MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

2009 ANNUAL REPORT
TUARASCÁIL BHLIANTÚIL

including the Report of the Inspector of Mental Health Services 2009

Mental Health Commission | Coimisiún Meabhair-Shláinte

MENTAL HEALTH COMMISSION
ANNUAL REPORT 2009

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

To raise to the best international standards the quality of mental health services provided in Ireland and to protect the interests of all people who use mental health services[1]

[1] "mental health services" means services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist".
Section 2, Mental Health Act 2001.

Contents

Chairman's Foreword

In 2009 we made some progress on a number of fronts in the area of mental health. However the overall pace of change towards a modern best-practice model of service provision is disappointingly slow. As we continue to operate in an environment of great economic difficulty and Exchequer shortages, the Commission is determined to continue to press for the implementation of Government policy on mental health.

The Commission has consistently expressed disappointment at the pace of implementation of the key Government policy in the area of mental health *A Vision for Change*. The core of this policy is the move from institutional care to community care. Such a change is international best practice but is given added urgency because of the poor condition of some of Ireland's approved centres, a point made clearly and repeatedly in the reports of the Inspectorate of Mental Health Services.

It is therefore welcome that the Minister of State John Moloney has backed his clearly stated support for this policy with a statement that he has secured €50 million from the Department of Finance to fund the development of community based facilities. The intention is to repay the money to the Department of Finance through the sale of older institutions and the land around them. It is to be hoped that this is the start of a process rather than a one-off move.

The Commission was also pleased at the Minister of State's announcement that the new Central Mental Hospital would not be built beside the proposed new prison at Thornton Hall in North County Dublin. While we are very supportive of a new Central Mental Hospital we always believed that it should not be adjacent to a prison for various practical reasons and more importantly because choosing this location would unnecessarily stigmatise patients of the new Hospital.

The Commission continued its regulatory role in 2009, with its Inspectorate inspecting all approved centres. The reports of these inspections will provide the basis for action that can be taken by the Mental Health Commission. The Commission has made it clear that conditions in some approved centres, in particular some older ones, are entirely unacceptable and that if they do not improve the Commission can and will impose conditions on such centres, including a direction that they no longer admit new patients. The report of the Inspector published here recognises improvements in some approved centres which were sought by the Commission, but finds no discernible overall improvement in standards. If required, action will be taken during 2010 in accordance with the Commission's statutory powers.

Good structures of service delivery ultimately deliver good services. In 2009 14 Executive Clinical Directors (ECDs) were appointed within the mental health services. 13 of these will have clinical responsibility for "super-catchments" of between 200,000 and 400,000 people each, while the 14th is National Executive Clinical Director for Forensic Mental Health Services. The Executive Clinical Director role is consistent with *A Vision for Change*. They will provide clear clinical leadership. I look forward to working with these clinical leaders in furthering the development agenda for mental health services.

Within the Mental Health Services we are all working towards ensuring that service users' views and experiences are central to the services and how they are provided. In 2009 we worked on the development of the Headspace Toolkit, a website and written resource pack to assist young people availing of mental health services. It is designed to equip young people being treated for mental illness to speak up for themselves, assert their rights and get involved in decisions concerning their care and treatment. This will be launched in early 2010.

During 2009 we also developed the first National Mental Health Service Collaborative, an initiative bringing policy-makers and on-the-ground professionals together to achieve a particular policy aim. This collaborative, involving the HSE, two Dublin Hospitals and the Mental Health Commission is focussing initially on turning into reality the agreed aim that each patient should have an individually tailored

care and treatment plan focused on their recovery. This too is part of the attempt to bring patients' experiences and individual needs to the heart of Mental Health Services.

The Commission believes that applications for involuntary admission of patients should whenever practicable be made by an authorised officer – an officer of the HSE of a prescribed rank or grade who is authorised under the Mental Health Act. However in 2009 the number of applications for involuntary admission by authorised officers rose only marginally from 4.6% in 2008 to 5.8% in 2009. Applications by spouse or relative fell from 63.9% to 61.8%, while applications by members of the Garda Siochana fell from 22.8% to 22.6%. This virtually unchanged position is disappointing.

Finally I would like to warmly welcome our new Chief Executive Hugh Kane to his post. Hugh takes over from Brid Clarke who retired in December 2009.

