist services: those patients receiving care in long-stay wards and units, and residents in 24-hour nurse supervised community residences. These people represent those who suffer from the more severe, enduring and disabling mental illnesses, where the consequences of the illness impedes a person's ability to live a fully independent life. In some services, where deinstitutionalisation is well advanced the majority of long-stay patients have been discharged, and only small numbers of elderly patients remain.

A number of catchments do not contain large institutions. These include the Kildare/West Wicklow catchment, the Cluain Mhuire catchment, and the West Cork catchment. St. James' Hospital has a 16-bed pre-discharge ward. Beds in this ward are frequently blocked due to the lack of a rehabilitation team and the insufficient supply of supported residences in the community. These beds, however, are more appropriately considered as part of the acute complement, which serves both adult services and mental health services for the elderly.

Four large mental hospitals have closed since "Planning for the Future"; Our Lady's Hospital in Cork, St. Patrick's Hospital in Castlerea, Our Lady's Hospital in Ennis and St. Columba's Hospital in Sligo. The relocation of patients from these hospitals occurred in various ways. In Cork, many long-stay

patients were transferred to other hospital facilities such as St. Finbarr's Hospital in Cork, St. Stephen's Hospital in North Cork, Heatherside Hospital in Buttevant and to St. Patrick's Hospital in Mallow. Few were transferred to 24-hour staffed community residences, as evidenced by the low provision of such facilities in the city catchments of North and South Lee. Patients from St. Patrick's Hospital in Castlerea were variously discharged to community accommodation, care of the elderly facilities and to a programme of "fostering" where members of the community were paid to "foster" a discharged patient. These fostering arrangements are no longer used. The majority of long-stay patients in St. Columba's Hospital in Sligo were discharged to community residences, or to care of the elderly services. When Our Lady's Hospital in Clare closed significant numbers were discharged to community residences, as can be seen by the level of provision of 24-hour community facilities in that catchment. However, a significant number of elderly long-stay patients were transferred to beds in a community hospital and to a purpose-built private nursing home, bought for the purpose by the former Mid-Western Health Board. All these beds remain under the care of the mental health service and have therefore been included in the number of long-term care beds available. With the closure of Our Lady's Hospital in Ennis, a number of patients with intellectual disability were discharged to hostels in the community. While it is fully accepted that these people should be under the care of the intellectual disability service, agreement has not been reached between the HSE and the local voluntary sector service provider on this matter. Hence, these people remain under the care of the mental health service.

A number of other mental hospitals have reduced the number of long-stay beds considerably and the only patients remaining are elderly patients under the care of a specialist mental health service or persons with enduring mental illness. St. Davnet's Hospital in Monaghan has 34 remaining long-stay beds, all under the care of the specialist mental health service for the elderly. St. Ita's Hospital in Portrane has 76 long-stay beds. Fifty nine of these beds are under the care of the mental health service for the elderly, the remainder are under the care of a specialist rehabilitation mental health service. St. Conal's Hospital in Letterkenny has just 26 remaining long-stay beds and the service has given priority to developing a specialist rehabilitation mental health service for these patients and for those in their community residences.

While the majority of hospitals have made considerable progress in reducing the number of long-stay patients a number of hospitals continue to have unacceptably high numbers of long-stay beds. These include all the mental hospitals in the South East, (the former South Eastern Health Board), St. Loman's Hospital in Mullingar and St. Stephen's Hospital in Cork. It is not surprising that these are the hospitals with the highest rate of generating new long-stay patients. None has a specialist rehabilitation mental health service and the catchment service statistics suggest that these services have made little progress towards reorienting their service to a community base.

DE-DESIGNATION OF WARDS

In the middle years of the 20th century, Ireland had one of the highest rates of psychiatric hospitalised morbidity in Europe. These high rates, coupled with the realisation that some people, particularly the elderly and those with an intellectual disability, may be inappropriately placed in mental institutions led to a drive to decrease numbers in mental hospitals. This endeavour pre-dated "Planning for the Future" and as part of this endeavour units, predominantly those containing elderly long-stay patients and patients with an intellectual disability, were de-designated – a process whereby they were no longer considered to be part of the formal complement of psychiatric beds. This process occurred even when responsibility for staffing and management of the units remained with the mental health service. Some units were handed over to the geriatric care services or the intellectual disability services, even though the psychiatric nurse staffing remained. While this exercise decreased the numbers of patients deemed to be resident in mental hospitals, it did not decrease the number of patients in institutional care.

The process of de-designation has had varied success. What is of concern to the Inspectorate is that many de-designations took place without individual assessments of patients taking place. Elderly long-stay patients can still have significant mental illnesses or problems related to dementia and it is accepted

internationally that persons with an intellectual disability have a higher than average risk of having a co-existing mental illness or severe behavioural disturbance. In the absence of specialist mental health services for the elderly and for those with an intellectual disability, de-designation left many vulnerable people without easy access to the mental health care they needed. For this reason, in addition to inspecting all designated long-stay wards and 24-hour nurse staffed hostels, de-designated units that were identified as still being under the management of the mental health service were included in the inspections for 2005. Many de-designated units for persons with intellectual disability have been moved to the intellectual disability service. Many others with intellectual disability and mental illness are in the care of voluntary agencies in non-approved centres. Both these groups are considered particularly vulnerable by the Inspectorate and are discussed further in this report.

INSPECTION OF LONG STAY WARDS

The Inspectorate visited 95 long stay wards in psychiatric hospitals and de-designated units providing care to approximately 1800 patients. These wards and units cater for people with varying needs - those with enduring mental illness, some with an intellectual disability and some requiring specialist care for the elderly. Very few patients on these wards and units are under the care of specialist teams. A small number of wards caring for elderly patients are under the care of psychiatry of later life teams, but none of those with intellectual disability were under the care of the appropriate specialist teams.

Where large psychiatric hospitals are still in existence, patients continue to be admitted to long-stay wards either directly or through transfers from admission wards. This unacceptable practice was particularly evident in the South East in St. Otteran's Hospital in Waterford, St. Senan's Hospital in Wexford, St. Luke's Hospital in Clonmel, St. Canice's and St. Dympna's in Carlow/ Kilkenny and in St. Loman's Hospital in the Midlands. In Limerick, patients are transferred to a long-stay ward in St. Joseph's Hospital if there is a bed shortage on the acute wards. In Cork, the North Lee service has traditional access to a number of long-stay beds in St. Stephen's Hospital. The practice of continuing to use long-stay beds in an unregulated manner results in an inappropriate mix of patients with differing needs being cared for on individual wards and increases the risk of patients becoming long-stay. In 2005, 240 patients nationally became new long-stay (had been in hospital continuously for one year) and the five hospitals mentioned above accounted for over 50% of these.

Most patients in long stay wards have not undergone any formal assessment of care and accommodation needs and most do not have an integrated care and treatment plan. In some cases, regular psychiatric and medical reviews of patients have not taken place. Some hospitals have engaged general practitioners to look after the medical needs of patients and this has resulted in a better standard of medical care. There is very little multidisciplinary input into most of these units in relation to patient assessment, care planning and therapeutic interventions. Although some patients may attend activities off the ward, there are few therapeutic activities based on need available for patients on site. In many wards patients were inactive for most of the day.

In a very small number of wards, where there is a specialist rehabilitation team in place, active rehabilitation programmes, with formal assessment of need, integrated care planning and therapeutic activities occur. In other wards efforts have been made, despite the absence of a rehabilitation team, to put a rehabilitation programme in place and to provide access to some therapeutic activities.

Most long stay wards are located in large psychiatric hospitals built in the mid-1800s. The physical conditions of many of these wards are poor, with inadequate sanitary facilities, lack of privacy and absence of personal space. In a few cases, conditions on the wards are extremely poor, with leaking ceilings, damp, peeling paint, holes in the walls and no curtains around beds. Some wards are locked, in the absence of clinical risk assessment, and in a small number of hospitals patients were locked in their bedrooms at night, again, in the absence of risk assessment. Efforts had been made in some wards to make the accommodation as comfortable as possible but they remain unsuitable and inadequate as accommodation.

Patients in long stay wards, some of which are needlessly locked, remain a vulnerable group of people living in poor conditions with little in the way

of therapeutic assessment, therapeutic activities and multidisciplinary care planning. They are to a considerable extent the forgotten people in the mental health service. Many have lost contact with family, their friends and their community of origin, and so lack the vital support and advocacy role that such personal contacts provide. While peer advocacy services have now developed in most areas, long-stay patients currently have little opportunity to avail of this service.

INSPECTION OF 24-HOUR NURSE SUPERVISED COMMUNITY RESIDENCES

The Inspectorate visited 127 community residences that are staffed on a 24-hour basis by nursing staff. These units contained approximately 1700 residents. In the main part, resident in such units have enduring mental illnesses and have spent considerable periods in long-stay care in psychiatric hospitals. Many were discharged as part of the closure or down-sizing of large mental hospitals. The age of residents in individual units can range from the early twenties to the late eighties.

The majority of these residences provide ongoing care with variable availability of rehabilitation programmes. As in the case of long-stay wards, however, only a small number are under the care of specialist rehabilitation teams. In these units, the emphasis is on rehabilitation and maximising independence. However, in some areas, particularly in urban areas such as Dublin, Cork, Galway and Limerick, there is a lack of suitable, follow-on accommodation with appropriate levels of supervision to which residents can progress. This results in some residents remaining in units that have inappropriately high levels of supervision relative to their need, and this in turn leads to lack of movement from acute units and long stay-wards to 24-hour supervised residences.

Nationally, a significant number of people with intellectual disability remain under the care of the mental health services. Some residences have been developed exclusively for people with intellectual disability who remain under the care of the mental health services and who have also spent long periods in long stay care in psychiatric hospitals. This is particularly the case in East Galway and in Clare. The emphasis in these residences is to provide homely, permanent accommodation in small, domestic-styled units. Most of these facilities were found to be appropriate to the needs of residents, however, all residents should have access to specialist mental health services for persons with intellectual disability.

The majority of 24 hour supervised units for people with mental illness are too large, having up to 20 residents. There are a small number of units that have less than 10 residents and some units have between 20 to 30 residents. These larger units approximate to "wards in the community" with institutional designs and practices and are unable to provide adequate individualised rehabilitation programmes.

Integration into the local community is variable. In general, residences that are located in towns and cities tend to become part of the local community with residents using local facilities, public transport and leisure activities. A significant number of residences, however, are located in areas that are isolated or at considerable distance from any facilities. The residents are dependent on taxi services or mental health service transport to access most facilities, resulting in little meaningful integration and continued isolation from the community.

Apart from residences where there is a rehabilitation team in place, there is little input from a multidisciplinary team. Residents are generally under the care of a local General Practitioner and are reviewed in the unit or at outpatient clinics by the treating psychiatrist. Nursing staff in the residences were found to be dedicated and to be providing a caring service. In some cases, they were developing rehabilitation programmes in the absence of any rehabilitation team.

The absence of specialist rehabilitation teams mean that for many long-stay patients, the move to the community was primarily a relocation exercise related to hospital closure rather than a true rehabilitation exercise. Without exception however, all residents who spoke with the Inspectorate stated that they preferred being in the residence rather than in a long stay ward in the hospital. The main reason cited for this preference was the increase in freedom and independence. In the absence of on-going specialist care, however, many will not reach their full potential.

Specialist rehabilitation teams are necessary, not only to provide a service to long-stay patients and residents in supported community facilities, but to provide a service for the new patients in services who present with severe and enduring illness. In the absence of specialist services, such patients will not receive the focused care they need. They all too often have multiple admissions to hospital, that do little to address their problems and once discharged, lack the essential, ongoing interventions that are needed to assist them in reaching their maximum potential. In some services they are sent to long-stay wards, a practice that is guaranteed to lead to further disability. It is the lack of appropriate services to such patients that has brought community psychiatry and "care in the community" into disrepute in many countries. At present there are only six rehabilitation teams nationally – in the St. Ita's service in Portrane, the Tallaght/St. Loman's service in Dublin, the East Galway service, the Clare service, the Cavan/Monaghan service and the Sligo service. Only one of those teams, the Clare team, is fully resourced in terms of multidisciplinary team members.

"A Vision for Change" emphasises the need to develop these specialist services nationally. As these are services for some of the most severely disabled or potentially seriously disabled people attending the mental health service, the implementation of this recommendation must be given high priority.

MENTAL HEALTH SERVICES FOR PERSONS WITH INTELLECTUAL DISABILITY

People with an intellectual disability are recognised as having a higher than average risk of developing a mental illness. Others, as a consequence of organic brain damage or as a secondary consequence of their disability can present with behavioural disturbance, varying from mild disturbance to a level of disturbance that may place themselves or others at risk. Traditionally in Ireland, services to persons with an intellectual disability were provided by a range of non-statutory and voluntary agencies, with a number of religious orders being among some of the biggest providers of services in the non-statutory sector. Others, with intellectual disabilities ranging from the mild to the profound were placed in mental hospitals. It then became national policy to move such people out of mental hospital, ostensibly to community-based services. In the Inspector's view, this movement failed many of the people it was meant to serve in two fundamental ways. Many people with the more severe levels of disability continue to live in institutional settings, either in de-designated mental hospital wards or units, or in institutions run by non-statutory agencies, and in the movement out of the mental hospital system, many no longer received the psychiatric care they needed.

Specialist mental health services for people with intellectual disability have been very slow to develop. In part, this has been contributed to by a wide-spread desire to make a clear distinction between mental illness and intellectual disability. Many families of those with intellectual disability would consider it deeply stigmatising to their family member to be considered to have a mental illness in addition to an intellectual disability and some professionals in intellectual disability services would consider it so also. The evidence supporting the higher risk of such disorders is ignored.

Some non-statutory and voluntary agencies providing services to persons with intellectual disability applied for funding for consultant psychiatrist posts. Such posts were in the majority of cases, set up in the absence of dedicated teams, and provided a service only to those people in receipt of services from that particular agency. State-provided mental health services were slow to be developed and at the present time there is no HSE Region in the State with an acceptable level of service for people with intellectual disability and mental illness. There are insufficient consultant posts in all regions, and those posts that do exist have no multidisciplinary teams associated with them.

It was reported to the Inspector that in some areas that individual assessments of residents in institutional care are revealing a diagnosable mental illness or behavioural disorder in up to 50% of residents. A significant percentage of residents are on major psychotropic medications. The deficiencies in service availability nationally results in the majority of these residents not receiving adequate levels of specialist mental health care.

There are only two units nationally that are approved for the inpatient care of persons with intellectual disability and mental illness – St. Joseph's service in St. Ita's Hospital in Portrane and Stewart's Hospital in

Dublin. It is of concern therefore, that given the increased risk of psychiatric morbidity in this population, persons with intellectual disability and mental illness may be receiving care in settings that are not approved. There is no statutory inspection process for either community-based or institutional-based services for persons with intellectual disability. There is no national record of the levels of use of particular practices, such as restraint, seclusion or the use of medication without informed consent or against resistance. Apart from the two units mentioned there is no record of the use of practices in behaviour management programmes that may limit a person's freedom or impact on their rights to bodily integrity. The state does not yet have legislation that protects the rights of vulnerable persons or that provides a guardianship system for adults who have impaired mental capacity. As a result, adults with intellectual disability are outside the legislative framework that ensures the protection of their rights when they are in receipt of mental health care. The seriously deficient level of service availability is also likely resulting in a significant under-estimation of need in this population. The Intellectual Disability Database attempts to assess the amount of unmet need in this population, but if diagnostic assessment is left to personnel with no or limited specialist psychiatric training, psychiatric morbidity in this population is likely to go unrecognised.

The tradition of treating persons who have intellectual disability and mental illness outside the formal mental health service structure, in an un-regulated environment, is now well entrenched nationally. Because of the stigma associated with mental illness, there is significant resistance among some voluntary and non-statutory service-providers to this situation changing, while others fully recognise the serious anomalies in the current situation. There is widespread failure to accept that persons with intellectual disability and mental illness need the same team-delivered specialist service mental health service as do persons with mental illness who do not have an intellectual disability. As a result, in all services, both statutory and non-statutory, consultant psychiatrists work without dedicated specialist teams, even in those services where there are significant numbers of other professional staff. The Inspector has been informed of situations where consultant psychiatrists have been requested to prescribe psychiatric medication and not been involved in the overall care plan of the patient. There have been incidences where consultant psychiatrists have been asked to "prescribe" seclusion or restraint, in unapproved setting, for patients who are not under their comprehensive care.

During the inspections of 2005, the Inspector met with as many statutory, non-statutory and voluntary providers of services to persons with intellectual disability as was possible. The situation varied nationally between regions, with some regions having no mental health care service, some having lone psychiatrists who were called on to act in the manner described above and other services where it was deemed that everyone attending a particular intellectual disability service that had a consultant psychiatrist attached was deemed to be patients of that psychiatrist. It is of particular concern that psychiatric treatment and care, and behavioural management programmes for seriously disturbed persons are occurring in un-approved setting.

There are a number of national issues that must be addressed urgently, some relating to the mental health care being provided to persons with intellectual disability, some relating to their general protection.

It is recommended that all consultant psychiatrists currently working in the field of intellectual disability should be assigned to a population catchment area rather than to individual service providers. All such posts should have an associated team, staffed by professionals with appropriate mental health training. This professional staff can be drawn from staff already working in the intellectual disability services, who have the necessary training, experience and interest. All persons with moderate, severe and profound intellectual disability and a mental disorder or mental illness in institutional care should be under the formal care of the local catchment specialist mental health service, so that the psychiatric care and treatment of those individuals comes under the legislative framework of the Mental Health Act 2001. This Act will protect the rights of persons receiving care and will also protect those professionals providing care. It will ensure that standards of mental health care delivery, set by the Mental Health Commission, will apply equally to those with an intellectual disability and those without. All regions must have access to approved units for the inpatient

care of persons with intellectual disability who require that level of intensive intervention.

