MHC
Coimisiún Meabhair-Shláinte
Mental Health Commission

ANNUAL REPORT 2008
TUARASCÁIL BHLIANTÚIL

including the Report of the Inspector of Mental Health Services 2008

Mental Health Commission
Coimisiún Meabhair-Shláinte

MENTAL HEALTH COMMISSION ANNUAL REPORT 2008

INCLUDING THE REPORT OF THE INSPECTOR OF MENTAL HEALTH SERVICES

Book 1

Part 1

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 ensuring the interests of those involuntarily admitted pursuant to the provisions of the Mental Health Act 2001 are protected and to fostering and promoting high standards in the delivery of mental health services

CONTENTS

PART 1

Chairman's Foreword 6
Introduction – Chief Executive Officer 8
Commission Members (April 2007 – 2012) (At time of appointment) 9

CHAPTER 1 **11**

Mental Health Commission: Functions & Structures 13

CHAPTER 2 **17**

Strategic Plan 2006 - 2008 19

CHAPTER 3 **21**

Progressing the Strategic Plan 2006 – 2008 23

PART 2

CHAPTER 4 **55**

National Review of Mental Health Services 2008 56

APPENDICES **69**

CHAPTER 5 **97**

Overview of Catchment Mental Health Services within HSE Area – Catchment Reports by HSE Area 97

CHAPTER 6 **283**

Additional Information 285

BOOKS 2-7

Report of the Inspector of Mental Health Services is available on CD-ROM (see back of report)

CHAIRMAN'S FOREWORD

The year 2008 showed again that bringing about change in Ireland's Mental Health Services is a most challenging task. This has been the case over the past number of years when there was additional revenue available. We can expect it to be even more challenging now that we are entering a period of great economic difficulty and exchequer shortages. As 2008 came to an end, the extent of the global and national economic difficulties had become apparent.

Therefore the publication in September by the Commission of a report showing the economic benefits of investment in services to deal with mental health problems was timely. The report, ***The Economics of Mental Health Care in Ireland***, was prepared by Eamon O'Shea and Brendan Kennelly of the Irish Centre for Social Gerontology and the Department of Economics at NUI Galway.

The report showed that mental health problems cost the economy over €3 billion a year. While ultimately decisions on resource allocation are grounded in societal values, the report presented sound economic reasons as to why investment in mental health services would more than repay its cost. In other words, investment in mental health services is good for our economic well-being as well as for our health.

The investment the Commission wants to see is in community treatment facilities to replace the institutional care approach. This is the core of Government policy as outlined in its policy document, ***A Vision for Change.***

While there were a number of restatements of commitment to ***Vision for Change***, I must once again record the Commission's disappointment at the lack of progress towards its implementation. In the introduction to the 2007 Annual Report I stated: "While acknowledging that Vision for Change involves a seven to ten year programme of change and development, the Mental Health Commission was disappointed and concerned at the absence of progress in 2007." It is with great regret that I make the same statement again in relation to 2008.

The recruitment restrictions imposed by the HSE in relation to core multidisciplinary staff has affected the ability of mental health services to meet current needs and provide a comprehensive range of evidence based therapeutic interventions to service users.

The new economic realities mean we must concentrate not just on the amount that is spent on mental health services, but on how it is spent. The Commission's Quality Framework for Mental Health Services in Ireland asserts that the systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services. In the context of the Quality Framework, it is disappointing to see there was poor compliance in relation to the regulations concerning the need for individualised care plans where service users were fully involved participants.

While increased funding can of course help deliver quality services, a key issue is also the governance of those services. While there are some examples of excellent audits, quality improvement measures and multidisciplinary management structures, we do not have the formal structures and processes that are needed.

The ambition of Government policy is to have a national network of comprehensive, community-based multidisciplinary mental health teams. This vision is far from reality. In 2008 the Inspector of Mental Health Services found that community teams often exist at very basic levels with insufficient approved posts. In some areas he also noted strong industrial relations resistance to the moving of mental health services from old hospital based settings and into the community.

The inquiry team established by the Commission continued through 2008 to prepare the report into care and treatment practices in St Michael's Unit, South Tipperary General Hospital and St Luke's hospital, both in Clonmel. The report itself was published in 2009 and therefore not within the period covered by this annual report.

During 2008 the Commission's own inspection process focussed on concerns about the care and treatment of residents in these units and the 2009 annual report will detail the steps taken by the Commission to have these concerns fully addressed in the best interests of patients.

Central to this is the development of community treatment facilities that will allow the closure of institutions such as St Luke's. At the core of a Vision for Change is the development of community based mental health multidisciplinary teams which will form the backbone of service delivery. Without this change, many service users will continue to be treated in unsuitable and outdated inpatient facilities at considerable cost to them as individuals, to the society in which they live and to the economy which suffers as a result of inadequate mental health services.

The reports of the inspections of all the approved centres are published in this annual report (Books 2-7). For the first time, however, these inspection reports were published in the Mental Health Commission's web site well before the annual report. In some cases in the past there was a gap of up to 15 months between an inspection being carried out and the final report being available to staff, service users and the general public. The policy of early publication arises from the fact that the earlier feedback is given, the quicker people will take any action required on foot of an inspection report.

During the year the Commission also took a clear position against the relocation of the Central Mental Hospital to Thornton Hall in North Dublin. The Chief Executive and I accepted an invitation from the Oireachtas Committee on Health and Children to give evidence on the subject. We said that we fully supported the replacement of the current Central Mental Hospital with a purpose designed, modern facility which promotes patient safety and dignity. However we said that the proposal to build it beside a prison would promote isolation, exclusion and stigmatisation of the residents, and that there were other reasons such as inadequate public transport connections that made the site inappropriate. The Commission said there should be a comprehensive assessment of the State's need for forensic mental health services undertaken as a priority.

Over the past year, the Commission members have applied themselves to the mandate and responsibilities set out in the 2001 Mental Health Act. They have ensured that respecting and promoting the best interests of the service user was core to the decisions they reached and I thank them for fulfilling this responsibility.

The work of this Commission would not have been possible without the knowledge, skill and dedication of its Executive to ensure the MHC operates in a highly effective manner, meeting the everyday challenges in a truly professional and responsive way. 2008 saw the appointment of a new Inspector of Mental Health Services, together with new appointments to the roles of Assistant Inspectors. Their professionalism and team work has resulted in a comprehensive report that will assist all stake holders' focus their minds on the strengths and positives developments as well the weaknesses and challenges within the Irish mental Health service.

Finally, the Commission would like to express its appreciation of the leadership of its CEO, Ms Bríd Clarke, who has effectively managed the operations of the MHC as an independent statutory body and ensured that the work plan for the Commission over 2008 was completed to the highest possible standard.

Dr. Edmond O'Dea
Chairman

INTRODUCTION – CHIEF EXECUTIVE OFFICER

I am pleased to introduce the seventh Annual Report of the Mental Health Commission including the Report of the Inspector of Mental Health Services, for the period ending 31st December, 2008, pursuant to Section 42, Mental Health Act 2001.

The year 2008 was a period of consolidation, review and development, following the full commencement of the Mental Health Act 2001 in November 2006.

The 2008 Annual Report provides information on the work of the Commission during 2008 in progressing the Strategic Plan of the Mental Health Commission. There is an increased emphasis in this report on the provision of quantitative data. The relative dearth of information on the mental health services in Ireland has been highlighted continuously by the Mental Health Commission and other organisations. The information contained in this Annual Report on such areas as involuntary admissions of adults, voluntary and involuntary admissions of children, and compliance with regulations for approved centres will assist in the planning, development and review of mental health services in Ireland. The Commission's commitment to mental health services research, in particular, will provide us with further information on outcomes for service users. During the next 12 months two Mental Health Commission funded research studies will be completed - one looking at intervention in home and community based services in general adult psychiatry and psychiatry of later life, and the second study looking at adult community mental health teams: determinants of effectiveness. Both of these studies are examining core aspects of a modern mental health service.

The Mental Health Act 2001 includes provisions in relation to the review of the operation of the Act. Section 42(4) refers specifically to a review to be completed by the Mental Health Commission not later than eighteen months after the operation of Part 2 of the Mental Health Act 2001 (the provisions relating to involuntary admissions). The Mental Health Commission published this report in July 2008. This review concluded that the Mental Health Act 2001 had made important improvements for the protection of individuals involuntarily admitted for mental health treatment. The report found that Ireland has made significant strides in protecting the human rights of individuals within the mental health system, and that the 2001 Act is in compliance with international human rights conventions. The review has also identified areas for future attention including the preparation of a Code of Practice on the 2001 Act and commissioning research on the involuntary admission process. These are priorities for the Mental Health Commission.

The Mental Health Commission has received, again this year, significant support and advice from many people and organisations within and external to mental health services. These collaborative links are invaluable to the Mental Health Commission. I wish to extend in particular my appreciation to the mental health division of the Department of Health and Children for their continued support and assistance.

Consolidating our achievements to date and ensuring service quality will enable us to address the challenges ahead. The support and guidance of the Mental Health Commission members during 2008 is greatly appreciated. The extraordinary effort and commitment of all our staff provides a firm foundation for our commitment to continuous quality improvement within the organisation. I wish to extend my sincere appreciation to everyone within the Executive Team of the Mental Health Commission.

Bríd Clarke
Chief Executive Officer

COMMISSION MEMBERS (APRIL 2007 – 2012) (AT TIME OF APPOINTMENT).

Dr. Edmond O'Dea
Chairman
Principal Psychologist
Health Service Executive
West

Mr. Brendan Byrne
Director of Nursing
Carlow/Kilkenny Mental
Health Services

Ms. Emile Daly
Barrister-at-Law

Ms. Marie Devine
Bodywhys

Dr. Brendan Doody
Consultant Child
Psychiatrist
Health Service Executive
Dublin Mid-Leinster

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

Dr. Martina Kelly
General Practitioner

Dr. Mary Keys
Lecturer
NUI Galway

Dr. Eamonn Moloney
Consultant Psychiatrist
Health Service Executive
South

Mr. John Redican
Chief Executive Officer
Irish Advocacy Network

Mr. Martin Rogan
Assistant National
Director – Mental Health
Health Service Executive

Mr. John Saunders
National Director
Schizophrenia Ireland

Ms. Vicki Somers
Principal Mental Health
Social Worker
Health Service Executive
Kildare/West Wicklow
Mental Health Services

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.

12 meetings of the Mental Health Commission were held in 2008, including a two day meeting at the end of January and one teleconference. Members of the Commission also participate in committees established by the Mental Health Commission.

1.2 MENTAL HEALTH COMMISSION COMMITTEES 2008

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

AUDIT COMMITTEE

Mr. Gavin Maguire (Chair), Ms. Vicki Somers, Mr. Padraig Heverin, Mr. Brendan Byrne, Mr. John Redican.

WORLD MENTAL HEALTH DAY 2008

Mr. John Redican, Mr. Padraig Heverin, Mr. John Saunders, Ms. Rosemary Smyth, Ms. Marina Duffy.

CHILD & ADOLESCENT MENTAL HEALTH SERVICES COMMITTEE

Dr. Brendan Doody (Chair), Ms. Vicki Somers, Mr. Martin Rogan, Ms. Marie Devine, Ms. Bríd Clarke, Ms. Patricia Gilheaney, Dr. Susan Finnerty.

RECOVERY APPROACH WITHIN THE IRISH MENTAL HEALTH SERVICES

Mr. John Saunders (Chair), Mr. John Redican, Ms. Vicki Somers, Dr. Mary Keys, Ms. Bríd Clarke, Ms. Rosemary Smyth. Ms. Rhona Jennings

FORENSIC MENTAL HEALTH SERVICES COMMITTEE

Mr. Des McMorrow (Chair), Mr. Padraig Heverin, Mr. John Saunders, Mr. Brendan Byrne, Dr. Gerry Cunningham.

MENTAL HEALTH COMMISSION RESEARCH COMMITTEE

Professor Patrick Wall (Chair), Dr. Jim Campbell, Ms. Elizabeth Brosnan, Dr. Patricia Clarke, Dr. Elizabeth McKay, Dr. Eadbhard O'Callaghan, Dr. Dermot Walsh, Dr. John McCarthy, Dr. Claire Collins, Dr. Fiona Keogh.

POLICE AND MENTAL HEALTH SERVICES WORKING GROUP

Dr. John Owens (Chair), Dr. Mary McGuire, Mr. Martin Connor, Ms. Vicki Somers, Mr. Diarmaid McGuinness, Dr. Philip Wiehe, Mr. Gerry Coone, Superintendent John Shanahan.

WORKING GROUP ON CODE OF PRACTICE FOR MENTAL HEALTH SERVICES FOR PEOPLE WITH AN INTELLECTUAL DISABILITY.

Mr. Michael Kelly (Chair), Mr. Paul Alford, Ms. Michelle Bergin, Mr. Brendan Broderick, Ms. Caroline Cannon, Mr. Gerry Cobbe, Dr. Mary Davis, Dr. Philip Dodd, Ms. Bríd Leahy, Mr. Gerry Raleigh, Ms. Annie Ryan, Dr. Mary Staines, Ms. Olive Potterton, Ms. Patricia Gilheaney, Ms. Lisa O'Farrell

ASSISTED ADMISSIONS COMMITTEE

Ms. Emile Daly (Chair), Mr. Padraig Heverin, Mr. Brendan Byrne, Mr. John Redican, Dr. Eamonn Moloney, Dr. Gerry Cunningham.

MENTAL HEALTH SERVICES COMMITTEE

Dr. Brendan Byrne (Chair), Mr. Padraig Heverin, Dr. Edmond O'Dea, Mr. John Redican, Mr. John Saunders, Ms. Bríd Clarke

COMMITTEE ON SCHEME FOR MENTAL CAPACITY BILL 2008

Dr. Mary Keys (Chair), Mr. John Saunders, Mr. John Redican, Ms. Vicki Somers, Mr. Martin Rogan, Ms. Emile Daly, Ms. Bríd Clarke.

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, visiting and inspecting approved centres and other premises where mental health services are being provided as per Sections 51-53 Mental Health Act 2001, carrying out annual reviews of mental health services in the State and furnishing a report to the Commission as per Section 51 Mental Health Act 2001

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

MENTAL HEALTH COMMISSION STAFF 2008 (END OF YEAR).

Chief Executive Officer:
Ms. Bríd Clarke

Inspector of Mental Health Services:
Dr. Patrick Devitt

Director Standards & Quality Assurance:
Ms. Patricia Gilheaney

Director Mental Health Tribunals:
Dr. Gerry Cunningham

Director Corporate Services
Mr. Ray Mooney

Director Training and Information:
Ms. Rosemary Smyth

Consultant Psychiatrists:
Dr. Fidelma Corcoran
Dr. Nora Crowley Barry
Dr. Fiona Fenton
Dr. Maria Frampton
Dr. Eugene Hill
Dr. Evelyn McCabe
Dr. Maria Moran
Dr. Eugene Morgan
Dr. Maria Morgan
Dr. Dermot Walsh

Mental Health Information Officer:
Ms. Deirdre Hyland

Policy Officers:
Mr. Derek Beattie
Ms. Lisa O'Farrell

Assistant Inspectors:
Mr. Paul Collins
Ms. Patricia Doherty
Dr. Susan Finnerty
Ms. Rhona Jennings
Ms. Maeve Kenny
Mr. Des McMorrow
Dr. Fionnuala O'Loughlin

Administration:
Ms. Sandra Curran
Ms. Marina Duffy
Ms. Brid Flood
Mr. Kevin Foley
Mr. Andrew Goodwin
Ms. Deirdre Hanratty
Ms. Marie Higgins
Mr. Simon Horne
Ms. Emer Kelly
Ms. Joanna Macklin
Ms. Monica Martin
Ms. Erica McCluskey
Ms. Helena Moloney
Mr. Mathew Morenigbade
Mr. Adrian Murtagh
Mr. Brian O'Sullivan
Ms. Ulla Quayle
Ms. Colette Ryan
Ms. Eilis Scully
Mr. Stephen Somers
Ms. Anna Whiston

CHAPTER 2

STRATEGIC PLAN 2006 - 2008

STRATEGIC PLAN 2006 - 2008

The timeframe of the second Strategic Plan for the Mental Health Commission came to an end at the end of 2008. The plan chartered the direction and focus of the Commission over the past two years. As with the Commission's first Strategic Plan the priorities identified therein were based on the statutory functions of the Mental Health Commission as specified under the provisions of the Mental Health Act 2001. The five strategic priorities identified in the 2006 – 2008 plan were:

STRATEGIC PRIORITY 1

To promote, develop and evaluate the implementation of high standards of care and treatment within the mental health services.

STRATEGIC PRIORITY 2

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

STRATEGIC PRIORITY 3

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

STRATEGIC PRIORITY 4

To advocate for the integration and participation in society of people who experience or have experienced mental illness.

STRATEGIC PRIORITY 5

To maintain and enhance the organisation's systems and capacity to ensure the provision of a quality service by the Mental Health Commission.

GUIDING PRINCIPLES AND VALUES OF THE MENTAL HEALTH COMMISSION

The guiding principles and core values of an organisation define its ethos and culture. The Commission is guided in particular by the principles enunciated in the:

- Mental Health Act 2001
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
- United Nations Universal Declaration of Human Rights
- United Nations Convention on the Rights of the Child

- United Nations Convention against Torture and other Cruel and Inhuman or Degrading Treatment or Punishment
- United Nations Convention on Persons with Disability
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights.
- United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care
- European Convention on Human Rights Act 2003
- Disability Act 2005
- Equal Status Acts 2000 – 2004
- Child Care Act 1991
- Childrens Act 2001
- Freedom of Information Acts 1997 & 2003
- Data Protection Acts 1988 & 2003

VALUES:

Accountability and Integrity: The Commission is committed to expressing these values by operating at all times with probity and in a transparent manner.

Dignity and Respect: The Commission respects the dignity of those in contact with us and responds with courtesy and consideration.

Confidentiality: The Commission pledges to handle confidential and personal information with the highest level of professionalism and to take due care not to release or disclose information outside the course of that necessary to fulfil our legal and professional requirements:

Empowerment: The Commission recognises that empowerment lies through the provision of information, training and education in an accessible manner.

Quality: The Commission is committed to striving for continuous quality improvement in all its activities.

Achieving Together: The Commission is committed to collaborating for improvement through ongoing partnership, consultation and teamwork.

Work commenced during the latter part of 2008 on the preparation of the third Strategic Plan for the Mental Health Commission which will cover the period 2009 – 2012. This will be published in 2009.

CHAPTER 3

MENTAL HEALTH COMMISSION

PROGRESSING THE STRATEGIC PLAN 2006 - 2008

PROGRESSING THE STRATEGIC PLAN 2006 – 2008

Strategic Priority 1

To promote, develop and evaluate the implementation of high standards of care and treatment within the mental health services.

INTRODUCTION

Under the provisions of the Mental Health Act 2001, one of the principal overarching functions of the Mental Health Commission is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services (Section 33(1), Mental Health Act 2001).

The mandate of the Commission encompasses the broad spectrum of mental health services in Ireland, irrespective of the sources of funding.

INSPECTOR OF MENTAL HEALTH SERVICES

Section 51, Mental Health Act 2001 specifies the functions of the Inspector of Mental Health Services. In 2008, in line with its statutory mandate the Inspectorate of Mental Health Services visited and inspected every approved centre. Meetings were held with Local Health Managers (and equivalent managers in the independent and voluntary sector) and senior clinical staff. Following the recommendations of the 2007 inspection reports, the Inspectorate sought submissions during 2008 from teams working within the child and adolescent mental health services and the mental health services for people with an intellectual disability. The 2008 Inspector's annual review of mental health services in Ireland is reported in Part 2, Book 1. The detailed approved centres inspection reports are contained in books 2 – 6, on CD Rom and are published on the Mental Health Commission's website *www.mhcirl.ie*.

INQUIRY

Under the provisions of Section 55, Mental Health Act 2001 the Commission may or at the request of the Minister, establish an inquiry into:

Section 55, Mental Health Act 2001 provides for the establishment of an inquiry by the Commission (or at the request of the Minister) into:

(a) the carrying on of any approved centre or other premises in the State where mental health services are provided,

(b) the care and treatment provided to a specified patient or a specified voluntary patient by the Commission,

(c) any other matter in respect of which an inquiry is appropriate having regard to the provisions of this Act or any regulations or rules made thereunder or any other enactment.

As reported in the 2007 Annual Report of the Mental Health Commission, in June 2007 the Commission established an inquiry with the following terms of reference:

"To review care and treatment practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel, including the quality and planning of care and the use of restraint and seclusion and to report to the Mental Health Commission".

The Inquiry was concluding at the end of 2008 and the Report of the Inquiry Team will be presented to the Mental Health Commission in early 2009.

REGISTER OF APPROVED CENTRES

As a regulatory body, a key function of the Commission is to establish and maintain a register of approved centres (Section 64, Mental Health Act 2001). Section 63 of the 2001 Act provides for the prohibition of centres[1] that are not registered with the Mental Health Commission. The definition of centre is broad and therefore caution should be exercised when interpreting the term approved centre as the term does not solely refer to centres that are admission units.

During the period of 3 years from the commencement of Part 2 of the Mental Health Act 2001 on 1 November 2006, centres that had a person receiving care and treatment for mental disorder were deemed to be approved centres pursuant to Section 72(6). The *Review of the Operation of the Mental Health Act 2001* (Department of Health and Children, May 2007, p.40) stated that the *"The transitional period provided for in section 72(6) should be reduced following consideration of the views of the Mental Health Commission"*. The Mental Health Act 2001 (Period Prescribed Under Section 72(6) Regulations) 2008 (S.I. No. 44 of 2008) were signed by Mr Jimmy Devins T.D., Minister of State at the Department of Health and Children on 26th February 2008. The effect of these regulations was a reduction of the transitional period provided for in Section 72(6) from three years from the 1 November 2006, to one year and four months. In effect this meant that the 40 centres 'deemed' to be approved were required to apply for registration as an approved centre under Section 64 of the 2001 Act. The centres concerned were entered on the Register of Approved Centres on 1 March 2008. St Anne's Unit, Sacred Heart Hospital, Castlebar, Co Mayo; Tearmann and Curragour Wards, St Camillus Hospital, Limerick; and Cappahard Lodge, Ennis, Co. Clare were also registered as approved centres during 2008. The total number of Approved Centres at 31st December 2008 was 64.

To maintain awareness of the legal requirement for facilities that meet the definition of 'centre' to register with the Commission, advertisements were placed in three national newspapers in March and September 2008.

QUALITY FRAMEWORK FOR MENTAL HEALTH SERVICES IN IRELAND

The ***Quality Framework for Mental Health Services in Ireland*** was published by the Commission and launched by Mr Tim O' Malley T.D., Minister of State, Department of Health and Children, in March 2007.

At the time of publication of the ***Quality Framework*** *(QF)*, the Commission highlighted the importance of addressing implementation issues and stated that *"in addressing implementation issues, it is worthwhile to ask why quality programmes that involve change within large organisations/systems are successful in some organisations/countries and not in others."* (Mental Health Commission, 2007). In order to press forward with the transformational change agenda that is required to continuously develop a quality mental health service, appropriate supporting mechanisms are required. Chapter 3 of the ***Quality Framework for Mental Health Services in Ireland*** addresses implementation and covers the context for continuous quality improvement; provides an implementation plan for 2007 to commence the process; and specifies a number of critical success factors that impact upon the attainment of the implementation plan.

As previously stated by the Commission, the attainment of the standards in the Quality Framework is an incremental process that will not just happen, it requires leadership and active engagement of key personnel at all levels in the system with the central involvement of service users. Progress to date in reaching the standards in the QF is disappointing. The QF is applicable not only to approved centres but also to all mental health services. Government policy for mental health services ***Vision for Change*** (Department of Health and Children, 2006), in the main, addresses structural components of mental health services. Irrespective of the configuration of mental health services, a quality service will never be realised unless there is a change in culture, attitudes, behaviour and processes at all levels within the system as addressed in the Quality Framework. A clear governance pathway that provides for leadership, direction, time-bound targets and addresses responsibilities and authority at all levels within the mental health care system is essential. One of the key statutory functions of the Commission is to support, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services. The Health Service Executive is tasked with ensuring that these standards and practices are implemented across publicly funded mental health services nationally.

[1] "'Centre' means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder." (Section 62, Mental Health Act 2001)

The provision of individual care and treatment plans is also a statutory requirement for all in-patients in approved centres, Article 15, Mental Health Act 2001(Approved Centres) Regulations 2006 (S.I. No. 551 of 2006) and the registration of approved centres is linked with compliance with the regulations for approved centres. It is also Standard 1.1 of the Quality Framework (MHC, 2007) which is applicable to all mental health services.

"The registered proprietor shall ensure that each resident has an individual care plan"

Article 3 of the Regulations defines an individual care plan as follows:

"'Individual care plan' means a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation."

The Inspector of Mental Health Services is required, during inspection of approved centres, to ascertain whether the regulations for approved centres are being complied with. (Section 52(d), Mental Health Act 2001).

The findings of the Inspectorate in 2007 regarding compliance with the regulations for approved centres yielded a very low level of compliance with Article 15 (Individual Care Plan). An 83.6% compliance rating was returned in self assessment for this regulation compared to a compliance level of only 18% found by the Inspectorate. It is worth noting that several approved centres that indicated full compliance with this regulation in their self assessment, did not adequately demonstrate how they achieved full compliance with this regulation. It would appear that approved centres are of the view that individual care and treatment planning in accordance with statutory requirements is being provided, however the Inspectorate findings in 2007 would not support this view.

The MHC and HSE held 'Awareness Sessions' for mental health services, including advocates, in November and December 2007 regarding the Mental Health Act and associated Regulations, Rules and Codes of Practice and over 450 attended. One of the key recommendations from these sessions was that' Individual Care Planning procedures need to be developed as a matter of urgency'.

In response to the poor compliance with the statutory requirement for individual care and treatment plans and the specific recommendation relating to care planning that emanated from the aforementioned 'Awareness Sessions' The MHC, in partnership with the HSE has developed a joint proposal for implementation of Standard 1.1 of the Quality Framework, which will be implemented in 2009

The approach proposed in an inclusive one whereby Service users and carers are central and involved in all aspects of the proposal as well as mental health care professionals including management. The Mental Health Commission has a statutory mandate to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services. The suggested approach aims not only to promote, encourage and foster the establishment of good practice, but also to enhance the capacity of mental health services, thereby also addressing our mandate regarding the maintenance of high standards.

The Mental Health Commission and the Health Service Executive have developed a joint proposal for implementation of Standard 1.1 of the Quality framework, which will be implemented in 2009.

> Standard 1.1-*"Each service user has an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multidisciplinary team, i.e. a key worker."*

There are 24 standards in total. The attainment of the standard on individual care and treatment planning also addresses in part, 15 of the remaining standards as follows:

Standard Number:	
1.2	Each service user experiences a planned entrance to and exit from every part of a mental health service.
1.3	Each service user receives mental health care and treatment from a community based service that addresses the person's changing needs at various stages in the course of his/her illness and recovery process.
1.5	Therapeutic services and programmes to address the needs of service users are provided.
2.1	Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences.
2.2	Service user rights are respected and upheld.
3.1	Service users are facilitated to be actively involved in their own care and treatment through the provision of information.
3.2	Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent.
3.3	Peer support/advocacy is available to service users.
3.4	A clear accessible mechanism for participation in the delivery of mental health services is available to service users.
3.5	Service users experience a recovery-focused approach to treatment and care.
4.2	Service users in residential or day settings receive a well-balanced nutritious diet.
6.1	Families, parents and carers are empowered as team members receiving information, advice and support as appropriate.
7.3	Learning and using proven quality and safety methods underpins the delivery of a mental health service.
7.4	The care and treatment provided by the mental health service is outcomes focused.
8.1	The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols.

MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006 (S.I. NO.551 OF 2006)

Regulations for approved centres, were prescribed by Mr Tim O'Malley, T.D. Minister of State at the Department of Health and Children and came into effect on 1 November 2006 (Mental Health Act 2001(Approved Centres) Regulations 2006 (S.I. no.551 of 2006)).

> Compliance with the regulations is linked with registration as an approved centre. Therefore, unlike accreditation which is a voluntary process, approved centres are obliged to comply with the regulations.

The Standards and Quality Assurance Division, in adopting a continuous quality improvement approach to developing the quality of service provision, devised a process for approved centres to self-assess their current level of compliance with the approved centres regulations at the time of their introduction in November 2006. The purpose of self-assessment was two-fold; to raise awareness of statutory obligations and to identify areas of non-compliance so that corrective action could be commenced. The 2007 inspection reports of each approved centre facilitated the centres to compare their self assessed compliance levels with that of the Inspectorate. Each approved centre was requested

to provide an implementation plan to address the areas of non-compliance identified by the Inspector of Mental Health Services in 2007. The implementation plans received were made available to the Inspector prior to the 2008 inspections.

In 2008, the Inspectorate focused on assessing compliance with specific articles that approved centres breached in 2007. In addition, the Inspectorate re-inspected compliance against 6 articles as follows: 15 (individual care plan); 16 (therapeutic services and programmes); 18 (transfer of Residents); 19 (general health); 20 (provision of information to residents); and 21 (privacy).

Comparative analysis of compliance in 2007 with 2008 across the remaining 25 articles of the regulations is not available.

Figure 1 (below) provides a comparison of compliance with the above mentioned articles of the regulations for 2006 (self assessments), 2007 and 2008 (inspections).

Figure 1: National Level of Compliance

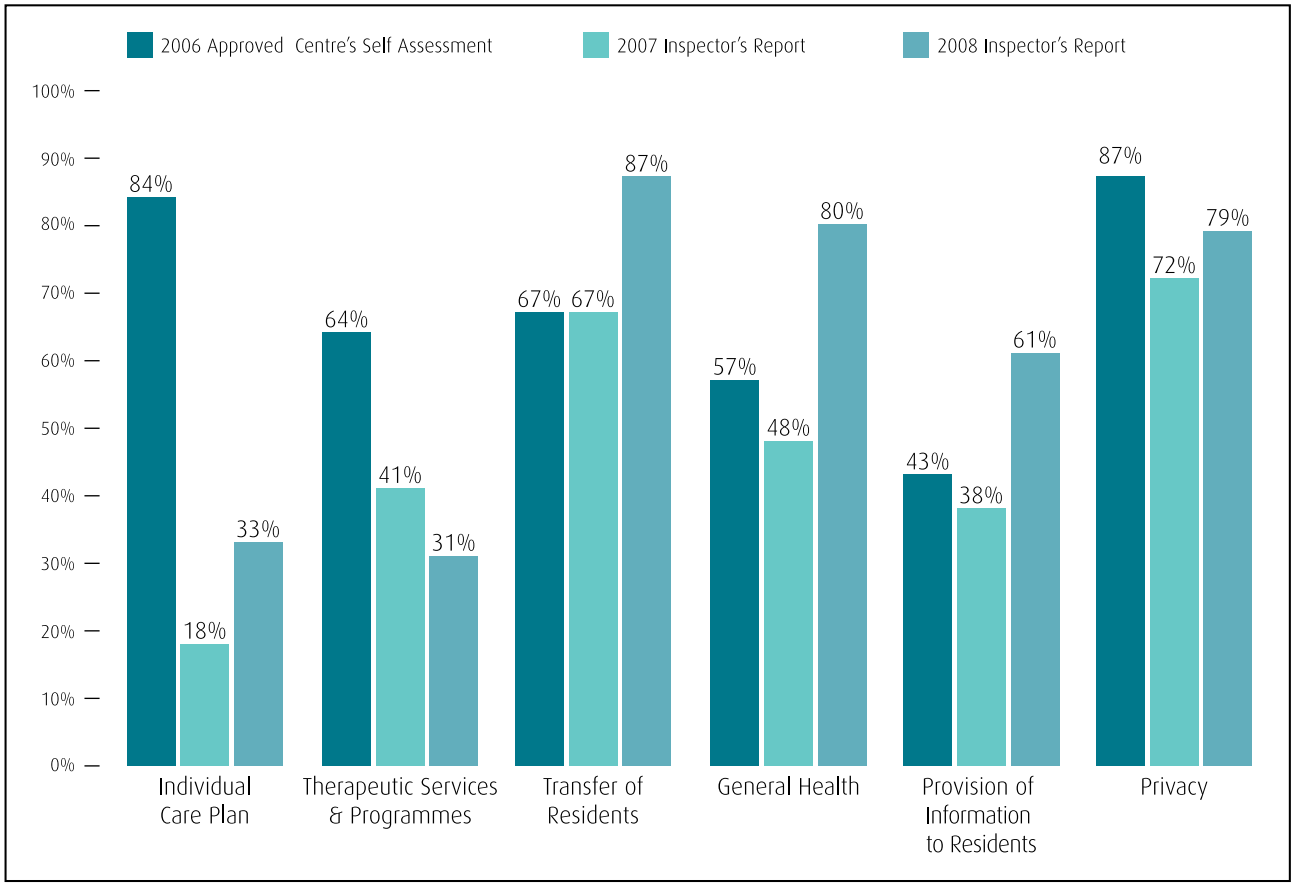
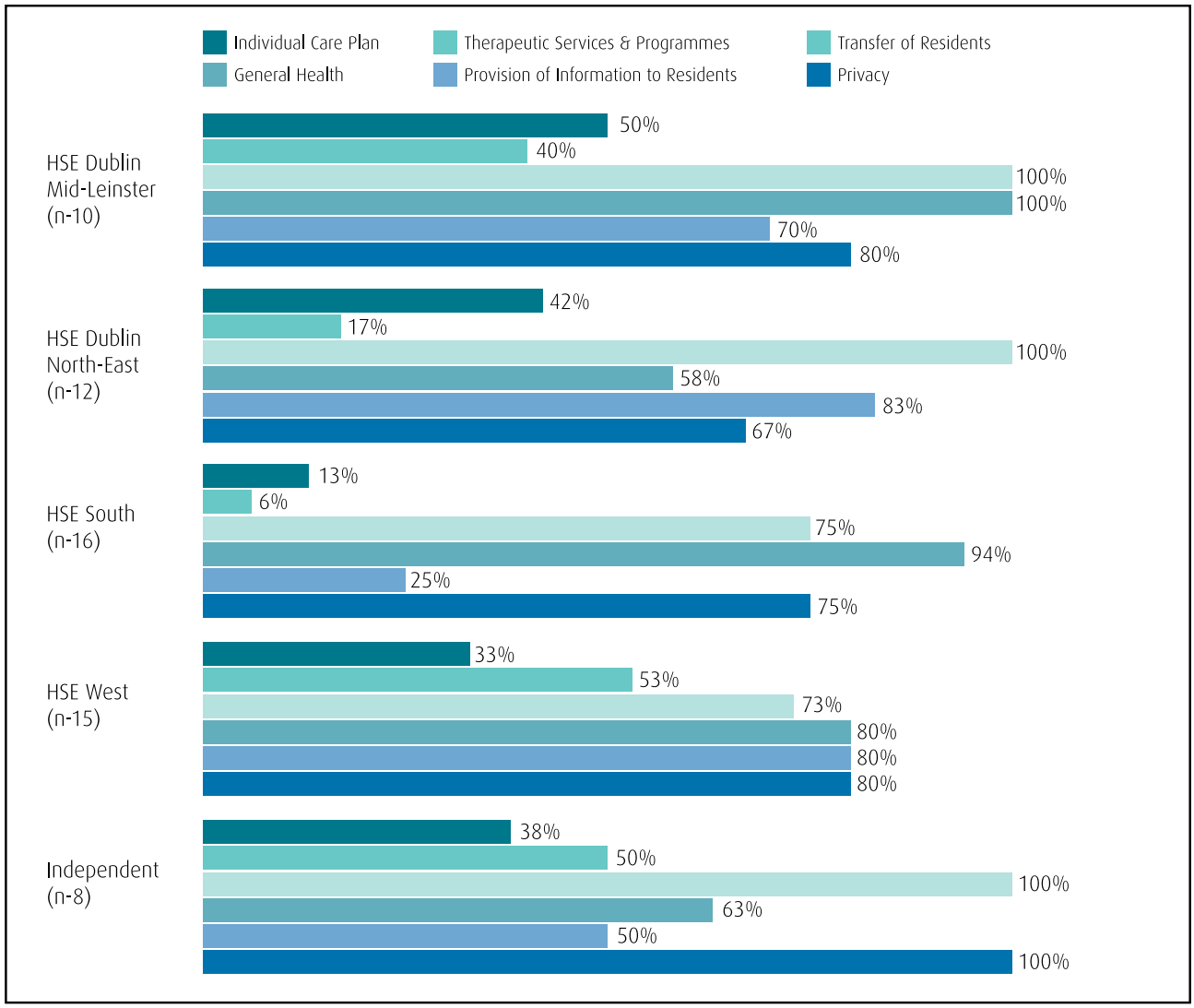


Figure 2 provides a comparison of compliance in 2008 for the above mentioned articles of the regulations by Health Service Executive (HSE) administrative areas. Independent and voluntary mental health service providers are also included.

Figure 2: Level of compliance in 2008 by Health Service Executive Administrative Area



CODE OF PRACTICE RELATING TO THE ADMISSION OF CHILDREN UNDER THE MENTAL HEALTH ACT 2001

VOLUNTARY AND INVOLUNTARY ADMISSIONS

There are separate provisions in the Mental Health Act 2001 in relation to the involuntary admission of children that require the HSE to make an application to the District Court. Details of the involuntary admission process are provided in the Commission's Code of Practice relating to the admission of children under the Mental Health Act 2001, *(Reference Number: COP-S33(3)/01/2006)*. The Mental Health Act 2001 Section 2(1) states that *"child"* means a person under the age of 18 years other than a person who is or has been married. The Mental Health Commission,

since its establishment, has consistently highlighted the lack of sufficient Child and Adolescent in-patient and day hospital facilities. The Mental Health Commission continues to hold the view that the provision of age appropriate approved centres for children and adolescents must be addressed as a matter of urgency. If children are admitted of necessity to approved centres for adults the provisions of the Code of Practice Relating to Admission of Children apply and these include a requirement to notify the Commission of such admissions.

ACTIVITY IN RELATION TO NOTIFICATIONS OF THE ADMISSION OF CHILDREN NOTIFIED TO THE MENTAL HEALTH COMMISSION

In 2008, the Commission was notified of the 392 admissions of children to approved centres[2]. This represents an 11% increase on the number of admissions notified in 2007[3] (n=352). Some of this increase can be attributed to the fact that in 2007 the admission data for one approved centre (HSE West) only related to the period from 25th May 2007 (date entered on the Register of Approved Centres) to 31st December 2007. If 2008 data are adjusted to account for the partial year of data in 2007 the year on year increase is 8%.

ADMISSIONS BY UNIT TYPE AND SERVICE PROVIDER

Table 1 summarises activity related to the notification of admission of children in 2007 and 2008. It provides a breakdown of the number and type of units that admitted children and the number and percentage of admissions by service provider (HSE Area or Independent Sector). There was a slight change in total number (n=36) and type of units (33 adult and 3 child) that admitted children in 2008 and a slight variance in the number of adult units that admitted children in HSE North East, HSE South, HSE West and the Independent Sector.

Table 1: Number and Type of Units. Number and Percentage of Admissions by Service Provider.

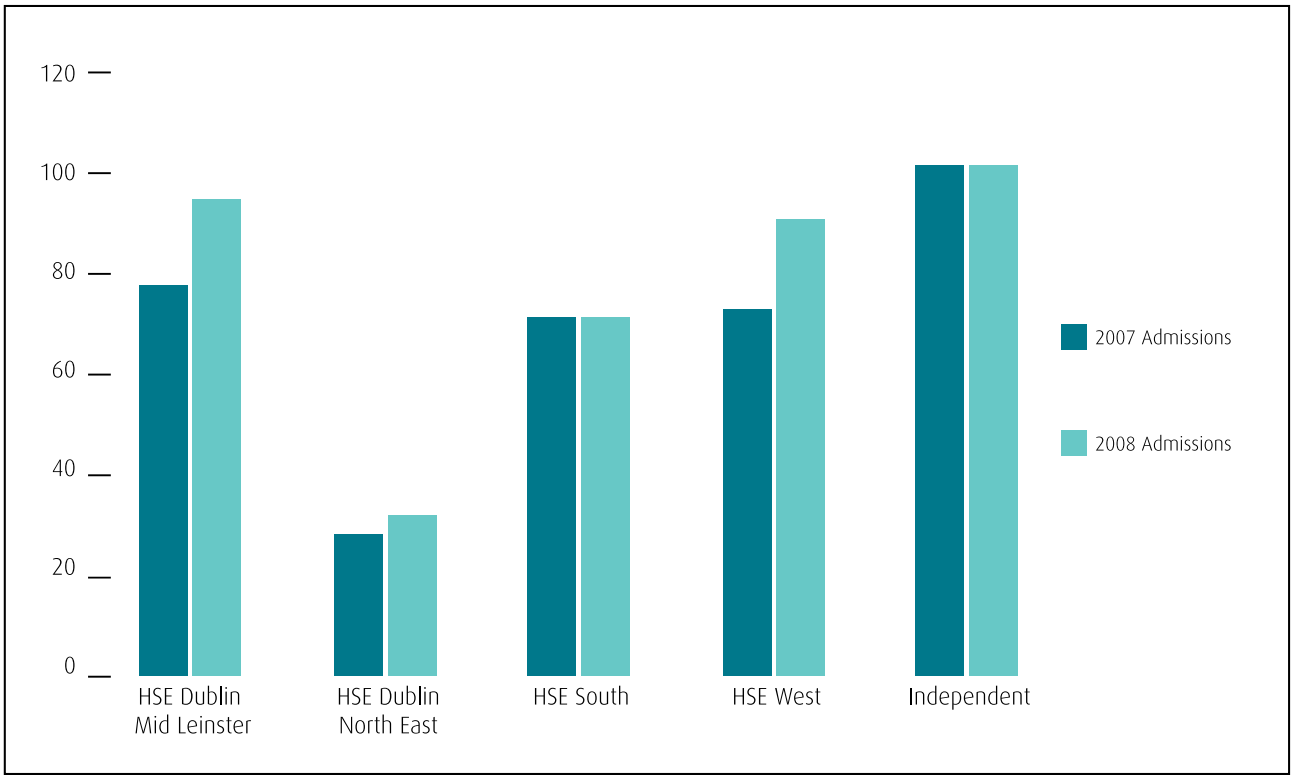
	2007			2008		
Service Provider	**Number and Type of Units**	**Number of Admissions**	**% of 2007 admissions**	**Number and Type of Units**	**Number of Admissions**	**% of 2008 admissions**
HSE Dublin Mid Leinster	7 adult units 1 child unit	78	22.1%	7 adult units 1 child unit	95	24.3%
HSE Dublin North East	6 adult units	28	8.0%	8 adult units	33	8.4%
HSE South	10 adult units	71	20.2%	9 adult units	71	18.1%
HSE West	7 adult units 1 child unit	73	20.7%	8 adult units 1 child unit	91	23.2%
Independent Sector	2 adult units 1 child unit	102	29.0%	1 adult unit 1 child unit	102	26.0%
Total	**35 units**	**352**	**100.0%**	**36 units**	**392**	**100.0%**

[2] Includes approved centres for adults (adult units), approved centres for children and adolescents (child units) and a child and adolescent unit in an approved centre which also admits adults (child unit).

[3] Since publication of the Mental Health Commission Annual Report 2007 updates were received in relation to 2007 child admission data and figures have been amended accordingly in this report.

Figure 3. shows the number of admissions of children in 2007 and 2008 by service provider. The largest increase in admissions in 2008 was in HSE West; 18 admissions (this can be partly attributed to full year of data in 2008 from one approved centre). HSE Dublin Mid-Leinster had the second largest increase; 17 admissions followed by an increase of five admissions in HSE Dublin North East. The number of admissions in HSE South and the Independent Sector were the same in 2007 and 2008.

Figure 3: Number of Admissions in 2007 and 2008 by Service Provider.



AGE AND UNIT TYPE

Table 2 summarises the number of admissions by age and unit type in 2007 and 2008. In 2008, 63% percent of admissions (n=247) were to adult units; 90% of these admissions (n=223) were 16 and 17 years of age and the remaining 10% (n=24) were 15 years of age or under. Thirty seven percent of admissions (n=145) were to child units; 62% of these admissions (n=90) were 15 years of age or under and the remaining 38% were 16 and 17 years of age.

Table 2: Numbers of Admissions by Age and Unit Type for 2007 and 2008

	2007		2008	
Age	**Adult Unit**	**Child Unit**	**Adult Unit**	**Child Unit**
≤15 years of age	14	99	24	90
16 and 17 years of age	203	36	223	55
Total (Admissions by Unit Type)	**217**	**135**	**247**	**145**

GENDER

In 2008, there were slightly more females 58% (n=229) than males 42% (n=163) admitted to approved centres, this represents a slight change to the gender breakdown in 2007; 59% female (n=207) and 41% male (n=145).

INVOLUNTARY ADMISSION

There were eight[4] involuntary admissions of children to approved centres in 2008; this represents an increase in the number of involuntary admissions reported in 2007 (n=4[5]). Six of these admissions were to adult units and two were admitted to child units. In 2007 all involuntary admissions were to adult units.

NUMBER OF ADMISSIONS

There was a total of 392 admissions in 2008, some children had more than one admission. Table 3 summarises the number of admissions that a child had (in one calendar year) in 2007 and 2008. The number of children that had one or two admissions increased but the number of children that had more than four admissions decreased in 2008.

Table 3: Number of Admissions by Number of Children. 2007 and 2008

Year	1 Admission	2 Admissions	3 Admissions	4 or more Admissions
2007	243	27	11	5
2008	277	36	11	2

ADDITIONAL INFORMATION REGARDING CHILD ADMISSION DATA

The number of admissions of children in 2007 in this report differ from those reported in the Health Research Board *HRB Statistics Series 5 Activities of Irish Psychiatric Units and Hospitals 2007* for the following reasons:

- The Commission's data on admissions of children only includes the admissions of children as defined in the Mental Health Act 2001 Section 2(1) states that *"child"* means a person under the age of 18 years other than a person who is or has been married. The HRB report on admissions of persons under 18 years of age.
- The Commission's admission data for one approved centre in HSE West was only for part of the year whereas the HRB admission data for this service was for the full year.
- The HRB reports on the legal status on admission, the Commission captures change in legal status and reports on the involuntary admission.

CODES OF PRACTICE – PUBLISHED DURING 2008:

CODE OF PRACTICE FOR MENTAL HEALTH SERVICES ON NOTIFICATION OF DEATHS AND INCIDENT REPORTING.

Following an extensive consultation process during 2007, Version 2 of the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting was published in January 2008.

Approved Centres are required to notify the Commission of all deaths of any resident, in accordance with Article 14(4) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Section 2.2 of the aforementioned code of

[4] Includes one re-grade of legal status from voluntary to involuntary (counted once as an involuntary admission).
[5] Includes one involuntary admission made under Section 13 of the Child Care Act 1991 and one re-grade of legal status from voluntary to involuntary (counted once as an involuntary admission).

practice. In 2008, a total of 42 approved centres notified the Commission of 179 deaths, a breakdown of information by service provider is provided in Table 4.

Table 4: Number of Approved Centres and Number of Death Notifications by Service Provider in 2008.

Service Provider	Number of Approved Centres that notified deaths	Number of death notifications
HSE Dublin Mid Leinster	7	21
HSE Dublin North East	8	45
HSE South	13	54
HSE West	8	32
Independent	6	27
Total	**42**	**179**

The code of practice also prescribes that day hospitals day centres and 24 hour staffed residences are required to notify the Commission of any sudden unexplained deaths within seven days of the death occurring. This information is currently being validated and will be reported on at a later stage in 2009.

CODE OF PRACTICE GOVERNING THE USE OF ELECTRO-CONVULSIVE THERAPY FOR VOLUNTARY PATIENTS.

Section 59(2) of the Mental Health Act 2001 required the Mental Health Commission to make rules providing for the use of electro-convulsive therapy (ECT) on patients. A patient under the 2001 Act is construed in accordance with section 14 and refers to a person to whom an admission or renewal order relates. The rules therefore apply to the use of ECT on a person involuntarily admitted to an approved centre only. As a consequence, in accordance with section 33(3)(e) of the Mental Health Act 2001, the Commission published a Code of Practice Governing the Use of ECT for Voluntary Patients in January 2008.

CODES OF PRACTICE – IN DEVELOPMENT DURING 2008:

CODE OF PRACTICE FOR MENTAL HEALTH SERVICES FOR PERSONS WITH AN INTELLECTUAL DISABILITY.

The Mental Health Commission set up a working group in June 2007 to develop a code of practice for the guidance of persons working in mental health services with people with intellectual disabilities. This group completed its work in April 2008 with the development of a draft code of practice for consultation with key stakeholders.

The Commission commenced this consultation in September 2008 and the National Federation of Voluntary Bodies and Inclusion Ireland were amongst the stakeholders who agreed to assist the Commission in carrying out this consultation. To facilitate this process, the Commission developed a consultation summary guide which was issued to all stakeholders. The closing date for receipt of the submissions was 23rd December 2008. A Code of Practice, informed by the findings from the consultation process will be published in 2009 and will be made available in accessible formats.

CODE OF PRACTICE RELATING TO ADMISSION, TRANSFER AND DISCHARGE TO AND FROM APPROVED CENTRES

The focus during 2008 in relation to the *Draft Code of Practice Relating to Admission, Transfer to and Discharge from approved centres* was on consultation. An external consultation process was commissioned and it was carried out between March and May 2008. The response from service users, carers and advocates was disappointing. The

Commission felt strongly that the views of these key stakeholders needed to be heard before the final code of practice was published. As a result, the Commission engaged the National Service User Executive (NSUE) to carry out a consultation exercise specifically to ascertain the views of service users, carers and advocates. This consultation took place between September and October 2008 and NSUE provided feedback from this consultation to the Commission in November 2008. The feedback from the focus groups was collated and analysed during December 2008. A Revised Code of Practice informed by both consultation processes will be presented to the Commission for consideration in 2009.

REVIEWS

- Rules Governing the Use of Electroconvulsive Therapy (Section 59(2) Mental Health Act, 2001);
- Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Section 69(2) Mental Health Act 2001)
- Code of practice on the Use of Physical Restraint in Approved Centres (Section 33(3)(e) Mental Health Act 2001)

The Rules referred to above were made by the Commission as required pursuant to Sections 59(2) and 69(2) of the Mental Health Act 2001 and came into effect on 1 November 2006. The Code of Practice on the use of Physical Restraint in Approved Centres was issued pursuant to Section 33(3)(e) of the 2001 Act and also came into effect on Ist November 2006. At the time of publication, the Commission advised that the rules and codes of practice would be kept under periodic review and revised as required, and in any event no later than 2 years from the date of the commencement of Sections 59 and 69.

Following tendering processes inviting external review of the Rules and Code of Practice, Prospectus Consultants were engaged to carry out both reviews. The purpose of the Reviews was threefold as follows:

1. To determine the need to revise the Rules and Code of Practice based on any new evidence that has come to light since the time of publication of these Rules in November 2006;

2. To assess any practice issues that may have arisen since the publication and implementation of the Rules and Code of Practice with a view to possibly updating based on significant or prevalent practice issues that have presented; and

3. To identify any weaknesses in the existing Rules / Code of Practice.

Prospectus completed the Reviews in November 2008. Following consideration by Commission Members of the recommendations in both Review Reports, the Executive will prepare revised ***Rules Governing the Use of Electroconvulsive Therapy, Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*** and a ***Code of Practice on the Use of Physical Restraint in Approved Centres*** in 2009.

DATA COLLECTION AND REPORTING UPDATES

ANNUAL INPATIENT CENSUS

In 2008, the Mental Health Research Unit of the Health Research Board (HRB) and the Commission signed a Memorandum of Understanding (MOU) which put in place a framework for reciprocal cooperation to assist each agency in meeting its responsibilities in relation to mental health services information in Ireland. Implementation of this agreement is intended to maintain and enhance each agency's effectiveness while avoiding duplication of effort to achieve required mental health services information.

Since 2004 the Mental Health Commission has carried out an annual approved centres inpatient census which has been reported on in our annual report. Since the MOU has been put in place the Commission has reviewed our data requirements to identify areas where the burden of data collection and duplication of effort for services could be reduced. It was agreed by both organisations that as there was very little year on year variance in the Commission's annual inpatient census returns and taking into account that the Mental Health Research Unit (MHRU) of the HRB carries out a more detailed national inpatient census at regular intervals (the most recent on 31st March 2006) that the Commission would no longer carry out an inpatient census. This decision took immediate effect in 2008 and therefore there is no annual inpatient census information in this year's annual report.

USE OF ECT, SECLUSION, MECHANICAL MEANS OF BODILY RESTRAINT AND PHYSICAL RESTRAINT

Approved Centres were required to return aggregate data on the use of ECT, seclusion, mechanical means of bodily restraint (to prevent immediate threat to self or others) and physical restraint in 2008. The Commission is currently validating and analysing this data and a report will be available during 2009.

TRAINING & DEVELOPMENT

During 2008 refresher training programmes were provided for Mental Health Tribunal Chairs, Consultant Psychiatrists, lay members, independent medical examiners and legal representatives. The programmes were designed, planned and implemented based on a training needs analysis of all the panel members and emergent case law. Newly appointed chairs, legal reps and consultant psychiatrists received induction training. Training programmes were accredited by the relevant medical and legal bodies to qualify for professional development status under their respective regulations.

A presentation was delivered on request by the Irish College of General Practitioners in October at the Autumn Scientific Meeting titled 'Does Mind matter in Occupational Health Practice'. The presentation focused on the role of the registered medical practitioner as per Section 10 of the Mental Health Act 2001.

The e-learning programme on the Mental Health Act 2001 was updated to reflect case law developments in 2008. The frequently asked questions (FAQs) section of the Mental Health Commission website was updated regularly and copies of judgments were circulated to all panel members.

The Mental Health Commission contributed to the National Facilitators training programme for Authorised Officers within the Mental Health Services. Three programmes ran between September and November, training mental health professionals to roll out the Authorised Officer Service.

The Mental Health Commission in August invited tenders for the provision of a 'Report on the Education/ Training Provision for Professionals Working in Mental Health Services in Ireland'. The contract was awarded to Professor Agnes Higgins, Trinity College Dublin. The report, it is intended will provide information on training and education which will facilitate informing and influencing future programmes. The Commission plans to utilise the report to develop a training strategy in collaboration with both academic and practice settings for the purpose of developing and implementing a mental health multi/intra professional training/education framework based on best practice. It is expected that the report will be completed by mid 2009.

DISCUSSION/POSITION PAPERS

On 17th April 2008 the Mental Health Commission held a one day conference entitled *"A Recovery Approach within the Irish Mental Health Services Translating Principles into Practice"* The conference was attended by over 230 delegates witin the mental health services sector. The Recovery Approach is a relatively recent development in

the Irish mental health care system and has been adopted by a number of countries including the United States of America, New Zealand and the United Kingdom.