The Mental Health Act 2001 recognises "significant intellectual disability" as having the potential to qualify as a mental disorder under conditions laid out in Part 1 Section 3. The presence of "abnormally aggressive or seriously irresponsible conduct" is part of the definition that must be fulfilled. Professionals working in the intellectual disability service must understand that persons who fulfil the criteria for having a mental disorder under the Act, and who are incapable of giving informed consent to treatment, must receive that treatment under the protection of the Mental Health Act 2001 and in a unit approved under that Act. To provide such treatment in the absence of informed consent, will be illegal. The introduction of the Mental Health Act will place particular responsibilities on consultant psychiatrists, to ensure that they, at all times, work under the requirements of the Act. To provide the protection of the Mental Health Act 2001 to both those receiving specialist mental health care and those providing specialist mental health care, it is essential to increase the availability of consultant psychiatrist posts in this specialist and to provide the necessary teams for comprehensive service delivery.

It is also recommended that all institutions providing care to persons with moderate, severe and profound disability come under an external, statutory inspection process, so that the care being provided to such persons is regularly and independently examined.

MENTAL HEALTH SERVICES FOR THE ELDERLY

Four national issues relating to mental health services for the elderly were common nationally: the provision of services to elderly persons with pre-existing mental illness; access to appropriate facilities for acute and more long-term care; access to generic support services for persons with mental illness and provision of appropriate care to those with known mental illness, who are residing in private nursing homes.

As with persons with intellectual disability, many elderly patients with mental illness who were long-stay in mental hospitals were "discharged" to de-designated units. Other long-stay patients were discharged to community facilities and aged there. With the initial introduction of specialist mental health services for the elderly, strict criteria applied to those who were eligible to access the service. Any person over the age of 65, who had attended a mental health service in the previous 10 years, was excluded. As services developed this 10-year exclusion criteria was lowered to 5 years in some areas, but remains at 10 years in others. This clause automatically excluded elderly patients who remained in long-stay wards and those in community residences under the care of the mental health service. It also excluded patients in de-designated units, geriatric facilities and private nursing homes if they, too, had been in receipt of care within the relevant time-frame. Again, as services have developed, the exclusion criteria relating to elderly persons in nursing home or geriatric care were relaxed in some services, but not in all. The justification for the exclusion criteria was inadequate service resources.

People with enduring or recurrent mental illnesses grow old, just as everyone does and it is difficult to justify the exclusion of these people from access to a specialist service solely on the basis that their illness began before the age of 65. Not everyone over the age of 65 with a pre-existing enduring or recurrent mental illness will need a specialist mental health service for the elderly. Some will want to continue to receive the care they need from the general adult team they know and others may not need referral. Some may have their needs more effectively and appropriately met by a specialist rehabilitation mental health service. But some, particularly those with mood disorders, will require the special facilities and interventions available from the specialist service for the elderly.

Research in the specialist mental health service for the elderly in St. James' Hospital has shown that persons over the age of 65 with a previous history of mental illness require a more intensive level of input than those whose illnesses starting after the age of 65. This research has national implications. However, it must not serve to further justify the exclusion of elderly people from specialist services, rather it should be used to evaluate the level and type of resource needed to provide appropriate levels of care.

Rehabilitation mental health services are seriously under-developed nationally, and many persons over the age of 65 who need this type of service do not have access to it. These people may already be excluded from the specialist mental health service for the elderly, and if the general adult mental health

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services do not fully embrace their care they can find themselves placed in an invidious position. This is the case in many long-stay wards around the country, where the physical and mental care of these patients is left to the most junior doctors, who may have little psychiatric or medical experience.

The solution to this issue is the provision of the necessary specialist service for these people, either a specialist mental health service for the elderly or a specialist rehabilitation service. In the interim, it is the responsibility of every catchment management team to ensure that all persons with enduring or pre-existing mental illness are receiving adequate care.

The physical care of elderly persons in long-stay ward of mental hospital is also of concern. It is recommended that all such patients have access to a general practitioner.

Few mental health services for the elderly have access to designated acute inpatient beds in discrete facilities. It is undesirable to admit elderly, sometimes frail people to acute psychiatric units which often have a high level of activity. Services nationally have identified the need for these dedicated beds and it is recommended that all new units that are planned should have sufficient numbers of beds for the elderly, adjacent to adult psychiatric units. Existing units, particular those that are not scheduled for replacement, should make every effort to develop such dedicated space. The need for dedicated units for the elderly becomes even more urgent with the advent of the new Mental Health Act, which allows for the involuntary admission of persons with disturbed behaviour in the context of dementia.

Some mental health services for the elderly nationally have notified the Inspector that access to generic services to the elderly may be more difficult for those known to be attending the mental health service. This is unacceptable and it is the responsibility of all senior managers in community services for the elderly to ensure that such patients are not discriminated against.

The final issue of concern is one that has recently come to national prominence, i.e. care of the elderly in private nursing homes. Elderly persons with mental illness are a particularly vulnerable group. Many mental health services have contracted beds in the private sector; others habitually use a particular nursing home. Some mental health services have discharged significant numbers of elderly persons with mental illness to private nursing homes as part of a hospital closure programme. It is of real concern that there are no national standards dictating the level and expertise of care that should be provide to such persons and these private nursing homes, even if they provide care to large numbers of elderly persons with known mental illness, are outside the remit of the Inspector of Mental Health Services. Until such national standards are in place it is the responsibility of each catchment management team to ensure that all elderly patients, discharged to nursing home receive the standard of mental health care they need.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

No mental health service exists in isolation from the society it serves and this is particularly the case with Child and Adolescent Mental Health services. Factors within society, that impact negatively on children and their families, will have an influence on the prevalence of mental health problems in young people and this, in turn, will influence the demand for services.

In meeting with child and adolescent mental health teams nationally, it became evident that a number of external factors were affecting all teams. Lack of support for vulnerable families was universally seen as problematic. Implementing the statutory demands of the Child Care Act 1991 takes considerable resource, but this Act does not address the needs of families who are struggling with issues that do not involve abuse. Support at community and primary care level to assist parents in acquiring general and specific parenting skills is sorely deficient. Yet, without this preventive approach, mild behaviour problems in young children may become more serious behaviour problems in young teenagers. Often, the only service available to a family in trouble is the child and adolescent mental health service, even though intervention at a much less specialised level is what is required. This scenario feeds considerably into the long waiting lists for such specialist services and time and again the Inspector heard of waiting lists for up to two years or longer. Services are obliged to prioritise more immediately

high risk presentations, such as severe mood disorders, early-onset psychotic illnesses, eating disorders, acute adjustment reactions and developmental disorders. As a result, children with problems that are less serious clinically are left to wait. Many never receive the necessary intervention.

There has been a national Primary Care Strategy in place for some years. This envisaged the development of primary care teams, that would make available team members in addition to the medical and nursing professions. Making family and child services available at this level would be far more cost-effective and less stigmatising than forcing families to wait years for a specialist service that may not be needed. Removing these referrals from the specialist child and adolescent mental health services would result in waiting lists that are far more realistic and would more accurately reflect those who need the specialist service.

In addition to a deficiency in child and family support services, there are issues within the educational system that impact on services. While more resource teachers have been made available at Primary School level, access to these services for children remains problematic because of rationing of access to the National Educational Psychology Service (NEPS). Child and adolescent mental health teams nationally have found that children are being referred to them for assessments that more appropriately would be carried out by the educational service.

Experiencing primary school as a positive event is an extremely important life issue for all children. A child who is experiencing difficulties in learning will be conscious of failure at an age when still too young to understand that they are not at fault. Such experiences can all too easily lead to behavioural problems both at school and at home and have wider consequences for the child's emotional and social development. Behavioural difficulties in children, whether due to educational difficulties or other reasons, are rapidly recognised by teachers. Such difficulties not only hinder the child's ability to learn and develop socially, it also interferes with other children's ability to learn. Developing easy-access, non-stigmatising support systems for parents, available through their primary care service, would be highly cost-effective in the long term. Ensuring that class sizes, particular for younger children, are at a level that allow individual attention, will also enhance any educational support or behavioural support services that are being offered. Mental health promotion is never more effective than when targeted at children and their families and investment in such services pays dividends in the future. The educational system is well placed to be the focus of many such health promotional initiatives.

There are two further issues relating to child and adolescent mental health services that exercise both child and adolescent mental health service personnel and adult mental health service personnel. These are the questions of access to inpatient beds and the vexed question of the 16-18 year old age group. For many years there has been an acknowledged lack of appropriate inpatient facilities for that small number of young people that require such specialist care. In the past year, inpatient units have been approved for both Cork and Limerick, an adolescent unit has opened in St. John of God Hospital and one is under consideration for the Tallaght campus. It is of concern to the Inspectorate that these units appear to be developing in the absence of a clear decision on the number and location of units required nationally. It became apparent to the Inspectorate in discussions with teams that the number of inpatient beds required is in keeping with the numbers recommended in "A Vision for Change". It is also of concern that the issue of beds is being discussed in isolation from broader service issues such as the required staffing of community mental health teams and the provision of appropriate community facilities for such teams.

The problematic question of the 16-18 year old age group generates heated argument between child and adolescent psychiatrists and adult psychiatrists. Yet to parents and non-medical personnel this argument seems senseless. This group is singled, not by virtue of any real difference between the average 15 year old and 16 year old, or the average 18 year old and 19 year old, but because in 1945 the Mental Treatment Act considered 16 the age at which someone could be admitted to a mental hospital on their own volition while the more modern Child Care Act and the Mental Health Act 2001 define a child as someone under the age of 18. While awaiting the final solution, every child should have access to the service most appropriate to their needs, irrespective of age. Boundary disputes between psychiatrists must not result in children being deprived of a necessary service.

The Inspector wishes to acknowledge the commitment and dedication by the Inspectorate Team in inspecting the centres and supervised residences throughout the country and preparing reports during 2005. The Inspector also wishes to acknowledge the administrative support received throughout the inspection process.

Dr. Teresa Carey
Inspector of Mental Health Services

Chapter 6

Child and Adolescent

Child and Adolescent Mental Health Services

(Counties Cork and Kerry)

Child and Adolescent Mental Health services in Counties Cork and Kerry are provided jointly by the HSE and the Brothers of Charity. The HSE provides services in the North Lee and North Cork areas, while the Brothers of Charity provide services in the South Lee, West Cork and Kerry areas.

Table 1 Population

Population	Total	Under 16	Under 18	16-18
Cork	447,829	100,730	114,833	14,103
Kerry	132,527	28,775	33,110	4,335
Total	**580,356**	**129,505**	**147,943**	**18,438**

Table 2 (a) Total Team Staffing

Teams	7
	Number of Approved Posts
Consultant Psychiatrists	7 (1)
Clinical Psychologists	8 (1)
Social Workers	8.5 (1)
Occupational Therapists	3.0 (2.5)
Speech and Language Therapists	1

Figures in ( ) relate to unfilled approved posts.

The development plan for Child and Adolescent Mental Health Services in the HSE Southern Area, Mol an Óige, recommends a minimum of 10 fully staffed multidisciplinary teams to provide for the needs of children and adolescents with mental health needs, including children and adolescents with intellectual disability. There are currently 7 teams in place, with staffing of these teams at various levels of completion (Tables 2(a) & 2(b)). One of the three additional teams is required for services in the North Cork/North Lee area and two are required for South Lee/West Cork and Kerry. In addition to the teams described above there is a regional specialist team for Autistic Spectrum Disorders, run by the Brothers of Charity. Services for children with intellectual disability and mental illness are currently provided on a sessional basis by the existing Child and Adolescent Psychiatrists on the Brothers of Charity teams.

A number of current priorities have been identified by both service providers. Although urgent referrals are seen as emergencies, there are waiting lists of up to two years duration in place and service development priorities reflect the need to address the staffing deficiencies that contribute to this delay. The HSE has identified the completion of staffing for the North Cork Team to be a priority. At present, the post of consultant psychiatrist, clinical psychologist and occupational therapist are vacant and staff on the North Lee team are attempting to cover these

Child and Adolescent
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Table 2 (b) Staffing of Individual Teams

TEAM	North Lee 1 HSE	North Lee 2 HSE	North Cork HSE	South Lee Team A BoC	South Lee Team B BoC	South Lee West Cork Team C BoC	Kerry Team D BoC
Population under 16 (16-18)	35,870 *(7,442)*		16,558 *(3,615)*	36,423 *(7,941)*	36,423 *(7,941)*	11,879 *(2,346)*	28,772 *(6,392)*
Consultants	1	1	1 *(1)*	1	1	1	1
Psychologists	2	2 *(1)*	1 *(1)*	1	1		1
Social Workers	2	2	1.5	1	1		1
Occupational Therapists	1 *(0.5)*	0.5 *(0.5)*	0.5 *(0.5)*				1 *(1)*
Speech and Language Therapists	0.5	0.5					
Nursing Staff				1	0.5		1
Other Therapists	1 SR	1 SR	1 SR				

Figures in ( ) relate to unfilled posts.

vacancies, adding to an already heavy workload. The recruitment of additional clinical psychologists, senior occupational therapists, psychiatric social worker and speech and language therapists are expected throughout the year. This recruitment will fill current vacancies and will add considerably to the effectiveness of existing teams.

The Brothers of Charity have identified the development of the South Lee/West Cork and Kerry services as a priority. Two additional teams are required and in addition, further posts in psychology, occupational therapy and speech and language therapy are required for the existing teams. The need for a Senior Registrar post for each team has also been identified and it is hoped that such appointments will have a positive impact on waiting list times for services.

A Steering Group has reviewed the existing services children with Attention Deficit Hyperactivity Disorder / Hyperkinetic Disorder (ADHD/HD) and has produced a comprehensive report on the needs of such children and the resources required to provide such services. It reiterates the need to fully implement MoI an Óige and recommends that services for children with ADHD/HD be provided through the further development of existing Child and Adolescent Mental Health Services.

A significant development in the region has been the approval of an inpatient unit providing a total of 20 beds. The design brief has been approved by the Department of Health and Children and sanction received for the appointment of a design team. It is envisaged that this unit will serve the entire HSE Southern Region, comprising counties Kerry, Cork, Carlow, Kilkenny, Waterford and Wexford. This unit, in additional to a proposed unit and Limerick and the existing unit in Galway will give in excess of 40 child and adolescent beds along the western seaboard.

Child and Adolescent Mental Health Services

(Counties Waterford, Wexford, Carlow, Kilkenny and South Tipperary)

Mental Health Services for Children and Adolescents in the HSE South Eastern Region are funded and managed by the HSE. There are currently four teams in existence, whereas the population requires a minimum of eight.

Table 1 Population

Population	Total	Under 16	Under 18	16-18
Carlow/Kilkenny	126,353	30,321	34,655	4,334
Wexford	116,596	28,428	32,239	3,811
Waterford	101,546	23,398	26,616	3,218
South Tipperary	79,121	18,764	21,517	2,753
Total	**423,616**	**100,911**	**115,027**	**14,116**

Table 2 (a) Total Team Staffing

Teams	4
	Number of Approved Posts
Consultant Psychiatrists	4
Clinical Psychologists	3.9
Social Workers	4.25
Occupational Therapists	0
Speech and Language Therapists	0

The HSE Southern Area has clear strategic plans for the development of mental health services for children and adolescents, including those children with intellectual disability or ADHD/HD. These development plans must be fully implemented, with due consideration being given to any resource implications arising from a growing population. It is also recommended that management of all components of Mental Health Services for Children and Adolescents be brought under a unitary management system, within the mental health services.

Existing teams are understaffed. Clinical psychology and social worker are under-represented and there are occupational therapy posts or speech and language posts. All existing teams have identified the need to bring team staffing up to the required level, and to increase the number of teams to eight.

At present the total catchment population of teams varies from a high of 126.353 in Carlow/Kilkenny to a low of 79,121 in South Tipperary, with similar variations in the numbers of under-16s and under-18s. Waiting lists vary, and can be as long as one year. Waiting list time is a particular problem in Carlow/Kilkenny, given the larger service population. Despite the under-staffing across all teams, all see children and adolescents up to the age of 17 or 18. Teams have found that the 16-18 year old age group, although accounting for only 12-13% of the under-

Table 2 (b) Staffing of Individual Teams

TEAM	Carlow / Kilkenny	Wexford	Waterford	South Tipperary
Population under 16 (16-18)	30,321 *(4334)*	28,428 *(3811)*	23,398 *(3218)*	18,764 *(2753)*
Consultants	1	1	1	1
Psychologists	0.9 *(0.1)*		2	1
Social Workers	1.7	0.8	0.75	1
Occupational Therapists				
Speech and Language Therapists				
Nursing Staff	1	1	1	1
Other Therapists	Counsellor; Sessional Play Therapist ; Sessional Art Therapist			

Figures in ( ) relate to unfilled posts.

18 population, can account for up to 40% of the work load. This age group can present with acute or emergency problems, such as suicidal ideation, adjustment disorders, more severe mood disorders, early psychotic disorders or eating disorders, all requiring urgent attention. To ensure that an early response to such problems does not lead to excessively long waiting lists for teams for younger children, it is essential that a sufficient number of fully staffed teams are developed so that the needs of this older age group and the different needs of younger children can be met comprehensively and equitable.

In addition to the deficiencies in staffing, the need for improved community facilities in a number of areas, including Carlow, Kilkenny and Dungarvan, was highlighted. The lack of access to inpatient beds was stressed by all teams. However, the annual requirement is low and all teams stressed the need for active community-based interventions to minimise the need for inpatient care. This will be particularly important if inpatient facilities for the region are to be placed in Cork, emphasising the urgency of bringing the number of teams and the staffing of teams up to the required level.

There is no single service structure for children with Attention Deficit Hyperactivity Disorder / Hyperkinetic Disorder. The development plan of services for this population group in the HSE Southern Area could provide a blueprint for a coordinated approach to these services in the region.

An innovative development within the services is a study into the mental health service needs of children and adolescents in the South East. A preliminary screening study into the South Tipperary area has already been completed. This study will provide valuable information for service planning not only for the South East but also for services nationally.

Child and Adolescent Mental Health Services

(Counties Clare, Limerick and North Tipperary)

Mental Health Services for Children and Adolescents in the Mid-West are provided by the HSE. The total population under 16 is 77,342 with an additional 11,176 between the ages of 16 and 18.

Table 1 Population

Population	Total	Under 16	Under 18	16-18
Clare	103,277	24,506	27,931	3,425
Limerick	175,304	38,474	44,166	5,692
North Tipperary	61,010	14,362	16,421	2,059
Total	**339,591**	**77,342**	**88,518**	**11,176**

Table 2 (a) Total Team Staffing

Teams	4
	Number of Approved Posts
Consultants	4
Psychologists	3 (1.4)
Social Workers	4
Occupational Therapists	0
Speech and Language Therapists	0
Nursing Staff	8 (2)
Child Care Leader	1
Child Care Worker	1

Figures in ( ) relate to unfilled approved posts.

At present all teams provide a service to children and adolescents up to the age of 16 and to those with mild intellectual disability and mental health problems. Average waiting times are approximately ten months.

There are currently four teams providing services in Clare, Limerick and North Tipperary, with the teams divided between East Limerick, West Limerick, Clare and North Tipperary. As with many of the developing specialties nationally, this service was adversely affected by the cap on public service employment, but has made some progress in the past year in making up staffing deficiencies. At the time of inspection, two nursing posts and 1.5 posts in clinical psychology were vacant, but the service hoped to fill these vacancies before the end of the year. Both occupational therapy and speech and language therapy are absent from all teams. No occupational therapy service is available, while some speech and language services can be accessed from community care. This is an unsatisfactory situation and priority must be given to complete the necessary multidisciplinary staffing of all teams.

A minimum of two additional teams are required in the region to meet the needs of the catchment population. Limerick City, in particular, has areas with high levels of urban deprivation where the need for child and adolescent mental health services is likely to

be increased. If child and adolescent mental health service in the region is to increase its target population to include all children and adolescents with mental health problems, including all those with intellectual disability and mental health needs, a further two teams will be required.

Access to suitable inpatient facilities has been identified as a continuing problem. In 2004 there were two admissions to the adult psychiatric unit and twelve psychiatric admissions to the paediatric ward. When children or young teenagers are admitted to adult psychiatric wards special nursing arrangements are put in place, but the practice remains fundamentally unacceptable. All teams identified the need for additional community-based staff, particularly nursing staff, to allow them to provide more intensive home- based care. The service has also submitted proposals for a regional community intensive therapy team to provide home-based care to acutely unwell young people and their families. The development of home-based services would considerably enhance the services available and would decrease the need for inpatient care. While the specialist team is suggested on a regional basis, the development of home-treatment capacity in all teams would be highly advantageous.

The service currently operates from two main centres in Limerick City and has accommodation in 11 outreach centres. Accommodation is unsatisfactory in many centres, with no centre being purposely designed as a child and adolescent facility. To further decrease the need for inpatient facilities and to maximise the community treatment potential of teams, improved, dedicated space is required.

All teams have similar protocols regarding emergency and urgent referrals. The average waiting time for non priority cases can be up to 10 months. All teams have highlighted the need to continue to address staffing deficiencies so that these waiting times can be decreased. A limited liaison service is provided to the paediatric units in the Mid-Western Regional Hospital Limerick. There are plans to devote 0.5 clinical nurse specialists to this service to address the needs of children with co-existing physical and mental health needs and to expand this into a paediatric liaison team in the future.

Approval has been granted for the appointment of a design team for the development of a 12-bed inpatient unit in Limerick. This unit, along with the units in Galway and Cork will give in excess of 40 child and adolescent beds along the western seaboard.

The child and adolescent service has taken initial steps to develop a computerised information system and have identified the need for a nationally agreed system to allow for the rational development of services and the systematic evaluation of teams.

Child and Adolescent Mental Health Services

(Counties Galway and Mayo and Roscommon)

Mental Health Services in Counties Galway, Mayo and Roscommon are provided in their entirety by the HSE.

Table 1 Population

Population	Total	Under 16	Under 18	16-18
Galway	208,844	46,530	53,181	6,651
Mayo	117,446	27,397	31,676	4,279
Roscommon	54,007	12,480	14,414	1,934
Total	**380,297**	**86,407**	**99,271**	**12,864**

Table 2 (a) Total Team Staffing

Teams	5
	Number of Approved Posts
Consultant Psychiatrists	5
Clinical Psychologists	1.2
Social Workers	7.3
Occupational Therapists	3
Speech and Language Therapists	2.5 (1)
Nursing Staff (Community-Based)	5 (1)

Figures in ( ) relate to unfilled approved posts.

There are currently five child and adolescent mental health teams in the HSE Western Area while up to 7 are required to meet the service needs of a growing population. The service lost approval and funding for one fully staffed teams in the cap on public service employment and is struggling to make up this loss. With the current team deployment, services in County Mayo are particularly deficient (Table 2 (b)) and an additional team is needed as a priority. None of the existing teams are fully staffed. There are deficiencies in all multidisciplinary staff grades, with particular deficiencies in nursing, clinical psychology, occupational therapy and speech and language therapy. Community facilities for a number of outpatient teams are unsatisfactory, including the current accommodation in Galway City at Lyradoon and St. Anne's and in County Mayo.

All teams have a unified approach to referral and assessment procedures. The goal is to see emergency referrals within 24–48 hours, urgent referrals within one week, semi-urgent referrals within six weeks and routine cases within three to six months. Urgent referrals include acute problems such as acute depression, suicidal ideation, psychotic disorders and eating disorders.

All teams embrace the concept of multidisciplinary assessment, as much as staffing allows. However, with deficiencies in team staffing there can be

Table 2 (b) Staffing of Individual Teams

TEAM	North Galway	South Galway	West Galway	Mayo	Roscommon & Ballinasloe
Population	62,877	65,767	66,222	117.466	67,964
Consultants	1	1	1	1	1
Psychologists				1.2	
Social Workers	3	2	1	2 *(0.5)*	1
Occupational Therapists	0	1	1	0	1
Speech and Language Therapists	0	0.5	1	1 *(1)*	1
Nursing Staff	0		1	1	1
Other Therapists	Family Therapist: 1			Family Therapist:	
	Play Therapist: 1			0.6 *(0.6)*	Child Care: 1

Figures in ( ) relate to unfilled posts.

significant delays after initial assessment, particularly for the disciplines of speech and language therapy and occupational therapy. Teams are conscious of the need to shorten waiting times both on referral waiting lists and on waiting lists for specialist assessments and treatments. Deficiencies in team staffing have lead to significant delays of more than two years and long waiting lists in Co. Mayo. Where families are assessed there are also significant delays, particularly for speech and language therapy and occupational therapy with some teams having no access to these disciplines. Completing the multidisciplinary staffing of all teams and providing an additional two teams is necessary for these aims to be achieved.

Services for children with Autistic Spectrum Disorder vary between the teams. The West Galway team has a special interest in developing a county-wide service for Autistic Spectrum Disorders, while the Mayo team participates in a multi-agency approach with community care and paediatric services. There is a regional service for children with Attention Deficit Hyperactivity Disorder / Hyperkinetic Disorder. All child and adolescent teams see such referrals.

The Child and Adolescent Mental Health Service in the HSE Western Area is the only service nationally to have access to 7-day inpatient beds. This service is currently placed in St. Anne's Children Centre in the city, and provides six acute inpatient beds, 14 day places and a special school. It is planned to relocate these services to a new site on the Merlin Park Campus, although the continuation of the special school has still not been clarified. The service as a whole is very anxious to hold on to, and further develop, the skill-base for inpatient care that has built up over the last 30 years.

Child and Adolescent Mental Health Services

(Counties Donegal and Sligo)

Child and Adolescent Mental Health Services in Counties Donegal and Sligo/Leitrim/West Cavan are provided in their entirety by the HSE.

Table 1 Population

Population	Total	Under 16	Under 18	16-18
Sligo/Leitrim/West Cavan	93,754	21,260	24,423	3,163
Donegal	129,008	32,635	37,251	4,616
Total	**222,762**	**53,895**	**61,674**	**7,779**

Table 2 (a) Total Team Staffing

Teams	2
	Number of Approved Posts
Consultant Psychiatrists	2 (1)
Clinical Psychologists	1.8
Social Workers	2
Occupational Therapists	0
Speech and Language Therapists	0
Nursing Staff (Community Based)	3.5
Child Care Workers	4

Figures in ( ) relate to unfilled approved posts.

There are currently two teams for the provision of Child and Adolescent Mental Health Services in the North West, both of which provide service for children up to the age of 17 or 18. A total of four teams is required for the population served. The existing two teams do not have complete staffing (Tables 2 (a) & (b). There are no occupational therapy or speech and language therapy services available and psychology services are accessed through the community care programme, as situation that is not satisfactory. At the time of inspection, one of the consultant psychiatrist posts (the Sligo team) had been vacant for ten months despite funding and approval being in place for a replacement. Previous recruitment campaigns had failed and the replacement post was with the national appointment body at the time and it was hope that the appointment process would be addressed quickly.

A number of priorities were identified by existing staff. Filling the existing consultant vacancy and the appointment of a third consultant psychiatrist post were identified as two factors that would significantly enhance the service. It was felt that, in the immediate future, an additional consultant could join the existing two teams and share existing team resources until additional team posts were approved. The lack of occupational therapy and speech and language therapy were highlighted.

Table 2 (b) Staffing of Individual Teams

TEAM	Sligo/Leitrim/ West Cavan	Donegal
Population under 16 (16-18)	21,260	32,635
Consultants	*(1)*	1
Psychologists	1	0.8
Social Workers	2	1
Occupational Therapists	0	0
Speech and Language Therapists	0	0
Nursing Staff	1	2.5
Other Therapists	Child Care: 2	Child Care 1.5

Figures in ( ) relate to unfilled posts.

Services for children with Attention Deficit Hyperactivity Disorder are reported to be under-developed regionally. The Donegal team provides a service for children with Autistic Spectrum Disorder and see seeing up to three new cases per week. They highlighted the lack of any specialist follow-on service for these adolescents when they reached adulthood. A similar service is not currently available in Sligo due to the absence of a consultant psychiatrist. Both teams recognised the need to develop services for other particular groups of children and adolescents; those with conduct disorders, mood disorders or substance abuse. A number of members of both teams are undertaking further training in cognitive therapy and family therapy, two interventions that will further enhance the services available to children and their families.

The service had piloted an innovation in Primary Care to improve access to specialist help at that level. It was planned that more minor, but still distressing, problems in younger children could be targeted. The need for a community-based nurse and psychiatric social worker was identified to provide this early-intervention service, but the staffing was not forthcoming. Such a development is to be strongly recommended. It will allow easier access for parents and children to interventions at primary care level and will likely have a positive effect on waiting lists for services. It will also help to address the dilemma, highlighted by both teams, of trying to provide an equitable service to both children and adolescents within their existing resources, when responding to the often more acute needs of adolescents may lead to growing waiting lists for younger children. The service does not have easy access to inpatient beds. Teams acknowledged that their bed requirement was modest, but, nonetheless, had to be addressed. The enhancement of the staffing of existing teams and the availability of three to four crisis beds were identified as two developments that could play a significant role in reducing the need for formal inpatient beds.

Immediate priorities for the child and adolescent service include improved multidisciplinary staffing of the existing teams, the filing of the vacant consultant post, the appointment of a third consultant psychiatrist and the provision of crisis beds. The development of the planned primary care intervention service should also re-visited.

Child and Adolescent Mental Health Services

(Counties Laois, Offaly Westmeath and Longford)

There are two teams in generic services for children and adolescents with mental health needs in the HSE Midland Area. There is one team for children with intellectual disability and mental health needs or with Autistic Spectrum Disorder, which is discussed in the section on mental health services for persons with intellectual disability.

Table 1

Population	Total	Under 16	Under 18	16-18
Laois/Offaly	122,437	30,567	34,883	
Westmeath Longford	104,999	25,722	29,402	
Total	**227,436**	**56,289**	**64,285**	

Table 2 (a)

Teams	2
	Number of Approved Posts
Consultants	3
Psychologists	4 *(1)*
Social Workers	4
Occupational Therapists	2 *(1)*
Speech and Language Therapists	1
Nursing Staff	4.6
Other Therapists	

Figures in ( ) relate to unfilled posts.

The generic teams provide care to children and adolescents up to the age of 16 including those who have an IQ greater than 50. Waiting lists can be up to two years.

Both teams are based at the local regional Hospitals in Mullingar and Portlaoise with outlying clinics taking place in Tullamore, Athlone and Longford. Community facilities are generally inadequate, with none of adequate space and appropriate design. There are no day hospitals and the level of staffing, particularly the low level of nursing staff on teams, does not allow the development of active day programmes or home-based care. There is no formal access to inpatient beds. In an emergency situation children and adolescents may be admitted to the local paediatric units or, in extreme cases, to the adult psychiatric units.

With the current level of team staffing, the service is over-stretched. As with many other services nationally responding to emergency referrals, particularly in the adolescent age group, leads to long waiting lists for others. An additional two teams for children and adolescents is needed to bring the service up to the required level for the population served and all teams require the full range of therapists. At the time of inspection there was no principal post in clinical psychology in the entirety of the mental health service in the Midland Area. Within the child and adolescent mental health service, as with the adult mental health services, the principal post in clinical psychology was based in the community care programme. This is a very unsatisfactory situation. A principal psychologist post should be established within the mental health services and have responsibility for developing psychological services within all mental health specialities.

The priorities for both teams include the development of an additional team and a formal service level agreement to allow access to inpatient beds when required.

Child and Adolescent Mental Health Services

(Counties Dublin City North and Dublin County North)

Mental health services for children in Dublin City North and Dublin County North are provided by seven teams. Five of these teams are part of the Mater Hospital Child and Adolescent Mental Health Service, while two teams are managed by the service in the HSE South Western Area.

Table 1

Population	Total	Under 16	Under 18	16-18
	*486,934	102,698	116,565	13,867

Population is less than that given as the area served is less than that of the former Northern Area Health Board.

Table 2 (a)

(excluding non-consultant staffing of the Liaison Service to the Children's Hospital Temple Street)

Teams	5
	Number of Approved Posts
Consultant Psychiatrists	5
Clinical Psychologists	7
Social Workers	6.5
Occupational Therapists	0
Speech and Language Therapists	4
Nursing Staff (Community Based)	0

Figures in ( ) relate to unfilled approved posts.

A minimum of ten teams is required to provide the necessary service level to the catchment population, with additional teams required to provide for the considerable liaison input required to child and adolescent facilities in the area. Of the five community teams in the Mater Hospital Service, none has nursing staff or occupational therapists.

Existing teams are considerably over-stretched with all team members carrying high case loads. The region served by these teams contains some urban areas with very high deprivation indices, with high levels of family disruption and social dereliction. There is a recognised and serious lack of family support services at community and primary care level, resulting in an increased demand for child and adolescent mental health services. The absence of any child psychiatric nurses on community teams limits the level of home-based treatment that can be offered to children, particularly to older children presenting with deliberate self-harm, adjustment disorders, mood disorders and early onset psychotic illnesses.

The catchment area has over 800 children in care, with 125 in residential care, some from other parts of Dublin City and County. Such children have a recognised need for support, but services are seen to be inadequate, particularly for adolescents in care. The need for increased psychological services at community care level was highlighted, as was the need for very close working relationships between child care services and mental health services for children and adolescents.

In addition to providing a service to the catchment population, teams provide a service to the Young Offenders facility in Oberstown and the secure non-offender unit in Ballyboden. Neither of these facilities

has dedicated specialist mental health teams. There is no specialist forensic child and adolescent service available, and when specialist consultations are required, teams have to look to the UK to provide it.

The area contains a busy children's hospital, Children's University Hospital Temple Street. The child and adolescent mental health service provides a comprehensive liaison service to specialist departments and a 24-hour emergency service. Whole-time-equivalent staffing of the service to Temple Street comprises 1.5 consultant psychiatrists, 4 clinical psychologists, 3 social workers, 1 occupational therapist, 1 speech and language therapist and 1 clinical nurse specialist. In 2004, the liaison service saw a total of 525 patients, including 148 new inpatients and 377 new outpatients. One hundred and sixteen of these new patients were emergency presentations to A&E.

In addition to the liaison and emergency service provided in the Children's Hospital Temple Street, a specialist service is provided for child and adolescent victims of sexual abuse and there is a developing service for adolescent sex offenders.

All community teams provide an Autistic Spectrum Disorder assessment service but have identified a deficiency in specific on-going services for these children and adolescents.

There is an adolescent day service based on the St. Vincent's Hospital Campus, and access to inpatient beds in Warrenstown. However, this unit is functioning at considerably below capacity, due to difficulties in staffing and can only provide a 5-day service. The lack of emergency inpatient observation beds is particularly acute given the high level of emergency presentations to the Children's University Hospital.

The child and adolescent service has been involved in many innovative projects to support parents and professional working with children and adolescents and to promote mental health awareness and coping skills in adolescents. There is an ongoing research programme to evaluate the use of biofeedback in the management of Attention Deficit Hyperactivity Disorder.

The service, including the Liaison Service in the Childrens University Hospital, has produced comprehensive development plans outlining necessary service developments and the resources necessary to implement these developments. Included in the highlighted developments needed are a dedicated service to the under-5 age group, a dedicated adolescent team with outreach services, a dedicated service to children with Attention Deficit Hyperactivity Disorder and a focused service to children of asylum seekers. The development plan also highlights the need for a forensic child and adolescent mental health service, a service that is not available anywhere in the country.

Child and Adolescent Mental Health Services

(Counties Louth, Meath, Cavan and Monaghan)

There are three teams providing child and adolescent mental health services in the North East. An additional four teams is required to provide the service level of one team for each 50,000 total population. Current team staffing is particularly deficient in occupational therapy and speech and language therapy.

Table 1 Population

Population	Total	Under 16	Under 18	16-18
Louth/Meath	233,753	58,091	65,758	7,667
Cavan/Monaghan	107,951	26,323	30,285	3,962
Total	**341,704**	**84,414**	**96,043**	**11,629**

Table 2 (a) Total Team Staffing

Teams	3
	Number of Approved Posts
Consultant Psychiatrists	3
Clinical Psychologists	3
Social Workers	7.5
Occupational Therapists	0
Speech and Language Therapists	1
Nursing Staff (Community Based)	10

Figures in ( ) relate to unfilled approved posts.