The recovery approach is a fundamental change in how we work with people who have a mental illness.

The recovery approach works on the premise that people who are diagnosed with severe mental illness can recover or reclaim meaningful lives. The conference allowed the opportunity for the Commission to outline to those within the mental health sector how this approach could work within the Irish mental health services and what everyone involved in the sector could do to make this a reality.

The recovery approach involves focussing on strengths and opportunities rather than on the limitations and symptoms of illness. It is a shift towards the service user and making them the single most important focus of the service. In order for this approach to succeed the entire mental health service and users of the service must work together to improve the quality of life for people with a mental illness

A recovery-focused approach to the treatment and care of service users is one of the standards identified in the *'Quality Framework for Mental Health Services in Ireland'* (Mental Health Commission, 2006). The delivery of this approach represents a significant challenge for service users, mental health professionals and providers, who must work together in partnership if this vision is to be realised.

The Mental Health Commission is of the view that providing a recovery focused service, that emphasises rebuilding and living fully satisfying, hopeful and contributing lives regardless of diagnosis, must be a core dimension of the philosophy and vision of future developments in the Irish Mental Health Services.

A Resource Pack was published by the Mental Health Commission also and launched at the conference. The pack contains, *The Recovery Journey – Position Paper MHC* (2008), *A Recovery Approach within the Irish Mental Health Services – A Framework for Development MHC* (2008), *A Vision for A Recovery Model in the Irish Mental Health Services MHC* (2007). Requests for the Resource pack have been constant since publication.

The Mental Health Commission is also represented on the Irish Mental Health and Recovery Education Consortium Advisory Group. The Irish Mental Health and Recovery Education Consortium's purpose is to develop, deliver and evaluate a mental health recovery education programme, using the Wellness Recovery Action Plan Approach (WRAP).

Work was finalised on the position paper on Forensic Mental Health Services for Adults in Ireland and the position paper will be published in 2009. The position paper on Multidisciplinary Team Working: From Theory to Practice will also be published in 2009. Work was progressed on the Mental Health Commission discussion paper on Child and Adolescent Mental Health Services with a publication date in 2009.

VISION FOR CHANGE

Vision for Change, national government policy on mental health services in Ireland was published in January 2006. The absence of meaningful progress in the implementation of Vision for Change remained an ongoing concern for the Mental Health Commission during 2008. The Mental Health Commission sought meetings with the Health Service Executive on a number of occasions during the year in relation to Vision for Change. The Mental Health Commission also met with members of the Independent Monitoring Group.

The Mental Health Commission's support for the implementation of Vision for Change was also reiterated at meetings with Minister Devins, Minister of State for Disability and Mental Health in April 2008 and subsequently Minister John Moloney Minister of State, Equality, Disability and Mental Health in July 2008.

Key areas highlighted by the Mental Health Commission in contact with the Health Service Executive and in press statements issued by the Mental Health Commission included:

- Non-appointment of the National Mental Health Services Directorate
- Non-implementation of recommendations on catchment areas
- Absence of multi-disciplinary team input at clinical level and in the implementation groups set up by the Health Service Executive.
- Absence of service user input in the National Implementation Group (HSE).

Strategic Priority 2

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

INTRODUCTION

1st November, 2006 marked the full commencement of the Mental Health Act 2001. From this date an independent review system for all persons involuntarily admitted became operative. The independent review system provides for the automatic independent review of all involuntary admissions by a three person mental health tribunal, consisting of a lawyer, consultant psychiatrist and a lay member. Prior to this review, a legal representative is appointed by the Mental Health Commission for each patient (unless s/he proposes to engage one) and an independent medical examination by a consultant psychiatrist appointed by the Mental Health Commission will have been completed.

In July 2008 the Mental Health Commission published its report on the operation of Part 2 of the Mental Health Act 2001, pursuant to Section 42(4) 2001 Act which states that:

"The Commission shall, no later than 18 months after the commencement of Part 2, prepare and submit a report in writing to the Minister on the operation of that Part together with any findings, conclusions or recommendations concerning such operation as it considers appropriate".

In addition to providing information about the implementation of reforms, the report provides an external commentary on the legislation and includes feedback from a consultation exercise with patients and service providers within the mental health services.

In this major review, the Commission concluded that the Mental Health Act 2001 has made important improvements for the protection of individuals involuntarily admitted for mental health treatment. The report found that Ireland has made significant strides in protecting the human rights of individuals within the mental health system, and that the 2001 Act is in compliance with international human rights conventions.

The review found that some changes to the 2001 Act are required. These include changes to ensure the rights of those patients being regraded from voluntary to involuntary status are protected. The review recommends the further examination of the procedures relating to the admission of a person with a mental disorder to an approved centre. The review also recommends the introduction of new capacity legislation – this would clarify how decisions are taken in relation to patients who are unable to participate in decisions about their care.

The Commission is also proposing a programme of research to further examine service user experiences before, during and after the process of involuntary admission. Arising from the detailed information in the report and its conclusions the Commission will commence a process of consultation with stakeholders to inform the preparation of a comprehensive code of practice for the 2001 Act for the guidance of persons working in the mental health services.

PROCEDURES FOR INVOLUNTARY ADMISSION (ADULTS)

The 2001 Act introduced provisions for a system of free legal representation for adults and independent reviews during their episode of involuntary admission[6]. This review is performed by a mental health tribunal during each period of detention.

[6] An episode is a patient's unbroken period of involuntary admission

It is important to note that the 2001 Act has provisions for two methods of initiating detention; an *Admission Order,* (Form 6) and a *Certificate & Admission Order to detain a Voluntary Patient (Adult),* (Form 13) which also detains for 21 days.

INVOLUNTARY ADMISSION (ADULTS) 2008

Analysis was completed on the number of adults who were involuntarily admitted using the provisions of sections 9, 10, & 14 of the Act in 2008. In such admissions the admission order is made by a consultant psychiatrist on statutory Form 6, *Admission Order*, which must be accompanied by an application (Form 1, 2, 3, or 4) and a recommendation by a registered medical practitioner, (Form 5). There were 1,420 Form 6 *Admission Orders* notified to the Commission in 2008.

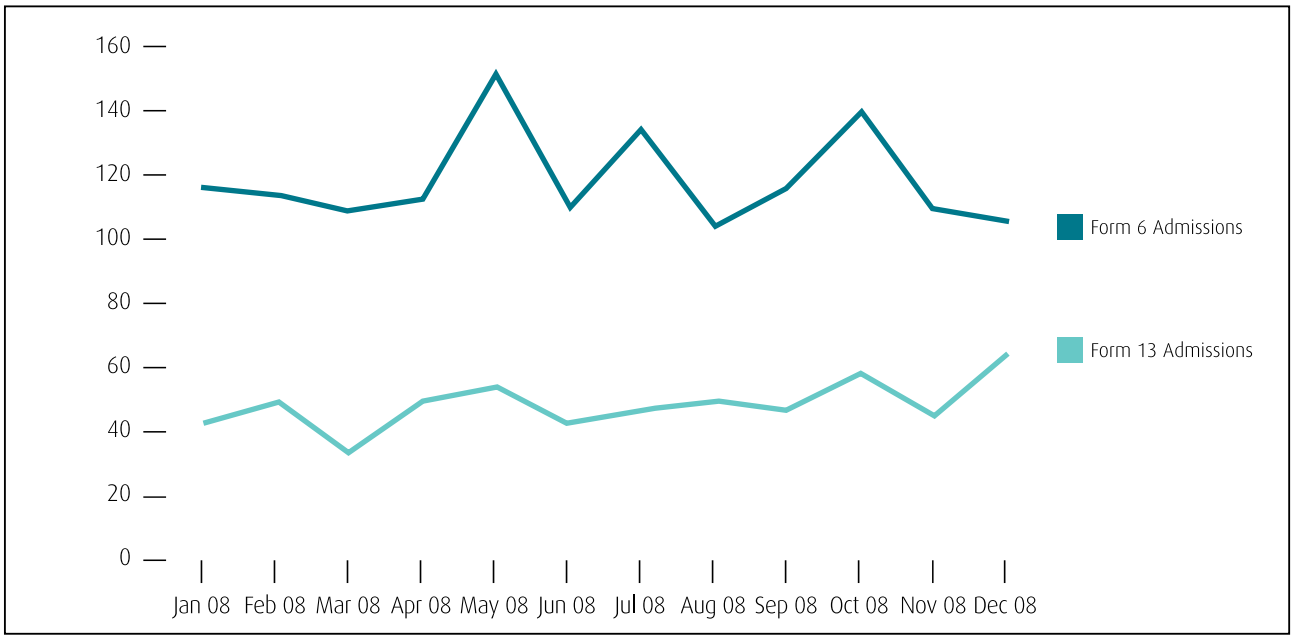
DETENTION OF A VOLUNTARY PATIENT; SECTION 24 MENTAL HEALTH ACT 2001

Section 24 Mental Health Act 2001 outlines the procedures relating to a decision to re-grade a voluntary patient to involuntary status. In such admissions the admission order is made on statutory form, Form 13 *Certificate & Admission Order to Detain a Voluntary Patient (Adult),* signed by two consultant psychiatrists. There were 584 such admissions notified to the Commission in 2008.

COMPARISONS 2007 - 2008

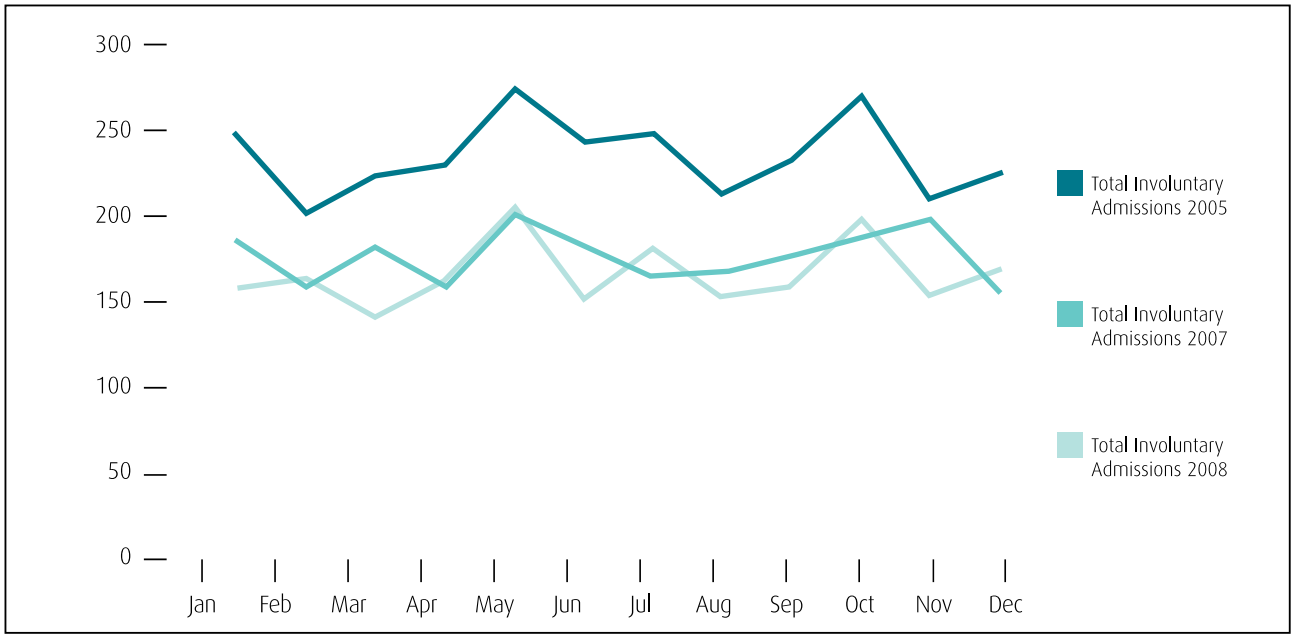
Figure 4. below summarises on a monthly basis both the above categories of involuntary admission for 2008, i.e. - Form 6 *Admission Orders*, and Form 13, *Certificate & Admission Order to Detain a Voluntary Patient (Adult)*. The number of Form 6 orders fall within a range from 104 to 150 per month, and the number of Form 13 orders fall within a range from 34 to 64 per month.

Figure 4: Monthly Involuntary Admissions 2008:
Form 6 Admission Orders, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)



Comparison was made of 2008 involuntary admission activity with that for a number of previous years. The year 2005 was chosen for comparison as this was the most recent full year of operation for involuntary admission procedures under the Mental Treatment Act 1945. Figure 5 below summaries these comparisons on a monthly basis and shows a decrease of 25% in overall involuntary admission activity from 2005 to 2007, and a further 6% decrease from 2007 to 2008.

Figure 5: Comparison of Total Involuntary Admissions 2005, 2007 & 2008



Further comparison of 2008 with 2007 shows the decrease in activity is accounted for by a 6% reduction in both the categories Form 6 *Admission Order*, and Form 13, *Certificate & Admission Order to Detain a Voluntary Patient (Adult)*.

Table 5 provides further analysis of involuntary admissions in 2008 by each approved centre, by HSE region, and for the independent sector.

Table 5: Involuntary Admissions By HSE Regions & Independent Sector 2008 (Adults)

	2008		
HSE WEST	**Form 6[a]**	**Form 13[a]**	**Total**
Ballytivnan Sligo/Leitrim Mental Health Services	45	16	61
St. Conal's Hospital Letterkenny	0	2	2
Acute Psychiatric Unit Carnamuggagh Letterkenny	48	17	65
Adult Mental Health Unit Mayo General Hospital Castlebar	57	9	66
St Brigid's Hospital Ballinasloe	40	13	53
Department of Psychiatry County Hospital Roscommon	22	12	34
Psychiatric Unit University College Hospital Galway	54	12	66
Unit 9A Merlin Park University College Hospital Galway			
Acute Psychiatric Unit 5B Midwestern Regional Hospital Limerick	70	18	88
St Josephs Hospital Limerick	0	3	3
Acute Psychiatric Unit Midwestern Regional Hospital Ennis	30	14	44
Orchard Grove Ennis			
An Coillin Castlebar	0	1	1
Teach Aisling Castlebar	1	0	1
TOTAL HSE WEST	**367**	**117**	**484**
HSE SOUTH			
St. Finans Hospital Killarney	2	0	2
St Stephens Hospital Glanmire Cork	24	8	32
Acute Mental Health Admission Unit Kerry General Hospital Tralee	56	20	76
South Lee Mental Health Unit, Cork University Hospital	70	22	92
St. Michaels Unit Mercy Hospital Cork	54	26	80
St Finbarr's Hospital Cork			
Carraig Mor Centre Cork	9	8	17
Acute Psychiatric Unit Bantry General Hospital	14	8	22
St. Dymphna's Hospital Carlow			
St. Canice's Hospital Kilkenny			
St. Luke's Hospital Clonmel	2	1	3
St. Michael's Unit South Tipperary General Hospital Clonmel	56	18	74
St. Senan's Hospital Enniscorthy	33	17	50
Department of Psychiatry St. Luke's Hospital Kilkenny	19	12	31
Department of Psychiatry Waterford Regional Hospital	30	17	47
St Otteran's Hospital Waterford	8	2	10
TOTAL HSE SOUTH	**377**	**159**	**536**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

	2008		
HSE DUBLIN NORTH EAST	**Form 6[a]**	**Form 13[a]**	**Total**
Acute Psychiatric Unit Cavan General Hospital	21	6	27
St. Davnet's Hospital Monaghan	12	7	19
Department of Psychiatry Our Lady's Hospital Navan	24	12	36
St Brigid's Hospital Ardee	50	7	57
ST. Vincents Hospital Fairview	70	30	100
St. Ita's Hospital Mental Health Services Portrane	39	18	57
St Joseph's Intellectual Disability Services St Ita's Hospital Portrane	0	0	0
Acute Psychiatric Unit , St Aloysius Ward Mater Misericordiae Hospital Dublin	13	11	24
St. Brendan's Hospital Dublin	27	18	45
Sycamore Unit Connolly Hospital	1	0	1
Department of Psychiatry Connolly Hospital	27	15	42
TOTAL DUBLIN NORTH EAST	**284**	**124**	**408**
HSE DUBLIN MID LEINSTER			
St. Loman's Hospital Palmerstown			
Jonathan Swift Clinic	43	30	73
Acute Psychiatric Unit AMNCH	55	20	75
Lakeview Unit Naas General Hospital	53	15	68
Department of Psychiatry Midland Regional Hospital Portlaoise	29	8	37
St. Lomans Hospital Mullingar	54	9	63
St Fintan's Hospital Portlaoise			
Newcastle Hospital	24	2	26
Elm Mount Unit St.Vincent's University Hospital	56	25	81
Central Mental Hospital			
TOTAL HSE DUBLIN MID LEINSTER	314	109	423
INDEPENDENT SECTOR	**Form 6**	**Form 13**	**Total**
St John of God Hospital Stillorgan	58	43	101
St Patrick's Hospital Dublin	21	31	52
St Edmundsbury Hospital Dublin			
Palmerstown View, Stewarts Hospital Dublin	0	1	1
Highfield Private Hospital			
Hampstead Private Hospital			
Bloomfield Wing Dublin			
Kylemore Clinic Ballybrack			
TOTAL INDEPENDENT SECTOR	**79**	**75**	**154**

[a] Form 6 Admission Order. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Table 6 shows Total Involuntary Admission Rates for 2008 (Adult) by HSE region and independent sector, with rates per 100,000 of total population. Boundary difficulties when defining some catchment areas makes any further breakdown of rates unreliable.

Table 6: Below Total Involuntary Admission Rates For 2008 (Adult) By HSE Region & Independent Sector

	Total Involuntary Admission Rate 2008 (ADULT)	Population[A]	Involuntary Admission Rate per 100,000 total population
HSE WEST	484	1,012,413	47.81
HSE SOUTH	536	1,081,968	49.54
HSE DUBLIN NORTH EAST	408	928,619	43.94
TOTAL HSE DUBLIN MID LEINSTER	423	1,216,848	34.76
INDEPENDENT SECTOR	154	N/A	
TOTAL (Exclusive of Independent sector)	1,850	4,239,848	43.66
TOTAL (Inclusive of Independent sector)	2,004	4,239,848	47.29

[A] Population figures taken from CSO census 2006

Analysis of Ireland's involuntary admission rates in 2008 reveals that involuntary admission rates per 100,000 of total population are significantly lower than in previous years. The national rate for 2008 is 47.29 per 100,000 of total population, including involuntary admissions to independent sector approved centres. The national rate for 2007 was 50.14 per 100,000 of total population, including involuntary admissions to independent sector approved centres.

AGE AND GENDER

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2008. Tables 7 and 8 below summarise these findings.

Table 7: Analysis by Age – Involuntary Admissions 2008 (Adults)

AGE	FORM 6	FORM 13	TOTAL	%
18 – 64	1168	520	1168	84%
65 and over	252	64	316	16%
Total	**1420**	**584**	**2004**	**100%**

Table 8: Analysis by Gender – Involuntary Admissions 2008 (Adults)

GENDER	FORM 6	FORM 13	TOTAL	%
MALE	792	319	1111	55%
FEMALE	628	265	893	45%
TOTAL	**1420**	**584**	**2004**	**100%**

TYPE OF APPLICANT

Analysis was undertaken of the categories of persons who applied for a person to be involuntarily admitted under section 9 of the Act in the period 2008. Table 9 below summarises this analysis.

Table 9: Analysis of Applicant: Involuntary Admissions 2008 (Adults)

Form Number	Type	Number	%
1	Spouse/Relative	908	63.9
2	Authorised Officer	65	4.6
3	Garda Síochána	324	22.8
4	Any other Person	123	8.7
	TOTAL	**1420**	**100%**

Comparison of the 2007 figures for type of applicant with the 2008 figures shows the number of applicants by spouse/relative has fallen from 69% to 63.9%, authorised officer fallen from 7% to 4.6%, Garda Síochána risen from 15% to 22.8% and any other person remained almost the same.

DIAGNOSIS

When the episode of involuntary admission is ended by the responsible consultant psychiatrist revoking the order the psychiatrist is requested to provide details to the Commission of the patient's diagnosis using ICD-10 diagnostic groups on statutory Form 14, *Revocation of an Involuntary Admission or Renewal Order*. Details of diagnoses reported to the Commission in 2008 are summarised in Table 10 below.

TABLE 10: ICD 10 Diagnostic Group Coded at Close of Episode (Adults) 2008

ICD-10 diagnostic groups	ICD-10 Code			Total Number of Episodes
1. Organic Disorders	F00-F09			99
2. Alcoholic Disorders	F10			29
3. Other Drug Disorders	F11-F19, F55			34
4. Schizophrenia, Schizotypal and Delusional Disorders	F20-F29			838
5. Depressive Disorders	F31.3, F31.4, F31.5, F32, F33, F34.1, F34.8, F34.9			153
6. Mania	F30, F31.0, F31.1, F31.2, F31.6, F31.7, F31.8, F31.9, F34.0			395
7. Neuroses	F40-F48			38
8. Eating Disorders	F50			8
9. Personality and Behavioural Disorders	F60-F69			18
10. Intellectual Disability	F70-F79			4
11. Development Disorders	F80-F89			0
12. Behavioural and Emotional Disorders of Childhood	F90-F98	See children sections		
13. Other Diagnosis	F38, F39, F51-F54, F59, F99			9
TOTAL				**1625**

It is of interest to note that the diagnostic group with the highest rates of involuntary admission is the grouping *"Schizophrenia, Schizotypal & Delusional Disorders* followed by that for *"Mania"*. This is similar to the findings for 2007.

REVOCATION BY RESPONSIBLE CONSULTANT PSYCHIATRIST

Section 28 provides the consultant psychiatrist responsible for the patient with the option to revoke an order where they become of opinion that the patient is no longer suffering from a mental disorder as defined in the Act. Where the responsible consultant psychiatrist discharges a patient under section 28 they must give to the patient concerned and his or her legal representative a notice to this effect, a statutory form number 14, *Revocation of an Involuntary Admission or Renewal Order*. Analysis of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 shows that there were 1,290 such instances in 2008. The patient may leave the approved centre at this stage or stay to receive treatment on a voluntary basis. The number of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 is not considered to be out of the ordinary. Analysis of length of period of involuntary admission has shown that around 50% of episodes of involuntary admission last less than 21 days, and only 1% last more than 1 year. This reflects the situation where patients' conditions improve over time and the Act's requirement that the patient is detained pursuant to an admission order or a renewal order only for so long as is reasonably necessary for his or her proper care and treatment (s28(2)(b).

REVIEW BY A MENTAL HEALTH TRIBUNAL

INDEPENDENT REVIEW BY A MENTAL HEALTH TRIBUNAL

The Mental Health Act 2001 provides for the patients' right to an automatic independent review of an involuntary admission. Within 21 days of an admission (or renewal) order, a three person mental health tribunal consisting of a lawyer as chair, a consultant psychiatrist and another person review the admission (or renewal) order. Prior to the independent review, a legal representative is appointed by the Mental Health Commission for each person 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. There were 2,096 hearings in 2008.

SECTION 17 INDEPENDENT MEDICAL EXAMINATIONS

As an admission or renewal order must be reviewed by a mental health tribunal within 21 days of the order being signed, the Commission must assign a consultant psychiatrist to conduct an independent medical examination as soon as possible after the order has been notified to the Commission. Additionally, in accordance with section 21 of the Act, all proposals to transfer a patient to the Central Mental Hospital must be reviewed by a tribunal within 14 days. Table 11 provides further details of the type of order for which the reports were required.

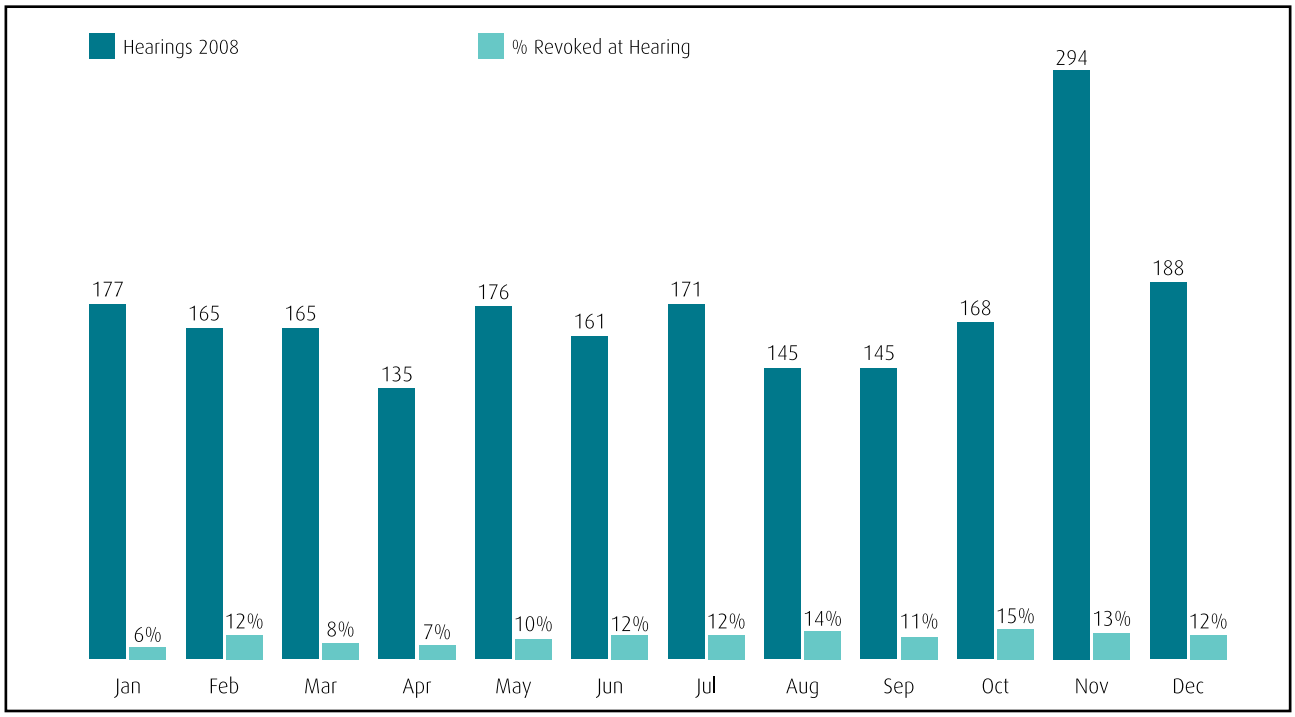
Table 11: Type of Order For Which Section 17 Reports Were Assigned 2007 (Adults)

TYPE OF ORDER	NUMBER OF REPORTS ASSIGNED
Involuntary Admission Order Form 6	1,420
Involuntary Admission Order Form 13	584
Renewal Orders	1324
Proposal to Transfer to Central Mental Hospital	10
TOTAL	**3,338**

REVOKE AT HEARING

Analysis was undertaken of the number of orders revoked at a mental health tribunal. Figure 6 below shows the number of hearings on a month by month basis for 2008 and the number of orders revoked (%) in each month. The number of hearings increased in November 2008 as a result of the enactment of the Mental Heath Act 2008 arising from a judgment in a judicial review.

Figure 6: Number Hearings & % of Orders Revoked at Hearing 2008



MENTAL HEALTH ACT 2008

On 30th October 2008, on the advice of the Office of the Attorney General, the Government introduced the Mental Health Bill, 2008. The purpose of the legislation was to ensure that otherwise valid Renewal Orders would not be invalidated by the anticipated decision of Mr. Justice M. McMahon in the case of S.M. -v- the Mental Health Commission and others which was scheduled to be delivered on 31st October 2008.

On 31st October, 2008 Mr. Justice McMahon delivered a written judgment in the case S.M. -v- the Mental Health Commission and others. Mr Justice McMahon was of the view that a Renewal Order made under Section 15(2) and 15(3) and which does not specify a particular period of time, but merely provides that it is an Order for a period "not exceeding twelve months", is not an Order permitted under the legislation and is void for uncertainty. Revised statutory forms were prepared and issued by the Mental Health Commission on foot of this judgment.Subsequent to the enactment of the Mental Health Act 2008, the Mental Health Commission received 206 Replacement Renewal Orders by midnight 5th November 2008.

Table 12 provides information in relation to these Replacement Renewal Orders (RROs).

Table 12

R.R.Os received by the Mental Health Commission.	206
Number of R.R.Os revoked before mental healthtribunal hearing	23 (11%)
Number of R.R.Os affirmed by mental health tribunals	157
Number of R.R.Os revoked at mental health tribunal	22 (12% rounded up)
Number of adjournments per Section 18(4) (for reasons unrelated to provisions of 2008 Act	4

CASES BROUGHT BEFORE THE COURTS

CIRCUIT COURT APPEAL

Section 19(1) of the 2001 Act states that a patient may appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him or her on the grounds that he or she is not suffering from a mental disorder. The appeal can only be made if the patient continues to be detained. There were 48 Circuit Court appeals filed in the period from 1st January to 31st December 2008. Some of these cases were withdrawn due to orders being revoked by the responsible consultant or patients not wishing to proceed. In relation to the cases that were heard by the Circuit Court, none resulted in an order being revoked.

ARTICLE 40.4.2 CASES

Where a person believes that they are unlawfully detained they, or another person on their behalf, may have recourse to the common law writ of *Habeas Corpus* which is embodied in Article 40.4 of the Constitution. Article 40.4 of the Constitution is a self contained constitutional mechanism to test the lawfulness of a person's detention and empowers the High Court to examine whether the person is being detained in accordance with the law. In 2008 there were 10 Article 40.4 cases brought that involved the Commission and/or a mental health tribunal. Of these 2 were appealed to the Supreme Court. In both Supreme Court judgments the decision of the High Court, where the patient was found to be in lawful detention, was upheld.

JUDICIAL REVIEW

Judicial review is a method developed at common law to enable an individual who is the subject of a government / statutory action to challenge the legality of that action in the Courts. The decision must have been made by a body or persons, with legal or statutory authority to determine questions affecting the rights of citizens and having the duty to act judicially. Judicial review is brought in relation to both legislative and executive actions. These reviews are heard by a Judge in the High Court and can be appealed to the Supreme Court. It is discretionary remedy. There were 11 Judicial Review cases issued in 2008 that involved the Commission and/or a mental health tribunal. Five of those cases are ongoing. The issues in two of the cases have already been determined by the High Court and one of those High Court cases has been appealed to Supreme Court.

Strategic Priority 3

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

INTRODUCTION

The Mental Health Commission published its Research Strategy in 2005. As outlined in the Strategy, the Commission views mental health services research as being centrally important to the development of high quality mental health services. Building capacity for mental health services research is one of the four action plans outlined in the strategy. The other three action plans which are highlighted in the strategy are; recording and disseminating knowledge of best practice in mental health services, creating links and collaborating research standards in mental health and setting the mental health research agenda.

FUNDED RESEARCH PROJECTS

The Mental Health Commission is currently funding four research scholarship projects. A fifth project was being considered for approval at the end of 2008.

- Dr. Siobhán Ní Bhríain: *Measurement of needs in the HSE-SWA: A Measure of Needs and Correlation with Intervention in Home and Community-based Services in General Adult Psychiatry and Psychiatry of Later Life*
- Professor Stiofán de Burca: *Adult Community Mental Health Teams: Determinants of Effectiveness*
- Dr. Ena Lavelle: *Rehabilitation and Recovery Services in Ireland: a multicentre study to investigate current service provision, characteristics of service users and 18 month outcomes for those with and without access to these services*
- Mr. Niall Turner: *A clinical trial of supported employment (SE) and the Workplace Fundamentals Module (WFM) with people diagnosed with schizophrenia spectrum disorders*

In 2008 the Commission's research committee undertook a review of the research scholarship scheme and at the end of the year a proposal for a new research grant scheme which would replace the scholarship scheme was being considered by the committee.

The focus of the new scheme would be to facilitate the development of innovative, high quality, multi-disciplinary mental health services research projects in Ireland.

RESEARCH STUDIES COMMISSIONED BY THE COMMISSION

In September 2008 the Commission published its report on the ***Economics of Mental Health Care in Ireland***. The report focused on the economic benefits of investment in services to deal with mental health problems.

The estimated cost to the economy of mental health problems in 2006 in Ireland was calculated as being over €3 billion, which is more than two per cent of GNP. The health care system accounts for less than one quarter of the costs. The main economic costs of mental health problems are located in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement. There are also costs related to the prison service, social services dealing with homelessness and informal care costs as well as lost output and productivity.

The significant human and social costs associated with mental health problems, including pain, suffering, stigma, reduction in quality of life and suicide were not included in the baseline estimates of €3 billion.

The report also contained economic survey results which showed the public would be willing to pay more for community based mental health services. The report highlighted the economic reasons for policy makers to invest more in mental health:

1. The economic cost of poor mental health in Ireland is very significant;

2. The Irish public has expressed a willingness to pay extra taxation for a mental health programme that would enable more people to live in the community;

3. There is a burgeoning economic base of evidence about particular interventions which have a positive effect on the quality of life of people with mental health problems.

On the publication of the Report, The Economics of Mental Health Care in Ireland, the Mental Health Commission reiterated its support for implementation of the Government policy on mental health, ***A Vision for Change.*** This policy requires substantial investment in the development of community treatment facilities to replace the institutional care approach. Resources are not infinite, therefore choices must be made between alternative uses of the same resource or service. The Mental Health Commission supports the authors' comments on the importance of economic analysis to aid decision making on resource allocation and on priority setting. While decisions on resource allocation are grounded in values, economics is a central tool in the making of these decisions.

RESEARCH COMMITTEE

The research committee met on three occasions in 2008. In line with the committee's terms of reference it guided and advised the Mental Health Commission on its research agenda.

Strategic Priority 4

To advocate for the integration and participation in society of people who experience or have experienced mental illness.

WORLD MENTAL HEALTH DAY 2008

Each year World Mental Health Day is marked in Ireland and worldwide on October 10th, this day being part of an international campaign to prioritise mental health issues.

The 2008 World Mental Health Day theme was: *"Making Mental Health A Global Priority: Scaling up Services Through Advocacy and Action".*

The Mental Health Commission hosted a seminar focusing on Mental Health Advocacy which was chaired by broadcaster Ms. Miriam O'Callaghan. The seminar took place on Friday 10th October in the Round Room, Mansion House, Dawson Street, Dublin 2. One hundred and eighty six people attended this special event.

Speakers at the Commission's 2008 event to mark World Mental Health Day included:

- Mr Paddy McGowan a mental health advocate and lecturer on mental health issues whose presentation was entitled *"Advocacy a right not a privilege."*
- Mr James Wooldridge a mental health advocate and founder of Positive Notions Training Consultancy which provides motivational speaking and mental health training services with a focus on inspiring positive action. Mr Wooldridge made a presentation on *"Advocating Mental Wealth".*
- Rúairí McKiernan, Chief Executive of Spunout *"Freedom to be in a SpunOut World."*
- Dáil na nÓg Councillors' Jennifer Hegarty and Robert McDonnell *"Views of Dáil na nÓg on Mental Health Issues for Young People."*

World Mental Health Day is an initiative of the World Federation for Mental Health, a global mental health organization with members and contacts in more than 150 countries and its aim is global mental health education, awareness and advocacy.

POLICE AND MENTAL HEALTH SERVICES

The work of the Police and Mental Health Services Working Group concluded at the end of 2008. The report of the working group will be presented to the Mental Health Commission in early 2009 and will be published following adoption by the Commission and the Garda Commissioner.

The terms of reference of the working group were "to review current national and international best practice models in 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.

MENTAL HEALTH AWARENESS

The Mental Health Commission was represented in the "Mental Health Awareness Group" established by the National Office for Suicide Prevention. The awareness campaign was developed to improve understanding of mental health and well-being in Ireland. This campaign commenced in late 2007 and continued in 2008.

A survey on public attitudes to mental illness, on behalf of the Mental Health Commission and DETECT, was completed in 2008. Findings from the survey will be published in 2009.

Strategic Priority 5

To maintain and enhance the organisation's systems and capacity and to ensure the provision of a quality service for the Mental Health Commission.

CORPORATE SERVICES DIVISION

EXPENDITURE

The non-capital allocation to the Mental Health Commission for 2008 was €21.026m. This figure was revised following discussion with the Department of Health and Children during the year as projected levels of expenditure in a number of areas did not proceed as expected. The provisional outturn for 2008 is €16.6m.

Key areas of expenditure included Mental Health Tribunal's, staff salaries, legal fees, office rental, I.T technical support and development and research projects. The accounts for 2008 will be submitted to the Comptroller and Auditor General as per Section 47 of the Mental Health Act 2001. The annual audited financial statements of the Mental Health Commission are available on the Mental Health website *www.mhcirl.ie*.

AUDIT COMMITTEE

The Mental Health Audit Committee met on four occasions in 2008 to conduct its business. Issues addressed by the Audit Committee included the report on the internal audit review of internal financial controls, review of information technology cost management report, corporate governance framework, review of the Mental Health Commission's procedures for arranging Mental Health Tribunals and expenditure authorisation levels. Recommendations from the above reports were reviewed and incorporated into current procedures.

FREEDOM OF INFORMATION

During 2008 the Mental Health Commission received 13 requests under the Freedom of Information Acts (1997 and 2003). Of these eleven were granted, one was transferred to another agency and one request was refused.

DATA PROTECTION

Two requests for information were received under the Data Protection Act in 2008 both of which were granted.

INFORMATION COMMUNICATION TECHNOLOGY

During 2008 the Mental Health Commission continued to develop its existing ICT systems in order to improve quality of data and increase efficiency in the area of Mental Health Tribunal scheduling. Changes were also introduced that increased security levels and enhanced "ease of use" to the secure on-line services available to Mental Health Tribunal panel members.

In recognition of the need to have contingency plans in place in the event of an untoward event the Mental Health Commission relocated it Disaster Recovery site to a more secure and resilient facility. All systems were successfully tested following this move.

HEALTH AND SAFETY

The Mental Health Commission has reviewed and updated its Health and Safety statement. Meetings are held on a regular basis with staff safety representatives and individuals have been supported in undertaking training in Health and Safety issues including Occupational First Aid training.

GENERAL SUPPORT SERVICES

The Corporate Services Division continue to provide support to the organisation across a wide range of areas not specifically mentioned above including staff recruitment, facilities management, procurement, risk management, corporate governance and compliance with a range of legislation.

MENTAL HEALTH COMMISSION ANNUAL REPORT 2008

INCLUDING THE REPORT OF THE INSPECTOR OF MENTAL HEALTH SERVICES

Book 1

Part 2

CHAPTER 4

NATIONAL REVIEW OF MENTAL HEALTH SERVICES 2008

NATIONAL REVIEW OF MENTAL HEALTH SERVICES 2008

Mental Health Act, 2001, Section 51:

The principal functions of the Inspector shall be:

(b) In each year, after the year in which the commencement of this section falls, to carry out a review of mental health services in the state and to furnish a report in writing to the Commission on

(i) the quality of care and treatment given to persons in receipt of mental health services,

(ii) what he or she has ascertained pursuant to any inspections carried out by him or her of approved centres or other premises where mental health services are being provided,

(iii) the degree and extent of compliance by approved centres with any code of practice prepared by the Commission under section 33(3)(e), and

(iv) such other matters as he or she considers appropriate to report on arising from his or her review.

1. INTRODUCTION

This is the fifth report of the Inspectorate of Mental Health Services as established under the Mental Health Act, 2001. It is an appropriate milestone at which to reflect on what progress has been made and how the mental health services have developed in that time.

Two major effects of the 2001 Act have been the introduction of mental health tribunals for detained patients of approved centres in 2006 and the introduction of regulations and rules relating to seclusion, restraint and electro-convulsive therapy (ECT).

The 2007 inspection was the first conducted against the rules, regulations and codes of practice and the report of that year expressed disappointment with the degree of adherence. While some improvement has been achieved in 2008, the levels of compliance and understanding of the purpose and significance of the regulations, rules and codes of practice are still disappointing.

From the broader perspective of the quality of care and treatment, little has changed, despite the introduction of ***A Vision for Change*** and the reorganisation of the delivery of health services under the Health Service Executive (HSE).

The "lumping" of mental health services into the Primary Community and Continuing Care (PCCC) directorate of the HSE with no separate directorate for mental health, has caused confusion and misunderstanding, muddied mission, and reduced decisional capacity.

As a result, people with serious mental illnesses requiring hospitalisation are in many cases still accommodated in 19th century buildings unfit for purpose.

Despite centralisation, there has been no real progress in equalising resources, financial or staffing, across regions. Comprehensive community-based services are still lacking in most parts of the country.

Apart from some local successes, no meaningful attempt has been made on a national basis to tackle the restrictive work-practices that still operate in some parts of the country, impeding the implementation of new initiatives.

Damning as these indictments are, and damaging as they are to the dignity of those who suffer from mental illness, there may be some tentative causes for optimism.

Difficult to measure perhaps, but detectable nonetheless, is a sense of the beginnings of a cultural shift in terms of increased professionalism, accountability and awareness of the importance of governance. The central importance of service users/patients is increasingly recognised by clinicians. Human rights obligations are increasingly understood. Impatience with Victorian psychiatry may be reaching critical mass.

Further cause for optimism is the continuing high calibre of mental health service staff of all disciplines, particularly in such areas as understanding of, and compassion for, human suffering and a deeply imbedded philosophy of care.

2. INSPECTION

Inspection, especially of those institutions where individuals are held involuntarily, is not a new concept. Its modern origins lie in the response to abuses resulting from the social phenomenon known as "the great confinement" of the 18th and 19th centuries, particularly in Europe and America. It is a fact of life that when individuals, especially vulnerable individuals, are detained, an imbalance of power exists between those detained and those holding the keys. Without rigorous human rights standards and frequent inspections, this is fertile ground for abuse or neglect.

More than detecting abuses and unsafe practices, inspection should also provide constructive feedback to those who deliver services, act as an educational resource, promote cross-fertilisation of progressive and innovative ideas and practices and, overall, act as a catalyst for continuous improvement. In addition, the inspection process should provide through evidence-based reporting a clear picture of the anatomy and functioning of services for service users, their families, the local community and the State, which has a fiduciary duty to ensure a high-quality value-for-money service.

This, then, is the principal audience for this report – people suffering with serious mental illness who use the mental health services, their families, the local community, clinical and administrative staff of the services and government.

2.1 STANDARDS AND QUALITY

According to statutory requirements, all approved centres are inspected against the regulations, rules and codes of practice. In addition, all mental health services inspected (approved centres or otherwise) are assessed regarding the "quality of care and treatment given to persons in receipt of mental health services".

Quality is a complex concept, but at its simplest, can be expressed as a comparison or measured degree of achievement against certain standards, against prior performance, or against others in a similar field.

The Mental Health Commission (MHC) has expressed in operational terms its concept of quality in the ***Quality Framework for Mental Health Services in Ireland*** document.

The Inspectorate team, composed of experienced clinicians of core mental health disciplines as well as a service user, also acts as a practical arbiter of quality.

In an ideal world, quality of care and treatment would be easily measured by straightforward outcomes. Mental health performance outcomes are notoriously difficult to pin down, especially when compared to such conditions as diabetes or cystic fibrosis. Very few mental health services internationally are at the point where outcomes can be the only measure of quality. By a process of triangulation, proxies such as unmet needs, inputs and process, are used instead. In addition, for individual conditions, evidence-based and consensus good practice guidelines are in existence against which current practice can be audited. Service user/patient and family questionnaires and feedback may also indicate quality. Technical compliance with statutory requirements, while important, should be regarded as no more than a basic first step.

On a more conceptual level, less measurable, but equally important are the "virtues" and the values espoused by individual clinicians and their leaders. Gawande, in his book ***Better*** has described three basis aspects of quality – 1)

conscientiousness, 2) a sense of "doing the right thing" and 3) ingenuity (as it applies to the individual patients who may have unique solutions to their individual unique problems).

The importance in the delivery of quality service of the integrity, character and commitment of individual clinicians cannot be overstated.

3. METHOD OF INSPECTION

Drawing from the above standards and concepts, the first aim of inspection of approved centres and other mental health services is to confirm that the human rights of patients are respected with no occurrence of abuse or neglect.

Two-thirds of approved centres are visited by appointment and will have been advised in advance to prepare for inspection all policies and documentation relating to regulations, rules and codes of practice.

In keeping with best international practice, one-third of inspections are unannounced. Centres may be chosen for unannounced inspections on a random basis, or where possible concerns exist.

A meeting is usually held at the outset with the members of the management team. Wards and treatment areas are visited, staff are interviewed and medical records are inspected. Service users are informed of the presence of the inspection team and are invited to discuss any issues. At the end of the inspection, a feedback meeting is held outlining positive developments, areas of compliance and of breach. A draft report is sent to the local management for factual correction. Final reports are presented to the Commission and sent to the local management. Reports are now published as soon as possible on the MHC website.

The management team of each catchment area is interviewed, usually at a separate meeting. Also invited are advocacy representatives and representatives of all disciplines. The focus throughout is directed on business plans, good practice, service developments, governance and attitude towards quality improvement.

4. MENTAL HEALTH SERVICES

Under the Mental Health Act, 2001,

"mental health services means services which provide care and treatment to persons suffering from mental illness or a mental disorder and under the clinical direction of a Consultant Psychiatrist."

On the basis of this definition, the distinction must be made between specialist psychiatric care or treatment for serious mental illness that would properly be within the remit of a consultant psychiatrist-led team and those vastly more numerous, less serious mental health conditions more properly treated in primary care.

Examples of serious mental illness are schizophrenia (characterised by severe impairments in thinking, feeling and perception and often associated with negative symptoms such as apathy and lack of motivation); bipolar disorder (alternating intense episodes of elation and depression and often associated with loss of contact with reality, impulsive behaviour and poor judgement); severe depression (which may be associated with lack of interest in food or normal activities, psychosis or suicidal intent); and severe personality disorder (characterised by severely maladaptive, long-standing patterns of behaviour, emotional instability, and frequent self-harm).

These types of conditions, especially in the acute phase, may require, in a medical environment, careful monitoring, care and treatment to minimise the risks of danger to self or others.

The consultant psychiatrist – a medical specialist usually with ten years of postgraduate training, at least five of which have been in psychiatry – has clinical and legal responsibility for the care and treatment of individual patients and

is the leader of a multidisciplinary team focusing on the biological, psychological and social needs of the patient. Multidisciplinary team members include nurses, clinical psychologists, social workers and occupational therapists in particular, as well as dieticians and speech and language therapists, who are all highly trained in dealing with the specialised needs of those with serious mental illness. As the acute phase of an illness subsides, psychosocial needs become more prominent to effect rehabilitation, recovery and successful reintegration into the community.

Specialist mental health services, with resources assigned for that purpose, should, therefore, be careful not to medicalise "problems of living". These should rightfully be the province of counselling or psychotherapy agencies in the community often associated with primary care teams.

5. COMMUNITY MENTAL HEALTH SERVICES

It is now regarded as international best practice that specialist mental health services be provided primarily in a community setting. Many forms and combinations of community treatment may be used. The most basic form is the "generic" multidisciplinary community mental health team located in a mental health centre that is convenient to service-users and their families. The community mental health centre or "headquarters" may also accommodate a day-hospital, an assertive community treatment (ACT) team (also called home care, or assertive outreach teams), a crisis team, a day centre or an outpatient clinic.

Ideally, in this type of arrangement, an individual with serious mental illness can obtain needs-based individual treatment of an acute or ongoing nature, without stigma and without unnecessary recourse to hospitalisation.

Another important feature of community treatment is the close relationship that can develop with local support, vocational and housing agencies. The important role of families in dealing with the burden of serious mental illness in a family member may be acknowledged through frequent home visits of an educational and supportive nature.

Ample evidence is available that this type of treatment is preferred by service users and their families, achieves better control of symptoms, gives rise to fewer episodes of relapse and traumatic hospitalisation and, overall, better promotes rehabilitation and recovery.

Providing this type of service in the community does not imply that it is equivalent to those mental health services provided in primary care.

An important, but sometimes overlooked, aspect of community treatment is the careful assessment and management of risk of violence to self or others. In making these determinations, adequate consideration must also be given to the rights of mentally ill people with respect to autonomy and liberty.

6. FINDINGS

6.1 LEADERSHIP

The lack of a separate Mental Health Directorate as recommended in ***A Vision for Change*** is a serious drawback to the implementation of what is Government policy and to the achievement of high quality standards.

Many former health board officials with long experience and excellent track records in mental health service administration have been subsumed into the PCCC Directorate with dilution of expertise and responsibilities.

In such an all-encompassing Directorate, specialist mental health services did not have adequate focus and were regarded as secondary in importance.

We found that, whereas in 2007 Local Health Managers (LHMs) had high rates of attendance at Inspectorate catchment area management meetings, in 2008, attendance rates were lower.

In an era of financial cutbacks, we had concerns that overall community budgets would be balanced by disproportionate cutbacks in specialist mental health services. Moreover, because of the absorption of mental health into the overall community service, confusion abounded as to the proper line of demarcation, if any, between primary and specialist services. We discovered examples of "donations" to the primary care services of staff resources that had been properly assigned to the specialist services. This was over and above what might be considered reasonable and effective liaison involvement.

We heard the notion expressed by some HSE personnel that psychiatry or mental health services were purely of primary care concern.

Without a clear directorate of a national mental health service, the lack of a clear, coherent philosophy and set of values was apparent.

Governance committees of local mental health catchments, in some cases, included disciplines from community care who were expected, without specialist knowledge, to supervise mental health specialists.

Overall, governance was weak and while there were sporadic examples of excellent audits and quality improvement measures, there was little evidence of any systemic or more formal structures or processes.

Since the formation of the HSE and the centralisation of administration, clinicians have reported to us great difficulty in obtaining decisions and receiving substantive information.

Consultant psychiatrists, in some cases, did not provide adequate clinical leadership to multidisciplinary teams in respect of treatment planning and service-user involvement.

6.2 BUILDINGS/PREMISES

The Victorian (and older) asylums comprise 15 of the 63 approved centres inspected (see the table in Appendix 1). Despite valiant efforts by local staff, these buildings are inadequate for the purpose of providing treatment to vulnerable individuals with serious mental illness according to human rights standards (see Appendix 2).

We have recommended to the Mental Health Commission that continuation of registration of these asylums as approved centres should be conditional upon the provision of continuously-updated, project-managed, time-line-specified and action-oriented plans for closure and provision of appropriate alternative accommodation.

Excellent examples of the provision of care in high quality, modern buildings do exist throughout the country, notably the Psychiatric Unit of St. Luke's in Kilkenny. Not all modern buildings, however, were compliant with regulations.

6.3 STAFFING

The concept of a national network of comprehensive, community-based, multidisciplinary mental health teams is still far from realisation. Community teams often exist at the most basic level with insufficient approved posts. Even those with provision for psychologists, social workers and occupational therapists are riddled with vacancies due to inability to recruit.

Nursing staff were still disproportionately located in hospital settings (see individual catchment report tables in Chapter 5). In some areas, we noted strong local industrial relations resistance to the rationalisation of wards in the old buildings and, in others, resistance to the replacement of hospital-based services by community services. Many nurses working in old institutions were approaching retirement and, understandably, were less receptive to work-practice changes.

Recruitment of nurses, even when finances allowed, was difficult. Many nurses were reluctant to work in the big city centres because of cost-of-living issues. The looming crisis in nurse staffing must be met by increased flexibility and creativity. Some catchment areas have made the leap to employing treatment aides or nurses' assistants, but others still resisted this change with great ferocity.

For any programme of communitisation of the mental health services to succeed, it is necessary that a Mental Health Directorate engage the representative organisations and solve these problems.

Despite pockets of hopelessness and despair, we found many examples of enthusiasm, innovation and high morale among all disciplines.

6.4 REGULATIONS AND RULES

When viewed as a whole, compliance with the regulations was disappointing. The main areas of poor compliance related to buildings/premises, staffing and individual care plans.

The operation of the rules relating to seclusion and physical restraint still had deficiencies, while the implementation of the rules concerning ECT were generally more satisfactory.

We attempted to analyse why so little improvement was evident in what was the second year of the new rules and regulations regime.

We concluded that, similar to national attitudes in previous years to drink-driving legislation, a cultural shift had not yet taken place among the clinicians. Consultants, in particular, had a tendency to view the documentary requirements as "mere technicalities" in many cases. Some consultants failed to understand the legal nature of the requirements, while others were unaware of the basis of these requirements in the State's human rights commitments. A number failed to view the matter from the perspective of the service users, who have a right to involvement in their treatment and to an integrated treatment plan. In many cases, it was a matter of "we've always done it this way".

Many of these factors could be summarised under the general heading "resistance to change". Change at this cultural, attitudinal, "softer" level is notoriously challenging and requires a strenuous commitment by management and leaders of representative bodies.

Somewhat paradoxically and ironically, in some of those services that have made a strong commitment towards community treatment, multidisciplinary teams based in the community have found it logistically difficult to assemble weekly for treatment planning at the acute centre. The Cluain Mhuire Service in Dublin has attempted to overcome this difficulty, and that of the administrative work in relation to the mental health tribunals, by locating a number of consultants primarily in the hospital.

6.5 INCONSISTENCIES OF MISSION AND SERVICE DELIVERY

We detected several inconsistencies in terms of treatment and the patient group served throughout the country. We saw inconsistencies among services regarding the severity of illness that should be treated at a specialist level. Many individuals with relatively minor or resolved illness continued to attend outpatient clinics or for ongoing psychotherapy.

Attitudes towards hospitalisation and tolerance of risk also varied notwithstanding variations in the availability of community services.

The management of alcohol-related problems was also inconsistent. Some consultant psychiatrists saw it as the function of the Mental Health Service to provide detoxification whereas best practice would indicate this should be carried out either in general hospitals or in primary care. Despite absence of an evidence base that residential alcohol treatment is more successful than outpatient programmes, many centres continued the resource-sapping practice of hospitalisation. Some areas had dedicated alcohol treatment programmes separate from the mental health service and others did not.

Management of personality disorders showed wide variation with some consultants preferring long hospitalisation and others community treatment. There was a dearth of – but also some good examples of – more progressive community-based psychotherapies for the long-term treatment of personality disorder.

A small number of catchments have embraced the concept of assertive community treatment and, with creative staffing arrangements, have succeeded in improving the treatment of individuals with serious illnesses without excessive recourse to hospital.

Some services had specialised rehabilitation teams, while others expected the psychiatry of later life team (when it existed) to automatically take over the care of the long-term hospitalised patients.

Allied to these inconsistencies was the uneven distribution of resources throughout the country. Territoriality or "wearing the county jersey" appeared to take precedence over genuine needs in terms of acquisition of resources, funding and staffing. We found examples of several inequitable discrepancies whose origins lay in the current or former existence of an asylum in the locality with associated staffing resources.