At the time of inspection one team was based in Cavan/Monaghan and two teams in Louth/Meath. The consultant psychiatrist on the Cavan/Monaghan team also provided liaison sessions to the paediatric unit in the Our Lady of Lourdes Hospital in Drogheda. All teams provide a service for the under-16 age group only and all teams have significant waiting lists. No out-of-hours emergency service is available and teams have no formal access to inpatient beds. As with many teams nationally, a recognised increase in the demand for educational assessments has occurred in recent years.

A number of service initiatives have been undertaken in the region which includes an anti-bullying programme for schools, a primary school prevention programme for vulnerable children and a programme for children whose parents are experiencing a mental illness.

A priority for the existing service is the development of additional teams, particularly for Counties Louth and Meath, both of which are experiencing significant population growth.

Child and Adolescent Mental Health Services

(Dublin South and Co. Wicklow, Dublin Southwest, Dublin Northwest, Co. Kildare)

Table 1 Population

Population	*Total	Under 16	Under 18	16-18
	925,960	196,483	222,654	26,171

* Populations are likely to be under-estimates as two of the existing HSE teams provide services in parts of the old Northern Area Health Board.

Mental health services for children and adolescents in Dublin Southwest, Northwest and Co. Kildare are provided directly by the HSE and services in Dublin South and Co. Wicklow are funded by the HSE and managed by the Bothers of Saint John of God. There are in total 17 consultant teams. Eight of these teams are in the HSE, and eight are funded by the HSE and managed by the Brothers of Saint John of God. Two of the HSE managed teams provide services in part of the old Northern Area Health Board.

The areas covered by these services have a total population of almost one million, an under-16 population of almost 200,000 and an under-18 population of almost quarter of a million.

HSE SOUTH WESTERN AREA

Child and Adolescent Mental Health Services in the HSE South Western Area cover the South Inner City, Lucan, Saggart, Rathcoole, Mulhuddart, Cabra, Finglas, Clondalkin, Ballyfermot, Blanchardstown, Castleknock and County Kildare. The total population is approaching 500,000 with in excess of 111,000 aged under16. There are currently eight teams in place providing services, while the population requires a minimum of 10. The development of teams was seriously adversely affected by the cap on public service employment and, at the time of its introduction, five Occupational Therapy posts were lost, as were five Senior Registrar posts, Nursing, Childcare, Speech and Language, Social Work and Psychology posts remained unfilled as vacancies occurred. The service has spent less than two-thirds of its allocated budget in the last year, due to its inability to fill necessary posts.

The region is experiencing high rates of population growth, including significant inward migration of young families, leading to rapid growth in the numbers of under-16 and under-18 year olds. The region also contains some areas with high rates of urban deprivation, with their associated increased risk of family problems and child and adolescent mental health problems. In areas such as these, the demand for child and adolescent mental health services is likely to be increased.

In addition to the lack of team development and the inadequate number of teams in the South West other factors impact on the child and adolescent service. Community facilities for most teams are described as inadequate and the inpatient unit in the region, which takes admissions from the whole country. Warrenstown, can only operate on a 5-day week basis due to staffing difficulties. Funding has been approved for a day facility on the Cherry Orchard Hospital campus and it is proposed that this service will cater for adolescent up to the age of 18. An

inpatient unit is also proposed for the Tallaght Hospital campus catering for older adolescents.

Existing teams have identified a lack of community resources for children in care, resulting in some children being referred to the specialist mental health services when intervention at a less specialist level would address their problems. There is also growing concern over the issues of alcohol and drug use among young people and the need for an integrated approach between child and adolescent mental health services and addiction services was highlighted.

There are four multidisciplinary teams and a specialist school in Beechpark providing services to children and adolescents with Autistic Spectrum Disorder. This Service was set up to provide services for Children on the Autistic spectrum of normal IQ or mild intellectual disability. However children of moderate to severe intellectual disability and ADS are attending this classes as mental health services for children and adolescents with an intellectual disability are very poorley developed in the region, such children can be significantly disadvantaged as a result.

EAST COAST AREA

Mental health services for children and adolescents in the HSE East Coast Area and part of the HSE South West Area are funded by the HSE and managed by the Brothers of Saint John of God. There are eight whole-time-equivalent consultant psychiatrists, providing services out of Rathgar, Tallaght, Dunlaoghaire, Bray and Wicklow. In excess of 2.73 whole-time-equivalent consultant posts are based in Rathgar/Crumlin. One of these teams is dedicated to the day hospital.

The service has a number of specialist facilities including a day treatment unit for children up to age seventeen and a special school for children with complex developmental or emotional difficulties. Both these facilities are based in Rathgar. There is an additional day treatment unit for young children in Dunlaoghaire. St. Peter's School takes children up to age 18 and offers educational alternatives to the Group and Leaving Certificate examinations.

The majority of teams take referrals on children up to the age of 16. Different teams have different approaches to the provision of services to particular patient groups, such as children with Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder. Waiting lists can be up to two years for non urgent referrals. Teams identified a particular lack of services for children with Autistic Spectrum Disorder and difficulty in accessing those specialist services that do exist. As with many other services nationally, teams have identified a lack of child and family services at primary and community level, leading to referrals to the specialist services by default. There is also a perception that deficiencies in the National Educational Psychology Service has resulted in referral to the specialist mental health service of children with primary learning difficulties.

As with teams in the South West, the lack of specialist forensic services and the lack of substance abuse services for adolescents were highlighted.

Mental health services for children and adolescents in the HSE South Western Area and the HSE Eastern Area share many problems. The most significant is the apparent lack of a cohesive plan to develop and coordinate services for this large and growing population. This has resulted in uneven provision of existing services, a failure to develop necessary services, such as forensic and substance abuse services, and a lack of a coordinated approach to solving common recruitment problems.

The availability of 16 teams falls short of the 20 teams that would be required to meet the service provision level of one team for each 50,000 total population. None of the existing teams has full staffing and shortages are particularly acute in speech and language therapies and nursing. There is a serious lack of child and adolescent psychiatric nurses for community teams and for the inpatient facility at Warrenstown. The effect on the inpatient facility is to limit the number of beds and the number of days the service is operational. The effect on community teams is to limit significantly the amount of home-based treatment that can be delivered. This nursing shortage is due in part to a lack of training opportunities and is further compounded by anomalies in pay structure which makes some less specialist grades more attractive.

Difficulties that affect child and adolescent mental health services nationally will often seem more acute in the Dublin region, by virtue of higher population

numbers alone and higher numbers of children living in areas with high deprivation levels. All teams highlighted the lack of child support services to children and families in difficulties and the lack of psychological support services for children in care. This lack means that children whose needs could be met at a less formal and specialist level are instead referred to the mental health services. Efforts to provide a fast response to urgent cases results in waiting lists of up to two years for less immediately urgent cases.

It is strongly recommended that mental health services for children and adolescents in the Greater Dublin, Kildare and Wicklow regions are planned, developed and managed in a unified manner.

Chapter 7

Mental Health Services for Persons with Intellectual Disability

Mental Health Services for Persons with Intellectual Disability

(Counties Cork and Kerry)

General services for persons with intellectual disability in the HSE Southern Area are provided by the HSE and 10 voluntary agencies. There is currently in excess of 3,500 persons on the intellectual disability database.

Table 1 Population

Population: 580,356	Required Teams	Current Provision
C&A Intellectual Disability	3	1 WTE Consultant – No dedicated Team
Adult Intellectual Disability	6	1 Consultant – No dedicated Team

Specialist mental health services for persons with intellectual disability are seriously under-developed.

Mental health services for children and adolescents with an intellectual disability are provided by sessional input from child and adolescent consultant psychiatrists in the child and adolescent mental health teams managed by the Brothers of Charity. These consultants, however, are already over-extended in providing a service to a significantly greater than recommended number of children and adolescents who do not have an intellectual disability. There are no dedicated multidisciplinary mental health teams associated with these consultant sessions.

The development plan for the area, Mol and Óige, has recommended increasing the number of Child and Adolescent Mental Health Teams to eleven and providing for the needs of children and adolescent with intellectual disability from this component. This highlights further the need to implement this plan.

Mental health services to adults with intellectual disability are critically under-developed. Services are provided by just one consultant psychiatrist who has no dedicated multidisciplinary team. This limited service is restricted to County Cork. The degree of under-development of this service is highlighted by the fact that national norms recommend 5 fully staffed teams to provide a comprehensive service to the population in the south.

There is no designated mental health inpatient unit for the treatment of persons with intellectual disability and mental illness or challenging behaviour. The absence of any such unit and the under-development of services are of particular concern given that over 250 people with challenging behaviour are resident in three units in the area – St. Raphael's in Youghal, Grove House in Cork and Killarney. The area is likely to require access to 12 approved inpatient beds for the treatment of mental illness and access to a further 8 beds for the management of challenging behaviour under the Mental Health Act 2001. These beds will have to be under the clinical direction of a consultant psychiatrist.

All mental health services for persons with intellectual disability should be under the one management system and be closely associated with the other specialist mental health teams in the area.

Mental Health Services for Persons with Intellectual Disability

(Counties Waterford, Wexford, Carlow, Kilkenny and South Tipperary)

General services for persons with an intellectual disability in the HSE South East are provided by a variety of voluntary agencies in addition to the HSE.

Table 1 Population

Population: 423,616	Required Teams	Current Provision
C&A Intellectual Disability	4	2 Consultants – No dedicated Team
Adult Intellectual Disability	4	1 Consultant – No dedicated Team

There are in excess of 3,000 persons on the intellectual disability register. A significant number of persons remain in institutional care including 160 in St. Patrick's in Kilkenny, 22 in St. Luke's Psychiatric Hospital in Clonmel and 27 in St. Senan's Hospital in Enniscorthy.

Mental health services to children and adolescent with intellectual disability are provided by two consultant psychiatrists under the management of the Brothers of Charity. There are no dedicated multidisciplinary mental health teams. The recommended number of teams for this population in the HSE South East is the equivalent of one team for every 200,000 total population. The appropriate number of multidisciplinary mental health teams required will depend on the relationship with Child and Adolescent Mental Health Services. A decision on the final relationship between these services should be reached as a matter of urgency as all mental health services to children and adolescents are significantly under-developed.

Mental health services to adults with intellectual disability are equally, if not more seriously, under-developed. There is just one consultant psychiatrist with no dedicated multidisciplinary mental health team. The area requires a minimum of four fully staffed teams. In addition, up to 12 inpatient beds for the management of mental illness in adults with intellectual disability are required and up to eight beds for the management of persons with intellectual disability and challenging behaviour. These beds must be approved under the Mental Health Act 2001. The location of these inpatient beds should be decided on a regional basis, taking in the needs of all counties in the HSE south and South East Region.

Mental Health Services for Persons with Intellectual Disability

(Counties Clare, Limerick and North Tipperary)

The principle service providers to persons with intellectual disability in the Mid-West are the HSE, the Brothers of Charity, the Daughters of Charity, St. Anne's Service, Roscrea and the St. Joseph's Foundation.

Table 1 Population

Population: 339,591		
	Required Teams	Current Provision
C&A Intellectual Disability	1-2	0.5 Consultants - No dedicated team
Adult Intellectual Disability	3	1.5 Consultants – No dedicated team

Mental health services are poorly developed and are largely isolated from the remainder of the mental health services. There are two consultant psychiatrists employed by voluntary agencies. Neither has a dedicated team of multidisciplinary professionals.

The region requires a comprehensive mental health service to be provided to the entire population of persons with intellectual disability, irrespective of which agency is providing general support services. The region requires between one and two teams for services to children and adolescent with intellectual disability. This service could be provided through an enhanced child and adolescent mental health service. It is essential that these teams have dedicated team members from the specialties of nursing, clinical psychology, social work, occupational therapy and speech and language therapy. The region also requires three teams for the provision of services to adults with learning disability, and again these teams must have dedicated staffing.

The region has a unit for people with mild or moderate intellectual disability who present with severe challenging behaviour, or serious mental illness. This unit is not approved under the 1945 Mental Treatment Act. If individuals in such a unit are being given any psychiatric medications, if they are under any kind of physical restraint, if seclusion is being used or if they are de facto detained in any way, such a unit will have to be under the clinical direction of a consultant psychiatrist and will have to be approved under the Mental Health Act 2001.

At the time of inspection, a number of adults with intellectual disability living in community residences in Clare continued to be under the care of the mental health services.

All mental health services for persons with intellectual disability should be under the one management system, should provide a catchment-based service and should be closely allied to the other specialist mental health teams in the region.

Mental Health Services for Persons with Intellectual Disability

(Counties Galway, Mayo and Roscommon)

General services for persons with intellectual disability in the Western Area are provided by a number of agencies including the HSE, the Brothers of Charity, Western Care and the Galway Association.

Table 1 Population

Population: 380,297	Required Teams	Current Provision
C&A Intellectual Disability	2	Sessional Input from C& A Consultants – No dedicated team
Adult Intellectual Disability	4	1

Mental health services are seriously under-developed. There are no dedicated teams for the provision of services to children and adolescents, and services for adults are provided by one consultant psychiatrist and 1.4 clinical psychologists. There are significant numbers of both adults and children in institutional settings including St. Brigid's Hospital in Ballinasloe, Arus Attracta in Mayo, Kilcornan in Galway and the John Paul complex in Galway. The only consultant in the area is employed by the Brothers of Charity. As a result, there are large numbers of individuals with intellectual disability and co-existing mental illness, challenging behaviour or dementia, who are without a specialist service.

There is a limited mental health service to children and adolescents in Mayo, provided by the Child and Adolescent Mental Health Team. However, this team is already seriously over-stretched, with an additional team required. There is no mental health intellectual disability service for children and adolescents in Galway or Roscommon. If services are also to be provided to children and adolescent with intellectual disability additional resources will be required.

The current state of under-development of the mental health service for persons with intellectual disability in the HSE Western Area requires urgent attention. Given the increased risk of mental illness in persons with intellectual disability, there are likely to be significant numbers of persons without access to an appropriate service. There are no approved inpatient beds in the region, giving rise to the concern that persons with intellectual disability may be receiving treatment in unapproved settings which should only be given in approved settings, and that there may be others who will require the protection of the Mental Health Act 2001.

Mental Health Services for Persons with Intellectual Disability

(Counties Donegal, Sligo, Leitrim and West Cavan)

There are two consultant psychiatrists for adult intellectual disability in the North West but neither has an associated multidisciplinary team.

Table 1 Population

Population: 222,762	Required Teams	Current Provision
C&A Intellectual Disability	1	Sessional input from C&A Services. No dedicated Team
Adult Intellectual Disability	2	2 Consultants – No dedicated teams

In the Sligo/Leitrim/West Cavan service clinical psychology, social work, occupational therapy and speech and language therapy have to be accessed from Intellectual Disability services and community care services and communication is through team meetings. The situation is similar in Donegal. This is an unsatisfactory situation as it is impossible to provide a coordinated, comprehensive mental health service to individuals when those professionals involved in the provision of the service are based in different programmes.

There are still substantial numbers of persons with intellectual disability living in institutions in the North West. Cregg House in Rossmore has 145 places, Cloonmahon has 100 and Sean O'Hare house in Stranolar has 60. A number of residents in these facilities have additional problems such as severe Autistic Spectrum Disorder, severe mental illness, challenging behaviour, Down's syndrome or dementia. Some residents of community hostels have also been identified as being in need of a specialist mental health service. Both consultant psychiatrists highlighted the difficulty in providing a comprehensive service to these people in the absence of multidisciplinary teams. In particular, the absence of community-based nursing staff was seen as a serious limitation. There are plans to recruit a community nurse to the teams in both catchment areas.

In addition to highlighting the needs for multidisciplinary teams, consultants identified the need for a small number of inpatient beds for person with intellectual disability and mental illness or challenging behaviour. A suitable location for a pilot programme has been identified, but both capital and revenue funding will be required to progress this.

Mental health services for children and adolescents are provided from the Child and Adolescent Mental Health Teams. These teams, however, are understaffed, and the number of available teams needs to at least double if comprehensive services to all children and adolescents are to be provided.

The needs of both children and adults with intellectual disability and co-existing mental illness or seriously challenging behaviour in the North West have been clearly identified. Fully staffed multidisciplinary teams must be put in place and an approved facility provided for those who require a period of inpatient care.

Mental Health Services for Persons with Intellectual Disability

(Dublin City and County, Counties Kildare and Wicklow)

Mental health services for persons with intellectual disability in Dublin City and County and Counties Kildare and Wicklow have traditionally been managed by voluntary agencies.

Such agencies employed consultant psychiatrists as part of the general service provided to persons with intellectual disability, but no dedicated mental health teams were built up. Mental health services are not developed on a catchment population basis by these organisations, but are provided to clients who are already attending their services. Funding is on a discrete individual basis and service provision is dependent on funding. The biggest service providers that operate in this way are St. Michael's House, Stewarts Hospital, St. Raphael's in Celbridge, and the St. John of God Brothers.

The mental health services provided directly by the HSE to persons with intellectual disability are organised on a catchment basis. There are two such services in the area, St. Joseph's Intellectual Disability Service in the North of the county and the South Side Intellectual Disability Service. The most important difference between these services and the voluntary agencies is that service provision is not dependent on discrete funding for individuals, but as statutory services, they are required to provide services to anyone who presents in need. In addition, if a patient is transferred to one of the statutory services from a voluntary agency, the related funding does not automatically follow.

Staffing of the statutory services, St. Joseph's Intellectual Disability Service and the South Side Intellectual Disability Service are seriously deficient, both in terms of the professional staff required to provide comprehensive support and personal services to clients, and in terms of the professional staff required to provide a specialist mental health service. St. Joseph's Intellectual Disability Service has just two consultant psychiatrists, no clinical psychologists, no speech and language therapists (although a community speech and language therapist provides a consultative service to St. Joseph's service 14 weeks per annum) no occupational therapists, no social workers. The South Side Intellectual Disability is in a similar situation.