We noted wide variations in the use of ECT as well as the use of seclusion and restraint and prescribing patterns. Variations appeared to be more a feature of local custom and preference than of evidence-based practice.

6.6 SERVICE USER INVOLVEMENT/ADVOCACY

All of the catchment areas except Sligo/Leitrim had an advocacy service. The local advocates were involved in all of our catchment area management meetings and by and large appeared to have a good relationship with the local management. Their work appeared to be mostly in the acute rather than the long-stay units. From our conversations with individual service users on inspections and from reports of the advocates, a number of themes consistently emerged. Service users felt there was undue emphasis on medication while in hospital. Hospital was found to be "boring" with little interesting activities, particularly in the evenings and at weekends. Service users in general felt they were well treated and that staff were respectful and professional.

Apart from isolated examples, there was little movement in service user involvement in local management committees.

6.7 QUALITY INITIATIVES/INNOVATIONS/RESEARCH

We came across many examples of local staff through local funding providing a range of services for the benefit and comfort of patients. These included the provision of garden furniture, sensory gardens and exercise equipment. Some staff bought presents for impoverished patients around Christmas. One staff member self-funded new unit furniture. Other staff continued to provide home visits despite curtailment of travelling expenses.

There was a definite increase in the number of audits undertaken and the number of service user and family questionnaires completed.

The Wisdom IT Project is under way in Donegal. This is a joint project between HSE and Health Research Board (HRB) to record mental health activity in both community and in-patient settings in response to recommendations in ***A Vision for Change***.

A number of centres now have intensive treatment areas for the more acutely ill providing higher staffing, more space and a more focussed approach.

Many areas were involved in research and publication most notably in the larger centres in association with local universities. We were particularly impressed with the DETECT Programme for the early detection and treatment of psychosis. We noted a lack of research of Mental Health Services and we encourage developments in this area.

We were encouraged to note the development of increased contact and cooperation between clinicians, service users and carers. We were most impressed by the West Cork Mental Health Cooperative Leadership Group.

6.8 RESOURCES

In an era of economic gloom, additional resources will probably not be forthcoming. Allocation of existing resources to mental health services should be transparent, should not be diverted, should provide value for money, and should prioritise the protection of the most vulnerable service users.

What we have seen recently with respect to financial cutbacks is the tendency to reduce staffing in community programmes to maintain acute in-patient programmes. This short-term type of solution will cause further problems in the future.

The effects of cutting resources to mental health services are often only apparent on a gradual basis after a number of years. This factor may make mental health cutbacks a soft target for administrators, but the detrimental effect on vulnerable people is no less devastating in the longer run.

Financial cutbacks, however, do offer an opportunity for clearer and more coherent thinking with respect to what services should be provided, and to whom, and might focus minds on the inconsistencies of mission and service delivery already mentioned above. Cutbacks also provide an opportunity to weed out inefficiencies and unproductive activities and may force the redeployment of existing staff and resources in more creative ways.

Again, this may be an opportune time to redress the imbalances in resource allocation throughout the country and prevent the poor practice of transferring patients from one catchment area to a neighbouring or more distant catchment because of shortages of beds and resources.

6.9 SUB-SPECIALITY SERVICES

While the development of sub-specialities is a natural development in terms of advancement of knowledge in specific areas and can provide benefit to those falling into these categories, there is also a danger which lies in the fragmentation of service and in "turf wars".

6.9.1 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

This sub-speciality has recently been charged with the responsibility of providing services to those up to the age of 18. Manifestly, the services were unable to fulfil this obligation. Over 200 children have been admitted to approved centres for adults in 2008. This practice is in-excusable, counter-therapeutic and almost purely custodial in that clinical supervision is provided by teams unqualified in child and adolescent psychiatry.

While plans are in place for new beds, the delivery is slow. In providing more child and adolescent beds, care must be taken that the services do not become imbalanced in favour of in-patient treatment.

Community facilities in terms of day hospitals and outpatient clinics are inadequate and waiting for an appointment can take longer than a year.

There is an urgent need to recruit adequately staffed, community-based child psychiatry teams. These teams should devise new and appropriate methods of screening new referrals and set a target for new appointments to be seen within a reasonable time (less than three months).

6.9.2 PSYCHIATRY OF LATER LIFE

We are grateful for tables showing clinical activities supplied by the Irish Association of Consultants in Psychiatry of Old Age (Appendix 3) in which is demonstrated increasing clinical load which is expected to increase even further as the population ages. Psychiatry of later life specialises in the treatment of the behavioural and psychiatric symptoms associated with dementia as well as new onset psychiatric illness after the age of 65. If recognised early, these types of conditions can be treated satisfactorily in the community. However, when hospitalisation is required, these patients require specialised units with staff specifically trained in dealing with old age problems. The practice, observed in many

general and adult acute psychiatric units, of frail, elderly and demented individuals mingling in busy common rooms with psychotic, irritable, younger patients is, frankly, dangerous and should be discontinued. Purpose-built units for psychiatry of later life should be made available across the country.

It is preferable that the older-aged individuals suffering from long-term psychiatric illness should be cared for in an assertive manner by appropriate rehabilitation teams. These individuals should not, by default, be placed under the care of the psychiatry of later life services.

6.9.3 INTELLECTUAL DISABILITY

Although having an intellectual disability does not, per se, require mental health treatment, intellectually disabled people do suffer a higher frequency of mental illness than the average population and occasionally severe behavioural disturbance. Generic residential care for the intellectually disabled is not a mental health service, though consultant psychiatrists may be involved on a consulting basis.

Unfortunately, many intellectually disabled people with challenging behaviour have been placed inappropriately in psychiatric hospitals designed for the general adult population without adequate provision of consultant psychiatrist-led specialist teams in intellectual disability. With adequate provision of these teams, it is likely that these challenging behaviours could be ameliorated to the extent that the individuals could be placed in more appropriate accommodation in the community and could lead more fulfilled lives.

6.9.4 REHABILITATION PSYCHIATRY

There has been some increase in the number of rehabilitation teams throughout the country, but the numbers are still far from adequate and the teams themselves are inadequately staffed.

Rehabilitation teams treat those individuals with the most serious, treatment-challenging illnesses (usually long-term) and with the most pronounced social and personal deficits. They have often been in institutions for many years and may have developed the institutionalisation syndrome.

As the most seriously ill group, these individuals should have the most intensive treatment but instead many are left to live out cold, empty, colourless lives in old institutions, forgotten and neglected.

Each member of this group should have an individual needs assessment and an aggressive treatment plan focusing on state-of-the-art medications or medication combinations, innovative psychosocial modalities, adequate placement and support, and the hope of recovery to a more fulfilled life.

Too often, we have witnessed rehabilitation teams responsible for the "neo-warehousing" of these individuals in smaller institutions, community-based, but called hostels. Often, little in the way of gainful, productive day-time activities are provided.

More positively, some areas have developed productive linkages with local housing agencies, both municipal and voluntary.

6.9.5 FORENSIC PSYCHIATRY

The mainstay of Irish forensic psychiatry is the service provided by the Central Mental Hospital, both at its Dundrum location and at clinics in the prisons in and around Dublin.

We are happy to report that great strides have been made in the improvement of the facilities at the Central Mental Hospital in terms of security-appropriate pathways of care and treatment planning. A consultant-led team also operates an innovative in-reach and diversion service at Cloverhill Prison.

The facilities at the Central Mental Hospital are recognised by all as inadequate and the provision for a new purpose-built forensic hospital is supported.

The lack of sufficient beds (partially caused by the difficulty in safely discharging long-stay patients) has, over 2008, caused a waiting list averaging 10 patients to develop at the prisons.

In addition, on a regional basis, many services with patients at serious risk of violence are forced to accommodate these patients, often with special nursing, without suitable forensic rehabilitation facilities and with no real prospect of early discharge.

The provision of an extra 10 beds at the end of 2008 is welcomed but unfortunately these will be located in a formerly vacated section of the old building.

There is an urgent need for the provision of regional Special Care Units as envisaged in ***A Vision for Change***.

Considerable frustration has also been expressed in the delay in obtaining Forensic Risk Assessments and, frequently, at the nature of recommendations that are impossible to implement in the current structure.

Several consultants have commented that the Forensic Risk Assessments appear to be overly cautious and, therefore, of limited practical value and have suggested that these assessments would be better provided by forensic experts based in, and with knowledge of, the local community.

Cork and Limerick are the only areas of the country with special provision for community forensic teams. More teams are required now and especially when the Special Care Units are developed. In order to provide a service responsive to local catchment needs, these units might better be managed locally and should obviously liaise closely with, but not necessarily be part of, the Central Forensic Service. This is an issue which will merit further debate.

6.9.6 ADDICTION PSYCHIATRY

Substance abuse or dependence can give rise to certain behaviours mimicking those of mental illness and, in addition, can be a cause of mental illness. Moreover, the use of substances can exacerbate existing mental illnesses and make rehabilitation more difficult. There is a strong need for mental health professionals to become and remain well versed in the problems associated with substance dependence and identify and refer to the addiction services those patients where this is the primary problem.

We have not had the opportunity in the past to inspect in detail these services, but look forward to doing so in the future.

6.9.7 LIAISON PSYCHIATRY

Individuals with mental illness are known to suffer physical ill-health at a higher rate than average and while in hospital for physical problems may require psychiatric assessment by the liaison psychiatry team. This service also deals with those psychological problems associated with physical conditions.

Another important aspect is dealing with psychiatric emergencies presenting to Accident and Emergency (A&E) departments. This can be very stressful and occasionally dangerous work that may be exacerbated by unavailability of beds.

An important issue when beds are unavailable is the safe and efficient transfer of patients to another hospital. Because of recent problems in this regard, this is an area which will merit inspection in the coming year.

6.9.8 PRIVATE SECTOR

Although technically not a sub-speciality of mental health services, the nature of the service provided in the private sector is, indeed, different to that in the public sector. The private sector accounting for 19% of all admissions in the State (Daly A, Walsh D, and Moran R (2007) HRB Statistics Series 5, ***Activities of Irish Psychiatric Units and Hospitals 2007***. Dublin: Health Research Board) is an important component of the national Mental Health Service.

On the one hand are those privately approved centres for the elderly with dementia and on the other hand, two major general psychiatry private hospitals, St. John of God Hospital and St. Patrick's Hospital in Dublin.

The building, staff, governance, systems of care and compliance with regulations and rules and codes of practice were of a high standard at St. John of God Hospital and St. Patrick's Hospital.

Particularly noteworthy, in respect of St. John of God Hospital and St. Patrick's Hospital, is the high number of admissions for alcohol and substance disorders.

While the two hospitals treat many patients with severe acute episodes of illness, there is, as yet, an absence of vigorous multidisciplinary follow-up on discharge to the community. It is noted that St. Patrick's Hospital has opened a number of regional community clinics where, hopefully, this type of work can be conducted.

Two family-owned approved centres catering for the elderly, Highfield and Hampstead Hospitals achieved 100% compliance with regulations and rules.

One of the advantages of the private sector is the tight, local governance and the ability to take prompt, decisive action with respect to innovation and progressive initiatives. In this regard, St. John of God Hospital operates an excellent child and adolescent service (Ginesa) and also provides in-patient services to the local HSE Cluain Mhuire Service. St. John of God Hospital and St. Patrick's Hospital provide secure care and ECT facilities to a number of HSE catchment areas. St. Patrick's Hospital has developed expertise in the treatment of eating disorders and also has plans to open a child and adolescent unit.

This development of liaison between the public and the private sector should be cautiously encouraged where obvious advantages of scale and expertise are evident. The temptation to off-load difficult cases will need to be resisted and precautions should be taken that services do not become fragmented and that proper clinical and financial governance is exercised by the public sector.

6.9.9 VOLUNTARY AGENCIES

Growth in this area continues satisfactorily with ever-improving linkages with formal services. Many service users derive excellent support and empowerment from involvement with such organisations as Schizophrenia Ireland (now SHINE), AWARE, GROW and local mental health associations.

These bodies drive the concepts of recovery and autonomy and should be further encouraged to continue and enhance their important work.

6.9.10 PSYCHOTHERAPY

The effectiveness of talking therapies has long been recognised in the mental health community for such conditions as depression, anxiety and more recently, psychosis. Until recent years, training for psychiatrists and other multidisciplinary team members in such therapies has been haphazard and under-developed. This is changing now with renewed emphasis on trainees acquiring basic psychotherapeutic skills arising out of the increasing evidence base for the effectiveness of such therapies as Cognitive Behaviour Therapy (CBT), Interpersonal Therapy and Family Therapy.

Among the multidisciplinary team members, clinical psychologists are expected to be especially skilled and knowledgeable in this area and as well as providing specialised psychological interventions, should provide a learning and supervisory resource for other team members.

Apart from the shortage of clinical psychologists employed in the health services, it appears to be the case in many services that the knowledge and skills of this group are under-utilised, particularly in respect to the treatment of individuals with serious personality disorder.

New psychotherapies such as Dialectical Behaviour Therapy (DBT) and Mentalisation-Based Treatment (MBT) (Linehan, M.M. & Dimeff, L (2001) ***Dialectical Behavior Therapy in a Nutshell***) (Bateman, A & P, Fonagy, (2004) ***Psychotherapy for Borderline Personality Disorder; Mentalisation based treatment***), conducted on a community basis with combinations of group and individual sessions have been shown to be effective in terms of reduction of symptoms, attendances at A&E, hospitalisations, and reduction in self-harm. Psychologists should be at the forefront of the provision of these services in community mental health centres.

7. CONCLUSIONS

7.1 We should aspire to a national specialist mental health service which

7.1.1 espouses and practises the values of caring, autonomy, individual respect, patient-centredness and commitment to high quality;

7.1.2 is led and motivated by a Mental Health Directorate which shares and professes these values;

7.1.3 is provided by clinicians who are highly trained and embody these values;

7.1.4 provides well-governed, high-quality systems of care;

7.1.5 adheres to all statutory requirements;

7.1.6 is primarily based in the community, but where hospital care is necessary;

7.1.7 is provided in premises of high standard.

7.2 Based on the 2008 inspection, we are some considerable distance from meeting these aspirations.

7.3 Even the most basic statutory requirements are not met on a consistent or universal basis.

7.4 A lack of identifiable national mental health leadership and accountability is frustrating the good-will and efforts of local management and clinicians to improve services.

7.5 Poor governance at national and local level causes service users to receive lower quality services than the resources employed should otherwise allow.

7.6 Many old buildings are unfit for purpose, facilitate the continuation of custodial practices and should be closed soon.

7.7 Restrictive work practices and over-emphasis on hospitalisation are still prevalent in several services across the country.

7.8 Inconsistency and unclear thinking abound regarding what services to provide, and to whom.

7.9 Community-based mental health services with sufficient staffing and appropriate skill mix are woefully inadequate in many parts of the country.

7.10 The inappropriateness and counter-therapeutic nature of admission of children to adult psychiatric units continues.

7.11 A cultural change is needed towards a value-driven service where behaviours are aligned with professed values.

7.12 This can only happen with a strong, accountable, central, national leadership driving these values.

7.13 A cultural change is also needed at the level of individual clinical disciplines. In conjunction with their respective representative bodies, disciplines should return to first principles, re-examine professional ethics and reaffirm guiding values.

7.14 The representative bodies of these disciplines, in conjunction with the HSE and private-sector employers, need to jointly engage in a continuous re-education programme with respect to leadership, teamwork, ethical principles, quality principles and compliance with statutory requirements.

7.15 The basic decency of mental health staff at an individual level and the tradition of care and compassion for the less fortunate are not in question.

7.16 The basic unit of any mental health service is the individual interaction between a person with a problem and another person professing the ability and training to alleviate that problem. The quality of that professional on an individual basis is, therefore, of paramount importance. We are fortunate that the quality of those professionals working in the Irish mental health services is of a high standard.

7.17 To achieve a national mental health service of international standard, we need a leader of proven ability who can intelligently harness the quality of individuals by effective education, motivation and leadership.

The major task of completion of the 2008 Inspection was only achieved by the dedication and commitment of all members of the Inspectorate team, inspecting and administrative, whose contribution is greatly appreciated.

Particular thanks are due to Dr. Susan Finnerty, Acting Inspector of Mental Health Services until May 2008, and to Colette Ryan, Senior Administrator of the Inspectorate.

Dr. Patrick Devitt
Inspector of Mental Health Services

APPENDICES

APPENDIX 1: THE PROVISION OF MENTAL HEALTH CARE IN LARGE PSYCHIATRIC HOSPITALS

There are 19 large psychiatric hospitals in Ireland, all providing long-term care, with ten also providing acute care. Eight of the hospitals date back to the 19th century. Since the early 1980s, it has been national policy to close large psychiatric hospitals and to provide care in the community and deliver acute in-patient care when needed in modern units in general hospitals.

OVERALL BED NUMBERS

Note: All the data used in the tables in this appendix was verified by the Local Health Managers.

HSE SOUTH

Total bed numbers reported in large psychiatric hospitals on 31 December 2008

	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Finan's, Killarney	0	60
St. Senan's, Wexford	31	88
St. Stephen's, Cork	35	90
St. Otteran's, Waterford	0	94
St. Dympna's, Carlow	0	53
St. Canice's, Kilkenny	0	54
St. Luke's, Clonmel	0	106
Total	**66**	**545**

HSE WEST

Total bed numbers reported in large psychiatric hospitals on 31 December 2008

	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Bridget's, Ballinasloe	41	65
St. Conal's, Donegal	0	27
St. Joseph's, Limerick	0	77
Total	**41**	**169**

HSE DUBLIN NORTH EAST

Total bed numbers reported in large psychiatric hospitals on 31 December 2008

	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Brendan's, Dublin	30	54
St. Ita's, Portrane	48	85
St. Davnet's, Monaghan	10	26
St. Bridget's, Ardee	30	24
St. Vincent's, Fairview	45	42
Total	**163**	**231**

HSE DUBLIN MID LEINSTER

Total bed numbers reported in large psychiatric hospitals on 31 December 2008

	Total Acute Bed Numbers 2008	Total Long-stay bed numbers 2008
St. Loman's, Palmerstown (rehabiltation beds only)	0	22
St. Loman's, Mullingar	44	75
St. Fintan's, Portlaoise	0	27
Newcastle Hospital, Wicklow	27	27
Total	**71**	**151**

CLOSURE PLANS

During 2008 the Inspectorate requested copies of closure plans for all the large psychiatric hospitals. There was variation between services as to how they were presented, some included plans in the Regional Level 2 HSE Business plan, others had local five-year plans and a number had yearly objectives set.

All services reported that the plans were dependent on additional funding. None of the plans had timelines with financial resources attached. It was disappointing to note that a number of hospitals continued to admit residents to institutional care and that some rehabilitation services were based in institutional settings.

LONG-TERM CARE

In 2008, the total number of beds available nationally in long-stay wards was 1,096. The highest number of operational long-stay beds (545) was in the HSE South region. They were provided across five hospitals. The bed numbers per hospital ranged from 115 to 60.

The lowest number of operational long-stay beds (151) was in the HSE Dublin Mid Leinster region. In some hospitals, the number of beds exceeded the number of residents and the beds remained available for admissions.

Total number of long-stay beds by HSE area in psychiatric hospitals on 31 December 2008 (intellectual disability and forensic not included)

HSE Area	Total Long-stay beds available by region
South	545
Dublin North East	231
West	169
Dublin Mid Leinster	151
Total	**1,096**

Number of long-stay beds in large psychiatric hospitals on 31 December 2008 (intellectual disability and forensic not included)

Approved Centre	HSE Area	Ranking	Long-stay bed numbers 2008
St. Luke's, Clonmel	South	1	106
St. Otteran's, Waterford	South	2	94
St. Stephen's, Cork	South	3	90
St. Senan's, Wexford	South	4	88
St. Ita's, Portrane	Dublin North East	5	85
St. Joseph's, Limerick	West	6	77
St. Loman's, Mullingar	Dublin Mid Leinster	7	75
St. Bridget's, Ballinasloe	West	8	65
St. Fintan's, Killarney	South	9	60
St. Brendan's, Dublin	Dublin North East	10	54

ACUTE CARE

Acute care continued to be provided in ten large psychiatric hospitals across the country. Dublin North East had the largest number of acute beds (163) in such hospitals. At the time of reporting, plans were at an early stage to address this problem in St. Ita's Hospital and at St. Vincent's Hospital in Fairview. It was reported that any move to sites at Beaumont Hospital and the Mater Hospital was years away. St. Brendan's Hospital continued to accept acute admissions despite the availability of a new unit at Connolly Hospital. There were also 12 low secure acute beds based in the hospital. The future location of acute care in the Cavan, Monaghan, Louth and Meath remained undecided. The co-location of acute care and continuing care in large psychiatric hospitals was resulting in the practice of moving people between wards when there were bed pressures and, without adequate planning, into long-term care.

Total Number of acute beds by HSE area in large psychiatric hospitals on 31 December 2008 (intellectual disability and forensic not included)

HSE Area	Total number of Acute Beds in large psychiatric hospitals	Approved centres providing acute care in large psychiatric hospitals
South	66	2
West	41	1
Dublin North East	163	5
Dublin Mid Leinster	71	2
Total	**341**	**10**

Number of acute beds in large psychiatric hospitals on 31 December 2008 (intellectual disability and forensic not included)

Approved Centre	HSE Area	Ranking	Number of acute beds
St. Ita's, Portrane	Dublin North East	1	48
St. Vincent's, Fairview	Dublin North East	2	45
St. Loman's, Mullingar	Dublin Mid Leinster	3	44
St. Bridget's, Ballinasloe	West	4	41
St. Stephen's, Cork	South	5	35
St. Senan's, Wexford	South	6	31
St. Bridget's, Ardee	Dublin North East	7	30
St. Brendan's, Dublin	Dublin North East	7	30
Newcastle, Wicklow	Dublin Mid Leinster	9	27
St. Davnet's, Monaghan	Dublin North East	10	10

INTELLECTUAL DISABILITY SERVICES

The number of people with an intellectual disability living in large psychiatric hospitals fell year on year. There is still some way to go nationally until all people are appropriately placed and under the care of a specialist team. Each year this has been an objective on the National Service Plan of the HSE – Disability Section. St. Senan's Hospital, Wexford closed one such ward in 2008 and relocated people to a new purpose-built unit in a nearby local community. St. Joseph's Hospital, Portrane, is a dedicated hospital for the care and treatment of people with an intellectual disability. In 2008 a new purpose-built streetscape development of ten bungalows was built. This was to close four traditional wards in the old building and a group home on campus. The new bungalows were expected to open in 2009. A new unit in Carlow was also to open in 2009. The Inspectorate had particular concerns regarding the provision of care and treatment to those residents with an intellectual disability living in St. Luke's Hospital, Clonmel, in 2008. These concerns were reported to the Mental Health Commission.

Residents with an intellectual disability per large psychiatric hospital, according to approved centre reports 2008

Name	HSE Area	Residents with an ID 2008	Access to ID Team
St. Joseph's, Portrane	Dublin North East	172	Yes
St. Otteran's, Waterford	South	Not Stated	No
St. Luke's, Clonmel	South	19	No
St. Senan's, Wexford	South	13	No
St. Fintan's, Killarney	South	Not Stated	No
St. Dympna's, Carlow	South	15	No
St. Bridget's, Ballinasloe	West	Not Stated	No
St. Joseph's, Limerick	West	14	No

SPECIALIST IN-PATIENT SERVICES

The closure of large psychiatric hospitals and a move from institutional care to care in more appropriate settings requires a plan for long-term care and specialist services at a regional level. In this area the need is low but the costs are high, as the care and treatment required is intensive. Reallocation of funding must be planned so that community services are in place before institution-based care is phased out. They may need to be registered as approved centres under the Mental Health Act 2001 to ensure residents' rights are protected and that they are subject to independent inspection.

From the Inspectorate's data it can be seen that a number of hospitals have low numbers of residents who require ongoing care and treatment but for whom alternative care settings are not appropriate. The main area is elderly people receiving care and treatment for disturbed behaviour in association with dementia. Nationally there is also an unmet need for low secure forensic units. A number of residents who require specialised low secure forensic services and a number of elderly patients are inappropriately placed in acute units.

CONCLUSION

The number of beds provided in large psychiatric hospitals has fallen in the last five years. The closure plans for the remaining 1,096 beds are piecemeal. Some services have retained beds although the numbers of residents have fallen. There is a lack of planning for specialist services to operate in tandem with the planning for the closure of large hospitals. It is disappointing to note that there are 341 beds available for acute care in ten institutional settings, some 24 years after ***Planning for the Future*** was published and adopted as policy. The Inspectorate is pleased to note that the number of people with an intellectual disability living in large psychiatric hospitals continues to fall. However the lack of access to appropriate specialised teams is of concern. The Inspectorate will continue to monitor the situation in 2009.

APPENDIX 2: HUMAN RIGHTS

Governments are obliged by the prevailing international human rights framework and, in Europe, the regional framework to respect, protect and fulfil the human rights of all citizens including those with mental disabilities.

The core international human rights instruments within the United Nations system are the Universal Declaration of Human Rights 1948, the International Covenant on Economic, Social and Cultural Rights 1966, and the International Covenant on Civil and Political Rights 1966. Together they are known as the International Bill of Rights and Ireland has signed and ratified all of them.

In Europe, there are the European Convention for the Protection of Human Rights and Fundamental Freedoms, also known as the European Convention on Human Rights or ECHR, and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The Government has incorporated the rights in these European conventions into domestic legislation.

The UN has developed a number of standards to assist countries and guide them in interpreting the international conventions. Perhaps the most detailed and most widely endorsed internationally are the Principles for the Protection of Persons with Mental Illness, also known as the MI Principles. They were developed in 1991. These are 22 principles that establish the minimum benchmark for human rights standards in mental health practice. These include the right to life in the community, right to treatment, right to medication, right to appropriate conditions in mental health facilities, right to procedural safeguards during involuntary admission, right to information, and the right to an individualised care plan.

In March 2007, the UN Convention on the Rights of Persons with Disabilities was signed by Ireland. It has not yet been ratified.

Mental health legislation is one important tool in promoting the rights of people with mental disorders and preventing human rights abuses. The Mental Health Act 2001 brought Ireland's mental health legislation in line with the European Convention on Human Rights. The Act established in law the Mental Health Commission and the Office of the Inspector of Mental Health Services. The Office of the Inspector of Mental Health Services has a broad remit to comment on the quality of care and treatment in mental health services and to establish compliance with any Regulations, Rules and Codes of Practice issued by the Commission to approved centres. They are important instruments in ensuring that services promote and protect the human rights of service users.

APPENDIX 3: PSYCHIATRY OF OLD AGE: RESOURCE AND ACTIVITY DATA 2006 (IRISH ASSOCIATION OF CONSULTANTS IN PSYCHIATRY OF OLD AGE)

I RESOURCE DATA PER SERVICE JAN – DEC 2006

Service	Date Est'd	Pop≥65	Con	NCHD		ACNO	CMHN	Sec	Other [1]	Acute Psych Beds	Day Hosp	L/S Psych Beds
				SR	SHO							
NAHB Area 6&7	1989	32,500	2.5 [2]	1	3	1 (DON)	3	2	1	6	√	40
SWAHB Areas 3& ½ 4	1991	20,228	2	1	2	0.5	2	2	3	9	√	X
ECAHB Area 1&2	1996	33,416	2	1	2	1	6	3	3.4	10	√	67
MWHB Limerick	1996	19,000	1	1	1	0	2	1	3.5	10	√ [3]	21
SWAHB Area 5&½ of 4	1998	15,600	1 [4]	1	1	0.5	2	1	7	Access only	√	X
MHB Laois-Offaly	1999	14,036	1.5 [4]	1	1	1	4.5	2	2	6	√	66
NEHB Cavan-Monaghan	2000	14,289	1	1	1	1	8	2	6	7	√	30
SEHB Waterford	2000	14,000	1	1	1	0.5	2	1	2.75	6	X	23
SEHB S. Tipperary	2000	10,200	1	-	1	1	2	1	1	5	X	22
MWHB Clare	2000	13,500	1	0	1	0.5	2	1	2	5	X	68
SEHB Wexford	2001	15,000	1	-	1	0	2	1	0.5	8	X	14
MHB Lf/Wm	2001	13,000	1	-	2	0.5	4.8	1	1	Access	√	70
SHB South Lee	2001	18,500	1	-	2	0.2	2.5	1	3	Access only	√ [3]	X
NWHB Donegal	2002	17,300	1	-	1	1	5	1.5	2.5	Access only	X	X
NWHB Sligo/ Leitrim	2002	14,600	1	1	1	1	4.25	1.5	2	4	√	X
NAHB Area 8	2002	18,600	2	2	2	1	3	1.5	3	7	X	36
SEHB Kilkenny [(4)]	2002	14,000	1	-	1	-	2	1	1	Access 4-6	-	24
WHB Mayo	2002	17,000	1	-	2	0.5	3	1	3	5	X	25
NEHB Meath	2003	13,000	1	1	1	0	2	1	1	Access 4	X	X
Galway West [(6)]	2004	25,500	1	1	0	0	1	0.5	1	X	X	X

X Resource not provided to the service.

1 Others includes: Occupational therapy, Social work, Psychology, Support workers, Behaviour therapy.

2 3.5 Consultants and 2 NCHDs from July '06.

3 Day Hospital (part-time only)

4 1.5 Consultants from July '06

II ACTIVITY DATA PER SERVICE FOR THE YEAR JAN – DEC 2006

Service	Referrals			Acute Unit/s Admissions	Day Hospital (s)		Long stay Admissions (total)	Respite Admissions	CMHN visits	Other Services
	TOTAL	DV	LV		Admissions	Attendances				
NAHB Areas 6&7	711	517	194	36	97	1841	8	15	3019	-
SWAHB Areas 3&½ 4	870	234	636	56	186	2565	7	17	2659	Mem Cl OPD
ECAHB Area 1&2	779	558	221	70	65	1114		25	3123	
MWHB Limerick	370	252	118	13	19	208	13	122	2396	OPD
SWAHB Area 5&½ of 4	480	202	278	11 [1]	51	1368	X	X	1367	-
MHB Laois-Offaly	335	260	75	35	263	696	5	18	2868	-
NEHB Cavan-Monaghan	441	344	97	25	18	1244	4	-	4876	
SEHB Waterford	389	247	142	41	X	X	10	8	1505	OPD
SEHB S. Tipperary	387	326	61	30	X	X	3	26		OPD
MWHB Clare										
SEHB Wexford	335	306	29	52	X	X	4	-	2398	Anx Mx Gp
MHB Longford/ Westmeath	271	216	55	36	42	1070	1	5	1148[1]	
SHB South Lee	319	190	129	20	10	378	X	X	1135	
NWHB Donegal	637	271	366	41 [2]	X	X	X	X	396	-
NWHB Sligo/ Leitrim	420	237	183	16	52	1085	X	X	2806	OPD
NAHB Area 8	925	341	584	40	X	X	5	37	961	-
SEHB Kilkenny	565	450	115	26	X	X	2	-	1847	
WHB Mayo	298	226	72	11	X	X	5	-	1577	
NEHB Meath	215	152	63	7	X	X	X	X	1042	-
Galway West	111	39	72	X	X	X	X	X	308	_

X Resource not available in the service so service cannot be provided.

1 Figures for 2 of 4.8 CMHNs only available

2 Under General Adult Psychiatrists.

APPENDIX 4: 24-HOUR NURSE-STAFFED COMMUNITY RESIDENCES 2008

In 2008, data on the number of people living in a 24-hour nurse-staffed community residence was collected. Data was also collected from services about the teams responsible for providing care and treatment to each residence and whether residents had a care plan. The majority of the residences opened while hospital wards were being closed over the last twenty years. The purpose at that time was to provide alternative accommodation to institutional care and also to provide active rehabilitation. There are no statutory regulations in place to govern their operation.

The number of 24-hour nurse-staffed residences was 132. Of these, 22 were dedicated to people with an intellectual disability who were in receipt of care from the mental health services and 1,664 places were provided in total. This exceeded the number of beds remaining in long-stay wards of psychiatric hospitals (1,096). The occupancy rate of residential beds was very high.

Places by HSE region

HSE Region	Total Number of 24 -hour nurse-staffed community residences	Total number of places
HSE West	34	445
HSE South	33	428
HSE Dublin North East	24	323
HSE Dublin Mid Leinster	19	254
Intellectual Disability national total	22	214

There was a wide variation across the catchments as to the number of residences; the number of people per residence; who had responsibility for their care; and the type of care plan that was in place. The largest number of residences in any one catchment area was 12, in Carlow/Kilkenny. The North Tipperary catchment had none.

The total number of rehabilitation teams (20) has grown over the last five years but the skill mix on the teams has not developed. Nationally there were 19 whole-time-equivalent (WTE) consultant psychiatrists, 23.5 NCHDs, 14.5 occupational therapists, 10.8 social workers and 3.9 clinical psychologists working in rehabilitation. Numbers of nurses were not counted due to variance in reporting of posts. There is evidence from the staffing numbers that there are gaps in the appointment of health and social care professionals to teams. Often where posts do exist they are split between teams or are part time. As a result, access to rehabilitation services for service users varies across the country. An additional variance is that in some catchments the rehabilitation team is not responsible for the care and treatment provided in the residences. Where general adult teams and rehabilitation teams are involved this is recorded in the tables.

The data is based on information received from each catchment area and includes residences for people with an intellectual disability nationally.

HSE West

Catchment	population	Number residences	Number places	Number with < 9 Places	Average per house	Number residents	Team Responsible
Clare	110,950	4	63	1	15	60	Rehabilitation
Donegal	139,856	4	75	0	18	58	Rehab and/or General Adult
East Galway	110,106	9	73	6	8	72	Rehab and/or General Adult
Limerick	184,055	4	74	0	18	74	Rehabilitation
Mayo	123,648	3	36	1	12	36	Rehab and/or General Adult
North Tipperary	66,023	0	0	0	0	0	n/a
Roscommon	57,185	1	16	0	16	16	General Adult
Sligo/Leitrim	99,875	7	91	3	13	81	Rehab and/or General Adult
West Galway	121,567	2	17	1	8	16	General Adult
Total		**34**	**445**	**12**		**413**	

HSE South

Catchment	population	Number residences	Number places	Number with < 9 Places	Average per house	Number residents	Team Responsible
Carlow/ Kilkenny	120,671	12	115	5	9	100	Rehab and/or General Adult
Kerry	139,835	5	71	0	14	71	General Adult
North Lee	167,536	4	75	0	14	75	General Adult
South Lee	179,133	1	18	0	18	18	General Adult
South Tipperary	83,052	2	27	0	13	27	Rehab and/or General Adult
West Cork	53,445	3	39	0	13	39	General Adult
Waterford	123,844	2	27	0	13	26	Rehabilitation
Wexford	131,749	1	10	0	10	10	Rehabilitation
North Cork	80,795	3	46	0	15	40	Rehabilitation
Total		**33**	**428**	**5**		**406**	

HSE DUBLIN NORTH EAST

Catchment	population	Number residences	Number places	Number with < 9 Places	Average per house	Number residents	Team Responsible
North West Dublin	165,755	10	143	0	14	139	Rehab and/or General Adult
North Dublin	225,145	3	31	0	10	31	Rehabilitation
Louth/ Meath	271,845	6	73	0	12	66	General Adult
Dublin North Central	143,333	2	30	0	15	30	Rehabilitation
Cavan/ Monaghan	118,791	3	46	0	15	41	Rehabilitation
Total		**24**	**323**	**0**		**307**	

HSE DUBLIN MID LEINSTER

Catchment	population	Number residences	Number places	Number with < 9 Places	Average per house	Number residents	Team Responsible
Dublin South East	110,000	3	35	0	11	35	General Adult
Dublin South City	134,969	3	30	0	10	28	General Adult
Dublin West/ South West	256,566	3	43	0	14	43	Rehabilitation
East Wicklow	109,472	2	26	0	13	21	General Adult
South County Dublin	175,000	1	21	0	21	21	General Adult
West Wicklow, Kildare	205,175	2	28	0	14	28	Rehabilitation
Laois/Offaly	137,616	2	31	0	15	31	Rehabilitation
Longford/ Westmeath	116,022	3	40	0	13	38	General Adult
Total		**19**	**254**	**0**		**245**	

Intellectual Disability and Mental Health Services National Returns 2008

Catchment	Number residences	Number places	Number with < 9 Places	Average per house	Number residents	ID Team in place
St. Joseph's Intellectual Disability Service, North Dublin	5	54	4	10	54	Yes
Clare	2	28	0	14	28	No
East Galway	8	48	8	6	47	No
Kerry	2	30	0	15	30	No
Wexford	2	16	1	8	16	No
Carlow/ Kilkenny	3	38	1	13	38	No
Total	**22**	**214**	**14**		**213**	

Many of the current residences were large in size. This is evident from the data. It is not unusual for people to share a house with 10 to 32 other people. Very few residences had less than nine people living in them. A number of residences for people with intellectual disability have been kept deliberately small.

Services were asked to self-report on the type of care planning in place. Again there were differences reported. Some residents had nursing care plans while others had multidisciplinary team (MDT) care plans in place. The quality of the care planning process was not assessed.

A number of services reported that some residents were elderly and required a higher level of general medical and nursing care. The properties were acquired some time ago and are now not life-time adaptable and causing some practical difficulties in providing ongoing care for elderly service users.

One new 24-hour community residence for adults was opened in 2008 in Carlow/Kilkenny. In Wexford, a community residence for people with an intellectual disability was opened in November 2008.

In a small number of catchment areas, services have developed links with county councils and voluntary housing providers to provide alternative housing accommodation. In these cases the tenancy arrangements are managed by the housing authority and the mental health services provide ongoing support to the tenant. This practice is welcomed.

The national policy document *A Vision for Change* states that in the future the majority of service users who require rehabilitation will not require community residential facilities but will need support to live in independent and individualised accommodation. *A Vision for Change* recommended that there should be a requirement for only 30 supervised places per urban area.

CONCLUSION

The growth of 24-hour nurse-staffed community residential placements has been significant. Many were opened with little planning as hospital wards were being closed. There is now a large cohort of people living in these residences in the full-time care of the State. The residents can be divided into two main groups, those in need of continuing care and those who require rehabilitation.

The current direction appears to be to accommodate people in large residences with limited opportunity for community integration. There is evidence that people are sharing bedrooms, sharing living space with a large number of other people and having little opportunity to be actively involved in a meaningful rehabilitation and recovery plan. There

are no statutory regulations in place to monitor such residences, though the ***Quality Framework for Mental Health Services in Ireland*** applies to all mental health services and does set out standards in the delivery of mental health services. Information as to whether it was in use in community residences was not collected.

The information supplied to the Inspectorate indicates that many residents do not have access to a rehabilitation team. Catchment areas offer differing models of service provision. Some have developed specialised services in rehabilitation, while others provide services as part of the general adult team remit. In some cases, a rehabilitation team has been requested but not funded. It was unclear to the Inspectorate why some rehabilitation teams were not responsible for residences in their area. There is no uniform approach to the organisation and delivery of rehabilitation services across the country. This makes it difficult to benchmark the quality of care and treatment being provided.

The future role of 24-hour nurse-staffed community residences in the Irish Mental Health Service needs to be examined further. There is a need for a wider debate on the number of residences required, their purpose, staffing requirements, and what standards are needed to ensure a quality service. The MHC/HRB study Happy Living Here (2007) also questioned many aspects of the role and function of community residences. It identified issues such as "responsibility for the provision of residences, the internal and external environment of the residences, the climate and culture within the residences, and rehabilitation and recovery philosophies of care".

The Inspectorate is planning to inspect and monitor a number of these residences in 2009.

APPENDIX 5: SERVICE USER INVOLVEMENT

SERVICE USER VIEWS

Service users have a unique perspective on mental health services and over the last number of years the views of service users have been incorporated into the inspection process at different levels. At a local level, members of the Inspectorate team met with residents during inspections of approved centres and included their comments in the inspection reports. At an organisational level, service user representatives were invited to attend catchment inspections to provide their perspectives about the quality of mental health services in particular areas.

Quality mental health services should ensure that service users have access to peer support and peer advocacy, as well as ensuring that they are involved at all levels of the mental health service, from the individual care plan to service planning and development. These are essential characteristics of recovery-oriented services. The Inspectorate was interested in the views of service users about the availability of peer support and advocacy, the level of involvement at different levels in the mental health services, and about the overall quality of those services.

AVAILABILITY OF PEER SUPPORT AND ADVOCACY

Most services fostered links with local peer-led initiatives and voluntary groups to provide peer support. Information about local groups was provided by the mental health services and was widely available in approved centres and other mental health facilities.

Mental health services have gone about the task of providing access to independent peer advocates in different ways. Most mental health services were working in partnership with either the Irish Advocacy Network (IAN) or Steer to ensure that service users had access to advocates who were experts by experience in mental health. Peer advocates were routinely visiting most approved centres, though with notable exceptions such as Ballytivnan, Sligo and St. Luke's, Clonmel. In Sligo, the mental health services were not providing access to peer advocacy for any service users, and this stood out in stark contrast to the efforts made by all other services to facilitate peer advocacy. In South Tipperary, the IAN was active in the area but was only funded to provide a service to one of the two approved centres. In Donegal, Steer was providing an advocacy service on request and was planning to expand this to weekly visits to the two approved centres in the area from January 2009. At St Joseph's mental health service for people with intellectual disabilities, a two-year pilot advocacy programme in partnership with Inclusion Ireland had started. A number of service users across the in-patient and community services were involved and ongoing staff education sessions were being held to support staff in the implementation of the programme.

There was a wide variation in the level of peer advocacy involvement across different types of facilities within the mental health service, e.g. day hospitals, day centres, and community mental health centres. In other areas, the IAN representative was actively involved with day hospitals, day centres and in facilitating peer-led groups. For example in North Tipperary, a 20 week course in self-advocacy had been facilitated. In other mental health services, advocacy had just begun and the initial focus was on providing it to approved centres or specific units within the approved centre, e.g. acute units. In these services, there were plans that advocacy would expand over time to be accessible to all mental health service users. However, in other areas, expansion of advocacy had been hindered by lack of resources, e.g. St Luke's Clonmel.

Under the Code of Practice Relating to Admission of Children under the Mental Health Act 2001, adult approved centres that admit children are required to provide access to age-appropriate advocacy. This was a significant gap across all approved centres.

LEVEL OF INVOLVEMENT IN MENTAL HEALTH SERVICES

In order to facilitate service user involvement in mental health services at all levels there is a requirement for capacity building. In this regard it is positive that Dublin South City, Dublin West/South West, Mayo and West Cork have been involved with the ***Cooperative Learning: Service Leadership for Mental Health Service Users, Carers and Service Providers*** course in DCU in order to increase capacity of service users, careers and services to work together.

Elsewhere, a service user representative and carer representative attend the heads of department meeting in Dublin South City. The IAN representative attends the heads of department meetings every month in St Vincent's Hospital, Fairview. In Dublin North West, advocacy is included on the agenda of the management team meetings to ensure ongoing discussion of issues. In Wexford, a service user representative had been invited to join the management team. In Waterford a nominee had been asked to join the executive management team and the implementation group for ***A Vision for Change***. In most catchments, the advocacy representative was part of the local implementation group for ***A Vision for Change***. Advocacy representatives and service managers reported that having regular meetings and having an identified person to liaise with on the ward about local issues worked very well.

Several services had a consumer panel and in Limerick a training programme was being developed to enhance skills related specifically to being a member of a consumer panel. In many services, advocacy representatives were part of audit and policy committees. In North Tipperary, a 20-week course in self-advocacy had been facilitated.

QUALITY OF SERVICES

Many approved centres were running Refocusing Projects and these were viewed positively by service users. The dedicated individual time provided by nurses to each resident was particularly valued. Most service user representatives reported that residents felt there were positive relationships between them and staff on the units. The role of occupational therapy programmes and activation programmes in facilitating services users' recovery was a positive theme. Regular community meetings between residents and service managers were effective in addressing issues quickly. Several services were routinely carrying out satisfaction surveys after discharge in order to inform and improve their service.

Most service user representatives reported that psychological therapies and other alternatives to medication were not available, or where they were available they were not sufficient, and more information about treatment options was needed. Many service users would have liked more time with their consultant psychiatrist and to be included more in decisions about medication.

In most catchments, service users noted they were not part of the management team. They also noted that service users and management generally shared similar concerns about lack of alternative appropriate resources to facilitate early discharge from in-patient units

A lack of leisure and recreational activities, especially at the weekends, was a challenge for service users and services. A number of services had tried to address this by surveying residents and extending opening hours of occupational therapy or activity areas but the take-up had been low. Further investigation is required to establish what the nature of the unmet need is.

APPENDIX 6: MEDICATION PRESCRIPTIONS IN APPROVED CENTRES 2008

INTRODUCTION

The Inspectorate examined 1,556 individual prescriptions from acute and long-stay units in approved centres during 2008. Some 530 prescriptions from 18 acute units were examined. A total of 526 prescriptions of residents in 23 different long-stay units were also examined. The prescriptions were collected at each approved centre on the day of inspection and reflect prescriptions there on that day. The emphasis in this review was on the condition of prescriptions, on the use of benzodiazepines, polypharmacy in the use of antipsychotics, and the percentage of residents on anti-epileptic medication being used as mood stabilisers. Other information was made available about dosages of medication and this will be presented at a later date.

In general, the prescriptions themselves were legible and clear, the name of the drug and dosage regime easily identifiable. However in the majority of prescriptions the signature of the prescriber was illegible, there was no printed version of prescribers' names, and it was unclear whether the consultant or NCHD had written the prescriptions. Some but not all units had a signature bank available.

There was wide variation in the format of prescription sheets. Some were old-fashioned card index systems, while others emulated the acute general hospital prescription format. Others were designed by the service themselves. A significant number did not record the residents' dates of birth and others did not incorporate the name of the hospital or unit. It was particularly noticeable that where a card index system was used there was much crossing out, writing underneath discontinued prescriptions and no separate area for PRN ('when required' or ***pro re nata***) or depot injection medication. The result was that card index prescriptions were often difficult to follow and this had the potential to lead to medication errors.

Generic names and trade names of medication were frequently mixed within the same prescription sheet. In many prescriptions it was impossible to tell when medication had first been prescribed, and therefore no way of telling the length of time a resident had been on a particular medication. This was of particular concern in the use of benzodiazepines, as outlined below.

BENZODIAZEPINES

Benzodiazepines have been used since the 1960s as tranquillizers for anxiety and as sleeping tablets. As such they are divided into sedatives and hypnotics. This review of benzodiazepine prescribing in approved centres looks at both benzodiazepine sedatives and hypnotics. Benzodiazepines can cause dependency that results in difficulties in discontinuing the medication after a certain length of time and it is recommended by all international guidelines that people remain on benzodiazepines only for a short period of time, from between 2 weeks to 4 weeks. They should only used for the treatment of anxiety symptoms and sleep disturbance after alternative therapies have been tried.

The Royal College of Psychiatrists recommends that benzodiazepines be used only if the anxiety is severe, overwhelming and distressing and then only for a short period of time. It is recognised that a small number of people may require benzodiazepines in the long term and this includes people who are already severely dependent on these drugs. Benzodiazepines are also used effectively to control epilepsy in some cases and they may be used as part of rapid tranquillization. Therefore, for the vast number of people, benzodiazepines should be used only for a specific purpose, for the shortest possible length of time, and in the smallest possible dose. Protocols are available for weaning people off benzodiazepines. In this review it was impossible to tell from the prescription sheets when medication had first been prescribed and therefore no way of telling the length of time a resident had been on a particular medication.

Benzodiazepines may be prescribed as a regular dose and/or as a "when required" (PRN) dose. A significant number of people in Irish approved centres are on both regular and PRN medication (Table 1 and 2). In Ireland, 43% of residents in acute units and 37% of residents in long-stay units are on more than one benzodiazepine at the same time.

In this review, the vast majority of PRN medication had no time limit for the prescription and had no review date written into the prescription. Most prescriptions specified how often it could be given during a 24-hour period. The commonest benzodiazepine prescribed was lorazepam, which has a short half-life and therefore is more likely to result in dependency if taken for an extended period of time.

There was wide variation in the different approved centres in the prescription of benzodiazepines. In some units there were very few prescriptions of benzodiazepines. Others had regular prescriptions for benzodiazepines for more than 50% of their in-patients at the time of inspection.

BENZODIAZEPINE PRESCRIPTION

Table 1: Numbers on benzodiazepines (BZD) in acute units

	Number	Percentage
Number of units	18	–
Total number of prescriptions	530	–
Total number of residents on BZD	359	68%
Residents on regular prescriptions of BZD	230	64%
Residents on PRN prescriptions of BZD	226	63%
Residents on both PRN and regular prescription of BZD	104	29%
Residents on more than one BZD	155	43%

Table 2: Numbers on benzodiazepines (BZD) in long-stay units

	Number	Percentage
Number of units	23	–
Total number of prescriptions	526	–
Total number of residents on BZD	313	60%
Residents on regular prescriptions of BZD	223	71%
Residents on PRN prescriptions of BZD	177	56%
Residents on both PRN and regular prescription of BZD	77	25%
Residents on more than one BZD	116	37%

MOOD STABILISERS

Up to a few years ago, the best-known and most-used mood stabiliser for people with bipolar disorder was lithium. More recently, anti-epileptic medication has increasingly been used as a mood stabiliser and to augment antidepressant medication. Of residents in acute units, 26% were on such mood stabilisers, and so were 36% of residents in long-stay units. The most commonly used were carbamezepine (Tegretol), sodium valproate (Epilim) and increasingly, lamotrigine (Lamictal). In the prescriptions examined the majority were prescriptions were for lamotrigine.

MOOD STABILISER PRESCRIPTION

Table 6: Prescription of mood stabilisers in acute units

	Number	Percentage
Number of acute units	18	–
Number of residents	530	–
Total number on mood stabilisers	139	26%

Table 7: Prescription of mood stabilisers in long-stay units

	Number	Percentage
Number of long-stay units	20	–
Number of residents	482	–
Total number on mood stabilisers	172	36%

ANTIPSYCHOTIC MEDICATION

Antipsychotic medication is used to treat symptoms of psychosis. It can be used in acute psychotic states, schizophrenia, mania or hypomania in bipolar disorders, and in depression. Ideally one antipsychotic should be used, but there are cases where two antipsychotics may be indicated. Antipsychotics are given either orally or by depot injection. The newer antipsychotics have fewer side effects than ones used previously, but can still cause sedation, weight gain, tremor and cardiac effects.

Clinical guidelines advise against prescribing more than one antipsychotic medication, with limited exceptions. However the rate of polypharmacy with antipsychotics has risen internationally. One of the main reasons for the use of combinations of antipsychotic medication is lack of response to one antipsychotic medication, which occurs in 30% of people with schizophrenia.

In this survey, 804 out of 1,056 of residents (76%) were on antipsychotic medication with just over 30% on more than one such medication. International studies show that about 44% of in-patients are on two or more antipsychotic medications.

ANTIPSYCHOTIC MEDICATION PRESCRIPTION

Table 3: Percentage on antipsychotic medication in acute units

	Number	Percentage
Number of units	18	–
Total number of prescriptions	530	–
Number of residents on antipsychotic medication	402	76%
One antipsychotic	261	65%
Two antipsychotics	122	30%
Three antipsychotics	19	5%
Four antipsychotics	0	0%

Table 4: Percentage on antipsychotic medication in long-stay units

	Number	Percentage
Number of units	23	–
Total number of prescriptions	526	–
Number of residents on antipsychotic medication	402	76%
One antipsychotic	217	54%
Two antipsychotics	149	37%
Three antipsychotics	32	8%
Four antipsychotics	4	1%

CONCLUSION

The condition of prescription sheets in approved centres was variable, with some having excellent prescription documentation, while others had deficiencies. The use of the old card index system was associated with poorer quality of prescriptions. The use of benzodiazepines in Ireland appears to be high with 63% of in-patients on benzodiazepines and 32% of these prescribed more than one benzodiazepine at the same time. The prescription of PRN benzodiazepines is 59%, in some units up to 80% of residents were on PRN benzodiazepines. It is impossible to tell from the current prescriptions how long a resident has been prescribed a particular medication and this review did not reference clinical files. The use of combinations of antipsychotic medication in Ireland is less than it is in other jurisdictions. The use of anti-epileptic medication as a mood stabiliser and to augment antidepressants has increased internationally over the past few years. At present in Ireland there are 31% of in-patients taking this type of mood stabilisers.

RECOMMENDATIONS

1. *Each approved centre should conduct an audit of their use of benzodiazepines.*
2. *The card index system of prescribing should be discontinued.*
3. *It should be ensured that NCHDs are proficient in the safe use of benzodiazepines and in writing prescriptions.*
4. *Each signature on a prescription should have a corresponding printed name.*
5. *Each prescription sheet should specify the resident's name, date of birth, and the name of the unit and approved centre.*

APPENDIX 7: INTELLECTUAL DISABILITY SERVICES 2008

The provision of intellectual disability mental health services is not structured along HSE area lines and services often cross recognised catchment boundaries. Nevertheless, provision of services falls roughly along these lines. Not all catchment areas had Mental Health Intellectual Disability (MHID) teams. Four had no dedicated teams; in other instances, the service was provided solely by the voluntary sector.

CATCHMENT TEAMS

Table 1: HSE Dublin Mid Leinster

Catchment	Dublin South City/South Kildare/ Wicklow	Laois/Offaly/Longford/Westmeath
Population (ID database)	5,532	830
Teams	3	1
– Consultant psychiatrist	3	0.5 by 2
– NCHD	0	1.5
– Psychology	0.5	0
– Occupational therapy	0	0.5
– Social work	0	0

Table 2: HSE Dublin North East

Catchment	Dublin North/St Joseph's Service	Louth/Meath/Cavan/Monaghan
Population (ID database)	4,946 (Dublin North East total)	4,946 (Dublin North East total)
Teams	2	0
– Consultant psychiatrist	2	Private sector
– NCHD	2	–
– Psychology	0	0
– Occupational therapy	0	0
– Social work	0	0

Table 3: HSE West

Catchment	Sligo/Leitrim	Galway/Mayo/ Roscommon	Donegal
Population (ID database)	859	1045	985
Teams	1	1	1
– Consultant psychiatrist	1	As required	0
– NCHD	–	0.5	0
– Psychology	0	0.2	0
– Occupational therapy	0	–	0
– Social work	0	0	0

Table 4: HSE South

Catchment	Cork/Kerry	Waterford/ Wexford/Carlow/ Kilkenny/South Tipperary	Limerick/Clare	Limerick East North Tipperary
Population (ID database)	4,168	918 (Wexford only)	Unknown	341
Teams	1	0	2	0
– Consultant psychiatrist	1	3 (Voluntary sector) 0.2 (HSE)	2.5	–
– NCHD	1.5	–	2	–
– Psychology	0	0	0	-
– Occupational therapy	0	0	0	0
– Social work	0	0	0	0

STAFFING LEVELS

There had been no change in staffing levels in provision of care to persons with an intellectual disability within the last year, except in the Laois/Offaly/Longford/Westmeath area, where a 0.5 WTE NCHD post was added, and in St. Joseph's Service in Dublin North East.

A significant element of service delivery was provided by the voluntary sector in many areas of the country; however, this was primarily only at the unsupported consultant psychiatrist level.

People with an intellectual disability who required admission to a psychiatric unit were generally admitted to the local psychiatric unit where, in some instances, the service had dedicated beds.

MULTIDISCIPLINARY TEAMS

In no part of the country were there full multidisciplinary teams, and the vast majority of teams had no MDT member at all, apart from medical and sometimes nursing staff. The service at St. Joseph's in Dublin North East reported that it had recruited a multidisciplinary team, which hoped to take up post early in 2009. Despite this, there was evidence that a system of introducing care plans to residents in community residences was occurring in some areas, e.g. Laois/Offaly/Longford/Westmeath.

COMMUNITY RESIDENCES

It was encouraging to see that the relocation to community residences of many long-stay residents in the Victorian institutions was continuing. Assessments of residents in St. Luke's Hospital, Clonmel, had been completed and planning for their requirements in alternative accommodation had been initiated. Residents in St. Brendan's Ward of St. Senan's Hospital were placed in more suitable accommodation in a purpose-built unit in Co. Wexford, with the result that this long-stay ward has now been closed. In Portlaoise, a number of residents moved from their accommodation in Alvernia to a community house.

IN-PATIENT UNITS

There were two in-patient units for persons with an intellectual disability and psychiatric illness. These were at St. Joseph's in St. Ita's Hospital, Donabate, Co. Dublin, and Palmerstown View in Stewart's Hospital, Palmerstown, Co. Dublin.

Palmerstown View: The unit, in the grounds of Stewart's Hospital, was a stand-alone unit with six beds. MDT care plans were in operation for all service users and there was good multidisciplinary functioning. Whilst this unit provided a comprehensive service to its residents, it did not provide any catchment-based services.

St. Joseph's: St. Joseph's service provided in-patient care for 172 residents in thirteen units. A new community home in Julianstown had been recently acquired and this had facilitated the transfer of some residents from St. Joseph's. Staffing levels had increased with the appointment of 13.5 WTE additional staff nurses and it was expected that a full multidisciplinary team would take up post in January 2009.The completion of a new residential facility of sixty beds, laid out in a streetscape model of ten 6-bed bungalows, was anticipated in early 2009.

CONCLUSION

The prevalence of psychiatric illness in persons with an intellectual disability is high, with rates ranging from 20 to 50 per cent. Despite this, publicly funded mental health services for individuals with an intellectual disability remained inadequate, and varied widely across the country. The document *A Vision for Change* recommends that mental health services for people with intellectual disability should be provided by a specialist mental health of intellectual disability team based in the catchment area. In the absence of increased funding, the scope for services to expand was limited. There had been little change in staffing levels, with the exception of those in St. Joseph's, but overall, the situation with regard to multidisciplinary teams was not encouraging. The continued move, where possible, from institutionalised living to conditions more suitable to modern living was to be welcomed, but was proving painfully slow. Provision of community-based services is an important aspect of care which is not readily accessible to many individuals with an intellectual disability, and there had been no progress in the establishment of a forensic service for those with intellectual disability.

APPENDIX 8: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES 2008

In 2008, each child and adolescent service was requested to submit details to the Inspectorate of staffing, business plans, length of waiting lists, developments and quality initiatives. This information was procured from the Local Health Managers. Most services completed templates and returned these on time, with varying levels of details. As far as was possible, despite the absence of some requested information, these details are reported.

STAFFING OF COMMUNITY CHILD AND ADOLESCENT TEAMS

There had been some improvements in staffing levels, as can be seen from Tables 1 to 4. The staffing varied between teams, reflecting different emphases in the way teams are staffed. Most increases in staffing had been in medical staff, especially at NCHD level, but the reason for this situation was unclear. It may be that this reflects the different types of service offered by different teams. Whatever the reason, it emphasised the lack of an accepted model of care, despite clear national mental heath policy on service provision.

Teams for the in-patient units in Galway, Dublin and Cork are currently being appointed. However, in general, the community mental health teams (CMHTs) were still considerably under-resourced.

STAFFING OF CATCHMENT CHILD AND ADOLESCENT CMHTS

Table 1: HSE Dublin Mid-Leinster

	Catchment 1	Catchment 2	Catchment 3
Catchment	Dublin SW, Dublin NW, Kildare	Dublin SE, South Co Dublin, E Wicklow	Laois, Offaly, Longford, Westmeath
Population under 18	n/a	n/a	70,311
Consultant psychiatrist	7.9	8.45	3
NCHD	15	8	5
Nursing	11.9	15.89	6.6
Psychology	10	11.99	3
Social work	9	10.8	1
Social care	1	9.69	0
Occupational therapy	0	8.8	2
Number on waiting list	188	No information	89
Length of time on waiting list	From 4 weeks to a year	From 3 to 14 months	From under 3 months to 1 year
Length of time on priority list	No information	No Information	No information

Table 2: HSE Dublin North East

	Catchment 1	Catchment 2
Catchment	Louth, Meath, Cavan, Monaghan	Dublin North (Mater)
Population under 18	110,391	74,163
Consultant psychiatrist	4.6	3.4
NCHD	8	4.4
Nursing	5.6	0
Psychology	3.7	9.7
Social work	4.8	6.4
Social care	0	0
Occupational therapy	0	2.5
Number on waiting list	85	382
Length of time on waiting list	From 3 to 9 months	From 1 month to more than 1 year
Length of time on priority list	From 5 days to 1 month	No information

Table 3: HSE West

	Catchment 1	Catchment 2	Catchment 3	Catchment 4
Catchment	Galway, Mayo, Roscommon	Sligo, Leitrim	Limerick, Clare, North Tipperary	Donegal
Population under 18	106,611	22,079	94,578	44,000
Consultant psychiatrist	4.5	0.4	4	2
NCHD	8.2	2	4	2
Nursing	7	0	5.9	3.2
Psychology	1	0.8	2.1	1
Social work	7.5	1.8	1.5	0
Social care	3.5	0	2	0
Occupational therapy	3.8	0	0	0
Number on waiting list	64 7 (for in-patient service)	198	351	171
Length of time on waiting list	Up to 3 years (2 since 2004)	No information	More than 1 year	`More than 1 year
Length of time on priority list	< 6 weeks	No information	Up to 3 months	

Table 4: HSE South

	Catchment 1	Catchment 2
Catchment	Cork, Kerry	Waterford, Wexford, Carlow, Kilkenny, South Tipperary
Population under 18	157,987	124,378
Consultant psychiatrist	7	4.25
NCHD	8.2	6
Nursing	3.6	4.6
Psychology	7.4	6
Social work	9.3	4.3
Social care	0	0
Occupational therapy	1.5	1
Number on waiting list	512	No information
Length of time on waiting list	Up to 30 months	From 25 days to 1 year
Length of time on priority list	Up to 10 weeks	Up to 1 month

QUALITY INITIATIVES

The provision of services such as parent support groups, adolescent groups and early intervention programmes varied widely. There was little consistency across catchment areas as to what was offered and no national standards for their implementation. Some services did not provide any details on quality initiatives in 2008. This was particularly striking in the Limerick, Clare and North Tipperary catchment. Most other services offered a good deal of information on their quality improvements, some of which were innovative and demonstrated the dedication of staff in trying to find methods of delivering service with minimum resource implications. There was evidence of audits, research, provision of information to children or adolescents and their families, training of staff, waiting list initiatives and specific programmes aimed at young people, among other programmes and initiatives. It appeared that in most areas there was a willingness and enthusiasm to provide prevention, early intervention and support as well as acute care.

ADMISSION OF CHILDREN

The admission of children to adult units continued despite universal agreement from all mental health agencies that this is inappropriate. There were 247 admissions of children to adult units during 2008. Of these, 24 admissions were of children under 15 years and 223 were of children over 16 years. (These numbers relate to the numbers of admissions, not the numbers of individual children). Most units do not meet Section 2.5 of the Code of Practice on the Admission of Children which was issued by the Mental Health Commission in 2006. Many children admitted to adult units were allocated individual nurses during their stay. While this provided protection, most adolescents found it intrusive and frustrating. Adult mental health staff were not trained to provide mental health care for children. The facilities were not age appropriate, there were no suitable age-related activities and there was no age-appropriate advocacy available. Most centres had no policies on family liaison, parental consent and confidentiality. The admission of adolescents to adult units appeared to offer protective rather than therapeutic care.

There were two dedicated approved stand alone centres for the admission of children and adolescents:

- **St Anne's Children's Centre in Galway** The most recent information from the Local Health Manager (December 2008) stated that this had ten beds but only six were operational. It had been stated previously that all ten beds were operational. The differences in information provided was confusing and failed to recognise the importance of adequate communication with all stakeholders.

- **Warrenstown House in Dublin** This had six operational beds. The unit was closed most weekends due to staff shortages. There were no social workers, no occupational therapists or psychologists available to the children in the unit. This was far from an adequate service for adolescent and children with complex mental health needs. A review of the services was under way at the time of inspection and should outline a more comprehensive service.

Two new in-patient units have been planned. There will be a purpose-built unit with 20 beds at Merlin Park in Galway and a new 20-bed unit in Cork. Building of both units had not commenced at the time of inspection. Interim arrangements were to be provided in 2009 in St. Stephen's Hospital, Cork. A unit for 17-to-18 year olds was due to open in St. Vincent's Hospital in Fairview, Dublin, in 2009.

WAITING LISTS

The number of children and adolescents on waiting lists for assessment varied widely (Tables 1 to 4). The information was provided by the Local Health Manager in each area but a significant number did not provide the information requested. The majority of emergency cases were seen immediately and priority cases were seen in a time frame ranging from immediately to one year. Despite the incomplete information provided, it can be reported that both the number of children and adolescents on routine waiting lists and the length of waiting time are substantial and demonstrate the national lack of community services for children and adolescents. Using the information provided by the Local Health Managers, though incomplete, there are over 2,000 children on the waiting list, and over 1,500 of these are waiting for routine assessments.

CONCLUSION

The worldwide prevalence of mental health difficulties in children and adolescents is approximately twenty per cent. It is obvious that in Ireland there is a major discrepancy between the services provided and the identified needs of children and adolescent with mental health problems. The frustration of parents and staff is apparent, and children and adolescents who require assessment and interventions lose valuable time while waiting for essential services.

There is a wide range of community programmes offered by the services, including education and support for parents, families and children. However national guidelines and adequate resourcing for these programmes should be provided.

There are 50 community mental health teams for child and adolescent mental health services. Although there have been modest increases in staffing in a few child and adolescent community services, they remain under-resourced. The majority of increases in staffing are of medical and nursing staff. Community teams do not have full complements of multidisciplinary staff and few have day facilities. The waiting lists are long and while serious cases are prioritised, it leaves children with less acute problems on waiting lists for an unacceptable length of time. It is well documented that children with mental health problems who do not receive appropriate timely therapy are more likely to require adult mental health services later in life. There appears to be an emphasis by the HSE on providing in-patient beds rather than developing community services and facilities. In the absence of adequate community facilities and staff it is likely that there will be greater demand on in-patient beds and less likelihood of early discharge to appropriate community services. There should be recognition of the fact that children with mental health problems need timely access to adequate services, in order to attain their full potential, and these should be provided as matter of urgency.

CHAPTER 5

OVERVIEW OF CATCHMENT MENTAL HEALTH SERVICES WITHIN HSE AREA

CATCHMENT REPORTS BY HSE AREA

CHAPTER 5 CONTENTS

HSE DUBLIN NORTH EAST 100

CAVAN/MONAGHAN MENTAL HEALTH SERVICES 100
DUBLIN NORTH CENTRAL MENTAL HEALTH SERVICES 106
LOUTH/MEATH MENTAL HEALTH SERVICES 112
NORTH DUBLIN MENTAL HEALTH SERVICES 117
NORTH WEST DUBLIN MENTAL HEALTH SERVICES 124
ST. JOSEPH'S INTELLECTUAL DISABILITY SERVICE 136

HSE DUBLIN MID LEINSTER 140

DUBLIN SOUTH CITY MENTAL HEALTH SERVICES 140
DUBLIN SOUTH EAST MENTAL HEALTH SERVICES 146
DUBLIN WEST/SOUTH WEST MENTAL HEALTH SERVICES 151
EAST WICKLOW MENTAL HEALTH SERVICES 156
KILDARE/WEST WICKLOW MENTAL HEALTH SERVICES 160
LAOIS/OFFALY MENTAL HEALTH SERVICES 165
LONGFORD/WESTMEATH MENTAL HEALTH SERVICES 171
SOUTH COUNTY DUBLIN MENTAL HEALTH SERVICES 177

HSE SOUTH 182

CARLOW/KILKENNY MENTAL HEALTH SERVICES 182
KERRY MENTAL HEALTH SERVICES 189
NORTH CORK MENTAL HEALTH SERVICES 194
NORTH LEE MENTAL HEALTH SERVICES 201
SOUTH LEE MENTAL HEALTH SERVICES 207
SOUTH TIPPERARY MENTAL HEALTH SERVICES 212
WATERFORD MENTAL HEALTH SERVICES 218
WEST CORK MENTAL HEALTH SERVICES 225
WEXFORD MENTAL HEALTH SERVICES 229

HSE WEST 235

CLARE MENTAL HEALTH SERVICES 235
DONEGAL MENTAL HEALTH SERVICES 241
EAST GALWAY MENTAL HEALTH SERVICES 246
LIMERICK MENTAL HEALTH SERVICES 252
MAYO MENTAL HEALTH SERVICES 259
NORTH TIPPERARY MENTAL HEALTH SERVICES 263
ROSCOMMON MENTAL HEALTH SERVICES 268
SLIGO/LEITRIM MENTAL HEALTH SERVICES 272
WEST GALWAY MENTAL HEALTH SERVICES 278

HSE DUBLIN NORTH EAST

CAVAN/MONAGHAN MENTAL HEALTH SERVICES

HSE Area	HSE Dublin North East
Catchment	Cavan/Monaghan
Mental Health Service	Cavan/Monaghan Mental Health Services
Population	118,791
Number of Sectors	4
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	30 September 2008

SERVICE DESCRIPTION

The Cavan/Monaghan catchment had two admission units, one in Cavan General Hospital, and one in St. Davnet's Hospital, Monaghan. Two long-stay wards operated in St. Davnet's Hospital. The psychiatry of later life team and the rehabilitation team provided a service to both counties. Both counties had Outreach teams and a large element of care was home based in the community.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The uncertainty regarding the provision of acute in-patient mental health services should be resolved.*

Outcome: The future of in-patient care was linked to ***A Vision for Change*** with the aim of replacing five hospitals with two regional hospitals. There was still uncertainty regarding this.

2. *Urgent repairs should be carried out in the in-patient units immediately.*

Outcome: Repairs had been carried out to the in-patient facilities, in St. Davnet's Hospital in Ward 15. One bedroom had been decommissioned.

3. *The staffing resource in the community mental health teams should be increased to ensure each team had a core multidisciplinary team.*

Outcome: Provision of a core multidisciplinary team (MDT) was not achieved owing to a lack of a social worker and psychologist in Cavan. A social worker had recently returned from leave.

4. *The core management team should include all disciplines.*

Outcome: The tripartite structure was still in operation.

5. *There should be a comprehensive program of activities for the residents in the in-patient units.*

Outcome: Programme improvements were noted in this area.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

It was felt that there was a need to improve the quality of in-patient services, which had not kept pace with the progress in the community service. Average bed occupancy in the acute units in Cavan and Monaghan was at 49 per cent and 52 per cent respectively.

A recent service group recommendation was to amalgamate the acute in-patient units, and that this should be in a new purpose-built unit. As the site for the new regional hospital had not yet been identified, it was not possible to identify the location of this proposed in-patient unit, but it was clearly felt that it should remain within the catchment area. Continuing care should be provided in a regional setting.

DEVELOPMENTS 2007-2008

- A recent survey of home-based patients and their families revealed that 90 per cent of respondents were happy with the community model.
- The relationship with the primary care service, using the Liaison Attachment model, was working to support and empower the primary care team.
- The Local Health Manager was continuing to progress the recruitment of a social worker, and would continue to prioritise other areas of the service. They were already establishing cross-border relationships in the area of eating disorders, amongst others.
- The service had a quality steering group that had representatives from all teams.
- Over the past year, initiatives had been developed in the areas of integrated files, provision of an information leaflet, and the establishment of a consumer panel.

HOSPITAL CLOSURE PLANS

The Inspectorate was not provided with a closure plan, but the service had a clear plan in relation to its in-patient services, as described above. This was dependant on the establishment of two regional hospitals.

QUALITY IMPROVEMENTS

- Training in cognitive behaviour therapy (CBT) for nursing staff was on-going, and to date 15 members of nursing staff had had training in this area. Two staff members were currently pursuing further training in CBT in the University of Ulster.
- Two nursing staff were now qualified as Nurse Prescribers.
- Two staff members were on a care assistant course.
- In the area of patients with a diagnosis of personality disorder, clinicians had set up a peer support group in which the psychologist had taken the lead role. This group met approximately once a month. The psychologist was currently conducting an audit of the case load.
- The numbers of residents in in–patient care and in hostels continued to be reduced.

SERVICE USER INPUT TO SERVICE

The representative of the service users stated that there were no significant issues, and it was felt that staff continued to work well with the service users. There was currently no group for service users in the area, but one was planned.

GOVERNANCE

The service currently operated a tripartite model consisting of clinical director, director of nursing, and administrator. The current model posed a difficulty taking into account the concept of MDT management as set out in ***A Vision for Change***. The service felt that there was a need for a more coherent definition of the management team.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	2
NCHD	4
Specialist registrar	1

Nursing staff

Post	WTE in post
ADON (clinical coordinator)	1
CNM3	1
CNM2	7
CNM1	2
CMHN	1
Staff nurse	18
CNS	7

Health and social care professionals

Post	WTE in post
Clinical psychologist	1
Social worker	1.3
Occupational therapist	0.66

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation team

Staffing	2008
Population	
Consultant psychiatrist	1
NCHD (including specialist registrar)	2
Dedicated team coordinator	1
CMHN	3
CNM3	2
CNM2	14
CPN	3
CNS	9
Staff nurse	37
Psychologist	0
Social worker	1
Occupational therapist	1
Community-based nurses	38

Psychiatry of later life team

Staffing	2008
Population	
Consultant psychiatrist	1
NCHD (including specialist registrar)	2
Dedicated team coordinator	1
CNM2	6
Staff nurse	22.9
CNS	9
Psychologist	0
Social worker	0.9
Occupational therapist	0.6
Community support workers	3

IN-PATIENT FACILITIES

In-patients continued to be admitted to acute units in St. Davnet's Hospital and in Cavan General Hospital. Occupancy of both units was about 50 per cent. Improvements in facilities had been carried out in St. Davnet's Hospital. Despite the uncertainty about the ultimate location of any new in-patient units, the plans to further upgrade facilities in St. Davnet's Hospital should be implemented.

MDT care plans were in operation at both centres. The restructuring of occupational therapy that was planned for Cavan would expand the range of activities available to residents there.

Because of the expanding population in the region, it was anticipated that the number of referrals to the admission unit in Cavan would increase in the coming years and provision of a liaison service in the hospital was envisaged. Currently, two liaison nurses provide a service for more than 500 referrals annually.

It had been decided within the service to provide ECT locally and two nurses were currently in training.

A group had been set up to look at future provision of psychiatry of later life services, given the plans for development of a regional centre. Both Cavan and St. Davnet's Hospital currently accepted psychiatry of later life admissions, and were able to see referrals without a waiting time.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

There was good compliance with Regulations, with the exception of those relating to therapeutic services and children's education.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Seclusion was not used and the service did not provide ECT on site in either approved centre. The Rules concerning mechanical restraint were complied with in the approved centre in Cavan General Hospital, but not in St. Davnet's Hospital.

CODES OF PRACTICE

Both centres were compliant with the Code of Practice on the use of physical restraint.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Woodvale	14 plus 2 respite	14	Rehabilitation	MDT
St. Jude's	13 plus 2 respite	12	Rehabilitation	MDT
Lisdarn	13 plus 2 respite	15	Rehabilitation	MDT

CONCLUSION

The service provided in the Cavan/Monaghan area continued to be significantly home based, with two units for acute admission, both of which had an occupancy rate of about 50 per cent.

Since the report of 2007, MDT care plans had been introduced and were operational in all units. There appeared to be satisfactory interaction between team members from the various disciplines. However, there remained deficits in the provision of multidisciplinary care due to continued vacancies in the areas of psychology, social work and occupational therapy.

A strong emphasis was placed on continuing audit and survey of patient services and ongoing needs within the service as a whole. Research was carried out in conjunction with the Royal College of Surgeons in Ireland.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Challenges in the forthcoming months include the validation of in-patient staff, given the emphasis to date on service provision in the community.*

2. *Enhancement of the quality of in-patient facilities should continue despite the changes in the delivery of services in the future. Expansion of the MDT care approach, introduced within the last year should continue.*

3. *The staffing resource in the CMHTs should be increased to ensure each team has a core multidisciplinary team.*

DUBLIN NORTH CENTRAL MENTAL HEALTH SERVICES

HSE Area	HSE Dublin North East
Catchment	Dublin North Central
Mental Health Service	Dublin North Central Mental Health Services
Population	143,333
Number of Sectors	6
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life Liaison
Date of Meeting	11 November 2008

SERVICE DESCRIPTION

The catchment area had two approved centres, the Acute Psychiatric Unit, Mater Hospital and St. Vincent's Hospital, Fairview, both providing acute in-patient care. There were six sectors that were poorly resourced. There was a liaison service in the Mater Hospital. There were two speciality teams one for rehabilitation and one for psychiatry of later life. Until very recently two distinct services operated in the catchment area without any sharing of resources or services. Over the past two years, a number of efforts had been made to provide a cohesive service. This included the appointment of one clinical director. However further integration was required.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The staffing levels in the community mental health teams should be increased to ensure each team has a core multidisciplinary team.*

Outcome: Two psychologists had been appointed. There had been no appointments of social workers or occupational therapists. The community mental health teams remained seriously understaffed.

2. *The core management teams should be inclusive of all disciplines.*

Outcome: The service now had a heads of discipline management team that met monthly. It included the manager of each discipline, clinical director and area and hospital managers.

3. *There should be a comprehensive programme of activities for the residents in the in-patient units.*

Outcome: There had been some progress but there were still deficiencies in the provision of activities.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The establishment of an executive management team which would be decision making had been achieved. The increase in psychology personnel had also been achieved.

Key issues for 2009 included opening the new adolescent unit, advancing the planning of the new acute unit in the Mater Hospital, upgrading of community facilities, and completing the realignment of sector boundaries.

DEVELOPMENTS 2007-2008

- A 6-bed unit for adolescents aged 16 to 17 years was due to open in February 2008. There were 15 further posts still waiting approval.
- A working group had developed a schedule of accommodation for an acute unit for the total catchment area, which would be included in the Mater Hospital development plan. The provision of the unit was expected to take from 3 to 5 years.
- A principal psychologist and a senior psychologist had been appointed to the adult service. A basic grade psychologist had been recruited to the adolescent unit.
- Further refurbishment of the psychiatric unit in the Mater Hospital had been completed.
- Sector divisions were in the process of being redrawn in order to provide maximum efficiency of service. This would also allow increased working with primary care teams.

HOSPITAL CLOSURE PLANS

There were no plans to close St. Vincent's Hospital, but instead to enhance the services it already provided. The development of a new 100-bed facility for elderly people on the site of St. Vincent's Hospital would allow a number of residents requiring more generic services for older people to be admitted to this new unit. This would result in the closure of one ward where facilities were less than optimal. With the presence of the acute unit in the Mater Hospital and the resulting closure of the admission unit in St. Vincent's Hospital, the rehabilitation and adolescent services were expected to make progress.

QUALITY IMPROVEMENTS

- The Mater sector had established a dedicated cultural psychiatry clinic for rapid assessment of migrant people with mental health difficulties.
- A Wellness Recovery Action Plan (WRAP) was run in the Mater Hospital by a social worker and occupational therapist. A further group was planned in 2009.
- A number of rehabilitation programmes had been developed, including a gardening project, art courses for service users, a rehabilitation kitchen in the rehabilitation unit, and cooking and everyday living skills in a medium support residence.
- There had been meetings held between the carers' groups and heads of discipline to provide information.
- Audits and research projects continue at both the Mater Hospital and St. Vincent's Hospital.

SERVICE USER INPUT TO SERVICE

A service user advocate attended the heads of discipline meetings on a monthly basis. A web site was available for service users and it was planned to post a frequently asked questions (FAQ) page. A weekly service was provided by the Irish Advocacy Network (IAN) to the acute unit in the Mater Hospital and to St. Vincent's Hospital. A service was provided on request to other areas.

The service users praised the staff and indicated that communication with their therapists had improved. Those who can attend activities have praised the programme offered in St. Vincent's Hospital. In the Mater Hospital, the attendance of a social worker was appreciated by service users. Service users appreciated the availability of fresh fruit in the units.

Service users continued to complain about the lack of consultation and discussion regarding the use of medication. Some expressed a desire to see their consultant more frequently and would like more interaction and protected time with nursing staff. Some also complained of boredom.

GOVERNANCE

The service now had a heads of discipline management team that met monthly. It was involved in operational planning. An IAN representative attended the meeting. A number of clinical audits were carried out.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	10
NCHD	16
Specialist registrar	4

Nursing staff

Post	WTE in post
DON	1
ADON	6
Nurses based in in-patient services	103.25
Nurses based in community residences	13.79
CMHN	18.5
Nurses based in day hospitals	14.63
Nurses based in day centres	3.5

CNS posts

Speciality	WTE in post
Substance abuse	2
Family therapy	2
Behaviour therapy	1
Care of elderly	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	4.5
Social worker	2.82
Occupational therapist	4

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Psychiatry of Later Life: This service spanned two catchment areas, Dublin North Central and Dublin North West. The team had admitting rights to six dedicated acute admission beds in a specialist old age unit based in St. Vincent's Hospital.

Liaison: This service was based at the Mater Hospital. There were five dedicated beds for this service in the acute unit.

Rehabilitation team

Staffing	2007	2008
Population	143,000	143,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	0	0.2
Psychologist	0	0
Social worker	1	1
Occupational therapist	1.2	1.2

Liaison team

Staffing	2007	2008
Population		
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0

Psychiatry of later life team

Staffing	2007	2008
Population over 65 years	32,500	32,500
Consultant psychiatrist	3.5	3.5
NCHD (including specialist registrar)	4	4
DON	1	1
Dedicated team coordinator	0	0
CMHN	4	4
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	1

IN-PATIENT FACILITIES

There was an over-provision of acute beds in the sector; 30 beds in St. Vincent's Hospital and 15 beds (10 sector beds and 5 liaison beds) in the acute unit in the Mater Hospital.

Acute Unit, Mater Hospital: The acute unit in the Mater Hospital was not suitable for the provision of acute in-patient service. Much effort had been made to bring it up to an acceptable standard but there was no high observation area, the entrance to the unit was poor, and there was limited space to provide activities. There was no prospect of producing structural improvements within the confines of the unit. Therefore the construction of a new unit or conversion of a more suitable unit in the Mater needed to proceed with haste.

St. Vincent's Hospital: St. Vincent's Hospital provided acute in-patient services, rehabilitation and continuing care. The opening of the 100-bed nursing home would allow closure, restructuring work and decoration to take place.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Acute unit, Mater Hospital: The lack of a care plan in the acute unit in the Mater Hospital had been resolved, as had the non-compliance issue in the Article on general health. The service was not compliant with the Articles on the provision of information to service users, in premises and in staffing.

St. Vincent's Hospital: At the time of initial inspection there were no care plans in St. Vincent's Hospital. Since then a care plan had been developed and was being rolled out. Therapeutic activities were to be linked to these care plans. Although the centre did not meet the Article for premises there was evidence that a number of deficits were being resolved. There was an inadequate number of health and social care staff to provide an appropriate level of input for the in-patient population.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Acute Unit, Mater Hospital: The acute unit in the Mater was not compliant with the Rule on seclusion. The non-compliance with the Rule on ECT was addressed. The centre was not compliant with Part 5 of the Rules on mechanical restraint.

St. Vincent's Hospital: At the time of initial inspection Part 5 of the Rules on mechanical restraint were breached. It was reported that this was in the process of being rectified.

CODES OF PRACTICE

Acute Unit, Mater Hospital: The acute unit in the Mater Hospital was not compliant with the Codes of Practice on physical restraint, admission of children and notification of death and incident reporting. It was compliant with the Code of Practice on ECT for voluntary patients.

St. Vincent's Hospital: Although the approved centre was not in compliance with the Code of Practice on the admission of children, this was expected to be rectified by the opening of the new adolescent unit early in 2009. The service had no risk management policy.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Grace Park was due for extensive refurbishment. The number of residents would be reduced to seven.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Grace Park	14	14	Rehabilitation	
Gallen House	16	16	Rehabilitation	

CONCLUSION

Staff in this catchment area continued to progress to a fully integrated service. There were still some difficulties in that the high observation area in St. Vincent's Hospital was not available to the Mater sector. It was evident that the appointment of an overall clinical director in 2007 continued to aid integration. There had been considerable effort made to remedy the non-compliance in the Regulations, in both approved centres, especially in the area of care planning. The community mental health teams remained seriously deficient in health and social care staff and were therefore limited in the service they could offer service users. The development of the adolescent unit for young people aged 16 to 17 years was welcome and should be functional in early 2009. The accommodation in both approved centres required attention but this should be addressed with the development of the nursing home complex and the new unit in the Mater Hospital.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Every effort should be made to have fully operational mental health teams with the appointment of a core mental health team.*

LOUTH/MEATH MENTAL HEALTH SERVICES

HSE Area	HSE Dublin North Central
Catchment	Louth/Meath
Mental Health Service	Louth/Meath Mental Health Services
Population	271,845
Number of Sectors	9
Number of Approved Centres	2
Specialist Teams	Psychiatry of Later Life (2 teams)
Date of Meeting	30 September 2008

SERVICE DESCRIPTION

The Louth/Meath catchment area had nine sector teams, five in Louth and four in Meath, with one psychiatry of later life team in each area. There were two approved centres in the area, St. Brigid's Hospital in Ardee and the Department of Psychiatry, Our Lady's Hospital, Navan. There was an outreach team in Meath and a nurse-led home-based team in both Louth and Meath.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *A fully multidisciplinary rehabilitation service must be provided in Louth/Meath.*

Outcome: The service still lacked a rehabilitation team.

2. *The staffing resource in all teams should be increased to ensure each team had a core multidisciplinary team.*

Outcome: There continued to be vacancies in the area of psychology and social work. Social workers were operating without management from a principal social worker.

3. *The core management team should be inclusive of all disciplines.*

Outcome: The tripartite model still continued, with psychology and social work representatives invited to attend the meeting every two months.

4. *There should be a comprehensive program of activities for the residents in the in-patient units, especially in the evenings and at weekends.*

Outcome: Since 2007, the service had contracted two occupational therapists who now provided a service for the residents of St. Brigid's Hospital and who also provide occupational therapy one day a week to residents under the care of psychiatry of later life. A pilot programme in which voluntary groups provided activity groups at the week-ends was being planned by the occupational therapists in St. Brigid's Hospital.

5. *The future of St. Brigid's Hospital should be clarified, along with plans for the provision of service for the long-stay residents.*

Outcome: The future of St. Brigid's Hospital was still unclear, particularly in respect of long-stay residents. A regional implementation team, with the clinical director and the director of nursing, was currently looking at the future of the hospital campus in Ardee and potential developments for the site.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

Nurses currently run consumer focus groups in Co. Meath, and there were plans to set up a carer focus group in Co Louth.

Sourcing a sector headquarters for the Drogheda area was currently under way and it was expected to be in place by 2009.

One of the hostels in the catchment area had been closed and discussions on future housing needs with the Louth and Meath county councils were continuing.

DEVELOPMENTS 2007-2008

- Home-based treatment was in operation in both sectors.
- A second psychiatry of later life team was set up in 2007 in the Louth area. However neither of psychiatry of later life teams had access to psychology services or, in the case of the Meath team, occupational therapy.
- A sector headquarters had been set up in Trim and personnel were in place.
- Multidisciplinary care planning had been established in the admission unit in Our Lady's Hospital, Navan since the last report and was reviewed regularly at team meetings. There were individual care plans in operation in St. Brigid's Hospital.
- Bathroom facilities in Our Lady's Ward in St. Brigid's Hospital had been upgraded.
- One of the sector teams in the Drogheda area had met with local GPs, and there were plans to hold further meetings to discuss home-based mental health care for their patients.
- Future plans for St. Brigid's Hospital remain unclear but local committees to implement ***A Vision for Change*** were addressing this issue.

QUALITY IMPROVEMENTS

- It was reported that the Louth/Meath catchment area was poorly resourced in relation to other areas, and although the funding for the service was ring-fenced, cost-containment measures were in place, posing challenges for development. Nurses trained in delivery of community-based psychiatry could not be deployed due to financial and staffing restrictions.
- Regular audits were carried out and groups such as the quality steering group and incident reporting group met regularly. The service was due to be assessed in the next year by the College of Psychiatrists for accreditation purposes. At present, all NCHDs were on a training scheme. The Department of Occupational Therapy in Trinity College, Dublin, offered supervision to the occupational therapists in St. Brigid's Hospital. As a result, a link had been established that promised to be of benefit to the hospital.

SERVICE USER INPUT TO SERVICE

The representative of the service users reported that there were few complaints in respect of the Louth/Meath catchment area. Residents were currently awaiting a suitable sheltered smoking area in St. Brigid's Hospital. A Carers group had been set up for psychiatry of later life in Co Meath, and a user group is was in operation.

GOVERNANCE

The service operated a tripartite model of governance, consisting of the clinical director, the director of nursing, and administrator. This group met together fortnightly and met with the LHM every six weeks.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	13
NCHD	19
Specialist registrar	6

Nursing staff

Post	WTE in post
DON	1
ADON	5.9
Nurses based in in-patient services	91.84
Nurses based in community residences	43
CMHN	9.9
Nurses based in day hospitals	0
Nurses based in day centres	15.5
Clinical placement coordinator	1.5
Nurse practice development coordinator	1
CNM3	3

CNS posts

Speciality	WTE in post
Alcohol counsellor	3.64
Family therapy	2
Deliberate self-harm	0.85
Affective disorder	2
Psychotic disorder	2
Behaviour therapy	1.42

Health and social care professionals

Post	WTE in post
Clinical psychologist	7.61
Social worker	7.31
Occupational therapist	2

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of Base
Psychology	Principal	Community Care

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

The Louth/Meath service had neither a rehabilitation nor a liaison team. There were two psychiatry of later life teams.

Psychiatry of later life team

Staffing	2007	2008
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
CMHN	3	1.8
Psychologist	0	0
Social worker	1	2
Occupational therapist	0	0
Day facility nurse staffing	0	2

IN-PATIENT FACILITIES

In-patients were admitted to the Department of Psychiatry, Our Lady's Hospital, Navan and to St. Brigid's Hospital, Ardee. Facilities at St. Brigid's Hospital had been improved in the past year.

MDT care plans were in operation only in Our Lady's Hospital. The lack of provision of MDT team members from a range of disciplines obviously limited the scope of full multidisciplinary input. However in St. Brigid's Hospital two occupational therapists had been engaged during the year, greatly enhancing the therapeutic programmes for residents there.

The future of St. Brigid's Hospital remained uncertain.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

There was good compliance with the Regulations in both approved centres, with the exception of the Article in respect of provision of therapeutic services. St. Brigid's Hospital, Ardee was not compliant with the Article relating to individual care plans.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Neither approved centre provided ECT on site and neither used mechanical restraint. Seclusion was used in both centres but St. Brigid's Hospital was not compliant with the Rules for its use.

CODES OF PRACTICE

The approved centre in Our Lady's Hospital, Navan was compliant with the Code of Practice in relation to physical restraint. St. Brigid's Hospital was not compliant with this Section.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Moorings, Dundalk	15	13	General adult	Nursing
St. Mary's, Drogheda	15	14	General adult	Nursing
De La Salle, Ardee	15	14	General adult	Nursing
Rath na Ríogh, Navan	12	10	General adult	Nursing
An Solasán, Dundalk	16	15	General adult	Nursing

CONCLUSION

It was clear, from both the inspection in July 2008 and the catchment meeting in September 2008, that the Louth/ Meath area was served by a dedicated team of mental health professionals. Full operation of MDT care plans across the service would enhance this care. Reconfiguration of existing staff had allowed the development of additional services such as outreach teams.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Increased resourcing of MDT teams should be made available, particularly in the area of occupational therapy.*
2. *The service needs a rehabilitation team, particularly in light of ongoing continuing care.*
3. *Improvement should take place in the provision of therapeutic activities for residents in both approved centres.*

NORTH DUBLIN MENTAL HEALTH SERVICES

HSE Area	HSE Dublin North East
Catchment	North Dublin
Mental Health Service	North Dublin Mental Health Services
Population	225,145
Number of Sectors	7
Number of Approved Centres	1
Specialist Teams	Rehabilitation Psychiatry of Later Life Liaison
Date of Meeting	27 November 2008

SERVICE DESCRIPTION

The North Dublin catchment area had a large population and there was one approved centre, St. Ita's Hospital, that provided it with acute care, rehabilitation and long-term care. The service had long-established speciality teams. The community mental health teams had received additional resources in the areas of social work, medical staffing and occupational therapy during 2008.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The process for refurbishing St. Ita's Hospital should be reviewed with the purpose of providing satisfactory living accommodation for service users.*

Outcome: Funding of 60,000 euro had been allocated to replacing furnishings, curtains and carpets in the admission and assessment units. Funding of 420,000 euro had been allocated for the refurbishment of bathroom facilities in the admission units. At the time of the meeting, it was reported that the design framework had been completed and it was the intention of the service to seek planning permission in January 2009.

2. *The process of care planning should be reviewed.*

Outcome: A pilot scheme in multidisciplinary care planning was completed. Workshops were to be held in January 2009, with a view to full implementation from March 2009.

3. *A modern acute mental health unit should be provided in a general hospital, in line with national mental health policy.*

Outcome: The continuing uncertainty about the future location of the admission service was a source of frustration to staff and was detrimental to residents' well-being. A site previously intended for the new admission unit had been now identified as the site of a co-located hospital. While a new site had been identified, the project group had met only once and had no clinical representative. Staff expressed the need for clarification at national level about the proposal for new developments. It was subsequently reported that the project team had reconvened.

4. *The multidisciplinary teams should be adequately staffed.*

Outcome: One senior registrar and two social workers, including a principal social worker and a senior occupational therapist (rehabilitation) had been appointed. The multidisciplinary teams remained under-resourced. Some services were outsourced privately to psychology or psychotherapy contractors.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The local health office had developed an integrated service 2006 –2011 development plan. This set out the requirements of the area to help improve service delivery through care group integration. The plan was not costed and there were no time frames available. In November 2007, the service published a strategic vision document on the future accommodation requirements of residents currently on campus. In March 2008, the service published an implementation plan for ***A Vision for Change***. A significant number of the priorities had no resources allocated and no time frames for commencement or completion.

DEVELOPMENTS 2007-2008

- Following the closure of a dedicated 7-bed acute admission unit for elderly care in October 2008, it was unclear at the meeting where such people were being accommodated. It was subsequently reported that all elderly acute admissions were referred to the general adult admission unit or directly to a continuing care ward.
- A senior registrar, a 0.5 whole-time-equivalent occupational therapy assistant, and two social workers were appointed to the service. In addition, it was subsequently reported that a senior occupational therapist was appointed to the rehabilitation service.
- A sensory garden for the long-stay wards based in the hospital was completed.
- Office space was allocated in the day hospital for the development of a dedicated psychotherapy service.
- A nurse was assigned to the psychiatry of later life team to develop a specialist service in dementia care.
- An acupuncture clinic was opened in Coolock for substance abusers.
- An audit undertaken by the rehabilitation team and published in ***Journal of Psychological Medicine*** outlined the need for high and low support accommodation for differing groups of residents.
- Coordination of services between rehabilitation and psychiatry of later life had facilitated the placement of 27 people in more appropriate accommodation.
- A social worker participated in the homeless agency review to address issues relating to discharges from hospital and homelessness in north Dublin. A report was due to be published in 2009.
- Two nurses had commenced a medication prescribing project.

HOSPITAL CLOSURE PLANS

There were plans for the closure of the hospital. Proposals by local management in the form of integrated service development plans (May 2006) and plans for implementing ***A Vision for Change*** (March 2008) were all contingent on a decision being taken on the future location of the acute in-patient beds. This decision had been pending since 1989. In the interim, the plans for the development of Beaumont Hospital had evolved and changed. Yet again this year the Inspectorate was informed of another group being re-established to look at the provision of acute care at Beaumont Hospital. In the meantime, service users were admitted to a hospital that was unsuitable and required considerable capital funding to bring it to an acceptable standard.

QUALITY IMPROVEMENTS

- A support group for children of parents with mental ill health was being run by a social worker.
- A Healthy Reading Scheme for people with mental health difficulties was established in conjunction with Fingal County Council.
- A number of service user questionnaires had been implemented at sector level and in the admission units.

- A number of modules in psychological education programmes were established in Artane.
- A number of new intervention groups were established in the rehabilitation service, including recovery, community and young adult groups. A number met in the evenings to facilitate service users.
- The rehabilitation team was delivering Wellness Recovery Action Plan (WRAP) training workshops in the hospital.
- An occupational therapy assistant was assigned to the elderly care continuing care wards on a sessional basis.
- An audit tool was developed to improve documentation compliance with the Rules and Codes of Practice. It was used by nursing staff.
- An internally developed information management system was piloted in two sectors. There were plans to extend the system next year.
- The service had been subject to hygiene audit by the National Hospitals Office. No results were available at the time of the meeting.
- There was an ongoing review of therapeutic activities and programmes available in the hospital.
- A number of risk management committees including infection control had been established.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a peer advocacy service to the residents on the admission wards on a weekly basis. The service was available on request to all other residents. The advocate reported that the service had developed over the last year and was well integrated. The number of volunteers had increased and the advocate had been invited to participate in a number of working groups.

Service users reported that they were pleased with the introduction of protected time on the wards, the expansion of the therapeutic programmes available including the self care and recovery groups. Of concern to service users was the condition of the wards, the lack of privacy, lack of psychological interventions, "no one to talk to" and the lack of shower facilities on the admission wards. A small number of service users expressed concern about the presence of illegal drugs on the acute wards.

GOVERNANCE

There was a full multidisciplinary management team structure in place.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	10
NCHD	21
Specialist registrar	3

Nursing staff

Post	WTE in post
DON	1
ADON	8
Nurses based in in-patient services	102
Nurses based in community residences	24
CMHN	15.62
Nurses based in day hospitals	9.5
Nurses based in day centres	6
Regional education department	13.5

CNS posts

Speciality	WTE in post
Acute psychiatry	1
Psychiatry of later life	1
Psychotherapy	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	3.7
Social worker	8
Occupational therapist	3
Psychotherapist	0.5
Art therapist	1
Art teacher	0.5

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of Base
Psychology	Principal	PCCC
Occupational therapy	Senior	Beaumont Hospital

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: One under-resourced multidisciplinary team provided a service to the entire catchment area. The recommendations of ***A Vision for Change*** had not yet been implemented. A senior occupational therapist was appointed.

Psychiatry of Later Life: The occupational therapy post was funded and managed by Beaumont Hospital. An additional 0.25 occupational therapy assistant post was appointed in 2008. There were a significant number of referrals from Beaumont Hospital to the team.

Liaison: There was a liaison service based in Beaumont Hospital. It was funded by the National Hospitals Office and also had links with the Royal College of Surgeons. Service users could access this service. There was a clinical protocol in place for the transfer of service users from the Emergency department to the admission wards at St. Ita's Hospital.

Rehabilitation team

Staffing	2007	2008
Population	222,000	222,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	2
Dedicated team coordinator	0	0
CMHN	5	0
Psychologist	0	0
Social worker	1	1
Occupational therapist	0	1
CNM2	1	1
Staff nurse	4	4
ADON	1	1
CNM3	1	1

Psychiatry of later life team

Staffing	2007	2008
Population	222,000	222,000
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	4	4
Dedicated team coordinator	0	0
CMHN (outreach)	2	2
Psychologist	1	1
Social worker	0	0
Occupational therapist	1	1
Occupational therapy assistant	0	0.25
ADON	1	1
CNS	1	1
Staff Nurse	0	1

Liaison team

Staffing	2007	2008
Population		
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Liaison nurses	1	1

IN-PATIENT FACILITIES

In patient facilities were provided at St. Ita's Hospital. Since the inspection, seven elderly admission beds had closed and service users had been relocated to other wards. The bed complement was 48 acute care, 31 rehabilitation and 53 continuing care.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The service was not compliant with seven of the Articles. There were plans in place to address deficits in care planning and access to therapeutic programmes. It was disappointing to note, yet again, that the physical condition of the hospital falls short of the basic requirement. It was reported that funding was allocated to address the inadequate bathing facilities but there was no clear time frame for completion. An action plan had been submitted to the MHC Standards and Quality Assurance Division to address the breaches.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was not compliant with the provision of privacy for residents placed in seclusion.

CODES OF PRACTICE

The service was not compliant with the Code of Practice on physical restraint (training need), admission of children (Section 2.5), and notification of deaths and incidents reporting (policy). It was subsequently reported that the service had developed a plan to address the deficits in training in 2009, had updated its policy on risk management and had submitted a plan to the MHC Standards and Quality Assurance Division to address the Code of Practice on children.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

The service had access to 31 places in 24-hour community residences, 28 medium support places, and 8 low support places. In addition there were 8 community rehabilitation residential assessment places. In total the team had access to 75 community places and 31 in-patient beds.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Kilrock	12	12	Rehabilitation	MDT
Inch	9	9	Rehabilitation	MDT
Carlton House	10	10	Rehabilitation	MDT

CONCLUSION

This was another difficult year for this service. A decision was taken to close the acute elderly admission beds in the context of a shortage of nursing staff and a worsening financial situation. There was no new progress on the development of an acute unit at Beaumont Hospital – after twenty years it still remains largely aspirational. In the interim, the conditions at St. Ita's Hospital were sub-standard and fell short of the requirements under the Regulations.

Against this backdrop, the clinical staff have initiated and developed new quality-based interventions across all the teams that were impacting positively for service users.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The conditions in the hospital must be of a standard that is acceptable and in compliance with the Regulations as long as the hospital remains open.*

2. *The future location of acute services for adults and elderly service users must be delivered in line with national policy.*

3. *The multidisciplinary teams must be adequately staffed with an appropriate skill mix to meet the needs of the population.*

NORTH WEST DUBLIN MENTAL HEALTH SERVICES

HSE Area	Dublin North East
Catchment	North West Dublin
Mental Health Service	North West Dublin Mental Health Services
Population	165,755
Number of Sectors	4
Number of Approved Centres	3
Specialist Teams	Rehabilitation (2 teams) Psychiatry of Later Life Programme for the Homeless Mentally Ill
Date of Meeting	24 November 2008

SERVICE DESCRIPTION

There were three approved centres in the North West Dublin catchment, St. Brendan's Hospital and the Department of Psychiatry and Sycamore unit at Connolly Hospital. The units in St. Brendan's Hospital were located in two old buildings which, because of their physical structures, were not suited to the provision of a modern mental health service. Connolly Hospital had a purpose-built admission unit, but only half the beds were available for use by the Department of Psychiatry. The catchment had areas with high levels of deprivation.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The admission unit in Connolly Hospital should be fully opened and admission to St. Brendan's hospital acute unit should cease.*

Outcome: The purpose-built acute unit at Connolly Hospital had still not been fully opened and admissions continued to St. Brendan's Hospital. Pine Ward was due to be vacated by the end of 2008 and ready for occupation in February 2009. However, the opening of the new beds was also dependant on approval of a request for 33 posts.

2. *All teams should be fully staffed to provide a mental health service in line with national policy.*

Outcome: One NCHD and one occupational therapist had been re-allocated from St. Brendan's Hospital to join the rehabilitation service. Two of the teams had a full multidisciplinary team (MDT) complement. The other teams remained seriously short of health and social care professionals and had lost posts since the last inspection.

3. *All essential maintenance in St. Brendan's Hospital should be carried out.*

Outcome: Maintenance books had been introduced and audits of them had been conducted. Units 8A and 8B continued to have maintenance issues.

4. *The new provision of mental health services on the St. Brendan's site should be progressed.*

Outcome: Although a master plan for the St. Brendan's site had been finalised there was no time frame indicating when work would begin. This plan involved the replacement of the units at St. Brendan's.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

Although the Health Service Executive's 2009 National and Regional Service Plans had not been finalised, the local service had earmarked the following the key issues for attention in 2009:

- Review of the rehabilitation services at St. Brendan's and in the community, with a view to creating a single service with shared responsibility.
- Opening Pine Ward at Connolly Hospital to facilitate all acute admissions from North West Dublin catchment.
- Developing Century Day Centre as a day hospital and sector headquarters in Century Business Park, Finglas.
- Refurbish 5 Church Street, Finglas, as a day care service aimed at meeting existing service users' needs.
- Developing Church Avenue Hostel from 5 to 10 places.
- Running an extra night programme in the alcohol service offering aftercare to people in full-time employment to support them in their recovery.
- Extending the advocacy programme across all areas of the service.
- Pursuing the psychologist business plan as an essential component of patient care.
- Expanding the outreach service of the homeless programme at Usher's Island and developing links between it and Access teams in the south side of Dublin, in line with the Homeless Development Report.
- Developing an advanced nurse practitioner (ANP) post in the bereavement service.
- The planned cessation of all acute admission to St. Brendan's was identified by the service as an essential component of the business plan.

PSYCHIATRY OF LATER LIFE

- The service was planning to pilot the new assessment form for the Fair Deal nursing home funding scheme.
- Seven posts lost in 2007 remain on the agenda for the service in order to enhance MDT functioning and develop an early onset dementia service.
- Given the absence of ring-fenced funding, the service had concerns about maintaining the level and quality of service provision.

DEVELOPMENTS 2007-2008

DUBLIN NORTH WEST

- Occupational therapy and clinical psychology undertook a review of the needs of clients attending Century Day Centre to establish how individual needs could best be facilitated in the context of the pressing need to set up a day hospital.
- Funding was secured for the development of a day hospital and sector head quarters in Century Business Park, Finglas and refurbishment of 5 Church Street as a day centre.
- Funding was secured for the redevelopment of Church Avenue hostel in Blanchardstown to add an additional five bedrooms. Consideration was being given to using this facility as a crisis house.
- Information leaflets were designed for the residents in the Acute Unit, Connolly Hospital, for users of the clinical psychology service, for medications and for users of the Cabra service.
- An occupational therapist from St. Brendan's Hospital was assigned to the rehabilitation team in May 2008.
- A dual-diagnosis intensive day programme had begun for clients referred to the alcohol programme in Stanhope Street.

- The clinical psychology service provided a cognitive behaviour therapy group intervention "Coping with Mental Health Problems" and expanded a mindfulness-based group intervention.
- A multidisciplinary family support group (social work, occupational therapy, nursing and clinical psychology) for family and friends of people with mental health difficulties had been established in the Cabra sector.
- The local implementation group for ***A Vision for Change*** had completed a mapping exercise of staff and location resources to enable considering restructuring within the *Vision* framework.
- Clinical psychology was providing teaching input to the psychiatry registrars on psychological models and approaches.
- Available clinical space in the service in the past year had facilitated accepting psychologists in clinical training from the TCD doctoral training programme (one per 6 monthly rotation).
- There had been greater multidisciplinary involvement and more integrated care planning in this the first full year with complete MDTs in Cabra and West Blanchardstown.
- The occupational therapy service use the vacated Church Avenue premises in to run a 9-week pilot independent living skills group which was open to all service users from all sectors in the area.
- The occupational therapy department commenced an innovative support group for eating disorders entitled "Saor" and facilitated a Women's Group to support women within the area and to encourage involvement in mainstream activities and events.
- A basic grade rotation was introduced in the occupational therapy service which was now in its second rotation. This innovative project was occurring between the mental health service and the general hospital department in Connolly Hospital.
- A Mothers Bereaved support group was set up by a CNS in bereavement service.
- A nurses' training pack on Self Administration of Medicines Programme (SAMP) was introduced.

ST. BRENDAN'S

- The closure of the Willows Unit.
- The re-opening of Unit 3A following refurbishment.
- Special care therapy service was transferred to the Willows Unit following some refurbishment.
- En-suite facilities were being installed in Unit 8A, with Unit O to follow.
- There had been a reconfiguration of male beds in Unit R – 13 male beds closed and patients were transferred to Unit 8B.
- Work had begun on the provision of a lift for Units 3A/3B.
- One NCHD and one occupational therapist had been freed for transfer to the North West Dublin rehabilitation team.
- A pilot programme of evening recreational activities commenced, facilitated by occupational therapy and nursing staff. The need for this was identified from feedback from the consumer panel and suggestion boxes.
- A befriending service by occupational therapy students from TCD commenced at the end of 2007, and this had continued for the 2008/2009 academic year.
- A community resocialisation project in the Cork Street area for adult men living alone had now included the residents in Weir Home.

- Eye Movement Desensitisation and Reprocessing (EMDR) sessions had taken place for a number of residents in Unit O, facilitated by an EMDR therapist from Northern Ireland.
- Weir Home had recently been redecorated and other refurbishments had taken place. Exercise equipment had been installed and a no smoking policy introduced.

PSYCHIATRY OF LATER LIFE

- The service had been involved at national and local level with the implementation of Fair Deal.
- The service acted in an advisory capacity with regard to the development of community geriatric general medicine in the area.

HOSPITAL CLOSURE PLANS

Written plan and time frame: The master plan for the St. Brendan's site had been completed. There were no time frames available showing when the remaining 5 units might be replaced as part of the Grangegorman Development Association plan.

Residents with intellectual disability in long-stay wards: This was a particular problem in St. Brendan's Hospital on Units O, 3A and 3B. Unit O was the only female secure unit and consequently residents with intellectual disability were accommodated here along with other residents with disparate needs.