St. Joseph's Intellectual Disability Service is particularly disadvantaged. Apart from Stewart's Hospital, which provides eight approved beds for the care of persons with intellectual disability who require inpatient care for the treatment of mental illness or behavioural disturbance, St. Joseph's is the only other service nationally that provides approved inpatient beds. The same discrepancy occurs with funding inpatient care as occurs in funding generic care. Stewart's Hospital is paid for any HSE patient who receives inpatient care, while in St. Joseph's funding does not relate to the number of clients it has or on the level of services that each individual requires.

There are a number of disadvantages in this traditional split in care provision between voluntary and statutory agencies. Comprehensive catchment-based services have never developed. No specialist mental health teams have been provided and specialist services for particular groups have never been developed. There are no forensic mental health services for persons with intellectual disability. There are no specialist, approved services for persons with intellectual disability and disturbed behaviour. There are no specialist services for persons with intellectual disability and substance abuse and there is no agreement on the provision of services to persons with mild intellectual disability who may be functioning at a considerably lower level.

To a considerable extent, the deficiencies in mental health service provision to persons with intellectual disability in this large population mirror the deficiencies that are evident nationally – the failure to develop dedicated teams for specialist mental health care, the failure to provide comprehensive catchment-based services, the failure to develop necessary services for particular patient groups, the discrepancy in funding and staffing between statutory and voluntary agencies and the failure to have any independent monitoring of service standards for those persons with intellectual disability who are in the whole-time care of specific agencies.

Mental Health Services for Persons with Intellectual Disability

(Counties Laois, Offaly, Westmeath and Longford)

Mental health services for adults and children who have co-existing intellectual disability and mental health needs are only at an early stage of development in the Midlands.

Table 1 Population

Population: 227,436	Required Teams	Current Provision
C&A Intellectual Disability	2	1
Adult Intellectual Disability	2	1 Consultant – No dedicated team

There is one consultant psychiatrist for adults, with no dedicated multidisciplinary team staffing. There is no assigned clinical psychologist and no access to speech and language therapy, to occupational therapy or social work. As in many other services, there has been a failure to recognise that mental health services for people with intellectual disability must be organised and delivered on the basis of dedicated multidisciplinary teams, and the provision of a lone psychiatrist or two is wholly insufficient.

There are significant numbers of adults with intellectual disability still resident in institutional settings. These settings include the HSE facilities of Lough Sheever in Mullingar with 55 residents, Alvernia in Portlaoise with 43 residents and St. Peter's in Castlepollard with 42 residents. An additional 56 individuals are in institutional care under the Sisters of Charity of Jesus and Mary. A review of individuals in HSE institutions is reporting up to 50% incidence of mental illness or significant behaviour disturbance and use of psychotropic medications in up to 75% of residents. These findings underpin the necessity of developing adequate specialist mental health services for this population. There are no approved inpatient beds within the service for the management of persons with intellectual disability who may require inpatient care for the management of a mental illness or disturbed behaviour.

Mental health services for children and adolescents with an intellectual disability are also under-developed in the area. There is a single consultant psychiatrist, again with no dedicated multidisciplinary team. There is a regional team for children with Autistic Spectrum Disorder comprising a consultant psychiatrist, clinical psychologist, speech and language therapists, occupational therapist, social work, outreach workers and nursing.

The existing mental health services for persons with intellectual disability and mental health problems are isolated from the remainder of the mental health services in the area. In addition, no discrete service plan is developed for these services, separate from service plans for generic support services for persons with intellectual disability. Both these factors have seriously inhibited the cohesive development of necessary services. The existing mental health service personnel recognise these deficiencies and have prepared detailed development plans for a comprehensive mental health service to all persons with an intellectual disability in the area. These development plans must be implemented as a matter of priority.

Mental Health Services for Persons with Intellectual Disability

(Counties Louth, Meath, Cavan and Monaghan)

Mental health services for persons with intellectual disability in the North East are the most under-developed nationally.

Table 1 Population

Population: 341,704	Required Teams	Current Provision
C&A Intellectual Disability	1-2	0
Adult Intellectual Disability	3-4	0

One consultant psychiatrist, with no associated team, is available to the entire region on only one day a week. An appointment to an additional consultant psychiatrist post for Regional Disability services is awaited. A consultant post attached to the Brothers of St. John of God is vacant.

The needs of the area should be well recognised as there has been a number of service development documents produced, describing the service that should be provided. It is difficult to understand, therefore, why such little progress has been made in providing the necessary services. At present, the responsibility for the development of mental health services for persons with an intellectual disability is within the generic learning disability programme. However, trying to develop a specialist mental health service in isolation from existing mental health services makes no sense and the responsibility for developing the necessary services must be placed with the existing mental health service management teams.

Of particular concern is the presence in the region of a large institution, housing over 200 persons with more severe levels of intellectual disability. This institution, Drumcar, is under the management of the Brothers of St. John of God. It has been estimated locally that 10-15% of these residents require a specialist mental health service. There is currently one post of consultant psychiatrist attached to the Brothers of St. John of God. This post should be transferred to the HSE so that, as services develop, they are developed on a catchment population base.

The lack of services to this vulnerable population in the HSE North East must be addressed as a matter of urgency. A comprehensive catchment service, with dedicated multidisciplinary teams must be developed for both adults and children. Access to approved inpatient beds must be provided for those who require inpatient treatment for the management of intellectual disability and mental illness or challenging behaviour.

Chapter 8

Mental Health Services for the Elderly

Mental Health Services for the Elderly

(Counties Cork and Kerry)

Specialist Mental Health Services for the Elderly are seriously underdeveloped in the HSE Southern Area. There is one team, where 5 are required.

Table 1 Total Population: 580,356

Population over 65:	Required Number of Teams	Current Number of Teams
69,391	5	1

Table 2 Staffing of the Service

Consultants	1
Psychologists	1
Social Workers	1
Occupational Therapists	1
Total Nursing Complement	4.4
Care Attendants	0.4

This single team is essentially limited to providing a service in the South Lee catchment, while all other catchments are without a specialist service. Team staffing is given in Table 2. Facilities for the team are inadequate. There are no dedicated inpatient beds so that acute admission facilities are in the acute psychiatric unit in Cork University Hospital. Male beds are upstairs in this unit, a situation that is wholly unsuitable for a service for the elderly. Long stay beds for the service are at a distance of 40 miles from the city, in Heatherside Hospital in Buttevant. This situation seriously limits ongoing family involvement and many carers have expressed their dissatisfaction with the absence of long-term care facilities closer to the city. One respite bed is available to the service in St. Stephen's Hospital in Glanmire. The only day hospital facility is access to two rooms borrowed from a community facility and available only two days a week.

Counties Cork and Kerry have a higher than average number of persons aged 65 and over – 12% of the population in comparison to 11.1% nationally. In rural areas of North and West Cork and in County Kerry, populations are relatively thinly dispersed, public transport is poor and access to service can be difficult. In addition to the higher than average number of elderly persons in the area, there are large numbers of elderly persons resident in long stay units and hospitals. Some of these are former long stay patients of Our Lady's Hospital in Cork, who have now become long stay patients in Heatherside Hospital in Buttevant, in St. Patrick's Hospital in Youghal or in St. Stephen's Hospital in Glanmire. These patients do not, and have never had, access to either a specialist rehabilitation service or a specialist service for the elderly.

The development of mental health services for the elderly in the south is lagging seriously behind almost all other areas of the country and must be addressed as a matter of urgency. An additional four teams is required and the staffing of these teams, in addition to addressing the multidisciplinary requirement, must reflect the needs of the area – large rural areas with few population centres and a thinly dispersed population. Appropriate community and inpatient facilities need to be developed. New teams must not be allocated purely along existing catchment boundaries, but must be allocated in such a way as to address the needs of the elderly population most efficiently.

As both mental health services for the elderly and specialist rehabilitation mental health services develop, the care of elderly, discharged long-stay patients must have access to the appropriate service. While awaiting these developments, the HSE must ensure that all remaining hospitalised long-stay patients have access to general practitioners for their physical health care needs.

Mental Health Services for the Elderly

(Counties Carlow, Kilkenny, Waterford, Wexford and South Tipperary)

Mental health services for the elderly in the South East are in the process of developing. There are four teams, which is the required number.

Table 1 Total Population: 423,616

Population over 65:	Required Number of Teams	Current Number of Teams
49,775	4	4

Table 2 Staffing of the Service

Consultants	4
Psychologists	
Social Workers	0.5
Occupational Therapists	1.5
Nursing Complement (Community)	8

Figures in ( ) relate to unfilled posts.

Each has a consultant psychiatrist and a minimum of two community based clinical nurse specialists. The remainder of the necessary team members, however, are under-represented. The South Tipperary team has a fulltime occupational therapist, while the Waterford team has 0.5 occupational therapist, 0.5 social worker and access to a clinical psychologist. The Wexford and Carlow/Kilkenny teams are lacking all multidisciplinary team members except nursing staff. All teams require the full complement of team staffing and additional community-based nursing staff are required to allow the development of active community- based care. A significant portion of this additional nursing staff can be deployed from the existing general adult complement, many of whom are still employed in the large mental hospitals remaining in the area.

No team has dedicated acute inpatient beds, so that all admit to the general adult psychiatric units in the relevant catchments. Each team has access to some continuing care beds, primarily in the old mental hospitals. The HSE South East has a high number of public elderly care beds – approximately 1,000. However, the specialist mental health services for the elderly do not find it easy to access such beds when needed. There is a lack of clear placement criteria and no central placement committee. In contrast to the high number of beds for the elderly, community supports are not well developed, and are difficult to access for the elderly with mental health needs.

The foundation for the provision of mental health services for the elderly is in place in the South East. Priority should now be given to building up the multidisciplinary staffing of the teams, the deployment of additional community-based nursing staff to allow the development of active home-based treatment and the provision of suitable facilities for community-based care and for acute and long term inpatient care. An identified priority for all teams is the development of appropriate facilities for those elderly persons with disturbed behaviour in the context of dementia.

Mental Health Services for the Elderly

(Counties Clare, Limerick and North Tipperary)

There are two teams providing mental health care to the elderly in the Mid-West. One is based in Co. Clare, with an elderly population of 12,220 and one in Limerick, with an elderly population of 19,084.

Table 1 Total Population: 339,591

Population over 65:	Required Number of Teams	Current Number of Teams
39,591	3-4	2

Table 2 Staffing of the Service

Consultants	2
Psychologists	1
Social Workers	1.5
Occupational Therapists	1
Community Mental Health Nurses	6

There is no service in North Tipperary with an elderly population of 8,189. Both existing teams face similar challenges. Neither has the full component of multidisciplinary team members and both have inherited old facilities for inpatient care of the elderly.

The Limerick-based team admits to the Adult Psychiatric Unit, 5B, in the Mid-Western Hospital. They have access to six designated beds but these form part of the general complement. The team also has access to beds in St. Camillus' Hospital. One 10-bed unit in St. Camillus' Hospital, under the care of the mental health service, provides assessment beds for persons presenting with psychological or behavioural disturbance in the context of a dementing illness and also provides respite care for persons with dementia. A second 27-bed unit provides continuing care for persons with dementia. Twenty one of these beds are under the care of the mental health services for the elderly and six beds are under the care of geriatric medical services. St. Camillus' also functions as the team headquarters and provides space for a small day hospital which functions just one day per week. The available facilities and space are inadequate for both a team headquarters and day hospital.

St. Camillus's Hospital is not designated under the 1945 Mental Treatment Act. However, as it is under the care of the mental health service for the elderly and is being used as an assessment and treatment centre for elderly persons with dementia, the team was anxious that it should be designated. It was inspected for this purpose and will be placed on the register of approved units when the Mental Health Act 2001 is fully implemented. However, it will require significant upgrading to make it suitable for the purposes for which it is used.

The second team for the provision of mental health services for the elderly is based in Clare. This team is not fully staffed and has no access to psychological services. There are only two community based nursing staff. The remainder of the nursing staff assigned to the service are based in long-term care facilities. The allocation of community-based nurses is insufficient to allow the development of active home-based treatments. There is a five bed unit designated for patients of the mental health services for the elderly in the Acute Unit in Ennis.

The mental health service for the elderly inherited two long-stay facilities when Our Lady's Hospital in Ennis closed and both facilities are largely occupied by former long-stay psychiatric patients. Cappahard is a former nursing home, with 44 beds. All residents are former long-stay psychiatric patients from Our

Lady's Hospital. It is planned that this unit will be used to provide acute assessment, respite care and long term care for persons with dementia complicated by severe behavioural or psychiatric problems. There is no day hospital facility for mental health services for the elderly in Clare. St. Joseph's Hospital has two units of 26 beds and 28 beds. The female unit is occupied by former long-stay patients from Our Lady's Hospital and staffed by psychiatric nurses. Sixteen beds in the male unit are also occupied by former long-stay psychiatric patients. The additional 10 beds in the male unit are under the care of the geriatric medical service. The male unit is staffed by St. Joseph's Hospital staff.

The mental health service for the elderly team has completed a comprehensive review of both long-stay facilities and presented a development plan to upgrade them and assign specific patient-care purposes to them. The need for adequate accommodation for both the psychiatry of the elderly team and the rehabilitation team has been identified and addressed in the plan.

The two existing teams providing mental health services for the elderly in the HSE Mid-West need their team staffing completed, and in particular need additional community-based staff. Both teams require high quality community facilities for the provision of services and existing long-stay facilities need to be re-developed. A third team is also required in the region. Once appointed, teams should be deployed to best address the needs of the elderly in the catchment and not be tied to existing catchment boundaries.

Mental Health Services for the Elderly

(Counties Galway, Mayo and Roscommon)

Mental health services for the elderly are seriously under-developed in Counties Galway, Mayo and Roscommon.

Table 1 Total Population: 380,297

Population over 65:	Required Number of Teams	Current Number of Teams
49,222	3-4	2

Table 2 Staffing of the Service

Consultants	2
Psychologists	
Social Workers	1
Occupational Therapists	1
Total Nursing Complement	23.6

Figures in ( ) relate to unfilled posts.

At present there is a limited service to part of County Mayo and to West Galway but the teams providing this service are lacking key members of staff. The West Galway team has no clinical psychologist, no social worker and no occupational therapist.

The West, like a number of other regions, has higher than the national average of persons over the age of 65 – 12.9% in comparison to 11.1%. Forty two thousand people aged 65 and over live in Galway and Mayo, both large counties with thinly dispersed populations. Less than 9,000 people over the age of 65 live in Roscommon. This population distribution highlights the necessity of developing mental health services for the elderly on a regional basis, rather than based on the out-dated catchment boundaries for adult services.

Mental health services for the elderly are so under-developed that a regional development plan must be drawn up and implemented as a matter of urgency. This development plan must address the number of teams required, the staffing of those teams, their location and the provision of the necessary community and inpatient facilities.

Mental Health Services for the Elderly

(Counties Sligo/Leitrim/West Cavan and Donegal)

The percentage of persons over the age of 65 in the North West is 13%, which is 2% higher than the national average. The region also has the challenge of scattered populations in a large geographical area.

Table 1 Total Population: 222,762

Population over 65:	Required Number of Teams	Current Number of Teams
29,349	2	2

Table 2 Staffing of the Service

TEAM	Sligo/Leitrim/ West Cavan	Donegal
Consultants	1	1
Psychologists		
Social Workers	1 *(1)*	1 *(1)*
Occupational Therapists	1	0.5
Nursing Staff	5	6

Figures in ( ) relate to unfilled posts.

Mental health services for the elderly in the North West are in the process of developing. Each team has part of the core staffing required, but clinical psychology is absent. All referrals to psychology have to go to a central allocation meeting, which is a highly unsatisfactory situation and does not in any way compensate for the lack of a team service. Both teams highlighted the need for additional community-based nursing staff to allow them to maximise the amount of home-based care that can be delivered and to minimise their need for inpatient beds. The service in Sligo has a Day Hospital premises which is the team headquarters. The Donegal team does not have a Day Hospital, and would give priority to the appointment of additional staff to provide home-based treatments.

Elderly patients with functional illness are admitted to the psychiatric units in Sligo and Letterkenny. Persons with dementia who cannot be managed at home are admitted to units for people with Alzheimer's Disease in Sligo and Carrick on Shannon. Both teams have highlighted the need for a small number of approved inpatient beds for people with disturbed behaviour in the context of a dementing illness.

Mental Health Services for the Elderly

(Counties Laois, Offaly, Westmeath and Longford)

There are two teams providing mental health services to the elderly in the Midland Area.

Table 1 Total Population: 227,436

Population over 65:	Required Number of Teams	Current Number of Teams
26,436	2	2

Table 2 Staffing of the Service

Consultants	2
Psychologists	0
Social Workers	1
Occupational Therapists	2
Nursing Complement (excl inpatient care)	13

The Laois/Offaly team have a day hospital facility and team headquarters in Portlaoise and have identified a need for a day hospital in Offaly. Designated inpatient beds are available in the new acute psychiatric unit in Portlaoise. The Longford/ Westmeath team has day hospital and team headquarters in Mullingar, and have identified the need for a day hospital in Longford. Admissions are to the admission unit attached to St. Loman's Hospital. At the time of inspection this admission unit was undergoing renovation, but no discrete inpatient unit for the elderly had been identified in the development plans. Longford/Westmeath does not have an outpatient clinic and both teams have identified the need for additional community-based nursing staff to increase the amount of domiciliary care that can be provided.

There are significant numbers of elderly patients still residing in St. Loman's Hospital in Mullingar and some elderly patients remaining in St. Fintan's Hospital in Portlaoise. Elderly patients in Ward 6 in St. Fintan's Hospital have been identified as requiring ongoing specialist care, as have some remaining long-stay patients in St. Loman's Hospital. Other elderly patients in St. Loman's Hospital have been identified as being fit for community placement. As with other teams for the elderly nationally, the teams in the Midlands highlighted the difficulty that elderly persons with a history of mental illness may have in accessing elderly care units.

There are no specialist mental health teams in rehabilitation psychiatry in the HSE Midland Area. The development of such teams, in addition to the presence of the mental health teams for the elderly, is essential if long-stay patients of all ages are to be provided with the care they need.

Both mental health teams for the elderly have half-time co-ordinators at Assistant Director of Nursing Level. The work-load of both teams warrants full-time personnel in these roles. As with mental health services for those with intellectual disability, no clinical psychologists are assigned to the mental health services for the elderly.