QUALITY IMPROVEMENTS

- A questionnaire seeking residents' views on ward rounds had been piloted on Ash Unit in Connolly Hospital. This was in direct response to feedback received from the Irish Advocacy Network (IAN) on this matter.
- Standardisation of all presentations, workshops and lectures given in the Stanhope Street alcohol programme to ensure best practice and continuity.
- Evaluation of the programmes in the alcohol service in terms of efficiency and outcomes.
- Hygiene audits had commenced in the hostels.
- An infection control committee had been established.
- Integration of clinical files had been achieved on the sector teams.
- Evaluation and review of the occupational therapy pilot independent living skills programme was taking place to inform future groups and to respond to service user need.
- A clear confidentiality statement had been developed for all clients of MH social work service.
- An innovative approach to health promotion was being developed in the acute units regarding smoking cessation by liaising with the smoking cessation officer in the hospital.
- An audit of Clinical Learning Environment for Nursing Students was being undertaken.
- A clinical nurse specialist support group had been established.
- Development of a medication management audit tool had begun.
- Team-based performance management had been implemented in the occupational therapy department.
- A staff orientation programme had been introduced for newly qualified staff and NCHDs.

- A Self Administration of Medication Programme (SAMP) had commenced.
- Clinical discussion groups had been started to facilitate continuing education.
- Solution for Wellness and smoking cessation programmes were introduced during 2008.

SERVICE USER INPUT TO SERVICE

For most of 2008, a representative from Irish Advocacy Network (IAN) visited Unit 3A and Unit 3B in St. Brendan's and Ash Unit at Connolly Hospital weekly. Unit 8A, Unit B and Unit O in St. Brendan's had access to the service on request. A recent development within the IAN had resulted in two advocates being available, one allocated to each hospital area. Consequently weekly visits to Unit 8A, Unit 8B and Unit O had recently started. The advocate also had some input into the day hospitals at Cabra and Coolmine.

Both hospitals had been proactive in including service users in a variety of working groups and projects. It was a credit to both approved centres that the IAN representative reported that service user concerns and comments were being taken seriously and acted on throughout the year. In Connolly Hospital, there was an identified senior nurse available as a main point of contact and this had been particularly helpful.

Service users, through the advocate, had identified a number of issues that had been improved in Connolly Hospital and in St. Brendan's and they commented specifically on the positive occupational therapy provision. There were a number of areas identified for improvement, particularly in relation to a need for more involvement regarding medication, more time with consultant psychiatrists, and alleviating boredom at the weekends.

An advocacy committee had been established during 2008 and had met regularly. Advocacy was included on the agenda of each management team meeting. This had led to ongoing discussion and agreement to proceed with service user involvement where appropriate. Liaison with the local advocate during 2008 had meant that a variety of issues that had been raised by patients of Ash Ward, Connolly Hospital Blanchardstown, had been addressed.

St. Brendan's Hospital had a consumer panel and an IAN representative attended. There was a consumer representative on Grangegorman Development Agency Consultative Body.

Regular consumer/residents meetings were taking place in community residences. "Let's Talk" community meetings were taking place on some units and the occupational therapy department.

Suggestion boxes had been placed in all units.

GOVERNANCE

MDT management: There was was an overarching multidisciplinary management team chaired by the Local Health Manager that dealt with matters of common interest, service development, and the future amalgamation of the two teams. The service reported that the establishment of the joint management team had improved communication, team-work, accountability and governance processes. These improved arrangements were complemented by the establishment of the MDT management teams for both St. Brendan's and the community. These took a discipline-based approach to the implementation and assessment of change. A significant difficulty in social work was that there was no team leader or social worker with management responsibility.

Clinical governance: This was provided by the existing clinical director structures in the Department of Psychiatry, Connolly Hospital, St. Brendan's Hospital and the psychiatry of later life service.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	14
NCHD	21
Specialist registrar	3

Nursing staff

Post	WTE in post
DON	2
ADON	13
Nurses based in in-patient services	131
Nurses based in community residences	80.5
CMHN	23
Nurses based in day hospitals	6
Nurses based in day centres	8
Other	9

CNS posts

Speciality	WTE in post
Addiction	6.5
Family therapy	3
Bereavement therapy	2
Behaviour therapy	2

Health and social care professionals

Post	WTE in post
Clinical psychologist	4
Social worker	6
Occupational therapist	21

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: The team served a population of 166,000 with headquarters on the North Circular Road and the facilities were reported to be excellent.

Psychiatry of later life: The service, based in the Mater Hospital, spanned two catchment areas, Dublin North Central and Dublin North West. The team's resources in Dublin North West included 40 long-stay psychiatric beds at Sycamore Unit, Connolly Hospital and Connolly day hospital.

Liaison: The liaison team in Connolly Hospital served a population of 166,000 and were all sharing one office. Additional office and consultation space were required.

Rehabilitation team

Staffing	2007	2008
Population	166,000	166,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	0	1
Dedicated team coordinator	0	0
CMHN	2	2
Psychologist	0	0
Social worker	0	0.5
Occupational therapist	0	1

Psychiatry of later life team

Staffing	2007	2008
Population over 65 years	32,500	32,500
Consultant psychiatrist	3.5	3.5
NCHD (including specialist registrar)	4	4
Dedicated team coordinator	0	0
DON	1	1
CMHN	4	4
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	1

Liaison team

Staffing	2007	2008
Population	166,000	166,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	2	1
Psychologist	0	0
Social worker	0.5	0.5
Occupational therapist	0	0

St. Brendan's Hospital programme for homeless people who are mentally ill

Staffing	2007	2008
Population*		
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
CMHN	1	1
Psychologist	0	0
Social worker	0	0
Occupational therapist	1.3	2
Day facility nurse staffing	2	4
Outreach worker	1	1

*One hundred and ten service users attend Usher's Island and the team serves a population of 2,000 homeless hostel beds.

St. Brendan's Hospital female low secure admission beds

Staffing	2007	2008
Population	12	12*
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0.5	0
Occupational therapist	1.5	1

*The 12 beds serve the population of the Eastern Region.

St. Brendan's Hospital male low secure admission beds

Staffing	2007	2008
Population	24	24*
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0.5	0
Occupational therapist	1.5	2

*The 24 beds serve the population of the Eastern Region.

St. Brendan's Hospital rehabilitation team

Staffing	2007	2008
Population	–	100
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	1.5
Dedicated team coordinator	0	0
CMHN	0.5	0.5
Psychologist	0	0
Social worker	1	0
Occupational therapist	2	1

St. Brendan's Hospital community services / nursing homes team

Staffing	2007	2008
Population*		
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	0.5
Dedicated team coordinator	0	0
CMHN	0	0.5
Psychologist	0	0
Social worker	0.5	0
Occupational therapist	1.5	0

*This team serves a population of 85 beds. Occupational therapy was provided by 2 occupational therapists covering units 3A and 3B. There was no dedicated occupational therapy service.

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

St. Brendan's

Article 7: One resident on unit 8A was being nursed in night clothes and this was not documented in the care plan.

Article 9: The special care units did not have a sufficient range of recreational activities.

Article 19: There was no documentation on Unit 8A, Unit O or Unit 3B that general health needs had been assessed within the previous six months.

Article 21: There was no private space available on Unit 8A and Unit 8B. One of the beds on Unit O had no partitions around it. Few single bedrooms were available, most of the bed provision was in dormitories.

Article 22: The premises, despite some refurbishment work, were unsuitable for the provision of a modern mental health service.

Article 26: The skill mix was not sufficient. There were no psychologists or social workers.

Department of Psychiatry, Connolly Hospital

Article 6: A food safety report was not submitted to the Inspectorate as requested.

Article 15: Individual care plans were not in place.

Article 17: The service was unable to meet the educational needs of children.

Article 21: Privacy was not maintained in the garden, which was overlooked on all four sides.

Sycamore Unit, Connolly Hospital

Article 15: The service did not have individual care plans as defined by the Regulations. There was no MDT input into care planning.

Article 16: Each resident did not have access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan and as defined by the Regulations.

Article 19 (1-2): Six-monthly physical health assessments were not documented in the clinical files.

Article 26: The skill mix of staff was not sufficient to meet the assessed needs of the residents.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

St. Brendan's Hospital

Seclusion: On Unit 8A, there was no record in the clinical files that were reviewed concerning whether or not next of kin had been informed about episodes of seclusion. The bathroom and toilet facilities on Unit 8A and Unit O were not satisfactory, although remedial work on Unit 8A was near completion.

Sycamore Unit

Mechanical Restraint: The practice on the unit was at variance with the written policy.

CODES OF PRACTICE

St. Brendan's Hospital

Physical Restraint: There was no record in the clinical files that were reviewed concerning whether or not next of kin had been informed about episodes of physical restraint.

Department of Psychiatry, Connolly Hospital

Admission of Children: The service had no provision for children's education.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan
Adelphi House	15	14	General adult	No
Ard na Gréine	10	10	General adult	No
Daneswood House	14	14	General adult	No
St. Elizabeth's Court	26	26	General adult	No
175 Navan Road	9	9	Rehabilitation	Yes
234 NCR, San Remo	10	9	Rehabilitation	Yes
266 NCR, Cherrymount View	15	15	Rehabilitation	Yes
Maysyl Lodge	12	12	Rehabilitation	Yes
Avondale Lodge	10	9	Rehabilitation	Yes
Weir Home	22	21	General Adult	Yes

CONCLUSION

The provision of clinical services at St. Brendan's Hospital had improved considerably since the last inspection. Multidisciplinary individual care plans had been introduced for residents and there were regular team meetings involving staff and residents. St. Brendan's remains seriously short of health and social care professionals, with no psychology and social work input despite the level of disturbance the service provides for. The Inspectorate noted that local clinicians and managers had implemented a number of changes and improvements and that significant further development would require resources beyond their scope for delivery.

Nationally there was a lack of access to high secure level beds resulting in pressure on St. Brendan's, which provides access to low secure beds. There was pressure both to fill this gap and a difficulty moving on patients from St. Brendan's Hospital who require a higher level of security. This had had an impact on a number of the units resulting in an untenable mix of residents who were acutely unwell, have an intellectual disability, or have varying levels of secure needs which it was not possible to provide for.

Overall, clinicians and managers in the service were frustrated with the ongoing delays in the opening of the additional 22 acute admission beds at Connolly Hospital. This had contributed to continuing admissions to St. Brendan's Hospital where the physical conditions of the premises and mix of residents was not tenable.

Regular meetings had commenced between St. Brendan's and North West Dublin acute/community services and the Local Health Manager, aimed at streamlining the service. More interdisciplinary teamwork was being delivered through specific projects in the community in an attempt to enhance MDT working given the limited numbers of health and social care professionals, and there was collaboration around service provision and development in the service between the clinicians, managers and service users.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The mix of patients on Unit 3A and Unit 3B was untenable and all admissions to these units should cease immediately.*

2. *The mix of patients on Unit O was untenable and gaps in current secure service provision for women should be addressed nationally by HSE.*

3. *To facilitate the cessation of admissions to St. Brendan's, there was an urgent need for the remaining beds at*

Connolly Hospital to be opened. The plan for Pine Unit to be handed over to the mental heath service early in 2009 should proceed promptly and without further delay. Funding should be made available for the recruitment of all additional staff required to run the unit.

4. *St. Brendan's Hospital should identify clearly and agree with HSE the nature of the service it will provide. Policies and procedures should reflect this service provision; in particular, admission and discharge policies should be clear.*

5. *Funding and approval should be made available to populate the teams with the full complement of health and social care professionals. This was particularly critical for the teams providing low secure beds at St. Brendan's Hospital and the Finglas team working in areas of high deprivation.*

6. *Remaining areas of non-compliance on the Regulations, Rules and Codes of Practices should be addressed without delay.*

7. *While refurbishment had taken place on some of the units at St. Brendan's, the premises were old and unsuited to the purpose for which they were being used. They should be replaced at the earliest opportunity, as was advocated in the Grangegorman Development Association plan.*

ST. JOSEPH'S INTELLECTUAL DISABILITY SERVICE

HSE Area	HSE Dublin North East
Catchment	North Dublin
Mental Health Service	St. Joseph's Intellectual Disability Service
Population	221,771
Number of Sectors	1
Number of Approved Centres	1
Specialist Teams	None
Date of Meeting	27 November 2008

SERVICE DESCRIPTION

The service provides mental health care for people with an intellectual disability from North Dublin. The service was going through a period of change and was due shortly to open a 60-bed purpose-built facility that would result in the closing of four traditional-style units in the red-brick building and a group home on campus.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *Service users should have access to a full mental health team including all disciplines.*

Outcome: The service had recruited candidates into the following posts: a senior dietician, a senior social worker, a senior clinical psychologist, a senior speech and language therapist, a senior occupational therapist and a senior physiotherapist. They were expected to take up employment in the first quarter of 2009.

2. *There should be a clear plan and resources provided to close the hospital and further develop the community-based service. In-patient services should be provided in a dedicated admission unit approved under the Mental Health Act 2001.*

Outcome: The new 60-bed streetscape development (10 bungalows of six beds each) would result in the closing of four traditional-style units and a group home on campus and provide state-of-the-art facilities which it was hoped would include an admission unit (depending on staff numbers).

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A comprehensive business plan for 2008/09 was submitted to the Inspectorate.

DEVELOPMENTS 2007-2008

- The nursing complement had been increased by an additional 13.5 whole-time-equivalent staff nurses.
- The acquisition of a new community home in Julianstown to facilitate the transfer of nine clients from the campus to community-based accommodation.
- The capital build of the new 60-bed streetscape.
- The recruitment of senior multidisciplinary team (MDT) members.
- The extension of the advocacy service.
- Establishment of an integrated risk, quality, health and infection control committee.

HOSPITAL CLOSURE PLANS

The service had undertaken a review of the dependency levels of all 169 residents. This review would enable the service to determine its future service provision to meet the needs of the residents and would result in the closing of some units within the hospital.

QUALITY IMPROVEMENTS

- The service had begun to implement the ***Quality Framework*** published by the Mental Health Commission. An initial pilot was undertaken in November 2008 to measure the services compliance against the standards within the framework. Although in the early stages of development, this was a very positive step taken by the service to ensure that it provides a quality service.
- A service-user-led best buddy system.
- Primary care liaison and participation through the community support office.
- Partnership with Target for adult education programmes.
- Reduction in the rates of seclusion.
- A number of clinical audits.

SERVICE USER INPUT TO SERVICE

A two-year pilot advocacy programme in partnership with Inclusion Ireland was currently under way. A number of clients from the service, both in the approved centre and the community, were involved and ongoing staff education sessions were held to support staff in the implementation of the programme.

In addition, the patient advocate facilitated a self-advocacy group for residents and aided individual advocacy meetings.

The local management team facilitated regular meetings with St. Joseph's Association for the Mentally Handicapped (Parents and Friends).

GOVERNANCE

There were regular meetings of the management team, including all disciplines when they were in post. There was an integrated quality, risk, health and safety and infection control committee. The service undertook a number of audits and was accredited by An Bord Altranais and the Royal College of Psychiatrists.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	2
NCHD	2
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	153.5
Nurses based in community residences	71
CMHN	4
Nurses based in day hospitals	0
Nurses based in day centres	0

CNS posts

Speciality	WTE in post
Community support team	4
Behavioural therapy	2
Health care assistants	202.5
Woodwork instructor	1
Montessori teacher	4.5
Gym instructor	1.5
Physical education teacher	1.5
House parent	1
Day services coordinator	1
Recreational therapist	1
Nursery nurse	1
Day services manager	1
Household staff	5

Health and social care professionals

One senior post per discipline had been approved, to commence employment in the first quarter of 2009.

Post	WTE in post
Clinical psychologist	0
Social worker	0
Occupational therapist	0
Physiotherapist	0
Other	0

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The service was non-compliant with six Regulations following the inspection in 2008. The service had submitted an action plan outlining its response to the inspection and how it would achieve full compliance.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was compliant with the Rules.

CODES OF PRACTICE

There was one area of non-compliance in the Code of Practice in relation to the notification of deaths and incident reporting.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

MDT care plans were expected to be piloted during 2009.

Residence	Number of places	Number of residents	Number of Respite Beds	Team responsible	Care plan
Avoca, Donabate	4	5	1	Intellectual Disability	Nursing
Glebe House, Malahide	6	6	0	Intellectual Disability	Nursing
Hilltop House, The Naul	7	7	0	Intellectual Disability	Nursing
Woodlawn, Blake's Cross, Lusk	5	5	1	Intellectual Disability	MDT
Clonmethan Lodge, Oldtown	30	30	0	Intellectual Disability	Nursing

CONCLUSION

The service had made significant progress in improving the quality of care it provided for the service users. The new capital development, the recruitment of senior MDT members and the community developments were positive initiatives that would further enhance the quality of care.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *There should be a dedicated admission unit as part of the new streetscape.*
2. *The health and social care professionals should be part of the management team following appointment.*
3. *The appointment of an additional community team should be considered.*

HSE DUBLIN MID LEINSTER

DUBLIN SOUTH CITY MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	Dublin South City
Mental Health Service	Dublin South City Mental Health Services
Population	133,095
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	Psychiatry of Later Life
Date of Meeting	5 December 2008

SERVICE DESCRIPTION

Dublin South City Mental Health Services provided comprehensive psychiatric care to a population of 133,095 within Dublin South City catchment, which contained high levels of social deprivation in all its sectors. Due to its location, the service received a considerable number of complex cases and cases that were out of area. The service was provided under a tripartite arrangement involving St. James's Hospital, St. Patrick's Hospital and HSE Dublin Mid Leinster. The population was broken down into three sectors, Camac (inner city) with a population of 44,003, Owendoher (suburban) with 67,374, and Drimnagh (inner suburbs) with 23,030.

Each sector was managed by a consultant-led multidisciplinary team (MDT). Acute admission facilities were located in Jonathan Swift Clinic, St. James's Hospital. This 51-bed unit was located centrally and consisted of 26 acute beds, 9 psychiatry of later life acute beds and 16 rehabilitation or step down beds. Community residential facilities were located throughout the catchment area.

A day hospital and sector headquarters were located at St. Martha's in Kilmainham and this facility was shared between three sector teams. Jonathan Swift Clinic was also the location of a day hospital, serving the Owendoher sector.

The Martha Whiteway day hospital was located in St. Patrick's Hospital and provided a service for the older population with mental health needs.

There was a sheltered workshop/day centre and a psychiatry of later life day hospital located in St. Patrick's Hospital, accessible by all the mental health teams in the catchment area. It was reported that this sheltered workshop/day centre was due to be re-located from St. Patrick's Hospital to a new location at the Meath Campus as part of the transfer of undertakings by the end of first quarter of 2009.

Outpatient clinics were located in St. James's and St. Martha's and there were approximately 18 consultant-attended clinics per week. It was reported that the waiting list times for outpatient clinics were low, approximately two to three months depending on the sector.

Each multidisciplinary team provided comprehensive care to the adult population of the relevant sector through domiciliary intervention, day hospitals, a day centre and outpatient clinics.

There were no places for old or new long stay patients. The service did not have home-based care or assertive outreach services. An out-of-hours service was provided.

There was a separate homeless service for Dublin South City. The consultant psychiatrist responsible for this service does not have admitting rights to St. James's Hospital.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *There should be a written plan to direct and guide the provision of services.*

Outcome: There was no written plan available that provided a clear direction of the provision of services. The service however did provide service plans for 2008 and 2009 that indicated future development priorities.

2. *All teams should be fully staffed and have community facilities to provide an adequate service.*

Outcome: The service does not have fully staffed teams. It was reported that the service had funding for two additional community nurses but these were lost due to the recruitment embargo. There were also vacancies in social work, occupational therapy and psychology.

3. *The provision of a fully staffed rehabilitation team should be a priority for the service.*

Outcome: This had not been achieved. However, the service reported that there was a rehabilitation-focused team meeting headed by an assistant director of nursing. A meeting was held every three months to discuss which residents were ready for independent living. One apartment was available to the mental health service through the partnership agreement with Dublin City Council. The service had managed to place five residents from a group home into independent living. The service had 55 rehabilitation beds in the community.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The service had produced a service plan that outlined the development priorities for 2008–09. No specific time frames or indications of funding levels were reported.

REVENUE DEVELOPMENTS

Priority 1: The development of a rehabilitation team.

Priority 2: Catchment area team enhancements in line with ***A Vision for Change.***

MINOR CAPITAL DEVELOPMENTS

A minor capital requirements list had been drawn up for the whole service, with priorities identified.

CAPITAL DEVELOPMENTS

The service had undertaken to grow in accordance with ***A Vision for Change*** and the Primary Care Strategy to develop sector services in line with the primary care networks. It was hoped that the result would be as follows:

CAMAC: The CAMAC sector would develop a sector headquarters, day hospital and outpatients on the Meath Campus.

Owendoher: The Owendoher sector would develop a sector headquarters, day hospital and outpatients between Terenure Health Centre Development and the Good Counsel Site, Ballyboden.

Drimnagh: The Drimnagh sector would develop a sector headquarters, day hospital and outpatients on the Emmet Road Health Centre Development.

Long-term care: The service plans to secure funding for the management of Phase II Bloomfield Care Centre Ltd to provide 50 long term care beds, 12 respite beds and a day centre in partnership with Bloomfield and Dublin West/ South West Mental Health Service. Service level agreements negotiations were in progress at present.

DEVELOPMENTS 2007-2008

Reconfiguration of sector boundaries: This sector reconfiguration began in October and was due to be reviewed at the end of the second quarter 2009.

Human resources: It was reported that posts subject to the transfer of undertakings and posts attached to St. James's Hospital were not lost. Vacant posts were lost. A review had been carried out in relation to administration staff and it was reported that the service allocated set administration staff to each sector.

Transfer of undertakings: In February 2006, the HSE announced that it was transferring the community service from St. Patrick's Hospital. This transfer was due to take place in January 2009.

Expansion of heads of department team: The heads of department team was expanded in accordance with A *Vision for Change* to a more inclusive structure. It was a priority of the service to further develop this structure.

Referrals: The service was currently piloting a draft referral form.

GPs: Work had been carried out by the service on education programmes for GPs.

QUALITY IMPROVEMENTS

- The service had developed a medication education programme that was available to all patients on the acute unit.
- The service had introduced risk screening for all admissions to the acute unit. This was managed by the admitting nurse and doctor.
- The services of a pharmacist were available for in-patient care and this was tied into risk management reviews.
- The service had revised its partnership model with Dublin City Council to improve access to housing opportunities for patients in this service. This had resulted in a number of successes, one of which had been the mainstreaming of a number of residents from a group home facilitating the pending closing of the facility.
- In response to recommendations, the service had created patient-centred care plans through a collaborative psychosocial model with the hostel residents.
- The service was in the process of developing an education programme in conjunction with primary care and a number of meetings have taken place.
- There had been significant developments in the area of MDT care planning in 2008. This initiative was currently running and was audited on a weekly basis by the clinical director and senior nursing staff.
- A satisfaction survey of carers and service users regarding the service was carried out and the results of this were due in the near future.

SERVICE USER INPUT TO SERVICE

The service had recruited another three members to attend the HSE/DCU Cooperative Learning: Service Improvement Leadership for Mental Health Service Users, Carers and Service Providers programme and these individuals (service user representative, service carer representative and service provider representative) continue to attend heads of department meetings. The Irish Advocacy Network (IAN) representative reported that relationships with the management of the service were good and meetings were held regularly between the IAN and a member of the nursing staff. The IAN representative also reported that service staff worked well with the patients. It was reported that there was a lack of leisure activities. A rodent problem had also been identified in the garden and that this was currently being addressed by the service.

GOVERNANCE

The governance structure in this service was as follows:

- corporate governance group
- executive management group
- heads of department
- MDT teams
- department meetings

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	6.5
NCHD	10
Specialist registrar	1.5

Nursing staff

Post	WTE in post
DON	1
ADON	2
Nurses based in in-patient services	32
Nurses based in community residences	9
CMHN	7
Nurses based in day hospitals	5
Nurses based in day centres	1
Other	3

CNS posts

Speciality	WTE in post
Psychiatry of later life	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	5
Social worker	5.5
Occupational therapist	7

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

It was reported that the psychiatry of later life service was due to locate its sector headquarters and day hospital to the Meath Campus in advance of the major capital plan. Minor capital had been obtained and an unoccupied unit was to be renovated to accommodate the service until the facility on the St. James's Hospital campus was completed. It was planned that renovations would be complete by the end of the first quarter 2009. There was a psychiatry of later life in-patient liaison service.

Psychiatry of later life team

Staffing	2007	2008
Population	18,012	18,012
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
CMHN	2	2
Psychologist	1	1
Social worker	1.5	1.5
Occupational therapist	2	1

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was compliant with Articles relating to food safety, communication, searches, individual care plan, children's education, transfer of residents, general health, privacy, health and safety, maintenance of records, and register of residents. The approved centre was non-compliant with Articles relating to residents' personal property and possessions, therapeutic services and programmes, provision of information to residents and staffing.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service reported that seclusion and mechanical means of bodily restraint were not used at the approved centre. The service was compliant with the Rules governing the use of ECT.

CODES OF PRACTICE

The service was compliant with the Codes of Practice governing the use of physical restraint, notification of deaths and incident reporting and ECT for voluntary patients. The service was non-compliant with the Code of Practice on the admission of children.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

The service had three 24-hour community residences with ten beds in each. Care plans had changed and they were now recovery-focused. Each resident was assigned a new key worker on an annual basis.

Residence	Number of places	Number of residents	Team responsible	Care plan Type
Quilca	10	8	CMHT	Yes
Ashdale House	10	10	CMHT	Yes
Woodlands	10	10	CMHT	Yes

CONCLUSION

The Dublin South City catchment area continued to be innovative and had introduced a number of quality improvement initiatives. The service had made progress in the area of rehabilitation by way of assessment of residents and placement of those ready for independent living, however, further progress in this area was stifled due to the lack of a fully staffed consultant-led rehabilitation team.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *There should be a written plan to direct and guide the provision of services.*
2. *There was an urgent need for a fully staffed multidisciplinary rehabilitation team for this service.*
3. *All teams should be fully staffed and have community facilities.*

DUBLIN SOUTH EAST MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	Dublin South East
Mental Health Service	Dublin South East Mental Health Services
Population	Approximately 110,000
Number of Sectors	3.5
Number of Approved Centres	1
Specialist Teams	Eating Disorder Psychiatry of Later Life
Date of Meeting	3 September 2008

SERVICE DESCRIPTION

Dublin South East had a population of approximately 110,000 and included the Dublin 2, Dublin 4, Dublin 14 and Dublin 8 postal areas. It had one approved centre, Elm Mount, and 3.5 sectors with four community mental health teams. There were also two psychiatry of later life teams and an eating disorder service. There were three 24-hour-supervised residences and three elderly care units.

Elm Mount unit was in St. Vincent's Hospital, Elm Park. It was a relatively new unit and had maintained a good decorative level.

A liaison service was provided by a 0.5 whole-time-equivalent (WTE) psychiatrist (0.5 was allocated to the eating disorder service), one nurse and one NCHD. There was also an academic post of 0.5 WTE with one senior registrar.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The absence of speciality teams in rehabilitation should be resolved with all senior management teams and local health offices in the wider area.*

Outcome: This had not been achieved.

2. *All multidisciplinary teams should be fully staffed and have community facilities to provide an adequate service.*

Outcome: A new purpose-built day centre opened on the campus in Vergemount with recreational areas, therapy areas, gym, training suite and a garden which was developed by service users. An additional social worker had been recruited. Apart from this there had been no additions to the multidisciplinary teams.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A draft business plan for 2009 was submitted. No time frames were given and levels of funding for 2009 were not available.

The plan outlined several areas that the service intended to address in 2009:

- The amalgamation of sectors to give two large sectors with headquarters in Eglinton Road and in Baggot St. Hospital.
- Funding for a liaison psychiatrist would be requested. It was planned to separate the eating disorder programme and liaison psychiatry into two separate services.

- A third consultant psychiatrist for psychiatry of later life would be sought to bring the service to one consultant per 10,000 elderly population.
- Further local developments in line with *A Vision for Change.*

DEVELOPMENTS 2007-2008

- The Vergemount Day Centre had been demolished and a new day centre opened on the campus in a purpose-built unit. This had recreational areas, therapy areas, gym, training suite and a garden that was developed by service users.
- A staff nurse had been deployed to the National Maternity Hospital. This was achieved within current resources.
- A number of community residences had been refurbished or were about to undergo refurbishment, namely Cois Céim, Rathgar Rd and Grosvenor Rd.
- The Biofeedback service had recommenced with 0.5 WTE nursing staff, again obtained within current resources.
- A new system was in place for storage and retrieval of clinical files. Approximately 10,000 files had been indexed to date.
- Psychiatry of later life had developed a link with nursing homes and provided education programmes.
- An additional social worker had been recruited.
- Two registrar posts had been re-graded to senior registrar posts.

QUALITY IMPROVEMENTS

- A home care assertive community treatment programme pilot was due to be rolled out during March 2009.
- There was a newsletter for service users in the psychiatry of later life service.
- There was a self-medication programme in the medium supervised residence.
- The information booklet was published in French and Polish as well as in English.
- Training of staff in CPR was completed and CPI training was in progress.
- Four staff undertook training in CBT and 60 staff trained in solution focussed training as part of the Refocusing Project.
- An ECTAS-approved course in ECT was delivered to staff.

SERVICE USER INPUT TO SERVICE

There was evidence of a good working relationship between the Irish Advocacy Network (IAN) and all elements of the mental health service. A patient satisfaction survey (SURE) had been initiated and there was collaboration between IAN and the services. IAN was beginning to plan extending its service to community facilities that was supported by the service. They were also involved in the Refocusing Project. The residents continue to complain about the lack of ventilation in Elm Mount, which had also been noted by staff working in the unit. Lack of appropriately delivered information for people with visual impairment was highlighted and the service and IAN agreed to collaborate in finding a solution to this. Residents had complained that there was only limited activities in Elm Mount but in the main this had been addressed through the occupational therapy department.

GOVERNANCE

The management team was multidisciplinary. Regular audits were carried out and feedback to staff was provided.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	4
Specialist registrar	2

Nursing staff

Post	WTE in post
DON	1
ADON	6
Nurses based in in-patient services	35
Nurses based in community residences	95
CMHN	7
Nurses based in day hospitals	5
Nurses based in day centres	5

CNS posts

Speciality	WTE in post
Cognitive behaviour therapy	0.5
Family therapy	2
Biofeedback	1
CMHN	2

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Principal	PCCC
Occupational therapy	Manager	General Hospital

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: There was no rehabilitation team. There were no plans outlined for a rehabilitation team in the 2009 business plan.

Psychiatry of later life: Psychiatry of later life served an elderly population of 33,000 with only two teams. A further team was required to allow an acceptable level of service.

Liaison: A liaison service was provided by a 0.5 WTE psychiatrist (0.5 was allocated to the eating disorder service), one nurse and one NCHD.

Eating disorder: The psychiatrist on the eating disorder team also provided a liaison service. The in-patient beds were provided in Elm Mount.

Psychiatry of later life team

Staffing	2007	2008
Population over 65 years		33,000
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	0	4
CMHN	6	6
Psychologist	1.8	2
Social worker	0.6	2
Occupational therapist	1	2

Liaison team

Staffing	2007	2008
Population		
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	1	1
Nurse	1	1

Eating disorder team

Staffing	2007	2008
Population		
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	0.5	2
Nurse	1	2.5
Psychologist	0	0
Social worker	0	0.5
Occupational therapist	0	0
Dietician	1	1

IN-PATIENT FACILITIES

Acute mental health facilities were in Elm Mount in St. Vincent's Hospital in Elm Park. This unit was in good decorative order and was a pleasant bright unit.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The Approved centre was compliant with the majority of the Articles of the Regulations. The service had been non-compliant in the provision of an individual care plan and also in the provision of children's education. Since the

assessment of compliance the service had completed an audit of care planning and had set up a monitoring system to ensure compliance with this Article of the Regulations.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was compliant with the Rules governing the seclusion, mechanical restraint and ECT.

CODES OF PRACTICE

The service was compliant with the Codes of Practice on ECT for voluntary patients and the notification of deaths and incident reporting. It was not compliant with the Code of Practice on the admission of children.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Cois Céim and Unit D and Unit E provided residential facilities for elderly service users and were under the care of the psychiatry of later life teams. At the time of the inspection a number of renovations were in progress and consequently there was some movement between the residences in order to vacate the residences where work was being carried out. There was no rehabilitation team and the remainder of the community residences were under the care of the community mental health teams. Morehampton Lodge had four rehabilitation beds that were not operational due to the absence of a rehabilitation service.

Residence	Number of residents
Rathgar Road	12
Morehampton Lodge	10
Grosvenor Road	13
Kerlogue Road Group Home	2
Cois Céim	20
Unit D	26
Unit E	26

CONCLUSION

Dublin South East operated a good in-patient and community mental health service despite understaffing of the community mental health teams. The plans to amalgamate the present structure to two sectors with more spacious headquarters were welcome and would provide a more comprehensive community service. There was evidence of team working and the service had an excellent record of training and auditing. Staff in the approved centre had achieved almost complete compliance with the statutory requirements for approved centres. The continuing absence of a rehabilitation team was disappointing as there was an evident need for such a service. As the two psychiatry of later life teams delivered a service for 33,000 people over the age of 65 years, there was an urgent need for a third psychiatry of later life team.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *There should be a fully staffed rehabilitation team for the service.*
2. *All multidisciplinary teams should be fully staffed.*
3. *Further development of community mental health facilities was required.*

DUBLIN WEST/SOUTH WEST MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	Dublin West/South West
Mental Health Service	Dublin West/South West Mental Health Services
Population	256,566
Number of Sectors	4
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life Liaison
Date of Meeting	18 September 2008

SERVICE DESCRIPTION

This service served a large population with high levels of deprivation in all sectors. There were two approved centres, Acute Psychiatric Unit AMNCH Hospital and Lora Centre, St. Loman's Hospital, Palmerstown. The Lora Centre had 12 residents on the day of inspection, having made considerable efforts to move residents into more appropriate accommodation in the community. The service continues to provide a community-focused service.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All teams should be fully staffed and adequately resourced, in line with national mental health policy.*

Outcome: The staffing situation was worse than last year. The service had lost posts in social work, psychology and occupational therapy, due to the HSE embargo on employment. The service had a number of nursing vacancies, and was covering the shortfall with agency staff and overtime. The cost of agency and overtime far exceeds the cost of filling the vacancies with substantive posts.

2. *Proposed developments of community residences should be reviewed in line with current available evidence.*

Outcome: The service intends to develop residences as discussed last year. The proposal was to have the residences in three modules, containing two areas with five beds and one with seven. All developments were to be linked with primary care developments.

3. *The core management team should be inclusive of all disciplines.*

Outcome: There had been no developments with this recommendation despite the representatives from social work, psychology and occupational therapy expressing a keen desire to progress this issue and highlighting issues arising for them as a result of exclusion from this top-level decision-making forum within the service.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The service reported that their business plan was the HSE national plan for mental health. There was no local interpretation available to the Inspectorate.

DEVELOPMENTS 2007-2008

- Extension of evening and weekend activities for residents and patients in the approved centre at AMNCH.

- Two members of nursing staff had successfully completed the Nurse Prescriber course and a further five had taken up the programme during the year.
- Three senior occupational therapists undertook post-graduate masters programmes in Disability Studies and Career Guidance (specialising in vocational rehabilitation).
- The HSE/DCU Cooperative Learning: Service Improvement Leadership for Mental Health Service Users, Carers and Service Providers programme had been successfully completed by three people associated with the service and a further three were due to be sponsored in the autumn despite funding cutbacks.
- A rehabilitation day programme had commenced. A multidisciplinary assessment tool and a multidisciplinary care plan had been introduced in the Rehabilitation Unit at St. Loman's.
- A carers group had been established in psychiatry of later life, with activities including the development of an information pack for carers.
- An education programme for children with parents with mental illness had been run jointly between the Tallaght and Clondalkin sectors.
- An Open Day was held on the 24 June in Clondalkin, where staff made presentations about the mental health service to invited local and national statutory and voluntary organisations in the health service.
- A physical activity group was being delivered in Clondalkin under the umbrella of health promotion for clients with severe and enduring mental illness, to promote exercise and social contact.
- A number of initiatives were underway to share learning and continue to enhance practices across different teams; these include development of (a) a revised Nursing Homecare Assessment form, (b) introductory package for the home care teams.
- A Pilot Post Graduate Psychiatric Nursing programme that leads to registration in the Psychiatric Division of the nursing register was underway in conjunction between HSE and a number of partner services and DCU. The Dublin West/South West Mental Health Service offers clinical placements to 7 course participants.

QUALITY IMPROVEMENTS

- User involvement/feedback through the SURE questionnaire had been implemented as part of the acute in-patient care Refocusing Project in the Acute Psychiatric Unit at AMNCH.
- A Solution to Wellness group had been established with clients in Orchard Road day centre. This was a multidisciplinary initiative between nursing staff and occupational therapists.
- A Wellness Recovery Action Plan (WRAP) programme was run over ten weeks in Ballyfermot. The DVD was being used as part of information, training and awareness for staff in the recovery model.
- A research project on occupational performance of people with severe mental illness was under way following placement into council-supported accommodation.
- The nursing recruitment and retention group had completed a research survey, due to be released soon.
- A number of audits had been completed in the service including: audit on nursing documentation, seclusion audit, and audit on clients who present with first onset psychotic illness.
- A multidisciplinary clinical governance team had been established.
- A multidisciplinary group had been established on integrated care planning and integrated patient records.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a service to both approved centres. The report on the Lora Centre highlighted a number of positive aspects: the residents spoke highly of the food, the staff, being part of a close-knit community, and being part of the MDT meetings. The negative aspects were being addressed by the management team. The residents in the approved centre in Tallaght spoke positively about the staff, peer support, occupational therapy, information on rights pertaining to the Mental Health Act 2001 being available, and about the new garden furniture. Some of the negative aspects centred on the lack of availability of talk therapies and counselling, residents' delayed discharge because of unsuitable, or lack of community accommodation, and on the fact that not all residents were aware of their care plan.

Governance

Not all disciplines were represented on the MDT management team. It was reported that there were a number of working groups and committees with MDT representation but the core management team consisted of the traditional tripartite model of the clinical director, director of nursing and hospital manager. A multidisciplinary clinical governance group had been established and the first meeting had been scheduled for two weeks after the inspection meeting.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	13.8
NCHD	18
Specialist registrar	2

Nursing staff

Post	WTE in post
DON	1
ADON	7.5
Nurses based in in-patient services	61.5
Nurses based in community residences	28
CMHN	13
Nurses based in day hospitals	14

CNS posts

Speciality	WTE in post
CMHN	13
Home-based care	4
Behaviour psychotherapy	1.5

Health and social care professionals

Post	WTE in post
Clinical psychologist	8
Social worker	8
Occupational therapist	13
Speech and language therapist	1
Dietician	2

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Liaison: A consultant psychiatrist provided a liaison service to AMNCH.

Rehabilitation team

Staffing	2007	2008
Population	256,566	256,566
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
CMHN	3	1
Psychologist	0	0
Social worker	0.3	0.3
Occupational therapist	2	2
Assertive outreach	0	3

Psychiatry of later life team

Staffing	2007	2008
Population	18,500	18,500
Consultant psychiatrist	1.5	1.8
NCHD (including specialist registrar)	2	2
CMHN	2	2
Psychologist	0	0
Social worker	2	1
Occupational therapist	1	1
Day facility nurse staffing	0	1

Psychiatry of later life home care team

Staffing	2007	2008
CNM2	1	1
CNS	0	0
Staff nurse	2	2
Occupational therapist	0	1
Social worker	0	1

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The Acute Psychiatric Unit, AMNCH, was compliant with all the Regulations. The Lora Centre was compliant with all but four of the Regulations.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The Acute Psychiatric Unit, AMNCH, was not compliant with the Rules on seclusion. The areas of non-compliance centred on communication.

CODES OF PRACTICE

The only area of non-compliance was physical restraint in the Acute Psychiatric Unit, AMNCH.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of residents	Team responsible	Care plan type
St. Columba's Hostel, Crumlin	19	Rehabilitation	
Grove House, Celbridge	14	Rehabilitation	
Beaufort House, Tallaght	10	Rehabilitation	

CONCLUSION

The two approved centres had a small number of areas of non-compliance related to the Regulations, Rules, Codes of Practice and Section 60, MHA, 2001. In other areas, the service continued to be involved in ongoing quality development as evidenced by the pilot projects, research, audits and clinical developments being undertaken and supported. However, for a service that was so progressive in some areas, it was difficult to understand the failure to develop a multidisciplinary core management team for the service.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The approved centres must ensure compliance with the relevant Regulations, Rules, Codes of Practice and Section 60, MHA, 2001.*

2. *The service should develop the management team to include heads of clinical psychology, social work and occupational therapy.*

3. *Funding should be made available to ensure multidisciplinary teams are fully resourced and staffed with a mix of professionals to address the needs of the population served and in line with national mental health policy.*

EAST WICKLOW MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	East Wicklow
Mental Health Service	East Wicklow Mental Health Services
Population	109,472
Number of Sectors	2
Number of Approved Centres	1
Specialist Teams	None
Date of Meeting	14 October 2008

SERVICE DESCRIPTION

The East Wicklow catchment area had a mixed urban and rural base. From its inception, the vision for the service had been community oriented, and there were two community-based services at Arklow and Bray. The in-patient service was in Newcastle Hospital, which had one admission ward with 30 beds and one long-stay ward with 30 beds. There were no speciality teams such as psychiatry of later life or rehabilitation in the service. There was no occupational therapist and psychology resources were limited. The service had 65 community hostel places.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The absence of speciality teams and psychiatry of later life needs to be resolved with all senior management teams and local health offices in the area.*

Outcome: There had been no appointment of speciality teams in the service.

2. *There should be an occupational therapist on each clinical team.*

Outcome: No occupational therapist had been appointed to the service.

3. *The core management team should be inclusive of all disciplines.*

Outcome: Due to the lack of full multidisciplinary (MDT) teams, it had not been possible to implement this recommendation. There was no service user on the management team but it was planned to correct this in the near future.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The service was keen to maintain the current level of provision of services in spite of cutbacks and difficulty in recruiting staff because of the embargo on recruitment.

In line with the plan to have catchment area sizes of between 300,000 to 400,000 population outlined in ***A Vision for Change,*** it was envisaged that the current catchment in East Wicklow would be reconfigured. In the projected new catchment area of East Coast/Midlands, it was likely that admissions would be to St. Vincent's Hospital, Elm Park. Because of the potential travel time to this service (up to two hours from the most southerly part of Co. Wicklow), the service might consider providing crisis houses for some admissions.

The view was expressed by the service that it had too many beds, i.e. 90 in total, but of these only 50 were actually acute psychiatric beds. In light of the service's plan to move to a more community-based service, there was a need

to develop more networks between agencies. It was planned to integrate sectors and it was expected this would be completed by the end of 2008.

DEVELOPMENTS 2007-2008

- There were developments in the admission unit. A library had been opened; a new health promotion noticeboard displays information on agencies such as the advocacy and local self-help groups. A new disabled access bathroom was under construction, and this would be followed by construction of a new kitchen in Glencree Ward.
- A multidisciplinary care plan had been introduced in the admission unit of the approved centre. There was now a facility for accessing laboratory results electronically from Loughlinstown Hospital.
- The DETECT early intervention in psychosis service had been extended to all Wicklow patients.

HOSPITAL CLOSURE PLANS

There were no closure plans at present.

QUALITY IMPROVEMENTS

- The service had improved quality service in its outpatients clinics. Patients were given appointment times, waiting times were no longer than 15 minutes, and all patients were reviewed by the consultant at least every fourth visit. The number of outpatient visits had been reduced and as a result, consultations were less pressurised.
- A Slí na Sláinte walk had been established in the grounds of the hospital.
- The service reported that it now delivered a more personalised and rapid assessment to its users.
- Sector coordinators had been introduced in the past two years.

SERVICE USER INPUT TO SERVICE

The service user advocate described a very interactive relationship with the staff. A private room was made available to meet with service users, and the recent introduction of the information stand in the ward was very helpful. There was a request for talk therapies to be more readily available to users. As yet, there was no service user on the management team.

GOVERNANCE

The management team had been extended to include a representative from the psychology service. The team met monthly with the chairperson of the Wicklow Mental Health organisation.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	4
NCHD	8
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	0
ADON	3
Nurses based in in-patient services	36.5
Nurses based in community residences	13
CMHN	5
Nurses based in day hospitals	2
Nurses based in day centres	6
Other (care staff, student)	9

Health and social care professionals

Post	WTE in post
Clinical psychologist	2
Social worker	2
Occupational therapist	0

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

There were no specialist teams in the catchment area.

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

An inspection of the approved centre in Newcastle Hospital was conducted in September 2008. It failed to meet the Regulations in respect of MDT care plans and consequently in provision of therapeutic services. Due to lack of appropriate skill mix, the centre also failed to comply with the Regulations in respect of staffing. The premises was also in need of some minor repairs to ensure safety to residents.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The centre was compliant with the Rules governing the use of ECT, and mechanical restraint, applied in respect of Part 5 of the Rules. The service did not use mechanical restraint otherwise. In relation to the use of seclusion, the service was non-compliant with the stipulation that an incident of seclusion should be discussed afterwards by the MDT with the resident.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Fitzwilliam House	12	11	General adult	Nursing
Ellerslie House	14	10	General adult	Nursing

CONCLUSION

The recommendations from the report of 2007 have not been implemented. There had been no provision of specialist teams to the service, and MDT care plans had been introduced in a limited way. The lack of properly resourced disciplines of occupational therapy, psychology and social work resulted in an inability to provide full multidisciplinary care to residents.

Despite the difficulty of funding and the embargo on recruitment, this service showed great commitment to the care of patients and residents. There continued to be very good collaboration between staff and the Friends of Newcastle, with clear benefits to residents of the hospital.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Specialist teams should be set up to provide rehabilitation and psychiatry of later life.*

2. *Provision of occupational therapy services and augmentation of psychology and social work staffing should be a priority within the service.*

3. *The implementation of MDT care plans should be extended to all residents in the approved centre.*

KILDARE/WEST WICKLOW MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	Kildare/West Wicklow
Mental Health Service	Kildare/West Wicklow Mental Health Services
Population	205,175
Number of Sectors	5
Number of Approved Centres	1
Specialist Teams	Rehabilitation
Date of Meeting	15 October 2008

SERVICE DESCRIPTION

The Kildare/West Wicklow catchment area had been per capita one of the lowest funded catchments in the country. It had an expanding population base but little or no increase in funding to allow adequate provision of service. The acute unit, Lakeview Unit, had 29 beds and for the majority of the time was operating at well over capacity. The community services were not sufficiently developed to provide an adequate alternative to in-patient care. This was despite an obvious commitment to community services over a number of years.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The core management team should be inclusive of all disciplines.*

Outcome: This had been achieved. There was now a multidisciplinary management team.

2. *All teams should be adequately staffed and community facilities put in place to deliver an adequate mental health service.*

Outcome: A senior psychologist and social worker were appointed. There had been no further addition of staff or improvement in community facilities for the community mental health teams.

3. *A psychiatry of later life team and a liaison team should be appointed.*

Outcome: There was no psychiatry of later life team.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A national mental health business plan for 2008 was provided. The only specific documented action for Kildare/West Wicklow stated that the HSE would map existing community mental health teams, carry out a gap analysis and carry out reconfiguration as appropriate. There were also plans to initiate multidisciplinary team (MDT) training and recruit staff nationally.

DEVELOPMENTS 2007-2008

- A principal psychologist and a social worker had been appointed

QUALITY IMPROVEMENTS

- A carers group in Naas had started.

- A joint review of day services in the North sector community mental health team had begun.
- Cognitive behaviour therapy had been introduced by the occupational therapist in the North West sector.
- Two groups specifically for men were operational in the area.
- There was an education programme for women with post-natal depression and also for carers and family members of persons with mood disorders in South Kildare.
- A 12-week programme for young adults who have newly been diagnosed with mental illness had commenced and it was planned to initiate an early intervention programme.
- A number of group therapies were running, including mindfulness training and a group for persons with personality disorders.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) was carrying out a SURE satisfaction survey of in-patients following discharge. Service users reported a positive relationship with all staff. Service users also stated that they found the Refocusing Project beneficial. More information regarding medication, care plan and treatment options was highlighted.

GOVERNANCE

The service management team was multidisciplinary, while the senior executive team consisted of the clinical director, the director of nursing and the service manager. Service users were not involved in the management team. The multidisciplinary management team were involved in active planning within the service and a number of clinical audits had been completed.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	9
NCHD	12
Specialist registrar	2

Nursing staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	35
Nurses based in community residences	15
CMHN	18
Nurses based in day hospitals	6
Nurses based in day centres	4
Home care	5

CNS posts

Speciality	WTE in post
Bereavement	1
Drama therapy	1
Rehabilitation	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	3
Social worker	6
Occupational therapist	6

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Principal	1

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Psychiatry of later life: There was no psychiatry of later life team.

Liaison: There was no liaison team.

Rehabilitation team

Staffing	2007	2008
Population	205,000	205,000
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	
CMHN	1	1
Psychologist	0	
Social worker	0.5	1
Occupational therapist	0	–

IN-PATIENT FACILITIES

Lakeview was a 29-bed acute in-patient unit in Naas General Hospital. On occasions, the unit had had to accommodate up to 36 residents. This was achieved by referral to hospitals in other local health areas.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Lakeview was not compliant with the Regulations regarding identification of residents, policies on communication, searches, children's education and risk management procedures. There was no care plan in place and as a result therapeutic activities were not linked to individual care plans.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Seclusion: The seclusion room was used as a bedroom on occasions and there were deficits in recording information about seclusion given to patients and next of kin.

ECT: The service was compliant in the use of ECT.

Mechanical restraint: Mechanical restraint was not used in the unit.

CODES OF PRACTICE

Physical restraint: There was a deficit in recording of information given to the resident and next of kin with regard to the physical restraint.

Admission of children: There was no policy on the admission of children and the facility was not suitable for the admission of children.

Notification of deaths and incident reporting: There was no comprehensive risk management policy.

ECT for voluntary patients: The service was compliant in the use of ECT for voluntary patients.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

There were two 24-hour supervised community residences each with 15 beds. Bramble Lodge in Newbridge and Larine House in Maynooth. The rehabilitation team have responsibility for these residences.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Bramble Lodge	14	14	Rehabilitation	
Larine House	14	14	Rehabilitation	

A third residence, Clonree House, although ready, cannot open due to staffing resource issues.

CONCLUSION

There was understandable frustration within the service at the lack of community resources. This had put enormous pressure on in-patient beds and much valuable clinical time was spent looking for in-patient beds in other local health areas. This also had implications for continuity of clinical care for service users and the ability to provide a comprehensive care pathway. Integrated care planning had not yet been implemented. However the commitment to provide community mental health service remains a priority in Kildare/West Wicklow, despite the inadequacy of staffing and facilities. The fact that a completed supervised community residence cannot open due to resource issues adds to the capacity difficulties and the provision of community accommodation. The rehabilitation team was poorly resourced and as a result cannot provide an adequate service. Despite this, there had been a number of developments within the service and the recruitment of a social worker and psychologist was welcome.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The new community residence, Clonree House, should be opened.*

2. *The rehabilitation team should be resourced in order to provide an adequate service.*

3. *There should be adequate staffing and resourcing of community mental health teams. This would decrease the pressure on in-patient beds by providing community-based service.*

LAOIS/OFFALY MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	Laois/Offaly
Mental Health Service	Laois/Offaly Mental Health Services
Population	137,616
Number of Sectors	3
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	21 September 2008

SERVICE DESCRIPTION

Laois/Offaly catchment provided services across three sectors, from two approved centres, St. Fintan's Hospital, Portlaoise and the Department of Psychiatry, Portlaoise, and from well-established community mental health teams. There were plans in place for the development of the St. Fintan's hospital site that included provision for the 27 residents remaining on the two remaining wards.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The core management team must be inclusive of all disciplines.*

Outcome: There had been no progress with this recommendation.

2. *All community mental health teams should have a single point of referral to the service and should be discussed at team meetings.*

Outcome: This was resolved, the social work department continues to take occasional referrals from clients and HSE staff.

3. *Staffing of all teams should meet the requirement of national mental health policy.*

Outcome: Staffing numbers did not meet the requirement of the national mental health policy.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The business plan for mental health was determined at a national level in the HSE and the service had implemented a local plan to meet the key requirements.

DEVELOPMENTS 2007-2008

- Commencement of 2.5 WTE permanent consultant psychiatrist positions for Portlaoise, Tullamore, and psychiatry of later life, one with a special interest in psychotherapy.
- Development of a psychiatric consultation liaison service to the Midland Regional Hospital, Portlaoise.
- Pilot GP outreach service set up in the Portlaoise sector.
- Appointment of a therapeutic instructor for 3 days a week, from 3 June, 2008.

- Four existing attendant staff were currently undertaking the healthcare assistant training course.
- Upgrade of cognitive behaviour therapy nursing post to Advanced Nurse Practitioner.
- Appointment of a permanent training officer, who commenced work on 1 August, 2008.

CAPITAL DEVELOPMENTS

- Completion of the rehabilitation/recovery unit, due to open in October 2008.
- The new day centre in Rathdowney, Birr Sector – a work in progress, but due for completion December, 2008.
- Offaly County Council approved the plan to complete the upgrade of Birr Community Mental Health Centre, for which development funding of €195,000 was provided.

HOSPITAL CLOSURE PLANS

The service presented an outline plan of the proposed development of the St. Fintan's Hospital site. The plan had not been approved, but did include provision for the 27 residents in St. Fintan's.

QUALITY IMPROVEMENTS

- Expansion of range of therapeutic activities in the rehabilitation/recovery services.
- An exhibition of paintings and sculptures by mental health services users in Tullamore and Rathdowney had been arranged in conjunction with Offaly and Laois County Council Art Officers. In Birr, an exhibition arranged in conjunction with Birr Mental Health Association and Birr Theatre and Arts Centre. The three exhibitions run in September and October 2008.
- Ongoing review and development of policies and standard operating procedures for the service.
- A psychiatric consultation liaison nurse (PCLN) outreach service for GPs was piloted in the Portlaoise sector.
- A staff attitudinal survey was conducted in relation to rehabilitation/recovery services.
- Nursing assessment tools had been introduced in Male 6 Ward.
- Updating of rehabilitation/recovery team assessment and care plan.
- Continued reorientation of community services in the Tullamore sector, resulting in reduction of waiting lists and increase in allocated patient times with consistency of consultant. A further new patient clinic in Tullamore was established.
- An increase in community-based services in the Portlaoise sector, with an additional new patient clinic and extra day hospital activities.
- Expansion of day centre activities in the Birr sector.
- An audit of outpatient clinics and urgent referrals was carried out in psychiatry of later life, and this had resulted in the modification of practice in the relevant area.
- An assessment tools portfolio was being produced and made available at every assessment for all multidisciplinary professionals in both Laois/Offaly and Longford/Westmeath, driven by the Laois/Offaly services. Training in the use of the tools portfolio had been completed for 30 staff in Laois/Offaly.
- Establishment of formal links with the primary care development officer, with arrangements for meetings with all sector teams.

- Ongoing training for staff in MHA 2001. Six MHA 2001 training sessions were provided to Garda Síochána members in their workplace.

SERVICE USER INPUT TO SERVICE

The service reported the following developments that involved or facilitated service user input:

- Continuing support of the Irish Advocacy Network (IAN).
- Report on rehabilitation/recovery service user survey 2008.
- The establishment of a multidisciplinary psychiatry of later life carer support group.
- The peer advocacy steering group, now in its fifth year of operation.
- HSE complaints procedure.
- The Lighthouse Club, an out-of-hours social networking unit run by service users in conjunction with the IAN.
- The Finding Your Way to Recovery group, a joint initiative between Mental Health Social Work, Primary Care Social Work and Schizophrenia Ireland, delivered in a community setting and led by a service user.
- Involvement, linkage and support of voluntary groups including housing in the area of mental health.

The IAN reported that close links were continuing with the service and that there was a positive attitude amongst the staff in relation the implementation of ***A Vision for Change*** and for peer advocacy. Residents have raised some issues with the advocate in relation to restraint, and the treatment programmes on the unit.

GOVERNANCE

The management team was not multidisciplinary but regular feedback to staff was provided. A number of local audits had been facilitated to govern clinical practice.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	8.5
NCHD	9
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	77
Nurses based in community residences	20
CMHN	14
Nurses based in day hospitals	5
Nurses based in day centres	5
Other	0

CNS posts

Speciality	WTE in post
CNS	9
Addiction Counsellors	4.5

Health and social care professionals

Post	WTE in post
Clinical psychologist	3
Social worker	4
Occupational therapist	5

OTHER PROFESSIONAL INPUT

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Principal	Health Centre, Portlaoise
Occupational therapy	Manager	Health Centre, Tullamore

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation team

Staffing	2007	2008
Population	91,870	91,870
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	0.5	1
Dedicated team coordinator	0	0
ADON	1	1
CMHN	2	2
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	0
Art therapist	1	1
Social skills instructor	1	1
Therapeutic instructor	0	0.6

Psychiatry of later life team

Staffing	2007	2008
Population	15,171	15,171
Consultant psychiatrist	1.5	1.5
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.75	0.75
CMHN	4	4.6
Psychologist	0	0
Social worker	1	1
Occupational therapist	1	1
Nurses based in day hospitals	0.75	2

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was compliant with the majority of the Articles of the Regulations but some maintenance issues remain outstanding.

Good care planning was evident in St. Fintan's Hospital, which had been specifically developed for a rehabilitation service.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was compliant with the majority of the Rules on seclusion, mechanical restraint and ECT.

The approved centre at Portlaoise was not compliant in documentation, patient assessment and the prescription of ECT for voluntary patients at the Department of Psychiatry, Portlaoise.

CODES OF PRACTICE

The service at Portlaoise was not compliant with the Codes of Practice on ECT for voluntary patients.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Erkina House, Rathdowney	17	17	Rehabilitation	MDT
Birchwood, Tullamore	14	14	Rehabilitation	MDT

CONCLUSION

The Laois/Offaly mental health service continues to provide a good standard of care. The rehabilitation service had developed comprehensive MDT care plans and this should be replicated in the acute unit. Further staffing resources remain a priority.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Any refurbishment work should be completed.*
2. *The approved centre at the Department of Psychiatry, Portlaoise, should develop MDT care plans as described in the Regulations.*
3. *The occupational therapy input to the Department of Psychiatry, Portlaoise, should be restored.*
4. *Documentation concerning ECT for voluntary patients should be reviewed and updated.*

LONGFORD/WESTMEATH MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	Longford/Westmeath
Mental Health Service	Longford/Westmeath Mental Health Services
Population	116,022
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	Psychiatry of Later Life Community Drug and Alcohol Service Liaison Psychiatry
Date of Meeting	6 November 2008

SERVICE DESCRIPTION

This service had a population of 116,022 spanning the three counties Longford, Westmeath and Meath. The Meath area accounted for 6,000 people of the total population. There were three general adult sectors: Longford, Athlone and Mullingar. Mullingar was the largest sector, with a population of 60,000 people. The sectors faced unique challenges in the provision of care to ethnic minority groups including asylum seekers, travellers and immigrants. Three sub-speciality services were provided, in the areas of liaison psychiatry, community drug and alcohol, and psychiatry of later life. In-patient care and treatment continued to be provided in an old psychiatric hospital. The service had access to 119 beds, of which 44 were acute, 40 elderly care and 35 enduring mental illness. Some improvements had been noted in the provision of community-based care, but admissions continued to be high, especially in the area of alcohol detoxification.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The HSE should ring-fence capital and revenue monies in order to prioritise the closure of the hospital.*

Outcome: There was no progress on this recommendation.

2. *Each resident should have a formal assessment of need completed.*

Outcome: The service reported that all residents within the hospital had had an assessment of need completed.

3. *A fully staffed rehabilitation team should be appointed.*

Outcome: There was no progress on this recommendation.

4. *All teams should be resourced in line with the requirements outlined in national mental health policy.*

Outcome: A 0.5 whole-time-equivalent (WTE) consultant psychiatrist was appointed to the psychiatry of later life team. There was no progress on this recommendation for the other teams.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

Priority areas identified by the service were formulated by the catchment management team and included in the wider Primary Community and Continuing Care (PCCC) business plan for Dublin Mid Leinster. A copy of this plan was submitted to the Inspectorate. It was anticipated that there would be a cut in the budget allocation for 2009. No budget forecasts were available at the time of the meeting.

DEVELOPMENTS 2007-2008

- In the absence of a rehabilitation team, a temporary 0.5 WTE consultant psychiatrist post and a 0.5 WTE CNM3 post were continued from 2007 to oversee the placement of residents. No new funding had been received for these posts.
- The care planning approach had now been introduced to all sectors.
- The community drug and alcohol service had introduced a cocaine clinic for a period of six months, from January to June 2008. It was concluded that the uptake by clients was limited and running of the clinic was not viable.
- The psychiatry of later life service had introduced a later life data base. The addition of a 0.5 WTE consultant in psychiatry of later life had reduced the waiting list to an average of two weeks.
- The Longford sector was piloting a personality disorder therapeutic service which involved assessment of potential clients with borderline personality disorders.

HOSPITAL CLOSURE PLANS

There was a full development control plan for the hospital site. It was reported by the service that closure of the hospital was dependent on central funding for the plan. It was reported that resettlement work completed with residents of two wards (St. Edna's and St. Anne's) had resulted in a 50 per cent reduction in bed numbers. There was a 25 per cent drop in bed numbers in St. Claire's Ward. The service reported that St. Claire's could close if additional funding was provided for a community residence. The Inspectorate requested information from the service on where residents were discharged to, but this was not received. The service also reported that further bed reductions were planned in 2009 despite no extra funding.

A total of 71 residents remained in the hospital on the day of the meeting. The hospital building was unsuitable for the provision of care and treatment. The absence of a rehabilitation team was another significant barrier to closing the hospital and resettling people in the community.

QUALITY IMPROVEMENTS

- Multidisciplinary team (MDT) care planning had been implemented across all the teams.
- The liaison psychiatry team were carrying out some collaborative research with the Mater Hospital liaison group.
- An audit on incomplete admission orders was presented at the Royal College of Psychiatrists meeting and the College of Psychiatrists of Ireland meeting during 2008. In addition, an audit of the efficiency and effectiveness of outpatient clinics in Ireland had been submitted for publication.
- The community drug and alcohol service had updated its under-18 protocol.
- The community drug and alcohol service presented a poster at the addiction meeting of the Royal College of Psychiatrists, Amsterdam, on the follow-up of substance misusers referred from liaison psychiatry to the community drug and alcohol service.
- The community drug and alcohol service was now providing full time nursing support to the methadone maintenance service for the Longford/Westmeath area, based at the treatment centre in Athlone.
- In the Mullingar sector, nursing and medical staff participated at GP awareness evenings that involved sharing of information between primary care and secondary care.
- In the Longford sector concordance skills staff training that outlined a pragmatic way for mental health professionals to talk to patients about their medication was introduced. It promoted service user involvement in decision-making and sought to develop their skills in dealing with their own illness.

- Education for staff and carers of people with dementia was in progress. This was provided by the psychiatry of later life team.
- A number of service user satisfaction questionnaires were completed by the social work and occupational therapy services.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a peer advocacy service to the catchment area. Peer advocacy was provided on a regular basis to the acute admissions wards. There were plans to formalise a process for residents in continuing care. In a written report, the IAN stated that service users were dissatisfied with the amount of time available to speak with medical and nursing staff. They also expressed concerns about the lack of outdoor space in the male ward and the lack of talk therapies. The advocate reported positively on the role of the activation unit in people's recovery. A number of support groups, including Schizophrenia Ireland, Mental Health Association, Grow and AA provided a service to the hospital.

GOVERNANCE

The catchment management team had been developed to include all disciplines. Service user groups were invited on a quarterly basis. There were no plans to provide full membership to service users.

Clinical governance was provided within disciplines through supervision. There was a weekly case conference/audit/journal club/didactic lecture attended by nursing and medical staff. Consultants from St. Loman's Hospital also contributed to the Midlands Regional Hospital.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	8
NCHD	10
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	113.1
Nurses based in community residences	37
CMHN	16.95
Nurses based in day hospitals	8
Nurses based in day centres	5.9
Addiction counsellor	5.82
Clinical placement coordinator	1
Nurse practice development coordinator	1

CNS posts

Speciality	WTE in post
Psychiatry of later life	4.92
CMHN	10
Liaison	2

Health and social care professionals

Post	WTE in post
Clinical psychologist	4
Social worker	3.5
Occupational therapist	3
Psychotherapist	0.7
Chiropodist	0.01

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Manager	PCCC
Occupational therapy	Principal	PCCC

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: There was no rehabilitation team appointed in 2008. In 2007 a part-time consultant psychiatrist and nurse were appointed from within existing budgets. This was due to be discontinued in 2009.

Psychiatry of later life: The service users had no dedicated access to clinical psychology or social work.

Liaison: A liaison service was provided at the Midland Regional Hospital. The hospital had a wider catchment area than the mental health services. All patients referred were assessed. A same-day service was provided in 90 per cent of cases. One of the nursing posts was funded by the National Hospital Office.

Rehabilitation team

Staffing	2007	2008
Population	116,022	116,022
Consultant psychiatrist	0	0.5
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	1
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Day facility nurse staffing	0	0

Psychiatry of later life team

Staffing	2007	2008
Population	116,022	116,022
Consultant psychiatrist	0	0.5
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	1
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Day facility nurse staffing	0	0

Liaison team

Staffing	2007	2008
Population	N/A	N/A
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
Nurse	2	2
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0

IN-PATIENT FACILITIES

In-patient care was provided in St. Loman's Hospital. On the day of the inspection, the following was reported:

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was non-compliant with seven Articles. In the non-clinical area, the condition of the premises for the provision of care and treatment was again highlighted as a deficit. In the clinical areas, the service was non-compliant with care planning, therapeutic services and programmes, and the provision of information to residents. Since the inspection, the service had amended the care planning forms and they were now operational.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was non-compliant with the Rules on seclusion and mechanical restraint because training for staff had ceased. Since the inspection, it was reported that a programme was in place to rectify the deficit.

CODES OF PRACTICE

THE SERVICE WAS NON-COMPLIANT WITH THE CODES OF PRACTICE ON PHYSICAL RESTRAINT DUE TO LACK OF TRAINING FOR STAFF. SINCE THE INSPECTION, IT WAS REPORTED THAT A PROGRAMME WAS IN PLACE TO RECTIFY THE DEFICIT.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

There were three 24-hour community-staffed residences, with a total of 39 residents at the end of September 2008. The residents had no access to a specialised rehabilitation team. Care was provided by the general adult teams and full-time nursing care. It was reported that each resident had an assessment of need completed.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ashford House	15	15	General adult	Nursing
Edgewater	13	12	General adult	Nursing
Glenavon	12	12	General adult	Nursing

CONCLUSION

This service had made a small number of positive steps in developing a community MDT approach in the provision of care. Difficulties identified by the Inspectorate in the past regarding access pathways to community mental health teams were being resolved and a draft operational policy was currently in circulation. There was evidence of ongoing quality initiatives and audit cycles within all disciplines. It was disappointing to note that were was no allocation of additional funding to close the hospital and relocate residents to more suitable accommodation in the community. The two posts currently allocated to the resettlement of residents from the long-stay wards would be discontinued in 2009 despite positive progress reported. This would result in 71 residents not having access to rehabilitation, still living in unsuitable accommodation, and using a significant number of nursing resources in the provision of institutional care. It was unjustifiable that this situation should continue in 2009.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *A fully staffed rehabilitation team should be appointed to progress the resettlement of residents to more appropriate accommodation.*

2. *Funding should be provided to implement in full the development control plan for the hospital.*

3. *The physical conditions in all wards must be of an acceptable standard as long as the hospital remains open.*

SOUTH COUNTY DUBLIN MENTAL HEALTH SERVICES

HSE Area	HSE Dublin Mid Leinster
Catchment	South County Dublin
Mental Health Service	South County Dublin Mental Health Services
Population	175,000
Number of Sectors	3 teams not sectored
Number of Approved Centres	No approved centres – admission beds in St. John of God Hospital, Stillorgan
Specialist Teams	DETECT early intervention
Date of Meeting	6 October 2008

SERVICE DESCRIPTION

The Cluain Mhuire service, established in 1971, provided a range of mental health services to people living in the South East County Dublin catchment area. Services were provided in a number of locations throughout South East County Dublin and include an acute day hospital, day centres, rehabilitation and training programmes and high, medium and low support hostels. The service was primarily funded by the HSE and in-patient beds were provided on a contractual basis through the St. John of God Hospital in Stillorgan, with on-going care provided by the Cluain Mhuire staff.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *There should be a speciality team appointed in rehabilitation and psychiatry of later life.*

Outcome: A rehabilitation team and psychiatry of later life team were not yet in place.

2. *The core management team should be inclusive of all disciplines.*

Outcome: The senior management team was still based on the tripartite model but recently multidisciplinary team (MDT) management had been introduced, meeting three times a year.

3. *There should be an occupational therapist on each clinical team.*

Outcome: Awaiting additional funding to employ one occupational therapist per clinical team.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A 2008–09 corporate business plan had been developed and implemented.

DEVELOPMENTS 2007-2008

- New premises in Blackrock for the DETECT early intervention in psychosis service and for FÁS-funded REACH rehabilitation programmes.
- The Centre for Living day hospital was to move to new larger refurbished premises at the beginning of 2009 and would operate extended hours.
- Application submitted for new psychiatric and psychological components of the National Gender Realignment Programme based at St. Colmcille's Hospital.

QUALITY IMPROVEMENTS

- **Mental Health Information System (MHIS):** A laboratory component had been added to existing clinical records ensuring same-day transfer of lab results from a local hospital, enabled by existing electronic systems.
- There was no waiting list for referrals.
- Post-discharge follow-up of people attending outpatients was reduced from 12 days to 4 days.
- The discharge summary was now sent to GP in 4 days, compared to 42 days previously.
- In-patient bed usage had steadily declined in recent years with the financial savings reinvested in staff and services to meet service user needs.

SERVICE USER INPUT TO SERVICE

There was continuing support of the Irish Advocacy Network (IAN).

Service users were well represented on various committees and overall feedback from service users was positive stating a professional, friendly and approachable service. However, difficulties in securing follow-on long-term secure beds had led to the delayed discharge of some in-patients from acute beds.

An eight-week carers support programme had commenced to support families caring for relatives with borderline personality disorder (BPD).

GOVERNANCE

The senior management team was still based on the tripartite model but recently MDT management had been introduced, meeting three times a year.

A good multidisciplinary clinical governance framework was in place.

All residents in the 24-hour supervised residences had a key worker care plan. They were due to have a full MDT care plan in place by Easter 2009.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	7.5
NCHD	10
Specialist registrar	5

Nursing staff

Post	WTE in post
DON	1
ADON	0
Nurses based in in-patient services	N/A
Nurses based in community residences	7
CMHN	10.41
Nurses based in day hospitals	4
Nurses based in day centres	4
Other	N/A

CNS posts

Speciality	WTE in post
Psychosis community mental health	3.62

Health and social care professionals

Post	WTE in post
Clinical psychologist	7
Social worker	7
Occupational therapist	1.5
Social care staff	11.82
Pharmacist	0.86

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: The service was awaiting the result of application submitted in early 2008 to the HSE to commence an assertive outreach service.

Suicide prevention nurse: The suicide prevention nurse continued to develop the role and positively enhanced communication between the primary care teams and the psychiatric teams.

Liaison DBT (Dialectical Behaviour Therapy): This service had developed from a pilot programme and was regarded by staff and users as helpful in management of patients with personality disorder. Initial indications showed a positive impact on reducing the numbers of admissions to both the hospital and attendances to the accident and emergency services.

DETECT: The DETECT early intervention programme was currently in its fifth year. It provided services across three catchment areas, from Wicklow to the inner city, with a total population of 375,000. The team had been involved in a number of public education programmes and in the provision of education to GPs. The project was jointly funded by the HSE and St. John of God Brothers religious order. The funding from St. John of God Brothers was due for review at the end of 2008.

Liaison team

Staffing	2007	2008
Population		
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN	1	1
Psychologist	1	1
Social worker	1	1
Occupational therapist	0	0
Suicide prevention nurse	1	1

DETECT team

Staffing	2007	2008
Population	375,000	375,000
Consultant psychiatrist	0.5	0.5
Post-membership registrar	3	3
Project Manager	1	1
CMHN	1.5	1.5
Psychologist	0.5	0.5
Social worker	0.5	0.5
Occupational therapist	1	1
Accommodation officer	0.5	0.5

IN-PATIENT FACILITIES

The service had a contract with St. John of God Hospital paying only for the beds that it used. Savings made by reducing bed usage could then be used by the Cluain Mhuire service.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was compliant with the majority of the Articles of the Regulations.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was compliant with the Rules on seclusion, mechanical restraint and ECT.

CODES OF PRACTICE

The service was compliant with the Codes of Practice on ECT for voluntary patients and the notification of deaths and incident reporting. It was not compliant with the Codes of Practice for physical restraint with regard to communication and documentation.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Oropesa Residence had 21 individual bedrooms with en suite facilities and provided 24-hour nursing care. Medium support and transitional hostel places had been transferred to the St. John of God Housing Association with each person having an individual tenancy.

Residence	Number of places	Number of residents	Respite beds	Team responsible	Care plan type
Oropesa, Stillorgan	21	20	1	General adult	Piloting integrated care plan

CONCLUSION

Cluain Mhuire was a community-based service that continued to expand and develop services in line with national policy and best practice. It was innovative in the use of its budget and in developing real links with community providers that had a positive impact on the lives of service users. As stated in the 2007 report, there was a need to develop speciality teams in rehabilitation and to employ occupational therapists on the teams.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *There should be an occupational therapist on each team.*
2. *There should be a speciality team appointed in rehabilitation.*
3. *The core management team should be inclusive of all disciplines.*

HSE SOUTH

CARLOW/KILKENNY MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	Carlow/Kilkenny
Mental Health Service	Carlow/Kilkenny Mental Health Services
Population	120,671
Number of Sectors	5
Number of Approved Centres	3
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	18 December 2008

SERVICE DESCRIPTION

This catchment spans two counties. The Inspectorate had been critical in the past of the lack of a unified approach to the development of services. The Inspectorate was pleased to note that the single multidisciplinary management team for the catchment was working together and developed a comprehensive plan for the entire area. The service had access to 151 beds based in three approved centres, St. Dympna's Hospital, Department of Psychiatry, St. Luke's Hospital, Kilkenny, and St. Canice's Hospital (44 acute beds, 90 continuing care beds and 17 beds for people with an intellectual disability). It had 157 places in 24-hour community residences. Of these, 39 places were for persons with an intellectual disability. In addition, it had a rich resource of nursing posts.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *There should be a single coherent management structure in place with clear lines of accountability. This team must put in place a clear plan for the closure of St. Dympna's Hospital and the development of a community mental health service.*

Outcome: There was a single management structure in place. Assessments have commenced on the residents in St. Dympna's Hospital. The absence of a dedicated rehabilitation team was a significant barrier to progress.

2. *There should be a fully staffed rehabilitation team appointed to the service.*

Outcome: There was some progress on this recommendation. A permanent consultant psychiatrist and CNS were appointed. The absence of dedicated health and social care professionals on the team was a significant limiting factor.

3. *The community mental health teams should be adequately resourced and staffed, in line with national policy.*

Outcome: There were no additional posts allocated in 2008. Consultant psychiatrist posts were interviewed and permanent appointments were in process at the time of the meeting.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A copy of the Primary Community and Continuing Care (PCCC) HSE South Level 2 business plan was submitted to the Inspectorate. The subsection on mental health had been localised to Carlow/Kilkenny area.

DEVELOPMENTS 2007-2008

- The service reported that multidisciplinary care plans had now been introduced to all three approved centres since the inspections. The Level 1 Modified Sainsbury Centre for Mental Health risk assessment tool had been incorporated into the multidisciplinary care plan.
- A replacement building for Kelvin Grove had been completed and was due to be occupied in early 2009. It would accommodate 17 people across four bungalows.
- A 24-hour nurse-staffed community residence (with eight places) was opened in November 2008. The opening of this community residence enabled the service plan towards the closing of St. Patrick's Ward.
- Full multidisciplinary team assessments had been completed in respect of residents from Kelvin Grove with assistance from health and social care professionals within community services. Residents had been selected for therapeutic activities in cooperation with a voluntary service provider, Delta Centre, Carlow.
- A joint Carlow/Kilkenny rehabilitation committee had been established by the rehabilitation consultant psychiatrist to oversee the assessment of all residents within the Carlow/Kilkenny Mental Health Services area to determine their suitability for a rehabilitation training programme. The Camberwell Assessment of Need (CAN) was used.
- From December 2008 a vocational rehabilitation clinical nurse specialist (CNS) had been assigned to work with the rehabilitation psychiatrist.
- Community mental health nurses and consultant psychiatrists engaged with primary care teams established within the Carlow/Kilkenny area.
- The numbers of new working groups were established in 2008 looking at ***A Vision for Change*** and Primary Care.
- A CNS post had been allocated to the liaison team.

HOSPITAL CLOSURE PLANS

There was a written closure plan for the two hospital sites. A list of current tasks being undertaken was submitted to the Inspectorate. In total, there were 54 beds in St. Canice's Hospital and 54 beds in St. Dympna's Hospital. It was reported that 17 beds would close when a new purpose-built unit for people with an intellectual disability opened in January 2009. A group had been established to develop plans for the long-stay wards in Carlow and Kilkenny.

QUALITY IMPROVEMENTS

- A group-based cognitive behaviour therapy intervention for people with clinical depression and anxiety was started.
- The ORCHID initiative, which aims to ensure service users have up-to-date and relevant information, was extended from the in-patient unit to the day hospital in Kilkenny.
- A closed group using mindfulness techniques was facilitated for services users with recurrent clinical depression.
- A drugs and therapeutic group was established. A new medication prescription system was being introduced.
- A number of papers were published in peer-reviewed journals by members of the medical staff. The results were being incorporated into clinical practice.
- A multidisciplinary critical incident review group had been established.
- A group was established to review child protection issues in the service and develop protocols for practice, with particular attention to admission of children.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a peer advocacy service on a weekly basis to the acute unit and on a sessional basis to the other approved centres. A number of rooms were provided by the service for meeting with residents in private. The peer advocate reported that service users were positive about a number of the group programmes, the ORCHID information service, staff and the quality of the food. Service users reported that the liaison service was working well for them. Service users had concerns regarding the future of the IT centre in St. Canice's Hospital and the over-reliance on medication. A number of maintenance issues in the acute unit were identified as needing attention. Clinical decisions were raised and it was agreed that these would be followed up by the service once consent had been received. It was agreed at the inspection that it would be useful for the IAN representative and the CNM3 in the Department of Psychiatry to meet regularly to discuss and deal with issues as they arise. Since the meeting, it was reported that contact had been established.

GOVERNANCE

There was a single management team in place, comprised of the clinical director, director of nursing Carlow, acting director of nursing Kilkenny, hospital manager, social work team leader, occupational therapist manager and senior clinical psychologist. The service reported that they hope to include a service user representative at some stage in the future and were working incrementally towards this by inclusion of service users representatives on other groups and committees within the service, specifically the local implementation group and the clinical governance group.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	11
Specialist registrar	1

Nursing staff

Post	WTE in post
DON	2
ADON	4
Nurses based in in-patient services	99.25
Nurses based in community residences	80.25
CMHN	26
Nurses based in day hospitals	9.75
Nurses based in day centres	5

CNS posts

Speciality	WTE in post
Community mental health	10
Vocational rehabilitation	4
Nurse counselling	3
Acute mental health	1
Substance misuse	3
Cognitive behaviour therapy	1
Psychiatry of later life	2

Health and social care professionals

Post	WTE in post
Clinical psychologist	3
Social worker	3.8
Occupational therapist	4

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Principal	PCCC
Psychology	Manager	PCCC

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Liaison: A service was provided in Kilkenny General Hospital.

Rehabilitation team

Staffing	2007	2008
Population	120,726	120,726
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN / CNS	0	1
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated nursing staff	5.75	5.75

Psychiatry of later life team

Staffing	2007	2008
Population	120,726	120,726
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1.5
Dedicated team coordinator	0	0
ADON	1	1
CMHN	2	2
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Day facility nurse staffing	0	0

Liaison team

Staffing	2007	2008
Population	Not returned	Not returned
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN / CNS	0	1
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0

IN-PATIENT FACILITIES

The catchment had access to 148 beds across three approved centres. There were 44 acute beds, 89 continuing care beds and 15 beds for people with an intellectual disability, for a total population of 120,000 people. There was a significant variation between the three approved centres in levels of compliance. Since the inspection, the service have reported that MDT care plans were now in place in all the centres and risk management systems and polices had been developed. Training in the use of the risk management tool had commenced and would be ongoing until all staff have received training.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Department of Psychiatry, Kilkenny: The centre was non-compliant in one area only, risk management.

St. Canice's Hospital: The centre was non-compliant with five Articles. Steps to rectify deficits had been reported.

St. Dympna's Hospital: The centre was non-compliant with four Articles. Steps to rectify deficits had been reported.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Department of Psychiatry, Kilkenny: The centre was non-compliant with seclusion, as staff were not receiving training or refresher courses in restraint. It was reported since the meeting that training was currently taking place.

St. Canice's Hospital: The centre did not use seclusion or administer ECT. It was compliant with Part 5 of the Rules on mechanical restraint.

St. Dympna's Hospital: The centre did not use seclusion or administer ECT. It was compliant with Part 5 of the Rules on mechanical restraint.

CODES OF PRACTICE

Department of Psychiatry, Kilkenny: The centre was non-compliant with physical restraint, admission of children and notification of deaths and incident reporting. Steps to rectify deficits had been reported.

St. Canice's Hospital: The centre was compliant with physical restraint, and non-compliant with notification of deaths and incident reporting. Steps to rectify deficits had been reported.

St. Dympna's Hospital: The centre was compliant with the Code of Practice on notification of deaths and incident reporting.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

The service had a significant number of 24-hour nurse-staffed community residence places for the total population served. The rehabilitation team had clinical responsibility for the 118 adult places and 39 speciality places for people with an intellectual disability. This number was due to increase by 17 places when Kelvin Court opened in January 2009. The type of care plan used was not returned by the service.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Tús Nua	7	7	Rehabilitation	Not returned
Mount Laken	10	10	Rehabilitation	Not returned
Park Lodge	9	9	Rehabilitation	Not returned
Kincora	14	14	Rehabilitation	Not returned
Greenbanks House	12	4	Sector teams North and South	Not returned
Beechwood	9	9	Rehabilitation	Not returned
Clann Nua	8	2	Rehabilitation	Not returned
Altamount House	13	13	Rehabilitation	Not returned
Millenium Court	7	7	Rehabilitation	Not returned
Court View	8	8	Rehabilitation	Not returned
Lismore Hostel	10	9	Rehabilitation	Not returned
Elm Park	8	8	Rehabilitation	Not returned

INTELLECTUAL DISABILITY 24-HOUR SUPERVISED COMMUNITY RESIDENCES

There were three 24-hour nurse-staffed community residences for people with an intellectual disability. A new purpose-built unit was due to open in January 2009. The type of care plan used was not returned by the service.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Sacred Heart	8	8	Rehabilitation	Not returned
Caomhnú	21	18	Rehabilitation	Not returned
Alacantra	9	9	Rehabilitation	Not returned

CONCLUSION

The service had made a number of changes in the last year that had improved the quality of care delivered to residents. There was a collective effort across all the disciplines and management to address the deficits in service provision. Arrangements were agreed within the service for health and social care professionals in particular to redeploy their resources in order to complete needs assessments of residents in long-term care. While this had facilitated some of the work of the rehabilitation team it also highlighted areas of unmet need, as there was an insufficient number of staff with appropriate skills mix to undertake intervention work indicated by assessment. Similarly, the service – in particular the medical staff – had completed a number of clinical audits which also highlighted areas of unmet need, again linked to insufficient numbers of staff with appropriate skills mix. The Inspectorate was pleased to report that a new purpose-built unit for people with an intellectual disability would open in 2009. The service had a significant number of resources in terms of both nursing posts and beds. It had been a challenge to develop a rehabilitation service from within these resources. There would be a need to reconfigure posts to ensure that the skill mix met the needs of the service users. Alternatives to in-patient acute care remained limited. Health and social care professionals were spread very thinly across teams which hampers effective and efficient team functioning and limit the service available to service users.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The rehabilitation team should be fully resourced with an appropriate skill mix of staff to ensure that it can provide more than assessment.*

2. *The community mental health teams must be resourced in line within national mental health policy recommendations.*

KERRY MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	Kerry
Mental Health Service	Kerry Mental Health Services
Population	139,835
Number of Sectors	5
Number of Approved Centres	2
Specialist Teams	Rehabilitation
Date of Meeting	10 September 2008

SERVICE DESCRIPTION

Kerry Mental Health Services consisted of two approved centres, Acute Unit, Kerry General Hospital and St. Finan's Hospital, Killarney, with five sector teams and a specialist rehabilitation team. There was funding for a psychiatry of later life team but recruitment to this team had been frozen in the HSE embargo in 2007. The service had developed a strategic plan entitled ***Vision into Action*** with the aim of developing community mental health services in Kerry in line with ***A Vision for Change***.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The community mental health teams should be adequately resourced so that they can provide a basic mental health service.*

Outcome: There had been no improvement in the resourcing of community mental teams. Psychologists, occupational therapists and social workers were shared across teams which hinders the development of cohesive team work, integration in teams and access to and continuity of care.

2. *The rehabilitation team should be enhanced to support the closure of the hospital.*

Outcome: The team had been enhanced, with the addition of a social worker and psychologist. However these posts were shared with a sector team. There was no occupational therapist on the team. This post had also been lost following the HSE embargo in 2007. The team was responsible for four of the wards in St. Finan's and the community hostels.

3. *There should be a fully staffed psychiatry of later life team.*

Outcome: It had not been possible to recruit to this team following the HSE embargo of 2007.

4. *The management team should be inclusive of all disciplines.*

Outcome: The management team was not representative of all disciplines. A heads of discipline group and various steering groups fed into the management team.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A business plan was submitted. The plan outlined the HSE national plan and the implications for the Kerry mental health service.

Key areas for the service include:

- establishing an implementation group for *A Vision for Change* in Kerry. A local strategic plan had been developed.
- undertaking a gap analysis in all community mental health teams in accordance with the norms identified in *A Vision for Change*.
- completing the recruitment of consultant psychiatrist posts subject to agreement in the consultant contract talks.
- identifying and selecting staff to undertake the role of authorised officer.

The service highlighted the plan to construct a continuing care and challenging behaviour unit, a rehabilitation unit and a community residence in Killarney to facilitate the closure of St. Finan's Hospital. It was hoped that this development would free staffing resources to enhance the community services and MDTs. The service also highlighted the need for a service for people with an intellectual disability and mental health diagnosis. It was hoped to develop a separate intellectual disability service in the future.

DEVELOPMENTS 2007-2008

- There was an increase of staffing resource to the rehabilitation team.
- Plans to develop a high observation area in the acute unit in Kerry General Hospital that would lead to the end of transfers to St. Finan's.
- The development of a strategic plan *Vision into Action* to develop community mental health services in Kerry in line with *A Vision for Change*.

HOSPITAL CLOSURE PLANS

The service described itself as being in a transition period while trying to close St. Finan's Hospital. The plan was to develop the high observation area in the acute unit, cease transfers to St. Finan's and build a 25-bed continuing care and challenging behaviour unit for older persons with mental disorders, a 15-bed intensive care rehabilitation unit, and a 10-bed community residence for the remaining residents in St. Finan's Hospital. This plan was dependent on capital funding.

QUALITY IMPROVEMENTS

- The development of MDT care plans in St. Finan's Hospital.
- The development of a sensory garden in the acute unit, Kerry General Hospital.
- The development of a portal system for accessing policies.
- The undertaking of a number of audits.
- The development of a patient information leaflet.
- Weekly communication meetings in the acute unit and community residences.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a service to the Kerry Mental Health Service and furnished a comprehensive report to the Inspectorate. Generally advocacy was well received in the Kerry service, however some barriers still remained. A number of positive aspects were highlighted, the overhaul of the acute unit, a new computer room, the new sensory garden, good access to nursing staff and good vocational follow-up. There were also a number of

negative aspects: the facilities in St. Finan's being unsuitable, transfers to St. Finan's to manage challenging behaviour, an increasing number of people under 18 being admitted, people having to wear night clothes during the day and some restrictions to bed areas during the day.

GOVERNANCE

The management team was not representative of all disciplines. This was not in line with ***A Vision for Change*** and restricted contributions to decision-making in the service. There was a heads of discipline group.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	10
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	6
Nurses based in in-patient services	134
Nurses based in community residences	56.5
CMHN	12
Nurses based in day hospitals	6
Nurses based in day centres	10.5
Intellectual disability services	33.5
Other	5.5

CNS posts

Speciality	WTE in post
Enduring mental illness	1
Therapeutic programmes	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	3
Social worker	3
Occupational therapist	3

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: The rehabilitation team had responsibility for four wards within St. Finan's and the community residences.

Rehabilitation team

Staffing	2007	2008
Population	139,835	139,835
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
ADON	0	0
CMHN	0	0
Psychologist	0	0.5
Social worker	0.5	0.5
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The service remained non-compliant in a small number of Articles in both approved centres. MDT care plans were not in place in all wards and the therapeutic programme was not linked to care plans. The skill mix of staff was not sufficient to meet the assessed needs of the residents. In St. Finan's there were some issues regarding the premises.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was compliant with the Rules except for training in relation to seclusion.

CODES OF PRACTICE

The service was compliant with the Codes of Practice except for training in relation to physical restraint.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of residents
Bridgeview House (IDU)	15
Archview House (IDU)	15
Island View	13
Killarden House	15
Teach an Churaim	12
Cherryfield House	17
Writers Grove House	14

CONCLUSION

The Kerry Mental Health Service provides satisfactory acute in-patient care and works well with service-user representatives. Obstacles to the rationalisation and closure of St. Finan's need to be overcome as a matter of urgency.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Community mental health services should be implemented.*
2. *St. Finan's Hospital should close.*
3. *A psychiatry of later life team should be developed.*

NORTH CORK MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	North Cork
Mental Health Service	North Cork Mental Health Services
Population	80,795
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	Rehabilitation
Date of Meeting	19 November .2008

SERVICE DESCRIPTION

The North Cork Mental Health Service served a population of 80,795 people. There were three sector teams with populations of 28,594, 29,737 and 22,464 respectively. In addition, the service had a limited rehabilitation team that covered the catchment area. It had no psychiatry of later life team. The acute in-patient service was provided in St. Stephen's Hospital, Glanmire, in 35 beds located in two units that were gender based. A day hospital located on the site was shared between the sectors and the rehabilitation team. At the time of inspection, 90 residents were accommodated in long-stay units on site and 23 residents were cared for in the dedicated Alzheimer's unit. These units catered for people from the North Lee, South Lee and West Cork catchment areas.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *Each sector team and the rehabilitation team should consist of a core multidisciplinary team.*

Outcome: Figures supplied by the service confirmed that there continued to be a serious shortage of health and social care staff on all teams.

2. *All residents should have a multidisciplinary care plan.*

Outcome: Multidisciplinary care plans had been introduced in some areas. Plans to introduce them more widely were impeded by the lack of the relevant staff members.

3. *Each unit should be self-staffing.*

Outcome: There was no progress on this issue, although discussions were on-going within the service.

4. *There should be a consistent approach to the training of physical restraint techniques.*

Outcome: Training recommenced in October 2008 after a two-year pause. A group had been established within the HSE to look at this area with a view to making recommendations at national level.

5. *HSE South policies in relation to the Regulations should be amended to reflect local practice.*

Outcome: Work had commenced on this issue.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The Level 2 business plan for the North Cork area was submitted to the Inspectorate. This identified deliverable goals for 2008 along with timelines and persons responsible for achieving the goals. In line with this, a North Cork implementation group for *A Vision for Change* had been established.

DEVELOPMENTS 2007-2008

- Work was progressing on the realignment of sector boundaries to ensure they matched those of Primary Community and Continuing Care (PCCC).
- Eight beds in St. Stephen's Hospital had been commissioned to provide an interim solution for the provision of an 8-bed child and adolescent unit. This was awaiting the completion of a purpose-built unit in Bessboro.
- New sector headquarters had been opened in Fermoy. A 14-bed high support housing project was opened in Fermoy in July, facilitating the closure of Unit 10. The day centre had to be moved to a more appropriate facility in the Summer of 2008. A CNM2 had recently been appointed.
- A 3-bed low support community residence was opened in Glanmire. The unit was unstaffed. Staff reported the unit was working well and improvements could be seen in level of functioning of residents.
- A day service commenced in Charleville in October.
- Three staff nurses had been assigned from the in-patient service to the rehabilitation team. An assistant director of nursing had also been appointed, with dual responsibility for both community and hospital.
- Two nursing posts had been reassigned to community services and liaison/self-harm. An induction programme was held with staff in the Emergency department, who welcomed the development.
- The catchment area now had 7-day community mental health services, as a result of closures and release of staff.
- The behaviour therapy service had been enhanced so that there was now a full-time behaviour therapy nurse in the Fermoy and Kanturk sector.
- Forty authorised officers had been trained for the HSE South.
- This service facilitated its own assisted admissions, which avoided the necessity of calling on external resources.

HOSPITAL CLOSURE PLANS

The Level 2 business plan for North Cork did not contain detailed proposals for the closure of the St. Stephen's Hospital. Unit 10 and Unit 11 were closed. The latter was being used for offices as well as a staff residence. The Inspectorate was informed that consideration was being given to reducing the acute beds at St. Stephen's Hospital to 19 and a comprehensive plan to facilitate the closure of the remaining long-stay facilities was currently being prepared.

QUALITY IMPROVEMENTS

- A multi-agency mental health information service opened in Fermoy, staffed by the North Cork service for two hours on Thursday mornings.
- Multidisciplinary filing system initiated. Improved medical records system and computerised tracking system in place.
- An internal hygiene and audit system was introduced with input from the catering manager and domestic supervisor.
- Catering department was active in adding to quality of life of residents. It had introduced a snack box system for people admitted out of hours and was providing for dietary preferences and for birthday celebrations. St. Stephen's

Hospital was participating in an initiative to reduce salt in the diet. A safe food management system had been put in place in hospital and community facilities

- Staff training was ongoing. Six nursing staff were attending the Higher Diploma in Enduring Mental Illness course at UCC. There was no training budget for health and social care disciplines and this was identified as a need for the service.
- More rigorous assessments were ensuring elderly people may be diverted to other services such as nursing homes, instead of being automatically admitted to psychiatric hospital.
- Families were being encouraged to visit residents and work was being done with them prior to visits.
- A psychology student on the rehabilitation team had tracked changes in the quality of life of residents who had moved to the community.

SERVICE USER INPUT TO SERVICE

A representative of the Irish Advocacy Network (IAN) reported that it had been made welcome in the North Cork Mental Health Service. IAN visited regularly and was positive about the services provided.

The IAN representative identified two areas for improvement:

- There was a need for more occupational therapy in St. Patrick's Hospital in Mallow, as TV seemed to be the only activity in some areas.
- Younger residents in some acute units complained that the occupational therapy provided was not stimulating enough.

It was reported that residents' families were being contacted with the help of an advocate to facilitate contact prior to their move to community residences.

GOVERNANCE

Multidisciplinary management team meetings based on ***A Vision for Change***, took place every 4 to 6 weeks. Managers of individual disciplines took responsibility for their own areas. The PCCC management also engaged with heads of disciplines.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	4
NCHD	8
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	130.11
Nurses based in community residences	18.32
CMHN	8.5
Nurses based in day hospitals	2.62
Nurses based in day centres	12.52
Nurse behaviour therapist in community	1.5
CNM3 with responsibility for training	0.82
Night superintendent	2

CNS posts

Speciality	WTE in post
Adult Mental Health	2.79
Liaison	0.5

Health and social care professionals

Post	WTE in post
Clinical psychologist	2.4
Social worker	0
Occupational therapist	3.5

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: This team had no dedicated day facility nursing staff, but had access to a day hospital in the grounds of St. Stephen's Hospital, which was shared between different teams.

Psychiatry of Later Life: There were a considerable number of residents in three psychogeriatric units from other catchment areas, i.e. North Lee, South Lee, and West Cork.

Rehabilitation team

Staffing	2007	2008
Population	80,795	80,795
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	3
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Nurses based in community residences		24

Psychiatry of later life team

Staffing	2007	2008
Population		
Consultant psychiatrist	0	0
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Day facility nurse staffing	0	0
Care staff	0	0

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The service was non-compliant with a number of Regulations. Each resident did not have a care plan as defined in the Regulations and the notes were not integrated. Therapeutic activities were not always based on an individual assessment and care plans. Feedback was not always recorded in the notes. Some teams did not have access to multidisciplinary team members. Appropriate education was not provided for children. Some information leaflets were out of date casting doubt on the ability of staff to provide information in a form and language that residents could understand, contrary to the Regulations. The Inspectorate was informed that this matter had since been rectified. The skill mix of the staff was not sufficient to meet the requirements of the residents.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The terms of the Rules were not applicable.

CODES OF PRACTICE

The service was not compliant with Section 2.5 of the Code of Practice in relation to the admission of children.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents*	Team responsible	Care plan type
Solas Nua Housing Project	14	14	Rehabilitation	MDT
Cois Alla Housing Project	18	14	Rehabilitation	MDT
Carrigabrick Lodge Housing Project	14	12	Rehabilitation	MDT

**At 31 October 2008.*

CONCLUSION

This service had made a number of positive changes in line with recommendations in ***A Vision for Change***. Facilities had been developed which allowed for the reduction of in-patient beds and the development of community resources. The advocate commented that residents' quality of life had improved. This observation had been noted in research undertaken by a trainee psychologist. The service continued to care for a large number of elderly patients from different catchment areas who may need specialised long-term care. There was a deficit in terms of psychiatry of later life and multidisciplinary staffing on other teams.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Each team should be fully staffed by MDT as recommended in A Vision for Change.*

2. *Consideration should be given to maximising resources in the HSE South by amalgamating some of the catchment areas in line with* ***A Vision for Change*** *recommendations.*

3. *Training needs for health and social care professionals should be addressed.*

4. *Efforts should continue to facilitate the provision of alternative accommodation based on assessed need, either in specialised rehabilitative care or in nursing homes.*

5. *Each unit should be self-staffing.*

NORTH LEE MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	North Lee
Mental Health Service	North Lee Mental Health Services
Population	167,536
Number of Sectors	5
Number of Approved Centres	2
Specialist Teams	Forensic Liaison
Date of Meeting	18 November 2008

SERVICE DESCRIPTION

North Lee in Cork had a population of over 167,000 and a high level of deprivation. There was one acute unit, St. Michael's Unit, with 50 beds. Carraig Mór, a separate unit, had a continuing care section with 20 beds. This unit also contains a psychiatric intensive care unit with 20 beds that was under the forensic services. There were five sectors which were undergoing reconfiguration. Liaison cover was provided by one NCHD under the supervision of a consultant psychiatrist.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *A fully resourced rehabilitation team should be appointed as a priority.*

Outcome: This had not happened.

2. *The future provision of mental health services across North Lee and North Cork should be agreed in order to progress the provision of service based on identified need.*

Outcome: There had been some progress in considering the amalgamation of North Cork and North Lee.

3. *All teams should have full multidisciplinary staffing as a basic requirement for the provision of service.*

Outcome: This had not been achieved.

4. *The regional forensic team should be developed and include a development plan for community placement.*

Outcome: This had not been achieved.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A Level 1/Level 2 business plan was available that was incorporated into North Lee Primary Community and Continuing Care (PCCC) 2008 business plan.

DEVELOPMENTS 2007-2008

- A replacement for Killeen Centre had been identified in the Erinville Hospital and refurbishment works were in progress. The Inspectorate had since been informed that the refurbishment had been completed and the training centre was due to open in December 2008. These works were possible through sourcing of special initiative funding 2008.
- Further refurbishment in 2008 took place at Block 7 resulting in additional group room and office accommodation to facilitate City North team.
- Clúid Housing was awaiting grant approval from the Department of the Environment to enable two houses to be made available to the North Lee Mental Health Services in Lios Rua, Ballyvolane, Cork.
- The service was currently reconfiguring the sectors in order to provide a more efficient and accessible service. There was a plan to amalgamate the catchments of North Lee and North Cork in order to maximise the use of current resources and provide a wider range of services for service users.

Forensic team developments

- There had been an increase in consultant psychiatrist staffing by two sessions a week. This had been done within the current staff complement.
- Refurbishment of Carraig Mór was currently under way.

QUALITY IMPROVEMENTS

- A revised ward-based psychology and nurse therapy programme was to be introduced. This was a new model of delivery that should increase the range of therapies available to patients and increase the amount of therapy time.
- A pilot scheme had been introduced with a GP Liaison Mental Health Nurse (part-time) in two GP practices.
- The community home-based team had opened the referral process to GPs and received the majority of referrals from that source. The main emphasis of this process was preventing first-time admissions to St. Michael's Unit.
- Occupational therapy department secured funding for Assessment of Motor and Process skills (AMPS) for five occupational therapists who have now completed their training. This was expected to promote more consistent improvements of living skills across the sector.
- A community-based men's group was set up to provide an out-of-hours service for people working.
- The occupational therapy department had conducted training in seating assessment to assist people with physical disability.

Forensic team quality initiatives

- A collaborative care plan had been introduced and a review of care planning had taken place.
- Training in risk assessment had been completed for staff in the unit.
- The service facilitated a conference on social inclusion in June 2008.

Forensic team quality improvements

- The psychology service had undertaken supervision in the practice of cognitive behaviour therapy through social work and nursing staff, resulting in increased accessibility for service users.
- Nursing, social work and occupational therapist provided an out-of-hours community-based men's group to facilitate those at work.
- Occupational therapy training on seating assessment had been completed to assist those with physical disabilities.
- An acting head of psychology appointed in North Lee Mental Health Services who participated in services development.

SERVICE USER INPUT TO SERVICE

An advocate from the Irish Advocacy Network (IAN) met quarterly with the principal social worker representing the North Lee management team. Carer support groups were run in community day centres. Various voluntary support groups met regularly in St. Michael's Unit. A service user representative was invited to attend a meeting of the North Lee local implementation group for ***A Vision for Change*** which also incorporated representatives from the child and adolescent services. Advocacy was available in Carraig Mór and an advocate attended St. Michael's Unit weekly.

Service users, through the IAN, recorded a number of positive observations on St. Michael's Unit, including the responses to the unit community meeting and the weekly meeting between the advocate and nursing staff. The lack of any access to open air was a major complaint from the service users.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	12
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	146
Nurses based in community residences	30
CMHN	15
Nurses based in day hospitals / day centres	18
Other – temporary staff panel	52

CNS posts

Speciality	WTE in post
Liaison	0.5
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	3

Health and social care professionals

Post	WTE in post
Clinical psychologist	4.6
Social worker	7
Occupational therapist	6
Art therapist	1
Woodwork therapist	0

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: There was no rehabilitation team.

Psychiatry of Later Life: There was no psychiatry of later life team.

Liaison: The liaison team was under-resourced and able to offer a limited service. One NCHD provided the service under the supervision of a consultant psychiatrist.

Forensic: The forensic team had 20 beds psychiatric intensive care beds in Carraig Mór. Due to the lack of both team members and community facilities the service was limited. However the appointment of a social worker and an occupational therapist had enhanced the service. There was a vacant psychologist post on the forensic team that had not been filled due to the HSE recruitment embargo.

Forensic team

Staffing	2007	2008
Population	620,525	620,525
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN	1	1
Psychologist	0	0
Social worker	1	1
Occupational therapist	0	1

IN-PATIENT FACILITIES

Acute in-patient services were provided in St. Michael's Unit in Cork City. There was an excellent care plan in operation. As there was no rehabilitation team and a lack of supported accommodation within the service, it was difficult to discharge those with long term mental illness to more appropriate accommodation. There was also a lack of external recreational area and an absence of outside smoking area.

REGULATIONS (S.I. NO. 551 OF 2006)

Neither approved centre was compliant with Regulations: some care plans had not been updated and were not linked to therapeutic activities; the policy in transfer of residents required updating and the information given to residents was incomplete in both centres. There was a lack of multidisciplinary staff to provide for the assessed needs of residents in St. Michael's unit.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was required to update protocols for the administration of ECT. The service was non-compliant in Part 5 of the Rules on seclusion and mechanical restraint.

CODES OF PRACTICE

The service did not have an up-to-date policy on the use of physical restraint. There was insufficient training of staff in managing violent episodes and there was no up-to-date record of staff training. Neither unit was suitable for the admission of children. Under the Code of Practice for notification of deaths and serious incidents, the service did not identify a risk manager or a person responsible for risk management. Up-to-date ECT protocols were not displayed.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Gougane Barra High Support Hostel	-	-	-	-
St. Colman's House High Support Hostel	-	-	-	-
Millfield House High Support Hostel	-	-	-	-
Owenacurra Centre, Midleton	-	-	-	-

*Information not provided by service.

CONCLUSION

There was evidence of good practice within the service despite lack of resources and the difficulties in the location of St. Michael's Unit. There was an excellent care plan in place. The service had been innovative in attempting to provide a community service in line with mental health policy and promoting access to services. The lack of team staffing, a rehabilitation team, and psychiatry of later life team and a liaison team had not changed since 2007. This directly impacted on the care received by service users and their access to services that should be available. However service users praised the care that they received within the service. There were initial plans to amalgamate North Lee and North Cork catchments to provide a more efficient service.

There a number of breaches in Regulations, Rules and Codes of Practice for approved centres that should be addressed, especially as the majority of these were resource-neutral.

The increase in staffing for the forensic team was welcome. However it was essential that a psychologist service be on a forensic team. A low support community residence was required as part of a rehabilitation service. The development of a full forensic service with appropriate community facilities, rehabilitation, outreach team and prison in-reach service had still not happened.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The lack of specialist teams should be addressed. Provision for a rehabilitation team, an enhanced liaison team and a psychiatry of later life team should be progressed.*

2. *Breaches in the statutory Rules and Regulations for approved centre should be immediately addressed as should breaches of Codes of Practice.*

3. *Multidisciplinary teams should be fully resourced.*

4. *The development of a full regional forensic service should be advanced as quickly as possible.*

SOUTH LEE MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	South Lee
Mental Health Service	South Lee Mental Health Services
Population	179,133
Number of Sectors	6
Number of Approved Centres	2
Specialist Teams	Psychiatry of Later Life Liaison
Date of Meeting	19 November 2008

SERVICE DESCRIPTION

South Lee Mental Health Services provided care in two centres. There was an acute admission unit at Cork University Hospital (CUH), with 46 beds, and a unit in St. Finbarr's Hospital that provided continuing care for long-stay residents. This unit comprised two wards, St. Catherine's with 21 beds and St. Monica's with 13 beds. The area was a mixed rural and urban one with some areas of high deprivation.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *The community mental health teams should be adequately resourced to provide a basic mental health service and provide a real alternative to hospital admission.*

Outcome: One community mental health nurse (CMHN) was appointed in May 2008.

2. *A rehabilitation team should be a priority for the service.*

Outcome: There had been no progress in this area. To assist in the provision of group homes, funds were committed for the purchase of two homes but these had not been backed by funding from the Department of the Environment.

3. *Senior management should continue to address the suitability and safety of the adult in-patient unit.*

Outcome: Work had commenced on the construction of a new reception area. As yet, no works had begun on Floor 1 but tenders were due to go out in the near future. There was no lift to the upper floor of the Acute Admission Unit of CUH, potentially placing patients there at risk in situations where physically ill patients have to be transferred to other units.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The business plan for the South Lee Mental Health Services was that of the South Lee Primary Community and Continuing Care (PCCC) service. It was described as a top-down business plan and the service felt largely ignored by senior management.

A gap analysis had been completed with a view to meeting the requirements contained in ***A Vision for Change*** but it was felt that no progress had been accomplished.

DEVELOPMENTS 2007-2008

- A day service facility was opened in the City South West sector to provide a limited range of services. This facility provided group work, one-to-one therapy and art therapy work. It was quite an active unit despite its limited remit.

- A CMHN was appointed to the City South East sector in May 2008.
- In March 2008 an occupational therapist manager was appointed in a temporary capacity for a period of six months. This worked well in addressing the needs of the service in respect of occupational therapy services, but this post had now expired. There remained only one occupational therapist in the service, allocated to the psychiatry of later life team.
- The service had secured a half-time consultant post in community care, but without the provision of a team.

HOSPITAL CLOSURE PLANS

There was no closure plan at present. There was some discussion around potential closure of St. Monica's Ward in St. Finbar's Hospital with consequent release of nursing staff to develop a more community-oriented service. However concern for placement of current residents on the continuing care wards would affect any such plans.

QUALITY IMPROVEMENTS

- MDT care plans had been piloted in the Ballincollig sector and had been well received. However, MDT plans were hampered by the lack of social work and occupational therapy. It was expected there would be input from psychology in January 2009.
- Groups had been established in the areas of anxiety management, a Wellness Recovery Action Plan (WRAP) programme, social skills, exercise and a self-medication programme. A dance programme was being run in conjunction with the VEC and the Cork Mental Health Foundation, catering for 8 clients.
- One CNS had recently qualified as a Nurse Prescriber.
- An exhibition featuring paintings by patients of the unit in CUH entitled "Expressions in Colour" was launched in July 2008.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a weekly service to patients of the unit in CUH and met residents fortnightly or monthly in the continuing care unit in St. Finbarr's Hospital. The advocate described being made feel welcome in the units and a number of issues had been resolved by means of meetings with nurse managers. Every six to eight weeks, a client focus group meeting was held in the unit in CUH and was supported by nursing staff.