Mental Health Services for the Elderly

Mental health services for the elderly in the former East Coast Area Health Board are seriously underdeveloped.

Table 1 Total Population: 271,249*

	Population over 65:	Required Number of Teams	Current Number of Teams
	33,416	3	1

Table 2 Staffing of the Service

Consultants	2
Psychologists	0.8
Social Workers	1
Occupational Therapists	1
Nursing Complement (Community)	4

The existing team serves Dublin City and South County only, leaving the Wicklow catchment without a service. The population served by the existing team requires a minimum of two fully staffed teams, while the addition of the population in the Wicklow catchment will require an additional team.

The area served by the current team contains three acute hospitals, all of which provide geriatric medical care. Partial liaison is provided in St. Vincent's University Hospital in that patients from the catchment are seen by the specialist team, while elderly patients from outside the catchment are seen by the adult mental health team, with a second opinion being provided by the specialist team if requested. A significant liaison work-load also comes from St. Michael's Hospital in Dun Laoghaire and Loughlinstown Hospital. This work-load is likely to increase with the appointment of two elderly care physicians to Loughlinstown. The majority of elderly patients in this hospital come from the Wicklow catchment, and once assessed by the specialist mental health team, there is a lack of continuity of care for such patients, as there is no specialist mental health team for the elderly in Wicklow.

* *Figures exclude the East Wicklow catchment, with an over-65 population of almost 10,000.*

The staffing of the existing team is entirely inadequate. With the existing level of nursing staff, in particular, the ability to provide active domiciliary care will be seriously curtailed. The team's headquarters and day hospital are based in Carew House on the grounds of St. Vincent's University Hospital. This facility is not ideal as the day hospital is on an upper floor. Inpatient care is provided in St. Vincent's University Hospital psychiatric unit. Six dedicated beds have been designated in the new Elmount Unit. These were not open at the time of inspection. Additional acute beds are purchased from St. John of God Hospital. Patients with behavioural or psychological disturbance in the context of a dementing illness are also admitted to purchased beds in St. John of God Hospital. Having acutely ill patients of the team on two hospital sites is not an ideal situation.

Mental health services for the elderly in the former East Coast Area Health Board are seriously under-developed in all aspects. The population of this region requires at least three fully staffed teams, and the high liaison requirement of the three acute hospitals in the region requires the equivalence of an additional team. The provision of facilities is wholly inadequate. There are insufficient inpatient beds for acute care and no realistic plans to develop a unit of sufficient size for the region. The existing day hospital facility is inadequate in size and location.

The region requires a comprehensive development plan for mental health services for the elderly to address these issues.

Mental Health Services for the Elderly

There are currently two mental health teams providing care in the HSE South Western Area. One is based in Dublin South City at St. James' Hospital and the second in Dublin West/South West.

Table 1 Total Population: 554,220

Population over 65:	Required Number of Teams	Current Number of Teams
43,814	3	2

Table 2 Staffing of the Service

	St. James'	Tallaght
Consultants	1	1
Psychologists	0	0
Social Workers	1	2
Occupational Therapists	1.5	2
Nursing Complement (Community)	4	5

There is no mental health service for the elderly serving the Kildare/East Wicklow catchment, with a total population of 178,515 and an over-65 population of 12,359.

The mental health service for the elderly based in St. James' Hospital serves an over-65 population of approximately 20,000. Staffing for the existing team is wholly inadequate. There is no psychology service, and only 4 whole-time-equivalent nursing posts serving the community and day hospital. The lone social worker also has supervisory responsibilities in the general adult psychiatric services. In addition to providing a specialist service to the catchment, the team also provides a liaison service to St. James' Hospital which has 200 dedicated beds for geriatric care and where 65% of admissions are over the age of 65.

In the absence of specialist rehabilitation services, this service originally took over the care of elderly, previously long-stay patients from St. Loman's Hospital and elderly patients from the general adult services based in St. James' Hospital. This is in contrast to many other mental health services for the elderly who excluded such patients from the outset. The service has been examining the mental health care needs of such persons and findings to date suggest that they require more resource intensive care than persons whose mental illness presents for the first time in later life. These findings have relevance for the provision of services to this very vulnerable group nationally.

Acute inpatient beds for this service are in St. James' Hospital. The location of these beds is not ideal as there is no access to a garden. Occupancy usually runs at 110%. There is limited access to facilities providing long-term care to elderly persons with mental illness or psychological or behavioural disturbance in the context of dementia. As a result up to 50% of acute beds may be occupied by patients requiring long-term care. The development of the new Bloomfield Hospital, a designated facility, offers some opportunities to address these problems.

The liaison requirement into the elderly care services in St. James' Hospital requires the equivalence of an additional team. A consultant psychiatrist post is being funded by the acute hospital to provide a liaison service, but this post does not come accompanied by any of the necessary additional team members.

The principal problems within this service are lack of adequate team staffing, lack of sufficient community-based nurses to provide active home-based treatments, lack of necessary staff to provide a comprehensive liaison service to the significant number of elderly acute hospital patients, unsuitable acute inpatient beds and insufficient access to long-term care beds.

The mental health service based in Tallaght Hospital was stalled for many years due to lack of staff and lack of access to acute inpatient beds. Some of these problems are now being addressed. A core home-based team of three community-based nursing staff, one social worker and one occupational therapist have now been appointed. It is planned that this service will reduce the need for inpatient beds. At the present, acutely ill patients are admitted to the general psychiatric beds and their care transferred to general adult psychiatric teams. This is a very unsatisfactory situation and leads to a complete lack of continuity of care.

The service has limited access to continuing care beds for elderly with either functional or organic illnesses. There are no such beds managed by the HSE and only limited access to beds within the private sector. Again the development of additional beds in the private, approved centre, Bloomfield may address some of these difficulties.

The third catchment in the former South Western Area Health Board is the Kildare/East Wicklow service. This catchment, with a total population of 178,515 and an over-65 population of 12,359 has no specialist mental health service for the elderly. This population requires one fully staffed team with appropriate facilities.

Mental Health Services for the Elderly

Dublin City North and Dublin County North

The mental health service for the elderly in Dublin City North and Dublin County North is seriously lacking in multidisciplinary team members.

Table 1 Total Population: 486,934

	Population over 65:		Required Number of Teams	Current Number of Teams
	48,395	30,000 (approx)	2	*1
		18,448	1	1

Table 2 Staffing of the Service Area 6 & 7

	Area 6 & 7	Area 8
Population over 65	29,947	18,448
Consultants	*1.5	2
Psychologists	0	1
Social Workers	1	0
Occupational Therapists	0	1
Nursing Staff (Community Based)	3	2

* *Second consultant psychiatrist post approved.*

There are no clinical psychologists or occupational therapists and only one social worker. There are only three community-based nursing staff, which seriously limits the amount of active home-based care that can be provided. The population served requires the equivalence of two multidisciplinary teams and while a second full-time consultant posts has been approved, no multidisciplinary staff have been approved for the team. A part-time consultant psychiatrist provides dedicated liaison input to elderly residents in private nursing homes.

The service in Dublin City North has two day hospitals, each staffed by two nurses. Acute inpatient beds are based in St. Vincent's Hospital in Fairview. Long-stay beds are based in Unit 3 in Connolly Hospital. This unit has long been recognised as being unsuitable for its purpose and the land on which it stands has now been sold. Alternative units on the hospital campus have been identified as being suitable, once refurbished, but at the time of inspection, no moves had been made to begin this process.

The service has a formal service agreement with two private nursing homes and utilises up to 67 beds for the care of elderly persons with mental illness, or with dementia accompanied by psychological or behavioural symptoms. These units have designated consultant psychiatrist input and input from community-based psychiatric nurses. The use of nursing home beds in this manner raises the question of appropriate registration for such facilities.

The over-65 population in Dublin City North stands at approximately 30,000 and requires the equivalent staffing for two teams. The resulting personnel could usefully function as a single team, maximising the expertise of all team members. The appointment of a second full-time consultant must be accompanied by the appointment of the necessary professional staff. Additional nursing staff, in particular, is particularly required to enhance the ability of the team to provide active domiciliary care. It is expected that the service will have a clinical nurse specialist in 2006.

The service had formulated plans to develop a service for early onset dementia, including an inpatient component of five beds. Staffing allocated for this service was thought to be inadequate and the service hopes to convert these posts to nursing and psychology posts for the community team. The team has identified the need for a Director of Nursing post. The designation of such senior posts should await

any management changes to be implemented following the new policy document, "A Vision for Change".

The total population of Dublin County North is 210,446 with an over-65 population of 18,448. The service has both acute and long-term care beds in St. Ita's Hospital. There are six acute assessment beds, 40 dementia care beds, 16 beds for elderly patients with enduring mental illness and three respite beds. The provision of beds in Beaumont for this service, as for the adult mental health service, is long delayed.

The service has a clinical nurse specialist who provides behavioural interventions for persons who have psychological or behavioural disturbance in the context of dementia. There are also two community mental health nurses, who provide domiciliary care. There is currently no day hospital facility but funding has been granted for a day hospital on the campus of Beaumont Hospital. The service provides a predominantly community-based service despite the limitations of team staffing, and in addition, carries a considerable case-load through consultation-liaison referrals from Beaumont Hospital and the geriatric day hospital.

As with the service in Dublin County North there are significant numbers of elderly patients in private nursing homes who have either a mental illness or a dementing illness and who require ongoing psychiatric care. The patients from Dublin County North are scattered through a number of facilities. There are over 50 beds formally contracted to the service with additional known patients receiving subvention or paying fees. All such patients are formally reviewed at least every 6 months.

The main requirement of this service is the appointment of additional nursing staff to increase the availability of active domiciliary care. While the provision of acute beds will ultimately be on the campus of Beaumont Hospital, the location of long-term care beds for those with dementia and enduring mental illness will have to be decided, once acute psychiatry moves from the St. Ita's Hospital campus. The provision of a day hospital on the Beaumont Hospital campus will further enhance the team's ability to provide community and day care.

Mental Health Services for the Elderly

(Counties Louth, Meath, Cavan and Monaghan)

Mental health services for the elderly are at an early stage of development in the North East. There are currently two teams, one serving Cavan/Monaghan and one serving County Meath.

Table 1 Total Population: 341,704

Population over 65:	Required Number of Teams	Current Number of Teams
35,978	3	2*

* *An additional consultant psychiatrist was due to take up post before the end of 2005.*

Table 2 Staffing of the Service

Consultants	2
Psychologists	0
Social Workers	2
Occupational Therapists	1

There is funding for an additional consultant psychiatrist, and one community-based nurse for a new team for County Louth. Neither of the existing teams has the multidisciplinary staffing required, with the Meath Team, in particular, being underdeveloped. The new team planned for County Louth also lacks the necessary input from clinical psychology and occupational therapy.

None of the admission units in the region have dedicated inpatient areas for psychiatry of the elderly. This is a disadvantage and rectifying this should be part of any development of new inpatient units or re-development of existing units. In addition to acute inpatient facilities the mental health services for the elderly will require designated beds for the ongoing care of persons with psychological or behavioural disturbance in the context of dementia.

The existing service in Meath has inadequate community facilities. While some funding has been made available to rectify significant design faults, the team requires a team headquarters and day hospital of appropriate design and space. Similar community facilities will be required for the new team to be based in County Louth.

Priorities for the mental health services in the HSE North East Area are the completion of multi-disciplinary staffing of all teams, the provision of appropriate community facilities in County Louth and County Meath and the provision of appropriate inpatient facilities for both acute and long-term care.

Chapter 9

Service Users

SERVICE USERS

During the Inspections of Mental Health Services in 2004, the Inspectorate initiated meetings with the Irish Advocacy Network (IAN) which offers peer advocacy. Peer advocacy is a service offered by people who have had a personal experience of mental health difficulties, which gives support and information to people with mental health difficulties. It also offers family support and staff awareness training. In some areas advocates are also part of management committees, consumer panels and other committees and working groups which aim to improve services and conditions for service users. The purpose of these meetings was to identify common views and concerns of service users around the country.

The Irish Advocacy Network stated that they were able to provide a service to most catchment areas in 2005 and that the advocacy service had integrated well into the mental health services. In most areas IAN find the mental health services accommodating and welcoming. It particularly praised those staff who assisted in setting up an advocacy service and enabled service users to contact an advocate.

The Inspectorate met with Irish Advocacy Network representatives in each former HSE Area, with service users who were inpatients and also met with a small number of carers and carers groups in different areas. The issues that service users requested the support of the IAN were as follows:

INFORMATION

Services users reported to the IAN that they often do not receive adequate information from their consultant psychiatrists about their diagnosis, their illness and treatment that they are offered. Information they receive was stated to be difficult to understand. In particular there is a lack of information about medication, its effects and the side-effects. Many feel that their doses of medication are too high and side effects too severe. Many service users feel that they do not receive sufficient information about their illness and that there is an over-reliance on medication with no alternatives to medication offered. There are also requests for more education about mental illness for children and spouses of service users. The IAN reported that there are information leaflets and brochures about the services in most hospitals, but service users require more individual information.

CARE PLANS

The lack of service user involvement in their care plan was highlighted. Many service users informed IAN that they are unaware of whether they have a care plan. Those that are aware of their care plan said that they have little or no input into it. Some also complained that their families are not always involved in their care. There are also complaints about the lack of access to social workers, clinical psychology and occupational therapists, with long waiting lists, particularly for psychology services. A number of service users said that they would like a choice in consultant psychiatrist and would like to be given the option of a second independent opinion but say that this is not readily available.

The lack of suitable placements on discharge was an issue for many service users. In urban areas some service users are homeless and the lack of suitable accommodation resulted in increased length of stay in admission units, long-stay wards and community residences. Attention was drawn to lack of follow-up on discharge, lack of information about support services after discharge and on the lack of services outside office hours, apart from emergency services. The distance to mental health centres is a problem for some service users especially when this is coupled with a lack or paucity of public transport.

There was criticism of the practice of initial assessment in Accident and Emergency (A&E) departments, with service users having to wait for long periods in A&E for a bed in the mental health admission unit. Service users would prefer to be assessed in the mental health unit if they are already known to the mental health services.

SERVICE USER RIGHTS

Although notices of patients' rights and complaints procedures are displayed in most units, some service users felt that they have insufficient information on their rights and are unaware of how to make a complaint about services. Some service users felt that if they did not consent to treatment offered they

would be detained under the Mental Treatment Act 1945 and/or moved to a locked ward. Some service users expressed the view that seclusion is used as a punishment and that the threat of seclusion is used as a means of obtaining compliance with treatment.

LACK OF ACTIVITIES

There were many complaints to IAN about the lack of activities for service users while they were in hospital. They complained of feeling bored and of having nothing to do. In units where there is an activation programme this is not available in most places after 1700h or at week-ends. In areas where there are programmes of therapeutic activities service users have reported that this was beneficial.

UNIT POLICIES

There are a number of policies in different centres that service users felt are unfair or restrictive. In a number of centres there is a policy of automatic nursing in night attire on admission which may continue for a number of days. Service users said that this contributes to their sense of powerlessness and vulnerability. Service users also complain that there are restrictions on the use of mobile phones.

The lack of comfortable indoor smoking facilities was highlighted. Most service users who smoke expressed a wish to smoke indoors. In many centres all smoking is outside in outdoor shelters which are described as cold and inhospitable. Indoor smoking facilities are, in the main, in poor condition.

Services users reported to the IAN that in some hospitals a number of units have locked doors and that service users are unhappy with this.

LACK OF COUNSELLING AND TALKING THERAPIES

In all reports from the IAN the lack of counselling and psychotherapy was highlighted. Service users would like access to counselling and feel that there is an over-reliance on medication. There is no availability of counselling or psychotherapy in some areas and long waiting lists in other areas.

There is concern expressed about access and custody of children. Service users feel that they are disadvantaged in obtaining custody of their children and also in access to their children due to their mental illness, particularly if children are in care.

PHYSICAL CONDITIONS

Many service users complained about the physical conditions in the old psychiatric hospitals, including lack of privacy and poor décor. There are concerns about the absence of lockable storage in the inpatient units and some service users have experienced theft of personal property. Some wards have no locks on toilet or bathroom doors and service users find this unacceptable. There are complaints about the mix of patients on admission units and the level of fear when some patients become disturbed.

The Inspectorate met with the Irish Advocacy Network in all regions in the country. There was marked similarity in the issues raised in all meetings with particular emphasis on the lack of information about illness, therapies and medication. Most of the issues raised are resource neutral and many are easily addressed. Most are issues that have been identified by the Inspectorate as areas of deficiency.

While advocacy services have extended to all services, those in long term wards and hostels often do not have access to this service despite the fact that they are most likely to find it difficult to represent themselves and often do not have family or carers to represent them. It is hoped that peer advocacy services will extend to this vulnerable group of service users.