The advocate, on behalf of patients, raised some concerns about their access to and relationship with their consultant and nursing staff. Recently there had been a noticeable change in the profile of patients admitted to the admission unit with consequent difficulties for patients. It was pointed out that these changes also caused challenges for nursing staff. There was an issue in relation to the cleanliness of the garden where patients were not inclined to bin litter such as disposable cups, and cigarettes, with the result that the garden was littered with rubbish.

During discussion with the advocate, it was clear that a mechanism to facilitate feedback would be helpful to service users and it was decided to set up a regular meeting so the advocate could give feedback to staff on issues of concern to patients.

GOVERNANCE

The South Lee Mental Health Service is was governed by means of a multisciplinary team (MDT). The management team was composed of members of the different disciplines of the MDTs and met every six weeks.

STAFFING

The provision of a full MDT team was significantly hampered by the lack of personnel in relevant areas such as psychology and occupational therapy. A temporary post of occupational therapist manager expired in November 2008, and the Department of Psychology reported a loss of a 0.5 WTE post within the last year.

Medical staff

Post	WTE in post
Consultant psychiatrist	8.23
NCHD	15
Specialist registrar	–

Nursing staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	56
Nurses based in community residences	8
CMHN	11.42
Nurses based in day hospitals	5.50
Nurses based in day centres	9.19
Other – temporary staff panel	20.09

CNS posts

Speciality	WTE in post
Liaison	2
Clinical placement coordinators	4
Nurse practice development coordinator	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	5.71
Social worker	3
Occupational therapist	1
Art therapist	1.31
Woodwork therapist	1

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Psychiatry of later life team

Staffing	2007	2008
Population	179,133	179,133
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN	2.85	1.82
Psychologist	0.8	0.8
Social worker	0	0
Occupational therapist	1	1
Day facility nurse staffing	0.8	0.8
Care staff	0.36	0.36

Liaison team

Staffing	2007	2008
Population	CUH in-patients CUH outpatients	CUH in-patients CUH outpatients
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	1	1
Social worker	0	0
Occupational therapist	0	0
Liaison nurse	2	2

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The admission unit at CUH was inspected in June 2008. The unit was in breach of Regulations relating to individual care plans and provision of therapeutic services, the latter due to lack of appropriate skill mix in the MDTs. The unit was also in breach of Regulations governing premises which led to practical difficulties in nursing elderly patients, in particular.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The centre was compliant with the Rules relating to seclusion, mechanical restraint, and ECT.

CODES OF PRACTICE

The centre was not compliant with the Codes of Practice governing physical restraint, admission of children, and notification of deaths and incidents.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Glenmalure	18	18	General adult, City South East	Nursing

CONCLUSION

It was disappointing to see that provision of full mental health services in the South Lee area continued to be under-developed due to budgetary constraints. There had been little expansion in the service with the exception of a half-time consultant post in community psychiatry. There remained a very significant lack of occupational therapy across the service, except in the area of psychiatry of later life. The psychology department had been reduced by a 0.5 WTE post. Staffing at a nursing level relied heavily on overtime and temporary nursing staff. It was disappointing to note there had been no progress on the development of a post in rehabilitation.

Despite these shortfalls, it was evident there was great commitment from all members of the service to provide a good mental health service for service users. Work had begun on the construction of a new reception area in the unit in CUH with plans for addressing the structural difficulties on the top floor. Despite the lack of a dedicated rehabilitation team, the general adult team had instituted a number of initiatives in this area.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *A rehabilitation team should be appointed in the service as a priority.*
2. *Staffing of the teams should be multidisciplinary and include an appropriate skill mix.*
3. *Work should progress on making the unit in CUH more suitable for all residents.*

SOUTH TIPPERARY MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	South Tipperary
Mental Health Service	South Tipperary Mental Health Services
Population	83,052
Number of Sectors	3
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	13 November 2008

SERVICE DESCRIPTION

South Tipperary had two approved centres, providing both acute care and long term care. St. Luke's Hospital had 106 beds and St. Michael's Unit had 49 beds. South Tipperary was also the provider of beds for the North Tipperary catchment. A decision regarding the future provision of service for North Tipperary had not been taken. Admissions from North Tipperary to St. Michael's unit continued. There were also a number of long-stay residents from North Tipperary in St. Luke's Hospital. This was a source of frustration for service users and providers and impacted directly on service provision. The service had a rich nursing resource and bed complement when compared with national policy recommendations. The approved centres continued to be the subject of a Section 55 Inquiry under the Mental Health Act 2001 during 2008. The findings of this Inquiry were not available at the time of the inspection.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *Admissions to St. Luke's Hospital must cease.*

Outcome: There were 19 admissions to date in 2008, including one first-time admission. The practice of sleeping residents from St. Michael's Unit in St. Luke's Hospital continued despite the fact that they were separate approved centres. The Inspectorate had been informed that this practice had now ceased.

2. *The transfer of acute and long-stay services for North Tipperary to HSE West should be planned and completed in 2008.*

Outcome: A report was completed regrading the future of the service provided to North Tipperary. It was not available and no decision had been taken on the transfer of residents or the service.

3. *The conditions in the hospital must be of a standard that protects the individual's autonomy and privacy as long as the hospital remains open.*

Outcome: The condition of the sleeping arrangements for men in St. Bridget's Ward was severely sub-standard on the day of the inspection. It was immediately reported to the Mental Health Commission and the HSE. A number of small refurbishments had been completed in St. Theresa's Ward, St. Mary's Ward and St. Paul's Ward.

4. *All the community and speciality teams should be staffed to the required level outlined in national policy.*

Outcome: No additional staffing numbers were appointed to the community mental health teams. The psychiatry of later life team gained two new posts, one in social work and one at clinical nurse specialist grade. Ten new nursing posts were appointed to the hospital.

5. *All residents with an intellectual disability living in the hospital must be located to more suitable accommodation based on assessed need. They should have access to a specialised mental health team.*

Outcome: There was no progress on this recommendation although all the residents had been assessed previously. On the day of the inspection (12 November), the Inspectorate had serious concerns regarding the lack of care and treatment provided to this vulnerable group, which were immediately reported to the Mental Health Commission and the HSE.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A five-year plan for 2006–10 was being used as the main business plan for the service. Completion was contingent on securing financial resources, including sale of the land banks surrounding St. Luke's Hospital.

DEVELOPMENTS 2007-2008

- St. Clare's Ward closed and 20 residents were relocated to nursing home care. Appropriate follow-up care was been provided by a resettlement team. This team consisted of a CNM3 and two staff nurses.
- Capital development of a day centre in Clonmel town had commenced. It was due for completion by February 2009.
- Planning permission for a community mental health team headquarters and day hospital was granted. It was expected that tendering for the project would begin in 2009.
- A report on the organisation and future delivery of services in North and South Tipperary was completed in October. The report was not available at the time of the meeting.

HOSPITAL CLOSURE PLANS

St. Luke's Hospital provided care and treatment to 106 residents in five wards. Residents had different needs: long-term continuing care, rehabilitation and resettlement, and care for residents with an intellectual disability. The future accommodation of long-stay residents from North Tipperary had not yet been decided.

QUALITY IMPROVEMENTS

- The development and introduction of a care plan approach had taken place in the acute unit and in the rehabilitation ward. The introduction was preceded by an education programme and the project was multidisciplinary. There were plans to extend the assessment and care plan to all residents. Feedback from the pilot sites would be used to improve the tool. Service user involvement was to be enhanced.
- Single case files had been introduced in pilot sites. This would be extended.
- A new card index and signature log system were introduced.
- A physiotherapy service was provided in St. Paul's Ward on a needs basis for residents.
- A system of MDT meetings were established in St. Teresa's Ward.

SERVICE USER INPUT TO SERVICE

The Irish Advocacy Network (IAN) provided a weekly peer advocacy service to St. Michael's Unit. The agency was not funded to provide a service to the residents in St. Luke's Hospital. This was highlighted in 2007. Of concern to service users this year were the fact that residents from St. Michael's Unit were being asked to "sleep out" in St. Luke's Hospital, the lack of input in care planning process, and the lack of information about medication. Since the meeting it had been reported that a peer advocacy service was now provided in St. Luke's Hospital.

GOVERNANCE

A clinical governance committee had been established with agreed terms of reference and was in the process of setting up seven sub-groups focused on clinical effectiveness, risk management, information management, implement of ***A Vision for Change***, practice development, policy development, and resource management.

The management team was based on the wider Primary Community and Continuing Care (PCCC) model. Since the last report, a principal social worker post had been approved and would be based in mental health services.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	5
NCHD	6
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	145
Nurses based in community residences	23
CMHN	0
Nurses based in day hospitals	9
Nurses based in day centres	4.4
Other	1

CNS posts

Speciality	WTE in post
Family therapy	3
Addictions	2
Liaison	1
Psychiatry of later life	3
CMHN	3
Cashel	4

Health and social care professionals

Post	WTE in post
Clinical psychologist	4
Social worker	3.6
Occupational therapist	3

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Manager	PCCC
Occupational therapy	Manager	PCCC

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Liaison: There was no liaison team provided to South Tipperary General Hospital. All new admissions presented directly to St. Michael's Unit rather than through the Emergency department.

Rehabilitation team

Staffing	2007	2008
Population	84,000	84,000
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN (resettlement)	1	3
Psychologist	0.5	0.5
Social worker	0	0
Occupational therapist	0	1

Psychiatry of later life team

Staffing	2007	2008
Population	84,000	84,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	2	3
Psychologist	0	0
Social worker	0	0.8
Occupational therapist	0.8	0.8

IN-PATIENT FACILITIES

There were two in-patient facilities, St. Michael's Unit (49 beds) and St. Luke's Hospital (106 beds). There was an over provision of beds in the catchment for the total population of Tipperary (149,075). In-patient facilities provided beds to North and South Tipperary catchment areas.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Acute Unit, St. Michael's Unit: The service was non-compliant in St. Michael's Unit with individual care planning, although it was at a stage that would ensure compliance within a short time frame. It was non-compliant on therapeutic activities, transfer of residents to other approved centres, provision of sufficient information to residents, and privacy afforded to residents. The condition of the premises was in the process of being addressed.

St. Luke's Hospital: The service was non-compliant in care planning and provision of therapeutic activities. This was coupled with lack of appropriate health and social care staffing on the wards and the availability of regular medical input in one ward. There was a deficit in the transfer of residents from one approved centre to another. Insufficient information was provided to the resident about medication. The premises did not meet the requirements of the Regulations. Risk management procedures were incomplete.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Acute Unit, St. Michael's Unit: The service was not compliant with the Rules of seclusion and Part 5 of the Rules on mechanical restraint.

St. Luke's Hospital: The service was not compliant with the Rules on seclusion and also non-compliant with the Rules on mechanical restraint under Part 5.

CODES OF PRACTICE

Acute Unit, St. Michael's Unit: The service was non-compliant with the Codes of Practice regarding the admission of children and regarding notification of deaths and incident reporting.

St. Luke's Hospital: The service was non-compliant in notification of deaths and incidences.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Lorica residence opened the previous December and the residents were under the clinical care of the rehabilitation team.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Lorica	10	8 (2 respite)	Rehabilitation	
Mount Sion	17	16 (1 respite)	General Adult	

CONCLUSION

Two wards closed in 2007 leading to a reduction of 20 beds. Service users were still offered a mainly bed-based service with deficiencies in community team resources. The development of a day hospital in 2009 was welcome. It was evident that unless key decisions were taken on the location of services for North Tipperary, unless financial resources were redirected to close the hospital, and unless corporate governance structures were improved, there was unlikely to be significant improvement in the delivery of the South Tipperary mental health service.

During an announced inspection in St. Luke's Hospital, the Inspectorate had serious concerns regarding the care and treatment provided in St. Bridget's Ward and St. John's Ward. There were deficits with the living conditions of people with an intellectual disability, evidence that regular psychiatric reviews of residents were not completed within the last year, and obvious ligature points in both St. John's Ward and St. Michael's Unit. Detailed information was available in the approved centre reports. The situation was reported as a matter of urgency to the Mental Health Commission. It was subsequently reported that these issues were being addressed and the practice of sleeping out had ceased. The Inspectorate will continue to monitor progress in all areas in 2009.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Urgent action must be taken to improve the care and treatment of residents in St. John's Ward and St. Bridget's Ward. This includes a complete assessment of individual residents' needs and the provision of therapy and care to meet those needs.*

2. *St. Luke's Hospital should be closed. In the interim, the conditions in the hospital must be brought to an acceptable standard.*

3. *Admissions must cease to St. Luke's Hospital, apart from appropriate admissions to the old age service and rehabilitation, which were located within the hospital.*

4. *The issue of provision of in-patient services for North Tipperary must be resolved at both management and clinical level.*

WATERFORD MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	Waterford
Mental Health Service	Waterford Mental Health Services
Population	123,844
Number of Sectors	7
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life Child and Adolescent
Date of Meeting	28 October 2008

SERVICE DESCRIPTION

There were two approved centres in the Waterford Mental Health Services area. The 44-bed acute unit was located on the campus of, and integrated with, Waterford Regional Hospital. The rehabilitation and continuing care facilities were located in St. Otteran's Hospital. There were 101 residents in St. Otteran's Hospital. The service had two 24-hour staffed community residences with 27 places, three medium support residences and 11 unstaffed community residences. There were seven community mental health teams, which were inadequately staffed.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

DEPARTMENT OF PSYCHIATRY, WATERFORD REGIONAL HOSPITAL

1. *There is a requirement under the Regulations for the unit to commence using integrated care plans.*

Outcome: There was no integrated care plan in operation.

2. *Policies must be updated to be Regulations and Rules compliant.*

Outcome: Policies were up to date and available to the Inspectorate.

3. *The composition of the sector teams should be enhanced with the necessary multidisciplinary input.*

Outcome: There had been no increase in staffing of the community mental health teams.

4. *A risk assessment should be completed regarding access to the garden for residents.*

Outcome: Clinicians stated that patients should access generic areas of Waterford Regional Hospital. Concerns were raised that identifying an external area for use by mental health patients would be a source of stigma. The garden was also overlooked by offices. Because of this, the smoking area was a room within the unit and those residents who were too unwell to access generic areas have no access to external space.

ST. OTTERAN'S HOSPITAL

1. The approved centre must develop policies and procedures in line with the Regulations and reflect local practice.

Outcome: Policies were up to date and available to the Inspectorate.

2. *There should be enhancement of rehabilitation team.*

Outcome: There was now a full time social worker on the team. Recruitment for an occupational therapist was in progress.

3. *There should be a written plan for the closure of the hospital, with time frames, reduction of bed capacity, and enhancement of speciality and sector teams to ensure residents have an adequate follow-up on discharge to the community.*

Outcome: Bed capacity had been reduced from 132 beds to 101 beds. There was a dedicated CNM1 post identified for implementing protocols in relation to discharge of patients to the community. An overall phased plan was due to be finalised by the end of 2008. A new unit at Grangemore was due to open in February 2009 and two community houses were being sourced to accommodate additional service users off campus.

4. *An interim plan and costings to address lack of privacy and conditions of a number of wards must be developed and action taken.*

Outcome: Bedside rails and curtains had now been installed in St. Joseph's Ward. There had been improvements in the smoking area of St. Claire's Ward. Refurbishment was on going in St. Aiden's Ward.

5. *Each resident must have an integrated individual care plan as defined in the Regulations.*

Outcome: This was not yet in place but care plans were being developed by the rehabilitation team.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The service had no written business plan.

DEVELOPMENTS 2007-2008

- The social work post had been increased to 1.0 WTE on the rehabilitation team.
- A reduction in bed complement from 132 beds to 101 beds.
- The Grangemore project had been completed to provide upgraded facilities for the rehabilitation unit (St. Claire's Ward) which would be operational from January or February 2009 following the fitting-out process.
- Planning permission had been received for a €1 million development at the acute psychiatric unit. This would include a dedicated space for holding mental health tribunals, increased multi-purpose rooms for one-to-one patient interaction and a 2-bed special care facility. Capital funding had not yet been made available.
- A review had commenced on role and repositioning of WAVE Rehabilitation Project.
- An inter-agency suicide prevention strategy for Waterford City had been introduced.

HOSPITAL CLOSURE PLANS

While there was no written plan outlining closure plans for St. Otteran's Hospital, it was clear that the closing process had commenced. The bed complement had been reduced from 132 to 101, St. Enda's Ward (17 beds) had closed and there was a reduction of bed numbers in St. Joseph's Ward from 34 to 28, as well as a reduction in St. Monica's Ward of 34 to 26 beds. A dedicated CNM1 post had been identified for implementing protocols in relation to discharge of patients to the community. An overall phased plan was due to be finalised by the end of 2008.

A new unit (Grangemore) was due to be opened in February 2009 to provide alternative rehabilitation accommodation for residents in St. Claire's Ward.

The rehabilitation team was actively involved in assessing and providing rehabilitation programmes for residents. However there was a serious deficit in that there was no occupational therapist on the team.

QUALITY IMPROVEMENTS

- Music therapy had been provided on a pilot basis across the service.
- A multidisciplinary policy/procedures committee was in place.
- There were links with the Friends of St. Aiden's Ward on issues of concern to relatives and on service improvement initiatives.
- A hospital hygiene and waste management committee had been established.
- A mental health services risk register is was being developed.
- An information handbook for the service was been finalised and was being printed.

SERVICE USER INPUT TO SERVICE

A service user nominee for executive management team and an implementation team for ***A Vision for Change*** had been requested.

Advocacy services were available every Tuesday to facilitate service user engagement within the service.

GOVERNANCE

The current executive management team was comprised of the clinical director, the psychiatry later life consultant, the rehabilitation consultant, adult psychiatrist with a lead on addiction services, the director of nursing, the occupational therapy manager, the social work team leader, the principal psychologist and hospital manager (chairperson). The service stated that they were waiting for an advocacy nominee.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	8
Specialist registrar	1

Nursing staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	110.6
Nurses based in community residences	21
CMHN	8
Nurses based in day hospital	2.5
Nurses based in day centres	7
Other	1 (addiction Service)

CNS posts

Speciality	WTE in post
Rehabilitation	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	5.5
Social worker	4.6
Occupational therapist	1

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: The rehabilitation team was inadequately staffed. There was an urgent need for an occupational therapist.

Rehabilitation team

Staffing	2007	2008
Population		93,595
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.5	0.5
CMHN	1	1
Psychologist	0	0
Social worker	0.5	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	22.25	22.25
CNS	1	1

Psychiatry of later life team

Staffing	2007	2008
Population		14,977
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.3	0.3
CMHN	2	2
Psychologist	0.3	0.3
Social worker	0.5	0.25
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
CNM2	1	1

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

St. Otteran's Hospital: The approved centre was non-compliant in providing an individual care plan and linked therapeutic activities. St. Joseph's Ward was unsuitable for the specific needs of the residents. There was no occupational therapist available to the approved centre and there was no policy on risk management procedures.

Department of Psychiatry: The approved centre did not meet the Regulations regarding appropriate visiting areas, the lack of an individual care plan and linked therapeutic activities, and the lack of occupational therapists. The service had progressed the provision of an information leaflet. The lack of privacy of CCTV monitoring had been immediately addressed by the service.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

St. Otteran's Hospital: The approved centre was compliant with the applicable Rules.

Department of Psychiatry: The centre was non-compliant in the use of CCTV monitoring in seclusion. This had been addressed by the service. The centre was compliant with the Rules on ECT and mechanical restraint.

CODES OF PRACTICE

St. Otteran's Hospital: The approved centre was compliant with the applicable Codes of Practice.

Department of Psychiatry: The approved centre was not a suitable facility for the admission of children. The centre was compliant with the Codes of Practice regarding physical restraint and notification of deaths and incident reporting.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ard na Deisce	14	13	Rehabilitation	
Spring Mount	13	13	Rehabilitation	

CONCLUSION

There had been some improvements in the service since 2007 with a number of quality improvements and the work of the rehabilitation team. There had been some progress in commencing the closure of St. Otteran's Hospital and the plan to open a new rehabilitation unit was welcome. It was disappointing that there had been no increase in community mental health team staffing. Consideration should be given to amalgamating sectors in line with national health policy, which would increase access to a wider range of services. Occupational therapist input was urgently required for the rehabilitation team and in the department of psychiatry. The service had not yet commenced integrated care planning and it was unlikely that it would be in place before 2009.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Each resident of the two approved centres must have an integrated individual care plan as defined in the Regulations.*

2. *Consideration should be given to amalgamating sectors in line with national health policy.*

3. *Community mental health teams should be adequately staffed in order to provide a comprehensive community service.*

4. *Local health management should actively support the closure plans for St. Otteran's Hospital and the rehabilitation team should be properly staffed as a measure to achieve this. A project team for closure of the hospital should be appointed from within the service.*

WEST CORK MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	West Cork
Mental Health Service	West Cork Mental Health Services
Population	53,445
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	None
Date of Meeting	10 September 2008

SERVICE DESCRIPTION

West Cork Mental Health Services covered a mainly rural population of 54,000 and a small number of urban areas. As a result of the large geographical spread of the population and the poor transport infrastructure in the area, the service was delivered by three sector teams. There was a focus on delivering and developing community based services. The area had one approved centre with 18 beds, which was located on the grounds of the General Hospital in Bantry.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *Senior management should seriously consider the provision of alternatives in patient facilities.*

Outcome: The first phase of the residential review had been completed and phase two was included in the business plan for 2008. Implementation would involve reconfiguration of staff and facilities and a rehabilitation unit was planned for Skibbereen.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

- Phase one of the residential review had been completed and phase two was to commence.
- Resolution of the problems identified in relation to assisted admissions to the approved centre.
- Implementation of the service's 5-year capital plan in line with *A Vision for Change*.
- Develop the third sub-sector in Clonakilty.

DEVELOPMENTS 2007-2008

- A local implementation group for *A Vision for Change* had been established.
- A 5-year capital plan had been developed for the future of the services in line with *A Vision for Change*.
- The service, in partnership with the West Cork Mental Health Forum, planned a week-long programme of activities, discussion and information-sharing throughout the area, to coincide with Mental Health Week in October 2008.
- The Droumleigh Resource Centre had been completed.
- The in-patient facilities in the approved centre were refurbished and an enclosed garden area was provided.

QUALITY IMPROVEMENTS

- Fully integrated clinical notes had been agreed by all staff and were due to be introduced in October 2008.
- The clinical psychology department had started a stress management group for out-patients.
- The pilot Home Focus programme had been evaluated by UCC and showed a reduction of 47 per cent in admissions among those who participated in it.
- Graduates from the HSE/DCU Cooperative Learning: Service Improvement Leadership for Mental Health Service Users, Carers and Service Providers programme were conducting research into the needs and experiences of service users.
- Carers research was being conducted in partnership with West Cork Community Services and other voluntary organisations.
- The residential review was in progress and implementation would involve reconfiguration of staff and facilities.
- A community mental health forum had been established as an alliance of community activists, service users, carers, Primary Community and Continuing Care (PCCC) and other service providers.
- A nurse practitioner worked from three GP practices in the area with patients presenting with mental health problems.

SERVICE USER INPUT TO SERVICE

Service users and carers were involved in several aspects of development and running of the mental health service. The Irish Advocacy Network (IAN) representative in the area reported excellent working relationships with the service and a commitment to partnership and inclusion. The service had a designated person to act as a point of contact and this was working well. Graduates from the DCU Service Improvement Leadership programme for mental health services have completed a questionnaire to be used to conduct research and provide valuable and currently unavailable audit information on the service.

GOVERNANCE

The service had a multidisciplinary catchment management team that provided management support and structure with a clear strategic leadership for future development of the service. The team included heads of discipline, the local health manager, general manager, team co-ordinator and acting section officer. Membership of the local implementation group included these professionals as well as a representative of service users, carers and a representative from the child and adolescent mental health service.

STAFFING

There were three sector teams that combined their functioning because of the geographical spread of the population and the poor resourcing of the core multidisciplinary team members. There was a single point of access to the teams through the team co-ordinator.

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

There were no specialist teams in the West Cork catchment. In view of the small catchment population, the service had hoped that a psychiatry of later life and a rehabilitation team could be developed jointly with one of the adjoining

catchments. There was also an absence of liaison, intellectual disability mental health, and child and adolescent mental health services.

IN-PATIENT FACILITIES

The approved centre was located in the general, hospital. It was not a purpose built unit and this had given rise to some problems with the layout which was over three floors. The unit had recently been refurbished and a new enclosed private outdoor garden area had been developed. The service experienced a number of difficulties with assisted admissions and these were included in their business plan for 2008.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was non-compliant with the following Regulations: Articles 15 on individual care plans, Article 16 on therapeutic services and programmes, Article 17 on children's education, Article 20 on provision of information to residents and Article 32 on risk management procedures. The service subsequently reported that care plans had been introduced in September 2008.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Mechanical restraint, seclusion and ECT were not used in the approved centre.

CODES OF PRACTICE

The approved centre was non-compliant with the Codes of Practice relating to physical restraint, admission of children, and notification of deaths and incident reporting.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

In conjunction with the Friends of West Cork Mental Health Services, a garden was developed for Perrott House in Skibbereen. The three 24-hour staffed residential units were under the care of two of the sector consultants. The residents did not have multidisciplinary care plans linked to the monthly team meetings.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ard Réalt	–	9	–	–
Elmwood House	–	9	–	–
Perrott House	–	21	–	–

CONCLUSION

The West Cork Mental Health Services had good multidisciplinary team working relationships and fostered active partnerships with other statutory and voluntary agencies in the community. The service had a community focus and in this context it was frustrating for staff that funding was not available to continue the pilot Home Focus programme, despite evidence that it was effective and had a positive effect on reducing admissions to the approved centre. The population did not have access to any speciality services and facilities alternative to in-patient admissions were lacking. While the service had been innovative in introducing initiatives, the challenge going forward would be to sustain developments overtime and already there was evidence that this was under threat with the Home Focus pilot programme. Funding resources would be required to fill the basic gaps in the service.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The approved centre must be compliant with all the Regulations, Rules and Codes of Practice.*

2. *The sector teams should be adequately staffed with core members of the multidisciplinary team.*

3. *The service should continue to develop service initiatives in the current environment of financial and staffing restraints that can be sustained over time.*

WEXFORD MENTAL HEALTH SERVICES

HSE Area	HSE South
Catchment	Wexford
Mental Health Service	Wexford Mental Health Services
Population	131,749
Number of Sectors	2
Number of Approved Centres	1
Specialist Teams	Rehabilitation Mental Health Services for Older People
Date of Meeting	2 October 2008

SERVICE DESCRIPTION

Wexford Mental Health services provide a range of services to the population across the county. There were two large sector teams and speciality service teams in rehabilitation and psychiatry of later life. The service had a current bed complement of 120 beds, all based in St. Senan's Hospital. The remaining beds were divided into three main care groups, acute care, rehabilitation/intellectual disability and continuing care/elderly. There was a rich land bank of 116 acres.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All teams should be staffed to the required level outlined in the national policy document.*

Outcome: There was no progress on this recommendation. No additional posts were allocated to the teams. A number of nursing posts were redeployed following the closure of wards.

2. *All residents with an intellectual disability living in the hospital must be located to more suitable accommodation. Where this accommodation exists, resources must be put in place to open the services.*

Outcome: There were 22 people with an intellectual disability living in the hospital on the day of the meeting. It was reported that significant rehabilitation work had been completed with the residents in St. Brendan's Ward in preparation of their move to a new purpose built house in Oylegate village. It was reported that the residents moved on 27 October 2008. The remaining 13 residents in St. Christopher's Ward require two specialised units of 6 and 7 bedrooms. There were no capital monies available to progress this project.

3. *There should be a mental health team for persons with an intellectual disability.*

Outcome: There was no progress on this recommendation.

4. *Regular maintenance and adequate cleaning must continue in St. Senan's Hospital as long as it remains operational.*

Outcome: It was noted during the inspection of the approved centre in June 2008 that there was a marked improvement in the general condition of the wards. Due to the age and size of the building there was an ongoing battle to maintain the building fit for purpose.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The service had a five-year plan, from 2007 to 2011. This plan was broadly in line with the national policy document ***A Vision for Change***. In addition the local health office had developed an implementation plan for ***A Vision for Change*** in the Wexford catchment area. All disciplines and the service user representative had been involved in the process. A statement of the current services and a statement of the requirements under ***A Vision for Change*** had been completed for Wexford but an implementation plan on how the HSE planned to address the deficit between these two statements was not available.

DEVELOPMENTS 2007-2008

- In February 2008 seven-day services commenced at Summerhill and CARN House. The service was nurse-led and delivered at the weekends.
- Two health care assistants were appointed to the elderly care ward in June 2008. Additional posts were planned. Two more posts were appointed in late October to facilitate the relocation of residents with an intellectual disability from the hospital.
- An assertive outreach nursing post was created from existing resources.
- The residents of St. Brendan's Ward had been prepared for discharge by the rehabilitation team and had moved to their new home in Oylegate. This was due to release one nursing post for community re-deployment.
- A pilot GP suicide crisis assessment nurse (SCAN) liaison service was introduced. This project was jointly funded by the service and the National Suicide Prevention Office. It covers 24 GP practices across the county. Initial findings were encouraging.
- The Mental Health Service for Older People (MHSOP) was currently assessing the needs of older people in the hospital. At the end of the process it would allow the team to transfer suitable residents to nursing home care. A significant barrier to achieving this aim was accessing additional funding to secure nursing home beds.
- The rehabilitation team had continued to work with residents from the hospital and placing them in appropriate accommodation based on needs. Significant enabling factors in this process had been having access to county council housing and the enhancement of the rehabilitation team in 2008. A good working relationship had been established between the team and the county council officers.

HOSPITAL CLOSURE PLANS

A written outline plan detailed the closure of St. Senan's Hospital by 2013. The service reported that it would close two wards by the end of 2008: St. Brendan's (intellectual disability) and St. Fidelma's Ward (elderly care). The total bed numbers on campus would then be 120. The rest of the plan was contingent on the provision of acute beds in Wexford General Hospital, the funding of a 12-bed rehabilitation unit currently at design stage (to open in 2010), the provision of a 14-bed challenging behaviour unit for elderly care, funding of placements in nursing homes, and the provision of suitable accommodation for the remaining residents with intellectual disability. There was no capital and revenues plan in place to achieve this plan. The service indicated that they would require additional revenue resources from January 2009.

QUALITY IMPROVEMENTS

- The rehabilitation team had introduced a Hearing Voices group and a Wellness Recovery Action Plan (WRAP) programme, and the Solutions for Wellness programme was extended.
- A review of the day services and vocational programmes were underway.
- The rehabilitation team was part of a national multi-centred research project funded by the Mental Health Commission.

SERVICE USER INPUT TO SERVICE

A number of developments had taken place in 2008. Services users' representatives were asked to join the management team. A representative was part of the local ***A Vision for Change*** Implementation plan. It was reported that attempts to establish a consumer council had commenced. Peer advocacy was provided by the Irish Advocacy Network (IAN) to the acute admission wards in St. Senan's Hospital. They reported positive improvements in the layout of the female ward, and the professionalism of the nursing and medical staff on the wards. Of concern to service users were the smoking area and the lack of stimulation.

GOVERNANCE

The management team consists of the hospital manager, director of nursing, clinical director, principal psychologist, and the occupational therapist manager from Primary Community and Continuing Care (PCCC). The service did not employ a principal social worker in the mental health services. The social work team leader was not a member of the management team. The Local Health Manager reported that the HSE was establishing a principal social worker for adult services across PCCC. Both the social worker team leader and senior occupational therapist expressed concerns that they were represented by managers outside the field of mental health, contrary to ***A Vision for Change***.

The service had established a number of groups to oversee nurse practice development, infection control, policies, ECT, household services, operations, service development and nurse education. The groups were representative of all appropriate parties. The health and social care professional groups reported that they had clinical supervision structures in place.

In addition the service was externally audited by An Bord Altranais, Finance HSE, and the environmental health and fire safety authorities.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	6
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1
ADON	6
Nurses based in in-patient services	103.75
Nurses based in community residences	15.5
CMHN	21
Nurses based in day hospitals	7
Nurses based in day centres	4
Addiction counsellors	2
Clinical practice	1
Locum cover	10.8

CNS posts

Speciality	WTE in post
Mental Health Service for Older People	3
CMHN	4

Health and social care professionals

Post	WTE in post
Clinical psychologist	3.6
Social worker	3.5
Occupational therapist	3

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Occupational therapy	Manager	PCCC

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Liaison: A nurse-led liaison service was provided to Wexford General Hospital.

Rehabilitation team

Staffing	2007	2008
Population	131,749	131,749
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.7	0.7
CMHN	3	3
Psychologist	0.4	0.4
Social worker	0.8	0.8
Occupational therapist	0.8	0.8
Day facility nurse staffing	3	3

Psychiatry of later life team

Staffing	2007	2008
Population	131,749	131,749
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.3	0.3
CMHN	4	4
Psychologist	0.6	0.6
Social worker	0.2	0.2
Occupational therapist	0.2	0.2
Day facility nurse staffing	1	1

Liaison team

Staffing	2007	2008
Population	131,749	131,749
Consultant psychiatrist	0	0
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
ADON	0	0
CMHN	1	1
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Day facility nurse staffing	0	0

IN-PATIENT FACILITIES

In patient care was provided in St. Senan's Hospital.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was compliant with a significant number of the Regulations when compared with 2007. The service was non-compliant with care planning on the long-stay wards, therapeutic services and programmes, staffing and the premises. The main barriers to compliance were the lack of health and social care professionals available to the residents, and that care was being provided in an unsuitable building that required constant maintenance.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service was compliant with the Rules on seclusion, mechanical restraint, and ECT.

CODES OF PRACTICE

The service was compliant with the codes of Practice on ECT for voluntary patients. It was not compliant with the Code of Practice on the admission of children and the notification of deaths and incident reporting (clinical governance).

24-HOUR SUPERVISED COMMUNITY RESIDENCES

The rehabilitation team had responsibility for both 24-hour community residences. Ardamine provides care to an elderly population. The house was unfit to meet their care needs and the number of beds had been reduced. Westlands provides care to residents with an intellectual disability. There were plans for a new 12-bed rehabilitation unit in St. John's Hospital. It was currently at design stage.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ardamine	10	10	Rehabilitation	MDT
Westlands	8	8	Rehabilitation	MDT

CONCLUSION

The momentum reported in the 2007 report had continued. There was a real sense that the service was keen to move forward and be creative and imaginative in achieving real changes within its existing resources. But this capacity was finite. In order to resettle the remaining residents from St. Senan's Hospital in suitable accommodation based on needs there was a need for the HSE to fund the local service closure plan with capital and revenue resources and in parallel develop community mental health teams and speciality teams with the appropriate resources and skill mix. Any capital realised from the sale of the rich land bank must be ring-fenced for the development of services in Wexford. Wider partnerships with the local county council in the provision of housing must be continued and developed as a model of best practice. The continued use of the hospital to provide care and treatment for people with an intellectual disability must cease, together with sleeping out practices.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Sleeping out residents in other wards around the hospital must cease.*
2. *All teams should be staffed to the required level outlined in the national policy document.*
3. *All residents with an intellectual disability living in the hospital must be relocated to more suitable accommodation. There must be a mental health team for persons with an intellectual disability.*
4. *The hospital closure plan must be funded and resourced.*
5. *Nursing home care must be funded for those residents for whom it is appropriate.*
6. *Any monies raised from the sale of lands must be ring-fenced for the provision of mental health services in Wexford.*

HSE WEST

CLARE MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	Clare
Mental Health Service	Clare Mental Health Services
Population	110,950
Number of Sectors	4
Number of Approved Centres	3
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	9 December 2008

SERVICE DESCRIPTION

Clare Mental Health Services provided mental health care to the population of a large geographical area. There were four sector teams, three approved centres and a rehabilitation team and psychiatry of later life team.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

The reconfiguration of service management in line with *A Vision for Change* was currently being progressed. Efforts continued to achieve full MDT membership in line with *A Vision for Change*, however progress had been slow due to the ongoing implementation of cost-containment measures within the HSE.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The Clare Mental Health Services business plan was encompassed in the Clare LHM/Primary Community and Continuing Care (PCCC) Business Plan. The overall focus of the business plan was to undertake actions to meet the requirements of *A Vision for Change*.

Business plan 2008 actions specific to Clare Mental Health Services were as follows:

- **Care plans:** Introduction and implementation of care plans currently being progressed within the service.
- **General adult psychiatry:** Completion of CMHTs in line with *A Vision for Change*.
- **Psychiatry of later life:** – Enhancement of the residential facility at Cappahard Lodge, which had been progressed on foot of receipt of capital funding.
- **Intellectual disability:** Residential community facilities at Cois Mara and Avonree for persons with intellectual disabilities continue to have no access to a specialist consultant-led multidisciplinary team (MDT).
- **Authorised officers:** Staff were identified and training had been provided, with the interim authorised officers being replaced by authorised officer who would fulfil this role in line with Mental Health Act 2001.

DEVELOPMENTS 2007-2008

- In October 2008, Cappahard Lodge was registered as an approved centre by the Mental Health Commission.

- Structural changes were carried out to Orchard Grove, an approved centre, to facilitate the future integration of female patients.
- A supervised community residence, Aughanteeroe, had been categorised as a step-down unit from Teach na Beithe, the intensive rehabilitation unit, leading to greater movement of clients with an earlier return to independent living.
- An accommodation review survey, led by the rehabilitation team, was completed and a number of recommendations made. The local Mental Health Association set up a Voluntary Housing Association called Fáilte Isteach, with a view to providing community-based clients with an appropriate standard of accommodation to enable independence in line with the recovery model of care.
- The service development group had been extended to include staff association representatives to provide a partnership forum.
- Two staff nurses were redeployed from residential services to facilitate the opening of the day centre in Shannon and the enhancement of nurse staffing at Scariff day centre.
- Nurse-led clinics in GP practices commenced in West Clare sector.

QUALITY IMPROVEMENTS

- Three staff members who obtained a B.Sc in the Professional Management of Violence and Aggression had been rolling out training to staff. The matrix of effectiveness of training had been completed for many of the Clare Mental Health Service facilities.
- Updated site-specific Safety Statements continue to be progressed to ensure compliance with the new national template and regulations.
- The Clare Mental Health Services as part of the Clare local health office PCCC area was a pilot site for the roll out of the Quality and Risk initiative.
- There was ongoing review of all policies, procedures, protocols and guidelines that have application within Clare Mental Health Services; the recommendations of the independent review of policies and procedures on Cappahard Lodge were currently being implemented and would also inform best practice in this area; A MDT care group infection control committee had been set up. A number of clients had been transferred following MDT assessment to more appropriate care settings, with a consequent reduction in the in-patient numbers in Orchard Grove.
- The Community rehabilitation team was currently progressing plans for a structured therapeutic day programme in the community to enhance ADL skills and personal care, thereby reducing the referrals for Teach na Beithe, enabling more focused outpatient work.
- The EMBRACE art project was initiated in the high support hostels in Ennis, Kilrush and Shannon; a social club commenced in Shannon to provide social inclusion and improved quality of life for clients; a gardening group had commenced in Ennis day centre with input of the clients from the centre and Orchard Grove.
- A patient-centred care project at Cappahard Lodge and the Refocusing Project in the Acute Psychiatric Unit continued to progress, leading to better outcomes for treatment and care interventions for these patients.
- The Community Rehabilitation Service areas have had their recovery care plans extended to all rehabilitation services areas. The care plan incorporated the electronic FACE risk assessment tool and the health and social assessment questionnaire which provides for a comprehensive care plan for clients of this service. A multidisciplinary care plan committee reported in October 2008 and on foot of its recommendation a paper-based multidisciplinary care plan was being piloted in the Acute Unit and in three general adult psychiatry community mental health team areas.
- Training was provided on both childcare legislation and HSE complaints policy.

- The Clare Mental Health Services Executive had given approval for the piloting of ICBT (intensive community-based treatment) in the West Clare community mental health team and consideration was to be given to its extension to other sectors depending on the feedback from the pilot.
- A mental health in primary care sub-committee continued to progress work vis à vis the reconfiguration of sector boundaries in line with ***A Vision for Change*** with a view to having future sector configurations matching those of the primary care networks. The North Clare community mental health team continued to consolidate its linkages with the recently established North Clare primary care team.
- The North Clare community mental health team had initiated a system involved all new patient referrals first undergoing a nursing assessment to indicate care and treatment options.
- Clare Mental Health Services had adopted a comprehensive risk management policy in conjunction with the clinical risk advisor as a proactive measure to put in place plans to manage service users who were presenting, or who had the potential to present, serious management difficulties.

SERVICE USER INPUT TO SERVICE

A representative from the Irish Advocacy Network (IAN) provided a report to the meeting representing service user views in relation to the Clare Mental Health Service. There were a number of positive comments concerning the relationship established between staff and residents, and access to information and support. Areas of concern included lack of awareness of care plans, too much emphasis on medication and lack of alternative treatments.

GOVERNANCE

The existing management structure of Clare Mental Health Services had been reviewed and was being reconfigured in line with ***A Vision for Change***. Although there were plans to develop an MDT management team, the proposed members of this team were not fully representative of the specialist mental health services.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	8
Specialist registrar	1

Nursing staff

Post	WTE in post
DON	1.18
ADON	8.56
Nurses based in in-patient services	44.23
Nurses based in community residences	130.22
CMHN	3
Nurses based in day hospitals	12.16
Nurses based in day centres	13.09
Other – temporary staff panel	1.37

CNS posts

Speciality	WTE in post
ECT	1
Community psychiatry	6
Rehabilitation	4

Health and social care professionals

Post	WTE in post
Clinical psychologist	5
Social worker	4.6
Occupational therapist	4.2
Addiction counsellor	2.5

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation team

Staffing	2007	2008
Population	110,800	110,950
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	1	1
CNS	4	4
Psychologist	1	1
Social worker	1	1
Occupational therapist	0	1
Nurses in community residences		59.52
Day facility nurse staffing	5	8.37

Psychiatry of later life team

Staffing	2007	2008
Population	12,921	12,921
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	1
CNS	0	2
CMHN	3	2
Psychologist	0	0
Social worker	1	0.6
Occupational therapist	1	1
Nurses based in approved centre		29.74

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Orchard Grove: The approved centre was non-compliant with one Regulation.

Acute Unit: The approved centre was non-compliant with two Regulations.

Cappahard: The service was non-compliant with 15 Regulations.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Orchard Grove: The approved centre did not use seclusion, mechanical restraint or prescribe ECT.

Acute Unit: The approved centre was non-compliant on training in relation to seclusion, although a programme of training was to be implemented.

Cappahard: The approved centre was non-compliant on one aspect of mechanical restraint.

CODES OF PRACTICE

Orchard Grove: The approved centre was compliant with the Codes of Practice.

Acute Unit: The approved centre was non-compliant on training in relation to physical restraint, although a programme of training was to be implemented.

Cappahard: The approved centre was compliant with the Codes of Practice.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Avonree	11	11	None	Nursing
Cois Mara	17	17	None	Nursing
Gort Glas	20	19	CRT	MDT
Deilginish	14	14	CRT	MDT
Orchard Lodge (Kilrush)	21	19 2 respite	CRT	MDT
Teach na Beithe	8	8	CRT	MDT

CONCLUSION

Clare Mental Health Services continues to provide a range of mental health services, which included three approved centres. One recently approved centre requires significant input to meet the requirements of the Regulations. There had been considerable improvements in the approved centre Orchard Grove.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The management team should be representative of all disciplines with a knowledge of the provision of mental health services.*

2. *All teams should be fully resourced.*

3. *Each approved centre should be compliant with the Regulations.*

DONEGAL MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	Donegal
Mental Health Service	Donegal Mental Health Services
Population	139,856
Number of Sectors	4
Number of Approved Centres	2 St. Conal's Hospital Acute Psychiatric Unit, Carnamuggah
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	16 December 2008

SERVICE DESCRIPTION

The Donegal catchment area was a predominately rural one with two main urban centres and was divided into four sectors . The geography of the area presents a number of challenges for the service in terms of facilitating access to various therapies. There were two approved centres, one long-stay unit at St. Conal's Hospital and an acute admission unit at Carnamuggagh. The unit at Carnamuggagh was a temporary one while a purpose-built unit was being constructed in Letterkenny General Hospital. There were specialist teams in rehabilitation and psychiatry of later life. All sectors had a residential resource and a day centre, but there was no designated day hospital for patients of psychiatry of later life. In addition, this team was poorly served in terms of a multidisciplinary team (MDT) approach as it currently lacked a social worker and occupational therapist. There was a day hospital in Letterkenny for all service users.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All teams should be resourced with the core complement of MDT members.*

Outcome: Teams were not fully staffed with all disciplines.

2. *The service should continue to progress the closure of St. Conal's Hospital and ensure the appropriate placement of the remaining residents.*

Outcome: The number of residents in St. Conal's was now reduced to 19 residents. It remained the intention of the service to close St. Conal's and the rehabilitation team had recently conducted assessments on the remaining residents with a view to moving them from St. Conal's.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The Inspectorate was provided with a comprehensive business plan for 2008. This plan included amalgamation of the two remaining wards in St. Conal's Hospital, which had since had to be reviewed following concerns raised by a family member of one of the residents. The role of the supervised residential units (SRUs) was to be expanded to provide an alternative to admission of patients to the acute unit. A new headquarters for the central sector was to be identified and developed. A crisis response service was to be developed and consumer panels were to be re-established. An advanced nurse practitioner (ANP) post was to be established in the area of eating disorders. It was also planned to deploy nine nurses to the community.

DEVELOPMENTS 2007-2008

- The old admission unit in Letterkenny General Hospital was demolished in 2008 and construction of a new unit was due to begin in 2009.
- An information system for mental health service (WISDOM) had been developed and had reached the stage of implementation of a pilot scheme that would last 18 months.
- Community mental health teams (CMHTs) had developed policies in the areas of referral, transfer and discharge of patients.
- The service had engaged with the local VEC to provide for the educational needs of resident children.
- An MDT protocol and referral pathway had been developed for the management of alcohol detoxification in Letterkenny Hospital.

QUALITY IMPROVEMENTS

- All staff completed Mental Health Act 2001 training. An information leaflet had been produced for residents of the admission unit.
- An educational programme involving service users, carers and staff was conducted through UCD, with the outcome due to be presented to staff.
- Individualised therapeutic programmes in occupational therapy had been developed with service users in the central sector.
- A patient satisfaction survey had been drawn up and would be circulated early in 2009.
- The CMHTs had produced a referral form for use by GPs referring patients to the service.
- The occupational therapist manager had completed a training programme in the Hearing Voices group and plans to introduce groups as part of the occupational therapy services.
- Some audits had been carried out, including an audit on note-taking and use of community versus in-patient beds.

SERVICE USER INPUT TO SERVICE

Advocacy for service users was provided by the advocacy group Steer. An advocate currently visited the approved units when requested, but from January 2009 there would be regular weekly visits. The advocate reported an excellent relationship with staff. The main issues arising from meetings with residents included concerns about housing benefits, support following discharge, and referral to local groups post-discharge.

GOVERNANCE

The management structure include representatives from psychology, occupational therapy, social work and the advocacy group.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	13
Specialist registrar	1

Nursing staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	75
Nurses based in community residences	50
CMHN	14
Nurses based in day hospitals	6.75
Nurses based in day centres	4

CNS posts

Speciality	WTE in post
Liaison	1
Family therapy	2
Cognitive behaviour therapy	6
Addictions	3
Counsellor	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	4
Social worker	4
Occupational therapist	4.5
Social care staff	4.2

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation team

Staffing	2007	2008
Population	139,856	139,856
Consultant psychiatrist	1 (special interest post)	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	1	1
CMHN	6	6
Psychologist	1	1
Social worker	1	1
Occupational therapist	1	0
Day facility nurse staffing	2	2
Support worker	2	4
Nursing staff	12.5	12.5

Psychiatry of later life team

Staffing	2007	2008
Population	approx. 18,000	approx. 18,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	1 (ADON)	1
CMHN	5	4
Psychologist	1	1
Social worker	1	1
Occupational therapist	0.5	0.5
CNS	1	1

IN-PATIENT FACILITIES

Nineteen residents continue to be accommodated in St. Conal's Hospital under the care of the rehabilitation team. It was anticipated that this unit would close in the future, with residents being placed in more suitable accommodation. The acute admission unit was located in a temporary facility close to Letterkenny General Hospital and would be transferred to the General Hospital on completion of a new unit there.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Compliance with the Regulations in both centres was generally good; however, residents in neither centre had individual care plans as described in the Regulations, and some policies remain in draft form only.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Seclusion and mechanical restraint were not used in either of the two approved centres. ECT was not used in St. Conal's Hospital. The admission unit in Carnamuggagh was compliant with the Rules relating to the use of ECT.

CODES OF PRACTICE

The approved centre in St. Conal's Hospital was compliant with the Codes of Practice relating to use of physical restraint (which was rarely used in the centre), and the reporting of deaths and incidents. The code relating to admission of children was not applicable.

In the Acute Unit, a draft policy was in place regarding admission of children and the service was non-compliant in some instances of recording the use of physical restraint and training of staff.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Rowanfield House	16	10	General adult	Nursing
Park House	19	13	General adult	Nursing
Cleary House	20	20	Rehabilitation	Nursing
Carndonagh	20	15	General adult	Nursing

CONCLUSION

Donegal Mental Health Services was a very committed service. The rehabilitation team was actively engaged in the process of assessing the remaining residents in St. Conal's Hospital with a view to transferring them to more suitable accommodation, given the commitment to close the hospital. There continued to be a lack of MDT members, most notably in the psychiatry of later life team. This was unfortunate given the population of older people in the catchment. The advocacy group provided an effective service to patients and was involved in certain management issues pertaining to service users.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *All teams should be adequately resourced with the full complement of MDT members.*

2. *The closure of St. Conal's Hospital should proceed and remaining residents be suitably placed in alternative accommodation.*

3. *All patients should have an individual care plan as described in the Regulations, and a single composite set of notes kept.*

EAST GALWAY MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	East Galway
Mental Health Service	East Galway Mental Health Services
Population	110,100
Number of Sectors	4
Number of Approved Centres	1
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	10 December 2008

SERVICE DESCRIPTION

East Galway had a population of 110,100. It had a large psychiatric hospital with four remaining wards and an acute admission unit. Over the past two years, a number of wards had closed and plans for closure of the remaining wards were progressing. There were currently 58 residents remaining in the four long-stay wards. The community service was well developed and there were nine small 24-hour supervised residences as well as eight supervised residences for people with intellectual difficulties who had been discharged from long-term psychiatric care. There were also eight medium support residences and 17 independent residences. There were plans to amalgamate East and West Galway catchment areas, and there had been progress in the activation of this plan.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *A psychiatry of later life team should be developed.*

Outcome: A full team had not been developed. A social worker was appointed in 2007. However there was no psychologist or occupational therapist on the team.

2. *The service should plan and integrate the merging of the East and West Galway services.*

Outcome: There had been progress in planning the merger of the two catchment areas and initial meetings had taken place with both senior management teams.

3. *All teams should be resourced with a core complement of MDT members.*

Outcome: There had been little progress on this recommendation. It should be noted that despite lack of full multidisciplinary teams, all service users within the sectors had some access to all disciplines.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A business plan for East and West Galway was submitted. This outlined the plan for implementation of ***A Vision for Change*** and included plans to close St. Bridgid's Hospital and Toghermore, a large residence in the community, and to carry out recruitment of staff and increased linkages with the voluntary services. A comprehensive local plan was also submitted relating to clinical issues, training for staff, carers and service users, development of assessments and integrated care pathways.

DEVELOPMENTS 2007-2008

- The number of long-stay beds continued to reduce. Fifteen residents were discharged to nursing homes under the Dowry Scheme.
- Work had been completed on developing common sectors with primary care.
- In Tuam, new offices had opened beside the day hospital.
- A social worker had been appointed to the rehabilitation team.
- A seven-day service had been initiated in three sectors and this was in progress in a fourth sector. This had contributed to the reduction in the admission rate to the acute unit.
- The Jigsaw project for young people was in operation in Galway. This provided integration of services and supports for young people through support and training, as well as identifying young people at risk from mental ill-health. One of its main focuses was early intervention facilitation of easy access to mental health services where necessary. It was a partnership led by Headstrong with HSE and Mental Health Ireland.

HOSPITAL CLOSURE PLANS

The process of closing St. Bridget's Hospital had continued through 2008. Ward 21A was now closed and Ward 16 was due to close in March 2009. The numbers of beds in the admission unit had dropped to 41.

QUALITY IMPROVEMENTS

- There was a comprehensive clinical, training and managerial plan for the acute unit.
- Consumer panels had been established and there was a service user council.
- Creagh training centre received a Green Flag for environmental work carried out in 2007.
- A number of clinical audits had been completed, including a smoking initiative, and audit of the use of cot sides, and an audit of the prescription of benzodiazepines.
- The Wellness Recovery Action Plan (WRAP) programme was currently being used in some parts of the service.
- A Traveller education programme was completed.
- Each sector had a comprehensive programme of quality improvements that included education programmes, use of recovery models, audits, and weekly MDT meetings in residences.
- The community services had been nominated for or had received a number of awards for excellence.

SERVICE USER INPUT TO SERVICE

Advocacy for service users was provided by the Irish Advocacy Network (IAN). The advocate described staff at the approved centre as friendly and approachable and there was no difficulty in reporting any complaints. The main issue concerning service users relate to the apparent reliance on medication as treatment and the lack of alternative therapies. The advocate also highlighted the lack of weekend activities in the unit. Some patients reported that they were not fully aware of their rights under the Mental Health Act.

GOVERNANCE

The senior management team was multidisciplinary. Clinical and management audits were carried out on a regular basis, with the results available within the service. There was evidence that these audits resulted in changes within the service.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	12
Specialist registrar	0

Nursing staff

Post	WTE in post
DON	1 (vacant)
ADON	8
Nurses based in in-patient services	108
Nurses based in community residences	129
CMHN	10
Nurses based in day hospitals	19
Nurses based in day centres	19
Other – addiction counsellors	9

CNS posts

Speciality	WTE in post
CMHN (stated above)	10
Addiction counsellor (stated above)	9
Cognitive behaviour therapy	2.5
Acute mental health	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	4
Social worker	4
Occupational therapist	4

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Principal	Community care

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: Although applications had been made for a psychologist and occupational therapy no funding had been made available for this. A social worker had been appointed.

Psychiatry of later life: Resources were currently based in the in-patient service. With the appointment of new staff the service would extend into the community. The appointment of a consultant psychiatrist was in progress.

Liaison: There was no liaison team.

Intellectual disability: This service was provided by the general adult mental health programme with 0.5 WTE dedicated NCHD and with assistant director of nursing input. There were eight supervised residences for people with intellectual disabilities, though a small number still remained in the hospital in long-stay wards.

Rehabilitation team

Staffing	2007	2008
Population	110,100	110,100
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0	1
Occupational therapist	0	0
Day facility nurse staffing	11	11

Psychiatry of later life team

Staffing	2007	2008
Population	110,100	110,100
Consultant psychiatrist	Access	1 (appointment in progress)
NCHD (including specialist registrar)	0	0.5
Dedicated team coordinator	1 CNM3	1 CNM3
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Physiotherapist	1	1
Dietician	0	0

Intellectual Disability team

Staffing	2007	2008
Population (as per national database)	110	114
Consultant psychiatrist	As required	As required
NCHD (including specialist registrar)	0.5	0.5
Dedicated team coordinator	1 ADON	1 ADON
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Nursing staff	57	57
Care assistants	46	46

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

At the time of the initial inspection, there were a number of policies required in the Regulations that remained in draft form. Signed policies were subsequently submitted. A number of six-monthly physical reviews were overdue. The Regulation on privacy was breached and there were breaches in the Regulation on premises. An improvement order was in place under Section 66 of the Health and Safety at Work Act 2005 and a significant number of staff had not been trained in the management of aggression and violence.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The ECT suite did not have a tipping trolley, although there had been one on order for some time. There was a breach of the Rule on mechanical restraint under Part 5.

CODES OF PRACTICE

There was an inadequate number of staff trained to be compliant with the Code of Practice on physical restraint. The approved centre was not suitable for the admission of children.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

There were nine 24 hour supervised residences for people with mental health difficulties and eight community residences specifically for people with intellectual disability who remain within the mental health services. There had been progress in reducing the beds but recent plans to close this facility had been shelved in view of the cost restraints of providing alternative accommodation.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Callow View, Shannon Rd. Portumna.	4	4	Portumna/Gort	Yes
2 Bridge Rd. Portumna.	4	4	Portumna/Gort	Yes
Tulla Hill Hostel, Loughrea	6	6	Loughrea/ Athenry	Yes
Brook House, Ballygar Rd, Mountbellew	7	7	Ballinasloe/ Mountbellew	Yes
Grove House, Moher, Ballinasloe.	6	3 + respite	Ballinasloe/ Mountbellew	Yes
Toghermore House	25 (including respite)	22	Tuam/Headford	Yes
3 Meadow Grove, Milltown Rd, Tuam.	5	5	Tuam/Headford	Yes
Riverview, Ballinasloe	10	9	Rehabilitation	MDT
Garbally Oaks, Ballinasloe	6	6	Rehabilitation	MDT

CONCLUSION

There had been significant developments in the East Galway service over the previous two years and this continued in 2008. The progress of closure of St. Bridgid's Hospital was continuing with a significant drop in numbers of residents. There was a comprehensive written local plan and ongoing reviews of the services. The community teams were well developed and there were strong links with voluntary and community groups and provision of regular education programmes. The Jigsaw model for young people demonstrated the willingness of the service to further community development through partnership with other agencies. The community service sectors now matched the primary care teams. The 24-hour supervised residences are, in the main, developed as appropriate accommodation for 5 or 6 service users. There were difficulties in compliance with Rules and Regulations for approved centres which should be urgently addressed. The ongoing mandatory training of staff was significantly deficient.

The service impressed as enthusiastic and committed to providing an excellent mental health service despite the lack of multidisciplinary members of community and specialist teams.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *All Rules, Regulations and Codes of Practice should be adhered to.*

2. *The training of staff in management of aggression should be addressed as a matter of urgency.*

3. *Community teams and specialist teams should be fully staffed.*

LIMERICK MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	Limerick
Mental Health Service	Limerick Mental Health Services
Population	184,055
Number of Sectors	5
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of Later Life Liaison
Date of Meeting	25 September 2008

SERVICE DESCRIPTION

Limerick catchment area had a population of 184,055. There were six sectors, a psychiatry of later life team, a liaison team, and a rehabilitation team. There was also a half-time forensic team, which at present was not operational. There were two approved centres, St Joseph's Hospital and Unit 5B in the Mid-Western Regional Hospital. There were 77 long-stay residents still remaining in St Joseph's Hospital. Uniquely the psychiatry of later life team was within the generic health services for older people.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All teams should be resourced with the core complement of MDT members.*

Outcome: Two additional consultant psychiatrist had been appointed. There had been no further recruitment of multidisciplinary staff for mental health teams.

2. *The service should progress the closure of St. Joseph's Hospital and ensure appropriate placement for the remaining residents.*

Outcome: This had not been achieved. There was little evidence of action on the plan for closure.

3. *The composition and organisation of the forensic team should be reviewed to take into account the needs of the population.*

Outcome: This has not been achieved

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A Level 2 business plan for the HSE Limerick was provided. This included the following:

- Implementation of ***A Vision for Change***, including a review of existing management structures, a multidisciplinary forum to link with the area executive and the national implementation group and the implementation of a strategic plan to relocate the 77 remaining residents of St. Joseph's Hospital.
- The development of a rehabilitation facility.
- The development of a high observation area in Unit 5B, due to commence in Spring 2009.

- Progression in developing the ePEX computerised information system.

A number of actions such as recruitment and appointment of staff, training initiatives, meetings of a multidisciplinary forum had been deferred due to industrial action and Circular 01/2008 which prohibits further appointment of staff.

DEVELOPMENTS 2007-2008

- A shared care system between rehabilitation and general adult psychiatry had been developed as a result of service reorganisation.
- A number of specific rehabilitation programmes had been developed for both in-patients, residents in 5B and those in community residences and day centres. This included day clinical rehabilitation services in Iniscarra day centre, which provides a 12-week rehabilitation programme. There was also a peer support programme available.
- An additional consultant psychiatrist post with a special interest in psychotherapy had been approved and interviews completed.
- An additional consultant psychiatrist in psychiatry of later life had been appointed in 2007.

HOSPITAL CLOSURE PLANS

The plan for closure of St. Joseph's Hospital was included in the business plan and had also been identified as a priority by the HSE. However there had only been a decrease of five residents since the inspection in 2007 and it was difficult to see how the closure could be achieved in the near future. There were 14 people with intellectual disability still remaining in different wards throughout the hospital.

QUALITY IMPROVEMENTS

- A multidisciplinary care planning group was established in 2007. A model of care was developed based on the recovery principles.This group consulted with service users.
- Intensive case management initiative had been undertaken by one sector. This resulted in an enhanced team approach to service user care. Preliminary analysis indicates high levels of service user satisfaction.
- A new team for training in Prevention and Management of Violence (PMAV) had been established. Assessments were undertaken to determine training needs of all staff.
- A number of audits in non-clinical areas had taken place.
- A number of conferences and workshops had been held for nurse training.
- A full programme of therapeutic activities was available in Inisgile residence and were linked to the care planning system. These programmes were audited regularly.
- There was an arrangement between HSE and the University of Limerick to provide clinical placements for five trainee clinical psychologists.
- The use of seclusion had ceased in St. Joseph's Hospital. The seclusion room was to be redecorated for use as a relaxation room. There was now no seclusion in the Limerick Mental Health Services area.
- The service stated that all sleeping out of residents from 5B to St. Joseph's Hospital had ceased.
- In psychiatry of later life, a multidisciplinary care plan, an assessment tool and information leaflets that include legal information had been developed. There was music therapy in St. Camillus Hospital.

SERVICE USER INPUT TO SERVICE

The consumer panel continued to operate. A training programme had been approved to develop skills related specifically to being a member of a consumer panel.

Regular meetings with service users were held regularly in community residences, in Unit 5B and in St. Joseph's Hospital.

A series of staff workshops on rehabilitation, recovery and empowerment were due to commence in October 2008. This was facilitated by the Irish Advocacy Network (IAN).

Service users in the clinical rehabilitation programme in Iniscarra day centre had developed a programme leaflet.

The Irish Advocacy Network (IAN) provided a service to in-patients, day hospitals and day centres. IAN have found the service to be supportive and welcoming, including being provided with keys to access Unit 5B and a private room. Feedback from service users to IAN had been positive, with most service users finding staff supportive. Service users, through IAN, reported that there was little awareness of care plans, not enough information about medication and a lack of talking therapies. They also complained that Unit 5B was always locked, and that they were often bored. Some servce users said that nursing staff sometimes were too busy to talk to them for very long, that time with medical staff was too short, and that they saw different doctors all the time. The service reported that there were plans to introduce protected time with staff and individual service users. Service users in St. Joseph's Hospital reported that there were very few activities, especially in the locked wards.

GOVERNANCE

The executive team consists of administration, clinical director and director of nursing. There was a multidisciplinary consultative group. Audits of clinical practise had taken place.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	8
NCHD	11
Specialist registrar	2

Nursing staff

Post	WTE in post
DON	1
ADON	8
Nurses based in in-patient services	146.5
Nurses based in community residences	51
CMHN	6
Nurses based in day hospitals	23
Nurses based in day centres	10
Other	29

CNS posts

Speciality	WTE in post
Crisis nurse	4
Elderly/Activation	1
Deliberate self-harm follow-up	3
Addiction	3

Health and social care professionals

Post	WTE in post
Clinical psychologist	5.8
Social work	4
Occupational therapist	3
Art therapist	1.2

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	WTE in post
Psychology	Principal	Limerick LH area

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

There had been no increase in staffing of the specialist teams. The forensic team was not operational at the time of inspection and its staffing resources had been deployed temporarily to Sector B, the largest sector in the catchment.

Psychiatry of later life: The psychiatry of later life team was currently in the Elderly Care Service instead of mental health. No other psychiatry of later life team in the country was in this position. The move to mental health had been discussed for a number of years and this had resulted in uncertainty in future planning for the service.

The day hospital was located in St. Camillus' Hospital and was functional only one day a week. There was a 10-bed assessment unit and a 15-bed extended assessment unit in St. Camillus' Hospital. This had now become an approved centre.

Rehabilitation team

Staffing	2008 WTE in post	2009 WTE in post
Population	184,055	184,055
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	2	2
Psychologist	0	0
Social worker	0	0
Occupational therapist	1	1

Psychiatry of later life team

Staffing	2008 WTE in post	2009 WTE in post
Population	30,000	30,000
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	0.5	2
Dedicated team coordinator	0	0
CMHN	2	3
Psychologist	1	1
Social worker	1	0.5
Occupational therapist	0	0

Liaison team

Staffing	2008 WTE in post	2009 WTE in post
Population	184,055	183,863
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	4	4
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

Unit 5B was compliant with all but three of the Articles in the Regulations. There was no care plan in four of the five adult sectors and as a result therapeutic activities were not linked to care planning for these residents. This was despite an extensive activity schedule in the unit. There was no occupational therapist in the unit.

St. Joseph's Hospital was also compliant with all but three Regulations. Not all residents had an individual care plan or access to therapeutic activities required to meet their needs. The condition of the premises was not in compliance with the Regulations although efforts were being made to remedy this.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Both Unit 5B and St. Joseph's Hospital were compliant with all Rules.

CODES OF PRACTICE

Unit 5B was not compliant with the Code of Practice on physical restraint as not all staff had been trained in the management of violence and aggression. However training was due to commence in October 2008.

As the unit was not an age-appropriate facility for the admission of children, Unit 5B did not comply with the Code of Practice for admission of children.

St. Joseph's Hospital was compliant with codes of practice where they applied.

Unit 5B was a 50-bed acute unit attached to the Mid Western Regional Hospital. Currently there was no high observation unit. However construction was due to start in the spring of 2009 of an observation unit and upgrading of the current building. Children continue to be admitted to this unit which was not suitable for children. All children were under the clinical care of the child and adolescent team. The nearest children's unit was in Galway, approximately 80km away.

St. Joseph's Hospital was an old style psychiatric Hospital. There were still 77 residents in five wards; a decrease of only five since the 2007 report. The service stated that it was committed to closing the hospital and there was a strategic plan for closure, but considerable work was required to achieve this: enhancing the rehabilitation service, obtaining suitable community residences and providing nursing home care for elderly residents who require this level of care. The condition of the building continued to deteriorate, although there was ongoing work to improve the facilities. However St. Martin's Ward, which was severely criticised in the 2007 report, had closed and residents moved to a ward that had been decorated and refurbished to a very high standard. Residents stated that they were very happy with the environment of this new ward. There was an overall lack of therapeutic activities in St. Joseph's Hospital, especially in the wards that were not under the rehabilitation team. There were plans to appoint a CNM2 in St. Martins Ward to facilitate rehabilitation programmes. Specialist in-patient rehabilitation was provided in the rehabilitation assessment unit under the rehabilitation team.

Of concern were the 14 residents with intellectual disability who were resident throughout the hospital. It appeared that there was little prospect of these residents transferring to the appropriate intellectual disability service.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

The 24-hour supervised residences were large, with 14 to 23 residents in each residence. A review of all residents of community residences had taken place. There were 75 residents in 24-hour supervised residences. There were also 35 elderly residents in a former nursing home who were highly dependent on nursing care. Due to lack of suitable medium and low support accommodation, there were difficulties moving clients to more appropriate and less supervised care. This group of 75, when added to the 77 residents of St. Joseph's Hospital, as well as those requiring community rehabilitation, represented a considerable task for the rehabilitation team, both in assessment and in providing optimum rehabilitation. It must also be noted that the rehabilitation team is understaffed with little prospect of increasing its staff in the current restrictions on recruitment. It was reported that the new system of care planning would be extended to all residences in 2009.

Residence	Number of places	Number of residents	Team responsible	Care plan type
O'Connell House, Gortboy	23	23	Rehabilitation	Nursing
Ferndale, Dooradoyle	20	20	Rehabilitation	Nursing
Ivernia, Croom	14	14	Rehabilitation	Nursing
New Strand House, Ennis Rd	17	17	Rehabilitation	Nursing

CONCLUSION

There had been some innovative care practices initiated in the Limerick mental health service. These included the shared care arrangements between general adult mental health services and rehabilitation, the intensive case management in one sector and the clinical rehabilitation day programme. The appointment of two consultants was welcome although the lack of appointments of other multidisciplinary team members was disappointing.

The lack of progress in closing St. Joseph's Hospital was evident. The plan to obtain community residences, to arrange appropriate care for those with intellectual disability and to source nursing home care remained a plan in 2008, but with little progress in achieving these arrangements. Meanwhile 77 residents remained in St. Joseph's Hospital as well as 75 residents in 24-hour supervised residences. The decrease of only five residents in St. Joseph's Hospital in 12 months was particularly surprising as this hospital was earmarked for urgent closure by the HSE. The vastly improved conditions for residents who were in St Martin's Ward, which had been severely criticised in 2007, was very welcome, and imagination and dedication was obvious in its design.

There was evidence of service user involvement in advising the multidisciplinary forum and in the consumer panel. Advocacy services were well supported in the service.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *At this stage the urgent closure of St. Joseph's Hospital should be advanced from plan to action.*

2. *More suitable normalised accommodation should be sought for those in large 24-hour supervised residences.*

3. *The rehabilitation should be enhanced to provide assessment and active rehabilitation for the above group of service users.*

MAYO MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	Mayo
Mental Health Service	Mayo Mental Health Services
Population	123,648
Number of Sectors	5
Number of Approved Centres	3
Specialist Teams	Psychiatry of Later Life Rehabilitation
Date of Meeting	2 December 2008

SERVICE DESCRIPTION

Mayo Mental Health service covered a wide geographical area that was primarily rural. The service it provides was mainly a community based service, and it was estimated that almost 95 per cent of its patients were treated within the community. The service had three approved centres, Adult Mental Health Unit, Mayo General Hospital, An Coilín, and Teach Aisling, and operated day centres and day hospitals in many small towns. It had a comprehensive psychiatry of later life team, a rehabilitation team and a recently appointed consultant in learning disability who also had sessions in the general adult service.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All of the teams should be resourced with the core complement of multidisciplinary team (MDT) members and staffing should take into account the difficulties in some sectors due to geographical spread.*

Outcome: Not all teams were fully resourced with MDT members. Three of the five general sectors and the psychiatry of later life have psychologists in their team. All the general sectors and the psychiatry of later life had social work and occupational therapy input in their teams. The admission unit had a half-time occupational therapist and limited access to social work.

2. *The specialist teams in psychiatry of later life and rehabilitation should continue to develop.*

Outcome: Both these teams continue to be developed, in particular, the recently established rehabilitation team.

3. *All community mental health teams (CMHTs) should have a single point of referral and all referrals should be discussed at team meetings.*

Outcome: Referrals were generally discussed at team meetings.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The Inspectorate was provided with a copy of a very comprehensive business plan. The An Coilín approved centre would have a bed complement of 25, of which 15 were continuing care beds and 10 rehabilitation. St. Anne's residential unit would have 12 beds. A seven-day service would be provided in Ballinrobe, Westport and Castlebar. Community services in psychiatry of later life would be enhanced. A number of areas in the training and occupational services needed to be addressed.

It was planned to invite tenders for the proposed construction of two new hostels in Swinford and Ballina.

DEVELOPMENTS 2007-2008

- A recently appointed consultant in learning disability also conducted sessions in the area of general psychiatry.
- The service operated a robust system of incident reporting and a new incident report form had been introduced. The risk manager was now informed if a member of staff was on sick leave for longer than three days as a result of an incident in the workplace. In addition, an audit was carried out to highlight areas in need of improvement.

QUALITY IMPROVEMENTS

- A working group on quality improvement had been set up, and quality service groups had also been started in centres outside the in-patient centres.
- A number of audits had been carried out, including an audit of involuntary admissions, an audit of referrals via the liaison nurses and a recent hygiene audit.
- The in-patient service was currently engaged in the process of gaining the ECTAS approval certification.

SERVICE USER INPUT TO SERVICE

Service user advocacy is was provided by the Irish Advocacy Network (IAN). The advocate visited a number of facilities and usually liaised with the assistant director of nursing and the director of nursing. Most of the issues which arose seemed to be able to be resolved through these meetings and the advocate reported a good relationship with management. Some issues which the advocate encountered related to boredom by service users after hours and the lack of a covered smoking area. In relation to service users working in the training centres, it was pointed out that there had been no increase in bonus payments for many years.

GOVERNANCE

Management still operated in a tripartite system, meeting once a week. Decisions taken were filtered through to the heads of departments, with who met management every two months.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	7.5
NCHD	9.5

Nursing staff

Post	WTE in post
DON	1
ADON	8
Nurses based in in-patient services	102
Nurses based in community residences	32.75
CMHN	50.7
Nurses based in day hospitals	3
Nurses based in day centres	23.2

CNS posts

Speciality	WTE in post
Liaison	2
Nurse practice development coordinator	1

Health and social care professionals

Post	WTE in post
Clinical psychologist	3
Social worker	6
Occupational therapist	7
Art therapist	4
Woodwork therapist	0
Senior pharmacist	1

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation team

Staffing	2007	2008*
Population		
Consultant psychiatrist	1	
NCHD (including specialist registrar)	1	
Dedicated team coordinator	0	
ADON	0	
CMHN	0	
Psychologist	0	
Social worker	0.2	
Occupational therapist	1.5	

*No 2008 figures were given for the members of the rehabilitation team.

Psychiatry of later life team

Staffing	2007	2008
Population		
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0.5	0.5
CMHN	3	4
Psychologist	0	0
Social worker	1	1
Occupational therapist	1	1
Day facility nurse staffing	0	0

IN-PATIENT FACILITIES

The Mayo catchment area had three approved centres, situated in Mayo General Hospital (32 beds), An Coilín (27 beds), and Teach Aisling (10 beds). The rehabilitation team had responsibility for An Coilín and Teach Aisling. Psychiatry of later life admited to the unit in Mayo General Hospital.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The unit in Mayo General Hospital was non-compliant in the Regulation relating to individual care plans.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The unit in Mayo General Hospital was compliant with the Rules governing seclusion and ECT. Mechanical restraint was not used in any of the centres. ECT and seclusion were not used in An Coilín or Teach Aisling.

CODES OF PRACTICE

A number of the practices governed by the Codes of Practice were not applicable to all centres. Where relevant, the centres were compliant with the exception of the Code of Practice relating to the admission of children in the unit at Mayo General Hospital.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

There were three community residences with 24-hour supervision. The Inspectorate was not provided with the current number of residents in these residences.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Swinford	5	5	General adult	MDT
Ballina	10	10	General adult	MDT
Fairways	21	21	Rehabilitation	MDT

CONCLUSION

Mayo Mental Health Services provides a primarily community-based service with day hospitals and mental health centres in many small towns within its catchment area. Despite its commitment to a community-based service, it does not provide a full seven-day service in the community. It had a comprehensive psychiatry of later life service and had a recently appointed rehabilitation team. It provided a limited liaison service by means of one NCHD and two nurses, and it was envisaged that this would be developed into a full liaison team. Service users were involved in many aspects of the service and were engaged in a panel to participate in shaping the future provision of services.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *All teams should be resourced with the appropriate skill mix to ensure provision of a full MDT approach .*

2. *The current management system of tripartite management would be improved by the introduction of MDT involvement.*

NORTH TIPPERARY MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	North Tipperary
Mental Health Service	North Tipperary Mental Health Services
Population	66,023
Number of Sectors	2
Number of Approved Centres	None
Specialist Teams	None
Date of Meeting	13 November 2008

SERVICE DESCRIPTION

North Tipperary was based in the HSE West administrative area. It served three large towns, Thurles, Nenagh and Roscrea. It had a small catchment with two reasonably well-developed sector teams. It was in the unique position of sourcing its acute admission beds and long-stay beds in another catchment area and HSE administrative area. All acute admissions were to South Tipperary General Hospital and with access to beds in St. Luke's Hospital. There was one consultant psychiatrist with dedicated responsibility for the in-patients unit at St. Michael's Unit and set sessions in St. Luke's Hospital. Both sites were subject to a Section 55 Inquiry under the Mental Health Act 2001 at the time of the inspection. The future of the service was uncertain. The population was too small to warrant specialist teams or independent access to beds, yet service users were entitled to a full range of services. Geographically North Tipperary was some distance from Clonmel and not served by a regular transport network. It was reported that a study was commissioned to decide on the future provision of care for service users in the area.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All of the teams should be resourced with the core complement of MDT members.*

Outcome: There were no additional resources to the two sector teams. There were no occupational therapists on either team.

2. *The service should develop and implement plans for the provision of appropriate accommodation and services to the remaining residents in St. Luke's Hospital Clonmel.*

Outcome: There was no progress on this recommendation. The North Tipperary services were not involved in the closure plans for St. Luke's Hospital.

3. *A decision regarding the location of the acute services should be made and implemented.*

Outcome: No decision had been taken.

4. *Plans for the long-term future of the service should take into account the rights of the population to access a range of services and care options that are difficult to provide in a small catchment.*

Outcome: There was no progress on this recommendation.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

No business plan was submitted. A list of targets for 2008 was given to the Inspectorate. The long-awaited report on the future of mental health services in Tipperary was not available at the time of the meeting.

DEVELOPMENTS 2007-2008

- A group representing both North and South Tipperary had completed a report after twelve months on the future of the service. It was unpublished at the time of the inspection.
- A MDT mental health assessment form had been developed. In-team training was due to take place in December for both sectors with a view to initiating the new way of working at the end of January 2009.
- A two-day workshop was held on organisational development looking at team co-ordination, policy and procedures and multidisciplinary team roles.
- A consultant psychiatrist or representative was attending meetings of primary care teams in the area. It was hoped to facilitate improved relationships between the newly developing teams and tertiary services.
- Evening medical clinics had recently started in Thurles in order to address the HSE policy requirement for extended hours of working. Some members of the multidisciplinary team had expressed interest in this and staff were examining the possibility of further extending this service.
- The service took part in a national audit of day services conducted by the National Audit Office of the HSE.
- The service had availed of National Lottery funds for local school projects.
- The out of hours team at Nenagh General Hospital had a post upgraded to CNS status.

HOSPITAL CLOSURE PLANS

North Tipperary had admitting rights to St. Luke's Hospital, Clonmel. At the time of the meeting it was reported that there were over twenty people from North Tipperary resident in the hospital. The majority were there for a considerable length of time. There was no plan available on the future provision of care for these people. Details of these facilities were provided in HSE South Tipperary Mental Health Services reports. North Tipperary provided a set number of consultant psychiatrist sessions to the hospital, as part of a local medical arrangement.

QUALITY IMPROVEMENTS

- A peer support centre, Áras Folláin, was formally opened in November in Neagh. A peer advocacy service was established by the Irish Advocacy Network (IAN) in the summer of 2008.
- A mindfulness-cased cognitive therapy group was routinely provided in the Neagh sector. It was due to be evaluated in 2009.
- A pilot project on relapse prevention in bipolar disorder was currently being developed and was due to be implemented in 2009.
- The waiting list for clinical psychology in the Neagh sector was reduced from 21 months to 8 months.

SERVICE USER INPUT TO SERVICE

A peer advocacy service was established in the service in the past six months. The IAN presented a report to the Inspectorate team. The advocacy service was delivered on a monthly basis in each day hospital. A 20-week course in self advocacy was facilitated and reported as very successful. Regular meeting were facilitated with staff to include

the service users on wider consultative groups. Service users reported concerns about the lack of information on medication.

GOVERNANCE

The management team was composed of all heads of discipline. Discussions had commenced on the inclusion of a service user on the team. Staff reported that the organisational analysis which had taken place earlier in the year would facilitate enhanced governance. There was no clinical director post for the catchment. It was unclear to the Inspectorate where the lines of accountability lay in relation to the clinical care and treatment provided in the two approved centres.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	3
NCHD	2
Specialist registrar	1

Nursing staff

Post	WTE in post
DON	1
ADON	0
Nurses based in in-patient services	0
Nurses based in community residences	0
CMHN	2
Nurses based in day hospitals	4
Nurses based in day centres	3
Other – CNM2	3

CNS posts

Speciality	WTE in post
CMHN	2
Therapeutic interventions	2
Crisis assessment and treatment	2

Health and social care professionals

Post	WTE in post
Clinical psychologist	3
Social worker	2
Occupational therapist	0
Addiction counsellor	2

In-patient team

There was no allocated MDT to this service. Disciplines based on the two sector teams do not follow people during in-patient care.

Staffing	2007	2008
Population	66,023	66,023
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: There was no rehabilitation team.

Psychiatry of Later Life: Funding approved in 2007 for a consultant psychiatrist, NCHD and CNS were lost in 2008 due to the HSE embargo on new posts.

Liaison: A nursing liaison service in Nenagh Hospital was provided by an acting CNM2 post. Two posts had been given CNS status in 2008.

Liaison team

Staffing	2007	2008
Population	66,023	66,023
Consultant psychiatrist	0	0
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
CMHN	0	0
Psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
CNM2 (acting)	3	1
CNS	0	1

IN-PATIENT FACILITIES

The service had admitting rights to St. Michael's Unit in South Tipperary General Hospital. Details of this facility were provided in HSE South Tipperary Mental Health Services reports. Theses services were subject to a Section 55 Inquiry under the Mental Health Act 2001 at the time of writing.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

There were no community residences in the area.

CONCLUSION

The future of this service yet again remained unclear. Year by year, the Inspectorate had been critical of the lack of a decision on the future provision of acute care and the resettlement of long-stay patients in St. Luke's Hospital, Clonmel. In the absence of any decision and plan to move forward, service users were being adversely affected. There was a continued absence of access to speciality teams for service users. The community teams were working well but it was disappointing to note that no occupational therapists had been appointed.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *A decision on the future plans for service organisation and delivery must be made as a matter of urgency.*

ROSCOMMON MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	Roscommon
Mental Health Service	Roscommon Mental Health Services
Population	57,185
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	None
Date of Meeting	3 December 2008

SERVICE DESCRIPTION

Roscommon was a small catchment area served by three sectors of approximately 20,000 population each. It had one approved centre for acute admissions, with 30 beds, located in Roscommon General Hospital. It had no specialist team, although because of its population over 65 years, it had been approved for a psychiatry of later life team, but the funding for this post had been deferred earlier in 2008. The service had one seven-day day hospital located in Roscommon town. There were three training centres located in Boyle, Castlerea and Roscommon, and the service had day centres in six locations throughout the catchment area.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *Plans for the long-term future of the service should take into account the rights of the population to access a range of services and care options that were difficult to provided in a small catchment .*

Outcome: The service continues to operate without any specialist team. Consequently, service users had no access to specialists in the areas of old age, rehabilitation or forensic psychiatry (despite the service providing psychiatric services to Castlerea prisoners).

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

The business plan incorporated the development of a new day hospital on a green-field site in Roscommon town, which would replace the current day hospital. In the acute unit in Roscommon General Hospital, it was proposed to provide a dedicated room for 16 to 18 year olds. (The Inspectorate had since been informed that this facility was now operational.) A high observation unit was was expected to be completed early in 2009, and there was a plan to provide a sensory garden for residents.

The plan also included provision of a rehabilitation and recovery team and it was anticipated that this would be in operation in late 2009 or early 2010.

DEVELOPMENTS 2007-2008

- A full community multidisciplinary team (MDT) had been established in the Castlereagh/Ballaghaderreen sector and a community residence was opened in Ballaghaderreen. The team met weekly and had developed an appropriate assessment form. All new referrals came to the team coordinator and assessment was carried out using the key worker system. The high dependency unit (HDU) was progressing and was due to open soon. The CMHN attended primary care meetings fortnightly.
- An extensive review of the training centres was under way at present. It was intended to integrate them using a rehabilitation-orientated model of care.

QUALITY IMPROVEMENTS

The service reported a number of quality improvements:

- Bathroom and toilet facilities in the approved centre had been renovated.
- The Melting Pot café, which was part of the training centre in Roscommon town, recently won a national award.
- The service also won an award for its group involving Women and Family Support, in the Athlone area.
- Two members of staff had trained in serious incident debriefing.
- One of the assistant directors of nursing from the service was a member of the quality group of Primary Community and Continuing Care (PCCC).
- A patient satisfaction survey had been conducted It also involved carers and families.

SERVICE USER INPUT TO SERVICE

Service user input was conducted by the Irish Advocacy Network (IAN). The advocate visited the acute unit once a week, and reported a good relationship with staff. Other facilities, including the day hospital and day centres, were also visited regularly. It was stated that residents were involved with their care plans and knew their key workers. Whilst the comments were generally positive, the advocate drew attention to the need for activities at the week-end and for the provision of a garden in the acute unit, funds for which were currently being sought from local voluntary agencies. The condition of one of the training centres was described as very poor and the lack of any increase in bonus payments in seven years was highlighted.

GOVERNANCE

Management meetings comprising nursing, medical and occupational therapy input were held monthly. Input to the meeting from social work and psychology was facilitated through the occupational therapist manager. A meeting for forward planning was held every three months.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	3
NCHD	4
Specialist registrar	1

Nursing staff

Post	WTE in post
DON	1
ADON	3
Nurses based in in-patient services	50
Nurses based in community residences	23.5
CMHN	4
Nurses based in day hospitals	2.5
Nurses based in day centres	24.5

CNS posts

Speciality	WTE in post
CNS	3

Health and social care professionals

Post	WTE in post
Clinical psychologist	1
Social worker	2
Occupational therapist	3.5

COMMUNITY MENTAL HEALTH TEAMS (CMHT)

In order to report on staffing for 2008, all local Health Managers were asked to give Community Mental Health Team Staffing Numbers by sector. No details on the distribution of staff by sector were available to the Inspectorate Team.

SPECIALIST TEAMS

There were no specialist teams.

IN-PATIENT FACILITIES

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The approved centre was non-compliant with a number of Regulations. Each resident did not have an individual care plan and therapeutic programmes were not linked to the individualised needs of the residents. Physical examinations were not carried out in residents who were in the unit for longer than six months. (The Inspectorate was later informed that each resident now had an Individual Care Plan, and that physical examinations were now carried out on residents who were resident for longer than six months.) The centre was also non-compliant with the Regulations relating to provision of information to residents, and mandatory training of staff. The service also lacked a written risk management policy.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

Although seclusion facilities were of a good standard, the service was non-compliant with the Rules relating to the recording of the use of seclusion, and training for staff had not been provided in the use of seclusion. A draft policy

only was in operation in regard to the use of mechanical restraint. The Rules relating to use of ECT were not applicable as ECT was no longer provided at the unit.

CODES OF PRACTICE

The service was not fully compliant with the Codes of Practice issued by the Mental Health Commission relating to use of physical restraint, admission of children and notification of deaths and incident reporting.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Castlerea	16	16	CMHT	Nursing

CONCLUSION

The catchment of Roscommon Mental Health Service had a relatively low population but geographically covered a significant area. The service was stretched in terms of delivering community services in the absence of any specialist teams and was looking to reconfigure its teams to provide an improved community service. Demographically, the population of its catchment area had changed in recent years and this was causing some difficulties for the teams, particularly in the bigger centres of population. An increase in the elderly population would seem to indicate the requirement for a team in psychiatry of later life. The introduction of MDT care plans in one sector was welcomed and it was hoped this would be replicated in the other sectors. A new purpose-built day hospital is was being constructed in Roscommon town.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *The high observation unit should be completed and commissioned as soon as possible.*
2. *Each team should be sufficiently staffed in order to provide a full MDT approach to the care of service users.*
3. *The training centre in Castlerea should be upgraded in light of the very poor condition of the current building.*

SLIGO/LEITRIM MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	Sligo/Leitrim
Mental Health Service	Sligo/Leitrim Mental Health Services
Population	99,875
Number of Sectors	5
Number of Approved Centres	1
Specialist Teams	Rehabilitation Psychiatry of Later Life
Date of Meeting	19 December 2008

SERVICE DESCRIPTION

The Sligo/Leitrim catchment area served a population of approximately 100,000. There were five sectors and one approved centre, located at Ballytivan, Sligo. The community mental health teams served relatively small sector area populations of 16,000 to 18,000 people. The service had two specialist teams, in rehabilitation and psychiatry of later life. These teams served catchment areas of 99,875 people . In addition, the service had an intellectual disability and a child and adolescence team. There were seven community residences, not all under the care of the rehabilitation team.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All teams should be resourced with the core complement of MDT members*

Outcome: While some progress had been made in this area, with the appointment of an occupational therapy manager, there were serious deficiencies in others. The service had just one psychologist, based at Markievicz House who took referrals only from the mental health service. The psychology service did not operate as an integral part of the multidisciplinary teams. In addition, patients were referred to psychologists based in Primary Community and Continuing Care (PCCC), but the needs of those with mental health difficulty were not prioritised.

2. *Peer advocacy services should be developed immediately.*

Outcome: This had not been done. No peer advocacy service was provided to residents.

3. *The provision of an acute facility should be developed as soon as possible.*

Outcome: Whilst staff were generally happy with the site identified, a further development plan was in progress and it was anticipated that provision of this unit was still some time away.

4. *A plan for regional special care facilities should be agreed and implemented.*

Outcome: No plan had been drawn up yet. The Inspectorate was informed that a national directive was awaited.

5. *The population served should have access to a full range of facilities, especially existing key services in rehabilitation and day services.*

Outcome: This had not yet been achieved. The service is was in the process of establishing a day hospital in the Leitrim sector.

6. The community residences should come under the care of the rehabilitation team without delay.

Outcome: One residence, Ashbrook, had been taken over by the rehabilitation team. Transfer of Castlecourt House was being negotiated. Bank House was to be closed in March 2009. The service intended that all special residential units would be under the care of the rehabilitation team within eighteen months.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A formal business plan with clearly defined goals, timeframes and costings was not presented to the Inspectorate. A document *Service Developments for 2008/2009*, incorporating new and proposed developments was presented instead. The proposals included introduction of integrated MDT care plans for all patients, both in-patients and those attending day services; development of primary care intervention; extension of services to patients outside of hours; a protocol was to be developed for use by all authorised officers. In the area of psychiatry of later life, a mobile day hospital was to be introduced and needs assessment of physically infirm elderly residents of supervised residences was to be carried out. Activities programmes in the admission and special care units were to be enhanced to include a seven- day programme.

DEVELOPMENTS 2007-2008

- Two site options for a new acute unit had been considered and a decision had been made on one. The Local Health Manager was hopeful that finance would be allocated for this development in 2010.
- A building was being renovated in Manorhamilton with a view to opening a day hospital there. This was awaiting completion of a snag list and appropriate staffing.
- The clinical director and director of nursing were members of Sligo/Leitrim Primary Care Implementation Group. Clinical staff were participating as members of the new primary care teams. A policy of direct referral by GPs to community mental health nurses was approved by the management team.

QUALITY IMPROVEMENTS

- The appointment of the occupational therapist manager will facilitate the establishment of good governance within the occupational therapy department. Three new residents groups had been initiated dealing with helping people plan their own goals, with stress management, and with community integration. An occupational therapy programme had been developed for the special care unit. An inter-generational art project took place in the day hospital which was very well received.
- One basic grade psychologist had been appointed.
- MDT meeting with care planning had commenced at Raheen day centre.
- MDT meeting had commenced at Markievicz House Day hospital.
- Interpreters had been introduced for individual patients in Sligo town.
- Two nurses completed a Nurse Prescriber course.
- Training in carer support was undertaken by clinical staff, resulting in identification of carers per sector team. The psychiatry of later life team had introduced a standardised carer's assessment. A training programme for carers had been developed with carers giving feedback on the programme.
- This team had introduced a mobile clinic service based on patient need in GP surgeries and had undertaken training with PHNs and hoped to repeat this in 2009. A working group had been established to review the operation of the day hospital. Steps had been taken to integrate services with both the acute general hospital service and with PCCC. This team had also developed a training module for nursing homes, to be piloted in 2009. A number of health promotion and de-stigmatisation initiatives were undertaken by the team.

- The rehabilitation and recovery team developed a multidisciplinary assertive outreach team. They developed appropriate protocols and training for staff in the use of standardised assessment tools. Service users were involved in the development of service initiatives. They were aware of the importance of social inclusion and were in contact with community-based services.
- Joint work with the Research and Education Foundation had facilitated health promotion and de-stigmatisation, i.e. Walking Back to Happiness and Zippy Friends a schools-based programme to promote emotional literacy and mental health in young children. Work with community groups had facilitated the development of bereavement support through the Living Links organisation.
- One nurse had completed a Master's Degree in Care Satisfaction and had produced a patient information pack. Feedback on the usefulness of this initiative was then gathered and assessed.

SERVICE USER INPUT TO SERVICE

No peer advocate programme operated in this service.

GOVERNANCE

The multidisciplinary management meeting decided policy at monthly meetings. A tripartite management team considered budgets, incidents and ensured all committees met as indicated.

STAFFING

Medical staff

Post	WTE in post 2007	WTE in post 2008
Consultant psychiatrist	7	7
NCHD	10	8
Specialist registrar	1	1

Nursing staff

Post	WTE in post 2007	WTE in post 2008
DON	1	1
ADON	5	5
Nurses based in in-patient services	104.5	104.5
Nurses based in community residences	76	61
CMHN	12	12
Nurses based in day hospitals	5.5	5.5
Nurses based in day centres	13.5	13.5
Addiction counsellor	6	6
Rehabilitation team	5	5

CNS posts

Speciality	WTE in post 2007	WTE in post 2008
Liaison	0	0
Clinical placement coordinators	1	1
Nurse practice development coordinator	0.5	0.5
Counsellors	10	11

Health and social care professionals

Post	WTE in post 2007	WTE in post 2008
Clinical psychologist	0	1
Social worker	4.5	4.5
Occupational therapist	7	7
Art therapist	2.5	2.5
Woodwork therapist	0	0

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Manager	PCCC
Social worker	Manager	PCCC

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation team

Staffing	2007	2008
Population	92,000	92,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	1 ADON	1 ADON
CMHN	5	5
Psychologist	0	0
Social worker	1	1
Occupational therapist	1	1

Psychiatry of later life team

Staffing	2007	2008
Population	92,000	92,000
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	1 ADON	1 ADON
CMHN	4	4
Psychologist	0	0
Social worker	1	1
Occupational therapist	1	1
Day facility nurse staffing	2	2

IN-PATIENT FACILITIES

The approved centre contained three wards. There was one male ward, one female ward and one special care unit. Multidisciplinary care plans had been introduced and residents were invited to attend the weekly MDT meetings. The occupational therapists had updated the therapeutic programmes available to residents. Some refurbishment work had taken place in the male ward but there were concerns regarding privacy for residents in the bathroom facilities. Plans for a new admission unit were in progress but, disappointingly, no commencement date had been set.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The service was non-compliant with some of the Regulations. In the case of residents who were in the unit for longer than six months, there was evidence that a number of physical examinations had not been carried out. Refurbishments had not been completed leading to problems in the premises. Most disappointingly, no peer advocacy group had been appointed to provide advocacy for service users.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

While the service was largely compliant with the Rules governing the use of seclusion, there was evidence that some patients had not been informed of the reason for its use. Mechanical restraint was not used in the unit and ECT had not been used in the past year.

CODES OF PRACTICE

The service was non-compliant with the Codes of Practice relating to the use of physical restraint and the admission of children. With regard to the code governing notification of deaths and incidents, the service had no comprehensive risk management policy.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

Residence	Number of places	Number of residents	Team responsible	Care plan type
Cypress	17	14	General adult	MDT
Sliabhan House	8	8	General adult	MDT
Ashbrook House	19	19	General adult/ Rehabilitation	MDT
Bank House	11	8	General adult	MDT
Linden House	15	13	General adult	Nursing
Benbulben House	10	8	General adult	Nursing
Castle Court	11	11	General adult	Nursing

CONCLUSION

The Sligo/Leitrim service was operating with limited MDT skill mix in its sector teams. Just one psychologist was employed in the mental health service while 14 were employed in PCCC. Because they have only one dedicated psychologist, access for many patients was through a common psychology waiting list operated through PCCC, where mental health needs were not prioritised. Similarly, the mental health service is was sharing access to psychiatric nurses trained in CBT with PCCC, without prioritisation being given to people referred by the psychiatric service. This system seemed to the Inspectorate to be most unusual, particularly since the funding for the service was from the psychiatric sector. There seemed to be some confusion as to the place of mental health within PCCC services. The document ***A Vision for Change*** calls for integrated multidisciplinary mental health teams while the primary care strategy calls for mental health to be part of the network. Mental health was a tertiary service which was often provided in the community. It was not a primary care service. Care should be taken that in broadening the remit of the mental health services, the specialised remit for those with serious and enduring mental health difficulties was not diluted. The budget should also be protected for the benefit of those most in need.

Although all staff welcomed the planning of a new admission unit in the general hospital, there was some anxiety about the finalising of this project the longer it continued.

A particularly disappointing aspect of the delivery of service within the catchment area was the absence of service user advocacy. Sligo/Leitrim remains the only service in the country not to provide this service to its service users, for reasons which remained unclear to the Inspectorate.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *Service user advocacy should be introduced.*

2. *All teams should be resourced with the appropriate MDT skill mix.*

3. *Provision of a new acute admission unit should be a priority.*

4. *Community residences should come under the care of the rehabilitation team as soon as possible .*

5. *Consideration should be given to reorganisation of sector teams into larger population groups and redeployment of existing staff to the catchment area specialist services.*

6. *The needs of people with serious mental ill-health should be prioritised by community staff funded by the mental health service.*

WEST GALWAY MENTAL HEALTH SERVICES

HSE Area	HSE West
Catchment	West Galway
Mental Health Service	West Galway Mental Health Services
Population	121,567
Number of Sectors	4
Number of Approved Centres	2
Specialist Teams	Psychiatry of Later Life
Date of Meeting	10 December 2008

SERVICE DESCRIPTION

West Galway catchment covered Galway City, an extensive area of North and West Galway and the Aran Islands. There were two approved centres: the Department of Psychiatry and Unit 9A, a rehabilitation/continuing care unit. The catchment area was a difficult geographical area for the provision of services and there was a significant rural and urban mix, with different levels of need. The community services were understaffed. There were serious deficiencies in the provision of supervised residences in the community. There was no liaison team despite the fact the acute unit was part of University College Hospital Galway (UCHG) and there was no rehabilitation team despite the fact that there was a rehabilitation/continuing care unit in the service.

PROGRESS ON RECOMMENDATIONS FROM 2007 REPORT

1. *All the teams should be resourced with the core complement of staff.*

Outcome: This had not happened. The community mental health teams remained seriously deficient in multidisciplinary staff.

2. *A liaison team should be appointed.*

Outcome: This had not happened.

3. *A rehabilitation team should be appointed.*

Outcome: This had not happened.

4. *The service should plan and implement the merging of East and West Galway services.*

Outcome: There had been some progress and joint senior management teams had met to discuss implementation.

OUTLINE OF LOCAL MENTAL HEALTH SERVICE BUSINESS PLAN 2008

A submitted business plan covered both East and West Galway. This included statements that the community teams would be developed, enhancement of the Jigsaw project for young people, review of data, development of the homeless service, and the development of a consumer council.

DEVELOPMENTS 2007-2008

- The psychiatry of later life team was now fully staffed with psychologist, social worker and occupational therapist. There was now a headquarters for the psychiatry of later life service in UCHG.
- A temporary arrangement was in place for 0.5 WTE consultant in rehabilitation linked with unit 9A to provide assessment and care plans for residents requiring continuing care or rehabilitation.
- The high observation area was completed and due to open early in 2009.
- The Jigsaw model had been introduced to both East and West Galway. This provided integration of services and supports for young people thorough support and training as well as identifying young people at risk from mental ill health. One of its main focuses was early intervention and facilitation of easy access to mental health services where necessary. It was a partnership lead by Headstrong with HSE and Mental Health Ireland.

QUALITY IMPROVEMENTS

- The service maintained its ECTAS accreditation for ECT.
- The service now had accreditation for Acute In-patient Mental Health Service (AIMS)

SERVICE USER INPUT TO SERVICE

Service users through the Irish Advocacy Network reported that there were a number of positive aspects to the service including the Wellness Recovery Action Plan (WRAP) programme, the activation unit, the garden, and good links with nursing staff. There was peer advocacy training in Galway and plans were under way to establish a consumer panel. The service users complained of the overuse of medication, the lack of therapies, lack of individual time with staff. A service user satisfaction survey was underway and had already brought about changes that service users have identified. On a more positive note, two individuals had recently published a paper on their experiences as service users, and service users were involved in an audit committee that was being developed.

GOVERNANCE

The senior management team still consisted of the clinical director, director of nursing and the service manager. However the Inspectorate was informed of advanced plans to enhance the senior management team to include other heads of discipline. A number of clinical audits had been completed and some were in progress. There were some difficulties in the Inspectorate obtaining requested information from the local health office.

STAFFING

Medical staff

Post	WTE in post
Consultant psychiatrist	5
NCHD	7
Specialist registrar	4
Registrar	2

Nursing staff

Post	WTE in post
DON	1
ADON	2
Nurses based in in-patient services	42.26
Nurses based in community residences	11.5
CMHN	10
Nurses based in day hospitals	4.19
Nurses based in day centres	9.07
Other – continuing care	16.5
Other – nurse training	3.5

CNS posts

Speciality	WTE in post
Clozaril CNS	1
Triage CNS	1
Clinical Behaviour Therapy CNS	0.5
CMHN CNS	8
Addictions	3

Health and social care professionals

Post	WTE in post
Clinical psychologist	3.41
Social worker	5.6
Occupational therapist	5.91

Other professional input

Professional staff not based primarily in the mental health services, but who formed part of the management structure of dedicated mental health staff, are listed below.

Post	Grade	Location of base
Psychology	Principal	Community care

Community Mental Health Team (CMHT) Staffing Numbers by sector are available on the Mental Health Commission website *www.mhcirl.ie*

SPECIALIST TEAMS

Rehabilitation: Apart form a temporary arrangement providing a 0.5 WTE consultant psychiatrist there was no rehabilitation team.

Psychiatry of later life: The psychiatry of later life team was now fully multidisciplinary and had a team headquarters and clinical area.

Liaison: There was no liaison team despite the fact that UCHG was a large regional hospital.

Psychiatry of later life team

Staffing	2007	2008
Population	19,415	19,415
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
CMHN	2	2
Psychologist	1	1
Social worker	1	1
Occupational therapist	0	1
Dedicated addiction counsellor	6	6

IN-PATIENT FACILITIES

Acute in-patient care was provided in the Department of Psychiatry in UCHG. The lack of a high observation unit had been problematic in providing care for residents who were acutely ill. However a new 7-bed high observation unit had been completed and awaited opening.

Unit 9A was located in UCHG, Merlin Park, on the outskirts of the city. Although its location was not within walking distance to the city centre there was a regular public bus service. Part of the unit was intended to function as a rehabilitation unit, complete with a flatlet. Due to the absence of a rehabilitation team it continued to provide continuing care. A community residence, Tully House, had been available for occupation by service users ready to be discharged form Unit 9A. This unit had not opened for reasons that were unclear to the Inspectorate. Residents in Unit 9A had expressed their anger and distress at not being discharged to this unit, especially as they were told repeatedly that the opening was imminent.

STATUTORY REQUIREMENTS FOR APPROVED CENTRES

REGULATIONS (S.I. NO. 551 OF 2006)

The Department of Psychiatry was compliant on the majority of Regulations. A recent food safety report highlighted areas of concern. The issue of lack of appropriate high observation would be addressed when the new high observation area was opened.

RULES (SECTION 59.2, MENTAL HEALTH ACT 2001)

The service had a number of breaches of the Rules on seclusion.

CODES OF PRACTICE

The service had a number of breaches of the Code of Practice on the use of physical restraint.

24-HOUR SUPERVISED COMMUNITY RESIDENCES

The continued delay in opening Tully House had been outlined in the section on In-patient Units above. There was insufficient availability of medium and low support accommodation. This in turn had led to some residents of the 24 hour supervised residences remaining in this level accommodation unnecessarily.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Breadagh House	7	7	All teams	
Sycamore House	10	8 + 1 Respite	General Adult	

CONCLUSION

The service was to be congratulated on achieving accreditation for both ECT (ECTAS) and for the Department of Psychiatry (AIMS). This had demonstrated the dedication and enthusiasm of all staff. The development of the Jigsaw model for young people was especially innovative. However the difficulties of providing an adequate mental health service to the catchment remain and this caused frustration for both service users and staff. The inability to provide adequately resourced community mental health teams and appropriate community accommodation, and to provide a rehabilitation team and a liaison team, seriously hampered the provision of a modern mental health service, which should provide adequate access for service users to mental health services. The uncertainty in the merging of East and West Galway had added to the difficulties, with staff unclear as to how the plan would be implemented. The delay in opening Tully House, as outlined above, was entirely unsatisfactory. Having a community residence ready but unopened for a number of years was a waste of scarce community resources and residents identified as ready for discharge were prevented from attaining their full potential within the community.

The service required an urgent injection of resources if it was to provide a basic mental health system, let alone a service in line with national mental health policy.

RECOMMENDATIONS AND AREAS FOR DEVELOPMENT

1. *A full rehabilitation team should be provided.*
2. *A liaison team should be provided.*
3. *Tully Hostel must be opened as a matter of urgency.*
4. *Clarity should be provided as to the exact nature of the provisions to progress the merging of East and West Galway. This should outline the plans for community services, the number of acute beds to be provided and the provision of specialist services.*
5. *A multidisciplinary senior management group should be in place by early 2009 .*

CHAPTER 6

ADDITIONAL INFORMATION

ADDITIONAL INFORMATION

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IRISH WEBSITES

Government Organisations

Department of Health & Children	www.dohc.ie
Government of Ireland	www.gov.ie
Public Service Information	www.citizensinformation.ie.

Health Service Executive

Health Service Executive	www.hse.ie
The Health Service Reform Programme	www.healthreform.ie

Independent & State Research Bodies/Organisations

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

Mental Health Professional Organisations and Health Professional Organisations

The College of Psychiatry of Ireland	www.irishpsychiatry.ie
Association of Occupational Therapists of Ireland	www.aoti.ie
Irish Association of Social Workers	www.iasw.ie
Irish College of General Practitioners	www.icgp.ie
The National Council for the Professional Development of Nursing and Midwifery	www.ncnm.ie
National Service Users Executive	www.nsue.ie
The Psychological Society of Ireland	www.psihq.ie
Irish Association of Speech and Language Therapists	www.iaslt.com

Mental Health Organisations and Advocacy Organisations

The Alzheimer Society of Ireland	www.alzheimer.ie
Aware	www.aware.ie
Bodywhys	www.bodywhys.ie
GROW	www.grow.ie
Headstrong	www.headstrong.ie
Inclusion Ireland	www.inclusionireland.ie
Irish Advocacy Network	www.irishadvocacynetwork.com
Irish Mental Health Coalition	www.imhc.ie
Mental Health Ireland	www.mentalhealthireland.ie
Samaritans	www.dublinsamaritans.ie
Shine	www.shineonline.ie
STEER	www.steermentalhealth.com
The Irish Association of Suicidology	www.ias.ie

Other

Age & Opportunity	www.olderinireland.ie
Amnesty International - Irish Branch	www.amnesty.ie
Simon Communities of Ireland	www.simon.ie
Expert Group on Mental Health Policy	www.mentalhealthpolicy.ie
Focus Ireland	www.focusireland.ie
Health Information & Quality Authority	www.hiqa.ie
HSE Libraries Online	www.hselibrary.ie
Irish Human Rights Commission	www.ihrc.ie
Irish Society for Quality & Safety in Healthcare	www.isqsh.ie
Law Reform Commission	www.lawreform.ie
National Federation of Voluntary Bodies	www.fedvol.ie
National Office for Suicide Prevention	www.nosp.ie
Ombudsman for Children's Office	www.oco.ie

Registration Bodies

An Bord Altranais	www.nursingboard.ie
Medical Council	www.medicalcouncil.ie

Staff Representative Organisations

IMPACT	www.impact.ie
Irish Hospital Consultants Association	www.ihca.ie
Irish Medical Organisation	www.imo.ie
Irish Nurses Organisation	www.ino.ie
Psychiatric Nurses Association of Ireland	www.pna.ie
SIPTU	www.siptu.ie

State Bodies

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

EUROPEAN, INTERNATIONAL, REFERENCE AND UK WEBSITES

European

Council of Europe	www.coe.int
HOPE	www.hope.be
Health – EU Portal	http://ec.europa.eu/health-eu/index_en.htm

International

United Nations – Human Rights	www.un.org/rights/
World Health Organization	www.who.int
World Federation for Mental Health	www.wfmh.org

Reference sites

Guidelines International Network	www.g-i-n.net
The International Society for Quality in Healthcare	www.isqua.org
National Institute for Health and Clinical Excellence	www.nice.org.uk
The Cochrane Collaboration	www.cochrane.org

UK

Department of Health UK	www.dh.gov.uk
Medical Research Council	www.mrc.ac.uk
Mental Health Alliance	www.mentalhealthalliance.org.uk
Mental Health Foundation	www.mentalhealth.org.uk
Mental Welfare Commission for Scotland	www.mwcscot.org.uk
NHS Choices	www.nhs.uk
NHS National Library for Health	www.library.nhs.uk
The Royal College of Psychiatrists	www.rcpsych.ac.uk
SANE	www.sane.org.uk
Social Care Online	www.scie-socialcareonline.org.uk
Sainsbury Centre for Mental Health	www.scmh.org.uk

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