Chapter 10

Glossary of Terms

Glossary

WORD/PHRASE	DEFINITION
admission order	the order authorising the reception, detention and treatment of the person concerned and shall remain in force for a period of 21 days from the date of the making of the order in accordance with Section 15 of the Mental Health Act 2001;
adult	any person who is not included in the definition of a 'child' in the Mental Health Act 2001;
advocate	a representative and supporter of service users' concerns and interests; may be formal or informal;
application	pursuant to the Mental Health Act 2001 means an application for a recommendation that a person be involuntarily admitted to an approved centre and "applicant" shall be construed accordingly;
approved centre	means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder that is entered on the register of approved centres maintained by the Mental Health Commission;
care	means all services and interventions provided to a person with a mental disorder and/or mental health problem by health sectors and other sectors, community organisations, family and carers;
catchment area	the area traditionally served by a district mental hospital. In many rural areas catchment boundaries correspond with county boundaries. In Dublin and Cork, catchments may correspond with community care areas. Services within a catchment are usually under the same management;
child	means a person under the age of 18 years other than a person who is or has been married;
clinical director	means a consultant psychiatrist appointed in writing by the governing body of each approved centre to be the clinical director of the centre under Section 71 of the Mental Health Act 2001;
clinical governance	a system for improving the standard of clinical practice including, clinical audit, education and training, research and development, risk management, clinical effectiveness and openness;
commission	means the Mental Health Commission established under section 32 of the Mental Health Act 2001;
community mental health team	a multi-disciplinary team offering specialist assessment, treatment and care to people in the community. The team should involve nursing, psychiatric, social work, clinical psychology and occupational therapy membership, with ready access to other therapies and expertise;
confidentiality	information to be kept private is safeguarded, with guaranteed limits on the use and distribution of information collected from individuals;
consent to treatment	consent to treatment is comprised of three key components: the provision of adequate information, decisional capacity, and voluntarism. The service user must be capable of understanding in simple language the nature, purpose and likely effects of treatment, be capable of retaining information for a sufficient period of time, to arrive at a decision and be

	able to communicate his/her decision. The service user's decision must be made freely, in the absence of coercion;
continuity of care	integration and linkage of components of individualised treatment and care across health service agencies, according to individual needs;
culture	a shared system of values, beliefs and behaviours;
day hospital	a facility that provides comprehensive treatment equivalent to that available in a hospital in-patient setting for acutely ill patients as an alternative or follow up to in-patient admission;
de-designation	the term used to indicate that part of a psychiatric hospital which has been formally separated from the main hospital and whose patients are no longer considered to be psychiatric patients. Accommodation for older people and patients with intellectual disability in a number of hospitals has been de-designated;
dignity	the right of individuals to be treated with respect as a person in their own right;
discharge	discharge is when a service user leaves an approved centre. In this context, it is a transfer in the location of the delivery of care from an approved centre to continuing support in the community, by primary care or community mental health services; or to an alternative care setting such as a nursing home or community residence; or possibly to a medical facility;
electroconvulsive therapy (ECT)	electroconvulsive therapy (ECT) is a medical procedure in which cerebral seizures are induced by passing a small amount of carefully controlled electric currents across the brain for three to five seconds. The patient receives a muscle relaxant and is briefly anaesthetised during the procedure. Its purpose is to treat specific types of major mental illnesses
examination	in relation to a recommendation, an admission order or a renewal order, means a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned;
functional area	means a functional area of the Health Service Executive as defined in the Health Board Regulations, 1970 (S.I. No. 170 of 1970) and in Section 7 of the Health (Eastern Regional Health Authority) Act, 1999; as amended by Section 67 of the Health Act 2004;
good practice	means approaches that have been shown to produce superior results selected by a systematic process and judged as "exemplary", "good", or "successfully" demonstrated. They are then adapted to fit a particular organisation;
health board	means a health board established under the Health Act, 1970, and the Eastern Regional Health Authority;
health service executive (HSE)	means the body which has replaced the health boards and the Eastern Regional Health Authority as the overall national body for delivery of health services pursuant to the Health Act 2004;

Glossary

home care team a multidisciplinary team, under the direction of a consultant psychiatrist, which provides assessment and intensive treatment on a domiciliary (home) basis for persons with acute episodes of illness;

independent sector privately funded mental health service providers;

integrated care and treatment plan a documented set of goals collaboratively developed by the service user and the multi-disciplinary team. The integrated care and treatment plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the service user. The integrated care and treatment plan is recorded in the one set of documentation;

intellectual disability database a database of persons with an intellectual disability in a defined area and nationally, giving details of care being provided and care that is likely to be required in the future;

inspector of mental health services means a consultant psychiatrist appointed by the Commission holding the office of the Inspector of Mental Health Services in accordance with Section 50 of the Mental Health Act 2001;

key worker a key worker is the prime therapist for each person and can come from any discipline. He/she is actively involved clinically with the individual.

learning disability a disorder in one or more of the basic cognitive and psychological processes involved in understanding or using written or spoken language; may be manifested in age-related impairment in the ability to read, write, spell, speak, or perform mathematical calculations;

legal representative means a barrister or a solicitor;

long stay A patient who has been continuously hospitalised for over one year.

mechanical means of bodily restraint is defined as the use of physical force for the purpose of preventing the free movement of a patient's body. This force may be applied by one or more persons. It may also be known as physical restraint;

mental disorder in the Mental Health Act 2001 "mental disorder" means mental illness, severe dementia or significant intellectual disability where- a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent. Under the Mental Health Act 2001 "mental illness" means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons; "severe dementia"

	means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression; "significant intellectual disability" means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person;
mental health centre	the mental health centre is the headquarters for one or more community mental health teams and is the base from which community services are provided. It will have facilities for outpatient contacts and may incorporate an acute day hospital;
mental health services	pursuant to the Mental Health Act 2001 means services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist;
mental health tribunal	means the Mental Health Tribunal(s) which the Commission shall from time to time appoint which or each of which shall be known as a Mental Health Tribunal to determine such a matter or matters as may be referred to it by the Commission;
multidisciplinary team (MDT)	a mental health team comprising of a variety of professional staff. Core team members generally are: psychiatrists, nurses, clinical psychologists, social workers and occupational therapists. Other special therapists may also be involved;
new long-stay	a patient who has become continuously hospitalised for over one year in the past year;
parents	includes a surviving parent and, in the case of a child who has been adopted under the Adoption Acts, 1952 to 1998, or, where the child has been adopted outside the State, whose adoption is recognized by virtue of the law for the time being in force in the State, means the adopter or adopters or the surviving adopter;
patient	pursuant to the Mental Health Act 2001 to a person to whom an admission order or renewal order relates;
policy	written statement that clearly indicates the position and values of the organisation on a given issue;
prescribed	pursuant to the Mental Health Act 2001 means prescribed by regulations made by the Minister;
primary care	includes the range of services that are provided in the community by general practitioners (GPs), public health nurses, general nurses, social workers, practice nurses, midwives, community mental health nurses, dieticians, dentists, community welfare officers, physiotherapists, occupational therapists, home helps, health care assistants, speech and language therapists, chiropodists, community pharmacists, psychologists and others;

procedure — written set of instructions that describe the approved and recommended steps for a particular act or sequence of acts;

psychosurgery — any surgical operation that destroys brain tissue or the functioning of brain tissue and which is performed for the purposes of ameliorating a mental disorder;

person(s) of unsound mind (PUM) — a person will be deemed to be of unsound mind where an authorised medical officer certifies that the person needs to be detained as a person of unsound mind and that they are unlikely to recover within six months. This is provided for in Section 163 of the Mental Treatment Act, 1945;

quality frameworks — show key concepts and the relations between them to guide analysis or other actions (e.g. a high-level model of an accreditation system, showing the different subjects covered);

register — means the Register of Approved Centres established and maintained by the Mental Health Commission in accordance with Section 64 of the Mental Health Act 2001;

regulations — mean the regulations that the Minister shall make, after consultation with the Commission, for the purpose of ensuring proper standards in relation to Approved Centres, including adequate and suitable accommodation, food and care for residents while being maintained in centres, and the proper conduct of centres, make such regulations as he or she thinks appropriate pursuant to Section 66 of the Mental Health Act 2001;

relative — in relation to a person, pursuant to the Mental Health Act 2001, means a parent, grandparent, brother, sister, uncle, aunt, niece, nephew or child of the person or of the spouse of the person whether of the whole blood, of the half blood or by affinity;

renewal order — means an order made by a consultant psychiatrist responsible for the care and treatment of a patient extending the period of detention of that patient in accordance with section 15 of the Mental Health Act 2001;

representative — a relative, friend or legal professional appointed by the patient, statutory organisation or court to represent the best interests of the patient;

seclusion — means the involuntary confinement of a patient alone in a room, furnished or unfurnished, day or night, from which the patient is physically, verbally or psychologically prevented from leaving. During seclusion the door may be open, closed, locked or unlocked. Or, seclusion, pursuant under the Mental Treatment Regulations, 1961 means the placing of a patient (except during the hours fixed generally for the patients in the institution to retire for sleep) in any room alone and with the door of exit locked or fastened or held in such a way as to prevent the egress of the patient (S.I. No. 261 of 1961)

sector / sectorisation — Planning for the Future described sectorisation as the process of providing a comprehensive service for a population of known size normally resident within a clearly defined district. The recommended population for a sector was 25,000-30,000. In many parts of the country, psychiatric services are organised in sectors on the model recommended in the Report;

service user	a person who experiences or has experienced mental illness and who uses or has used a mental health service. It includes a person who does not or did not choose to use a mental health service;
specialist mental health services	these include (but are not limited to) adult mental health services, child and adolescent mental health services, mental health services for older people, mental health services for persons with an intellectual disability and forensic mental health services. Each of these service categories provide inpatient care, in addition to residential and other community-based services;
spouse	in relation to the Mental Health Act 2001, means a husband or wife or a man or a woman who is cohabiting with a person of the opposite sex for a continuous period of not less than 3 years but is not married to that person; however for the purposes of Section 9 of the Mental Health Act 2001, "spouse" does not include a spouse of a person who is living separately and apart from the person or in respect of whom an application or order has been made under the Domestic Violence Act, 1996;
staffed community residence	24 hour nursing staffed community residence;
standard	a broad statement of the desired and achievable level of performance against which actual performance can be measured. The standard is the overall goal. It relates directly to the person receiving the mental health service. The standard outlines the objective that is expected;
temporary patient	a patient who is suffering from mental illness believed to require for his/her recovery not more than six months suitable treatment and is unfit on account of his/her mental state for treatment as a voluntary patient or who is an addict and is believed to require, for his/her recovery, at least six months preventive and curative treatment and who is detained on the legal authority of a Temporary Patient Reception Order (Mental Treatment Act, 1945);
treatment	in relation to a patient, includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder;
voluntary patient	pursuant to the Mental Health Act 2001 means a person receiving care and treatment in an Approved Centre who is not the subject of an admission order or a renewal order;

Chapter 11

Additional Information

Additional Information

Contacting the Mental Health Commission:

Mental Health Commission
Coimisiún Meabhair-Shláinte

St. Martin's House, Waterloo Road, Dublin 4.

t 01 6362400 f 01 636 2440

e info@mhcirl.ie

w www.mhcirl.ie

Solicitors:
Arthur Cox
Earlsfort Centre
Earlsfort Terrace
Dublin 2
Tel: 353-1-6180000
Fax: 353-1-6180618
www.arthurcox.com

Accountants:
Crowley's DFK
16/17 College Green
Dublin 2
Telephone: 01 6790800
Facsimile: 01 6790805
www.crowleysdfk.ie

Auditors:
The Office of Comptroller and Auditor General
Treasury Block
Lower Yard
Dublin Castle
Dublin 2
Telephone: 01 6031000
Facsimile: 01 6031010
www.audgen.gov.ie

Useful Websites

Listed below are a range of agencies and organisations providing, information, services and support in the broad area of health and more specifically in mental health.

IRISH GOVERNMENT ORGANISATIONS

Department of Health and Children	www.dohc.ie
Irish Government	www.irlgov.ie
Comhairle (Citizen's Information Database)	www.cidb.ie
Public Services Information	www.oasis.gov.ie

REGIONAL HEALTH AUTHORITIES

Health Service Executive	www.hse.ie/en/
Health Service Executive - Project Management Unit	www.hebe.ie
Health Reform Service Programme	www.healthreform.ie
Health Service Executive Mid-Western Area	www.mwhb.ie
Health Service Executive North Western Area	www.nwhb.ie
Health Service Executive North Eastern Area	www.nehb.ie
Health Service Executive Southern Area	www.shb.ie
Health Service Executive Midland Area	www.mhb.ie
Health Service Executive Western Area	www.whb.ie
Health Service Executive Eastern Region	ww.erha.ie
Health Service Executive Northern Area	www.nahb.ie
Health Service Executive South Eastern Area	www.sehb.ie

STATE BODIES

Office of the Minister for Children	www.nco.ie
National Disability Authority	www.nda.ie

Useful Websites

INDEPENDENT & STATE RESEARCH BODIES/ORGANISATIONS

Health Research Board	www.hrb.ie
The Irish Council for Bioethics	www.bioethics.ie
National Institute for Health Sciences	www.nihs.ie
Irish Social Science Data Archive	www.ucd.ie/issda
Irish Research Council for Humanities and Social Sciences	www.irchss.ie
Economic Research & Social Institute	www.esri.ie

IRISH MENTAL HEALTH PROFESSIONAL ORGANISATIONS, HEALTH PROFESSIONAL ORGNISATIONS & REPRESENTIVE BODIES

Irish College of Psychiatrists	www.irishpsychiatry.com
Irish Psychiatric Association	www.irishpsychiatricassociation.ie
The Irish College of General Practitioners	www.icgp.ie
The Psychological Society of Ireland	www.psihq.ie
The Irish Association of Social Workers	www.iasw.ie
The Association of Occupational Therapists of Ireland	www.aoti.ie
Irish Psychiatric Nurses Association	www.pna.ie
Irish Nurses Organisation	www.ino.ie
An Bord Altranais	www.nursingboard.ie
The National Council for the Professional Development of Nursing and Midwifery	www.ncnm.ie

Useful Websites

IRISH MENTAL HEALTH VOLUNTARY & ADVOCACY ORGANISATIONS

Mental Health Ireland	www.mentalhealthireland.ie
Aware	www.aware.ie
Schizophrenia Ireland	www.sirl.ie
Alzheimer Society of Ireland	www.alzheimer.ie
Irish Advocacy Network	www.irishadvocacynetwork.com
GROW	www.grow.ie
Bodywhys	www.bodywhys.ie
Samaritans	www.dublinsamaritans.ie
Inclusion Ireland	www.inclusionireland.ie

Other Useful Irish Sites

Age & Opportunity	www.olderinireland.ie
National Office for Suicide Prevention	www.nosp.ie
National Federation of Voluntary Bodies	www.fedvol.ie
Dublin Simon Community	www.dubsimon.ie
Focus Ireland	www.focusireland.ie
Human Rights Commission	www.ihrc.ie
Law Reform Commission	www.lawreform.ie
Irish Society for Quality and Safety in Healthcare	www.isqsh.ie

STAFF REPRESENTATIVE ORGANISATIONS

Irish Hospital Consultant Association	www.ihca.ie
Irish Medical Organisation	www.imo.ie
IMPACT	www.impact.ie
Irish Nurses Organisation	www.ino.ie
Psychiatric Nurses Association	www.pna.ie
S.I.P.T.U.	www.siptu.ie

USEFUL UK SITES

Department of Health UK	www.doh.gov.uk
Medical Research Council	www.mrc.ac.uk
NHS National Electronic Library for Health	www.nelh.nhs.uk
Royal College of Psychiatry	www.rcpsych.ac.uk
The Sainsbury Centre for Mental Health	www.scmh.org.uk
Electronic Library for Social Care	www.elsc.org.uk
SANE	www.sane.org.uk
Mental Health Alliance	www.mentalhealthalliance.org.uk
Mental Health Foundation (UK)	www.mentalhealth.org.uk

USEFUL EUROPEAN SITES

Council of Europe Human Rights Conventions and Protocols	www.conventions.coe.int
HOPE Hospitals for Europe	www.hope.be

USEFUL WORLD SITES

World Health Organisation	www.who.ie
United Nations - Human Rights	www.un.org
Amnesty International - Irish Branch	www.amnesty.ie

OTHER RESEARCH SITES

The Cochrane Collaboration	www.cochrane.org

Appendicies

Appendix 1 - In-patient Census form 2005

Instructions for Completing In-Patient Census Form as at Midnight 4th November 2005

PART I

1. INTRODUCTION

This document provides instruction on completing the inpatient census form as of midnight 04/11/2005. We recommend that you read it carefully prior to completing the census. Only the data types requested are to be supplied. If you have any queries about completing this form please email:

David O'Regan
Health Information Officer
Mental Health Commission
david.oregan@mhcirl.ie

2. TERMINOLOGY

The **Inpatient Facility Census** is seeking to capture information on residents of inpatient facilities. The Mental Treatment Act, 1945 (see page 6, Current Legal Status for definitions) specifically provides for their legal status. When discussing all persons in inpatient facilities (both voluntary and involuntary) the term '**resident**' will be used to indicate a person receiving care and treatment in an inpatient facility, on the night of census, 4th November 2005.

3. DATA PROTECTION ACTS, 1988 & 2003

The Mental Health Commission is registered with the Data Protection Commissioner and is aware of its responsibilities under the Data Protections Acts, 1988 and 2003 when collecting individualised patient data. To view the Commission's registration details and for further information on data protection, please see the website of the Data Protection Commissioner at http://www.dataprotection.ie .

What information and why is it being collected for 2005 Census

The Mental Health Commission has a statutory remit '…to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interest of persons detained in approved centres under this Act.' (section 33 (1) Mental Health Act, 2001) and is authorised to '..undertake or arrange to have undertaken such activities as it deems appropriate to foster and promote the standards and practices referred to in subsection (1).' (section 33 (2) Mental Health Act, 2001). The collection of inpatient service data fulfils a vital role as part this function.

The purpose of this census is to provide a snap shot in time of the number of residents in our inpatient facilities, their legal status, length of stay and diagnosis. Data are collected from all psychiatric inpatient facilities registered under the Mental Treatment Act, 1945. The collection of these data in an aggregated form was previously undertaken by the Department of Health and Children on the 31st December each year. This role is now the responsibility of the Mental Health Commission. The Commission will from now on collect this data in November of each year. It is the Commission's intention to collect and store this data electronically.

The Commission, for the first time in this census, is requesting the Personal Public Service Number (PPSN) and date of birth of each resident on the inpatient facility register. To facilitate the collection of the PPSN the Mental Health Commission has recently been included as a specified body under section 15, Social Welfare and Pensions Act, 2005 – personal public service number extension of provisions. This allows the Commission access to PPSN data (see sections 222 and 223, Social Welfare (Consolidated) Act, 1993 which allows for the sharing of information between specified bodies and ministerial departments).

This new way of collecting information will provide the Commission with long-term patient data, allowing it to identify the same patients in hospital over a given period of time, eliminating duplication and thus providing more accurate

APPENDIX 1 - In-patient Census form 2005

data. This will be of long-term benefit to all mental health service users providing more accurate information on the services provided.

Security, Confidentiality, Access & Use

From the information provided the Commission cannot and has no intention of identifying individual residents. All residents are guaranteed anonymity. Once the Commission receives all the requested data from the service providers, resident's age will be calculated from date of birth and date of birth will be deleted from the files.

The information provided will be stored in a secure location and the data will only be available to a limited number of designated personnel. The Commission will provide aggregated reports to all stakeholders.

It is the Commission's intention to keep this information solely for the purpose of reporting on mental health services.

4. SUBMISSION DATE

All completed forms to be returned to the Commission by **Friday 18 November 2005** either by email to david.oregan@mhcirl.ie or post to:

David O'Regan
Health Information Officer
Mental Health Commission
St. Martin's House
Waterloo Road
Dublin 4

APPENDIX 1 - In-patient Census form 2005

PART II

1. COMPLETING THE FORM

The inpatient census form is to be completed for all residents on the inpatient facility register as of midnight **04 November 2005**.

2. DATA REQUIRED

COLUMNS 1 – 3: UNIQUE RESIDENT'S ID

The Unique Resident's ID number is a unique number used by the inpatient facility to identify each resident on their inpatient facility's register as of midnight 04 November 2005.

Notes to entering information

On the attached form there are three columns provided for this number. The Mental Health Commission requires only **one** of these columns to be filled in.

- Personal Public Social Number (PPSN) in column 1, **OR**
- Chart number in column 2 **OR**
- A unique consecutive number for each resident in column 3 e.g. 001, 002, 003 etc.

The Personal Public Social Number is the preferred unique identifier to be supplied for each resident. The Mental Health Commission will require this number in the future when carrying out this census. If the PPSN is not available this year leave the column blank and please supply the Commission with either the resident's chart number (in column 2) or a unique consecutive number for each resident (in column 3).

From 2006 onwards the Mental Health Commission will require the Personal Public Social Number (PPSN).

COLUMN 4: SECTOR

Notes on entering information

Please enter the resident's sector (derived from the resident's address), if within the mental health catchment area. If the resident is from out of the catchment area, please enter, **OC** (out of catchment area)

COLUMN 5: DATE OF BIRTH

Notes on entering information

Please provide the Commission with the date of birth of each resident on the inpatient facility's register as of midnight 04 November 2005. The date of birth should be provided in the following format:

- If date of birth is known please enter it in the following format:
  - **00/00/0000** (Day/Month/Year) e.g. 18/07/2005
- If date of birth is unknown but year of birth is known please enter the year in the following format:
  - **0000** e.g. 2005.
- If neither the exact date of birth nor year of birth is known, please enter:
  - **UNK** for unknown.

COLUMN 6: GENDER

Notes on entering information

Please enter the resident's gender as either m or f where:

- **m** = male
- **f** = female

APPENDIX 1 - In-patient Census form 2005

COLUMN 7: ADMISSION DATE

The resident's admission date is defined as the date on which a resident was first admitted to **this** inpatient facility and has remained in **this** facility from that time without being discharged.

If the resident was transferred from another psychiatric inpatient facility the admission date is the date on which the resident was admitted to **this** facility.

Notes on entering information

Admission date is to be entered in the following format

- **00/00/0000** (day/month/year) e.g. 18/07/2005

If the exact admission date is not known, but the admission year is, please enter the year in which admission took place in the following format:

- **0000** e.g. 2005.

If neither the date nor year is known, please enter:

- **UNK** for unknown.

COLUMN 8: CURRENT LEGAL STATUS (AS OF MIDNIGHT 04 NOVEMBER 2005)

Voluntary Patient (Part XV Reception of Persons into Approved Institutions as Voluntary Patients, Mental Treatment Act, 1945)

The term 'voluntary patient' means a person who acting by himself/herself or, in the case of a person less than sixteen years of age, by his parent or guardian, submits himself/herself voluntarily for treatment for illness of a mental or kindred nature.

Involuntary Patients

The term involuntary patient means a person who is unable or unwilling to accept treatment and who requires treatment and is admitted as one of the following:

a) Temporary Patient (Part XIV Charter III Temporary Chargeable Patient Receptions Orders and Temporary Private Patient Reception Orders)

Admission under this heading takes place when it is believed that the patient requires recovery time of less than six months treatment and:

- is a patient who is suffering from mental illness,
- believed to require for his /her recovery not more than six months suitable treatment
- and is unfit on account of his her mental state for treatment as a voluntary patient

Or

- who is an addict and
- is believed to require, for his/her recovery, at least six months preventive and curative treatment (for definition see Section 3, Mental Treatment Act, 1945)

b) Person of Unsound Mind (PUM) (Part XIV Chapter I Chargeable Patient Reception Orders and Chapter II Private Patient Reception Orders, Mental Treatment Act, 1945)

Such persons are a category of patient who may be admitted to and detained in a district mental hospital under section 162 of the Mental Treatment Act 1945. Admission under this heading takes place when it is believed that the patient requires recovery time in excess of six months treatment.

APPENDIX 1 - In-patient Census form 2005

Ward of Court

The main purpose of Wardship is to look after the welfare and to protect the property of a person where this is considered necessary. The Office of Wards of Court is responsible for administering this process. There are two types of Wardship. One covers adults who may require the Court's protection because of mental incapacity. This covers the majority of persons taken into Wardship. The second concerns persons under 18 years of age who require the Court's protection for particular reasons and who when taken into Wardship are known as Minors.

Notes on entering information

Please enter each resident's current legal status as of midnight 04 November 2005. Legal status should be entered in the following format:

- Enter **VOL** for Voluntary
- Enter **TEMP** for Temporary
- Enter **PUM** for Person of Unsound Mind
- Enter **WOC** for Ward of Court

COLUMN 9: PRIMARY ICD-10 DIAGNOSIS

Notes on entering information

Please enter the primary ICD-10 code as recorded in the resident's chart in the following ICD-10 format:

- **Fx.xx**

If diagnosis is not recorded please enter:

- **NR** for not recorded

COLUMN 10: SECONDARY ICD-10 DIAGNOSIS

Notes on entering information

If there is a secondary ICD-10 diagnosis please enter as previously i.e. Fx.xx. If there is no secondary diagnosis recorded please leave blank.

COLUMN 11: RESIDENT'S LOCATION ON 04 NOVEMBER 2005

The resident's current location is included to indicate whether a resident, on the inpatient facility's register is currently in the inpatient facility or on leave.

Notes on entering information

- Please enter **RES** (resident in the inpatient facility) if the resident is in hospital on the night of the census, 04/11/2005.
- Please enter **OL** (on leave from the inpatient facility) if the resident is on the inpatient's facility's register but absent on parole, absent on leave, boarding out, or otherwise on leave on the night of the census, 04/11/2005.
- Please enter **LODGER** if a resident is lodging in the inpatient facility on the night of the census, 04/11/2005.
- Please enter **AWOL** (absent without leave from the inpatient facility) if a resident is on the inpatient's facility's register but absent without leave on the night of the census, 04/11/2005.

APPENDIX 1 - In-patient Census form 2005

COLUMN 12: WARD TYPE

The Mental Health Commission is seeking the type of ward on which a resident, who is in the inpatient facility, is resident on the night of the census, 04/11/2005.

Acute psychiatric unit (AU) is a psychiatric unit generally located in an acute general hospital (excludes acute beds designated for the elderly under the clinical direction of an old age consultant psychiatrist).

Acute old age psychiatry units/beds (AUOA) are acute beds/units under the clinical direction of a consultant led specialist team for old age psychiatry. These beds do not have to be in a separate unit/ward to the acute unit but have to be under the clinical direction of a specialist in old age psychiatry.

Long-stay ward (LS) is the term used to indicate wards which are used for long-stay patients i.e. a patient who has been continuously hospitalised for over one year.

Rehabilitation wards/units (RW) are identified as rehabilitation wards/units only if under the clinical direction of a consultant led specialist rehabilitation team (otherwise designate as long-stay wards).

Old age wards/units (OAW) are identified as old age wards or units only if under the clinical direction of a consultant led specialist team for old age mental health and provide continuing care for the elderly (otherwise designate as long-stay wards).

Intensive care unit/High observation unit (ICU) is a specialised inpatient unit within the mental health services providing observation and treatment of patients for whom management on an acute ward is not possible.

Notes on entering information

Please enter one of the following in the column provided:

- **AU** for Acute Unit (excluding acute beds designated for the elderly)
- **AUOA** for Acute Unit Old Age Psychiatry Beds
- **LS** for Long-Stay Ward
- **OAW** for Old Age Ward (providing continuing care for the elderly)
- **RW** for Rehabilitation Ward/Unit
- **ICU** for Intensive Care Unit/High Observation Unit

APPENDIX 1 - In-patient Census form 2005

Facility Name
Inpatient census

INPATIENT FACILITY CENSUS 2005

Inpatient Facility Name

No. of Beds as of midnight 04/11/2005

No. of inpatients on register as of midnight 04/11/2005

Mental Health Catchment Area

Date and time on which inpatient census to take place: Midnight Friday 04 November 2005
Please return by: Friday 18 November 2005

Any queries please contact David O'Regan, Health Information Officer, Mental Health Commission, 01-636 2427 email david.oregan@mhcirl.ie

ASSISTANCE FOR COMPLETING THE CENSUS FORM - ONLY ENTER THE DATA TYPES SPECIFIED BELOW - see guidance notes for further assistance
IT IS IMPORTANT TO BE FAMILIAR WITH THE GUIDANCE DOCUMENT WHEN COMPLETING THIS FORM

Field	Instructions
1 - 3 Resident's Unique ID Number:	Enter **only one** of the following; in Column 1, **PPS No**, (if available), **OR** in Column 2 **chart no**. **OR** in Column 3 a **unique consecutive no.** for each service user on the inpatient facility's register
4. Sector	Enter the resident's sector or enter OC for outside catchment area
5. Date of Birth:	Enter full date of birth in the following format - **00/00/0000** e.g. 30/09/2005 If only the resident's year of birth is known enter the year in the following format - **0000** e.g. 2005 If neither the resident's full date of birth nor year of birth is known enter **UNK** for unknown
6. Gender:	Enter **M** for male or **F** for female
7. Date of Admission:	Enter full admission date to **this** inpatient facility in the following format - **00/00/0000** e.g. 30/09/20005 If only the year of admisssion is known enter the year in the following format - **0000** e.g. 2005 If neither the resident's full admission date nor admission year is known enter **UNK** for unknown
8. Current Legal Status:	Enter each resident's current legal status as of midnight 04/11/2005 as **VOL** for Voluntary **OR TEMP** for Temporary **OR PUM** for Person of Unsound Mind **OR WOC** for Ward of Court
9. Primary ICD-10 Diagnosis:	Enter the exact ICD-10 primary diagnosis as recorded in the resident's chart in the following format - **Fx.xx** If there is no ICD-10 diagnosis recorded, enter **NR** for **not recorded**
10. Secondary ICD-10 Diagnosis	Enter secondary diagnosis in ICD-10 format (as above) if one is given, otherwise leave blank
11. Current Location:	If a resident is in the inpatient facility as of midnight 04/11/2005 enter **RES** for resident If a resident is on the inpatient facility's register but absent on trial, absent on parole, boarding out or otherwise on leave, enter **OL** for on leave If a resident is lodging in but not on the inpatient facility's register, enter **Lodger** If a resident is absent without permission please enter **AWOL**
12. Ward Type:	Enter the type of ward on which each resident, who is currently in hospital on 04/11/2005, is resident i.e. **AU** for acute unit, **AUOA** for acute old age beds/units under a specialist consultant psychiatrist, **LS** for long stay ward, **OAW** for old age ward, **RW** for rehabilitation ward, **ICU** for intensive care unit (or high observation Unit)

Mental Health Commission, St. Martin's House, Waterloo Road, Dublin 4

APPENDIX 1 - In-patient Census form 2005

Facility Name
Inpatient census

Resident's Unique ID Number - Only one required											
1. PPS No.	2. Chart No.	3. Unique ID	4. Sector (enter Sector name or OC for outside catchment area)	5. Date of Birth (00/00/0000)	6. Gender (M/F)	7. Admission Date (00/00/0000)	8. Current Legal Status as of midnight 04/11/2005 (VOL/TEMP/PUM/WOC)	9. Primary ICD-10 Diagnosis (Fx.xx/NR)	10. Secondary ICD-10 Diagnosis - if given (Fx.xx)	11. Current Location as of midnight 04/11/2005 (RES/OL/Lodger/AWOL)	12. Ward Type (AU/AUOU/LS/OAW/RW/ICU)

Mental Health Commission, St. Martin's House, Waterloo Road, Dublin 4

Appendix 2

Table 5.2: HSE Dublin Mid Leinster (includes the Central Mental Hospital)	
Total Population (census 2002)	1,141,943
Over 16 Population (census 2002)	888,805
Funding € (2005)	€129,907,640.82
Beds (2005)	630
Admission Rate (2004)[1]	742.5
Involuntary Admission Rate (2005)[2]	61.8
Total New Long Stay Patients (2005)[3]	87
Patients Who Became New Long Stay (2005)[4]	30

Table 5.3: HSE Dublin North East (includes St. Joseph's Intelluctual Disibility Service)	
Population (census 2002)	828,638
Over 16 Population (census 2002)	641,526
Funding € (2005)	€163,940,493.00
Beds as of 04/11/2005 (2005)	753
Admission Rate (2004)[1]	706.5
Involuntary Admission Rate (2005)[2]	82.9
Total New Long Stay Patients (2005)[3]	112
Patients Who Became New Long Stay (2005)[4]	35

Table 5.4: HSE South	
Population (census 2002)	1,003,972
Over 16 Population (census 2002)	773,556
Funding € (2005)	€165,578,129.00
Beds (2005)	1,263
Admission Rate (2004)[1]	768.1
Involuntary Admission Rate (2005)[2]	113.9
Total New Long Stay Patients (2005)[3]	224
Patients Who Became New Long Stay (2005)[4]	62

Appendix 2

Table 5.5: HSE West	
Population (census 2002)	942,650
Over 16 Population (census 2002)	725,006
Funding € (2005)	€187,319,459.00
Beds (2005)	703
Admission Rate (2004)[1]	707.0
Involuntary Admission Rate (2005)[2]	94.9
Total New Long Stay Patients (2005)[3]	98
Patients Who Became New Long Stay (2005)[4]	22

Table 5.6: Independent Providers	
Beds (2005)	626
Number of Admission (2004)[1]	4,067
Number of Involuntary Admissions (2005)[2]	180
Total New Long Stay Patients (2005)[3]	62
Patients Who Became New Long Stay (2005)[4]	19

1 Daly et al (2005), Activities of Irish Psychiatric Units and Hospitals 2004, p.89, Table 4.1, Health Research Board.

2 Based on information collected by the Mental Health Commission Tribunals Division on involuntary admissions and re-grading to involuntary status from January 2005 to December 2005 see chapter 4.

3 New long stay patients on the night of the inpatient census, 4th November 2005 (see chapter 4 for details of the inpatient census).

4 Persons who became new long stay patients between 1st January 2005 and 4th November 2005, the night of the inpatient census (see chapter 4 for details of the inpatient census).

Table 5.7: Mental health catchment area allocated funding 2005

Mental Health Catchment Areas	Population over 16 years	Funding (allocated) 2005	Funding per capita (over 16)
HSE Dublin North East			
Area 6 North West Dublin	111,318	€40,034,730.00	€359.64
Area 7 North Inner City Dublin	110,831	€21,631,528.00	€195.18
Area 8 North County Dublin	162,087	€57,699,886.00	€355.98
Cavan/Monaghan Mental Health Catchment Area	81,628	€21,061,070.00	€258.01
Louth/Meath Mental Health Catchment Area	175,662	€23,513,279.00	€133.86
HSE Dublin Mid Leinster			
Area 1 East Coast Dublin	134,551	€18,873,018.00	€140.27
Area 2 South East Dublin[5]	87,864	€13,034,159.00	€148.34
Area 3 South West Inner City Dublin[5]	111,633	€9,388,000.00	€84.10
Area 4 & 5 South West Dublin	185,592	€26,639,158.54	€143.54
Area 9 Kildare West Wicklow	133,363	€10,564,058.28	€79.21
Area 10 Wicklow	76,074	€10,954,659.00	€144.00
Laois/Offaly Mental Health Catchment Area	91,870	€19,142,270.00	€208.36
Longford/Westmeath Mental Health Catchment Area	79,277	€21,312,318.00	€268.83
HSE South			
Carlow/Kilkenny Mental Health Catchment Area[5]	96,032	€28,484,600.00	€296.62
Kerry Mental Health Catchment Area	103,752	€19,294,459.00	€185.97
North Cork Mental Health Catchment Area	56,953	€20,063,888.00	€352.29
North Lee Mental Health Catchment Area	120,166	€22,265,597.00	€185.29
South Lee Mental Health Catchment Area	131,056	€15,776,035.00	€120.38
Tipperary (Tipperary South and North)[6]	107,005	€22,532,309.00	€210.57
Waterford Mental Health Catchment Area[5]	78,148	€16,893,732.00	€216.18
West Cork Mental Health Catchment Area	38,924	€5,941,570.00	€152.65
Wexford Mental Health Catchment Area	88,168	€16,765,528.00	€190.15
HSE West			
Clare Mental Health Catchment Area	78,771	€23,002,016.00	€292.01
Donegal Mental Health Catchment Area	96,373	€18,408,670.00	€191.01
East Galway Mental Health Catchment Area	74,753	€36,894,000.00	€493.55
Limerick Mental Health Catchment Area	136,830	€30,549,618.00	€223.27
Mayo Mental Health Catchment Area	90,049	€24,619,000.00	€273.40
Roscommon Mental Health Catchment Area	41,527	€14,756,000.00	€355.34
Sligo/Leitrim Mental Health Catchment Area	72,494	€23,850,566.00	€329.00
West Galway Mental Health Catchment Area	87,561	€12,800,000.00	€146.18

5 There is a lack of clarity in the electoral divisions and therefore the population served by these Mental Health Services.

6 Tipperary South Mental Health Catchment Area over 16 population 60,357, funding €20,092,750.00. Tipperary North Mental Health Catchment Area over 16 population 46,648, funding €2,439,589.00.