It was a pleasure to work with Brid since April 2007. She was the founding Chief Executive Officer of the Mental Health Commission, a body established after 60 years of waiting for modern legislation on mental health. Brid took over this new body with no road map to guide her, brought it through the challenges facing every organisation set up to effect major change and has given us a respected and dynamic body that has already had a significant effect on mental health practice and has begun the work of fundamentally changing the attitudes of service providers, service users and the general public to mental health.

Hugh comes to the job with great experience of leading change and a commitment to implementing the modern vision of mental health services underpinned by the provisions of the Mental Health Act 2001 and in line with the strategic priorities of the Commission. They are two different people who share a passion for change and a sensitivity to the area in which they work. I and the Commission thank both for their commitment and determination and wish both of them well for the future.

Dr. Edmond O'Dea
Chairman

Introduction – Chief Executive Officer

I am pleased to introduce the eighth Annual Report of the Mental Health Commission, which includes the Report of the Inspector of Mental Health Services, for the year ended December 31st 2009.

This report sets out the work programme of the Commission during 2009 and how we are progressing to meet our strategic objectives as set out in our current Strategic Plan for the period 2009-2012.

As Chief Executive Officer I would like to recognise the work of the staff of the Commission. As an organisation we have a wonderful blend of experienced and talented professionals who are fully committed to the objectives of the Commission and work hard each day towards their achievement.

This report includes extensive information and data on all aspects of our activity, including particularly data on the involuntary admission of adults to approved centres, the admission of children and compliance with the regulations for approved centres. The information contained in the report should be of assistance to those who use the services, are involved in delivering services, reviewing services and planning the future development of mental health services in Ireland.

The Mental Health Commission continues to support the development of research within the mental health services and the development of linkages between services and centres of learning. The key focus and aim of our research is to bring best practice and excellence to the fore within the Irish mental health services.

The Mental Health Commission continues to be concerned about the slow implementation of national government policy for mental health *A Vision for Change*. In the current climate the development and provision of community based mental health services with a recovery based approach must be given the utmost priority.

Arising from concerns on the pace of implementation of *A Vision for Change* the Commission published a report in 2009 titled 'From Vision to Action? An Analysis of the Implementation of *A Vision for Change*'. This report critiques the current implementation plans and makes some recommendations on how the implementation plan and process might be improved.

The Commission continues to work with many stakeholders including service users and other agencies both statutory and non-statutory. We derive much support and direction for our work from these colleagues. I would like to thank them for their support in 2009. I would like particularly to thank our colleagues in the Department of Health and Children especially those in the office for Disability and Mental Health.

I would like to also mention those members of the media who continue to raise mental health issues, without this focus and support the drive to reduce stigma and bring about real change in mental health services would not advance.

As the incoming Chief Executive Officer I would like to acknowledge the enormous contribution made to the Mental Health Commission by my predecessor Ms. Bríd Clarke and to wish her well in the future.

Finally I would like to thank the Chairman and Commission members for their work and commitment to the Commission and their support to me and my staff since my appointment.

Hugh Kane
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. Daly resigned from the Commission December 2009*

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.

Twelve meetings of the Mental Health Commission were held in 2009, this included two 2-day meetings in February and April and two teleconferences. Commission members attendance at meetings was recorded as follows: Dr. Edmond O'Dea (12/12), Mr. Brendan Byrne (11/12), Ms. Marie Devine (9/12), Dr. Brendan Doody (7/12), Mr. Padraig Heverin (11/12), Dr. Martina Kelly (7/12), Dr. Mary Keys (9/12), Dr. Eamonn Moloney (11/12), Mr. John Redican (10/12), Mr. Martin Rogan (9/12), Mr. John Saunders (12/12), Ms. Vicki Somers (8/12), Ms. Emile Daly (0/12)* Ms.Daly was on maternity leave in 2009.

Members of the Commission also participate in committees established by the Mental Health Commission.

1.2 Mental Health Commission Committees 2009

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 2009

Mr. Brendan Byrne (Chair), Mr. John Saunders, Dr. Eamonn Moloney, Dr. Martina Kelly, Mr. Martin Rogan, 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, Ms. Rhona Jennings.

Forensic Mental Health Services Committee

Mr. Padraig Heverin, Mr. John Saunders, Mr. Brendan Byrne, Ms. Bríd Clarke.

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. Claire Collins, Dr. Fiona Keogh, Mr. Paddy McGowan, Professor Agnes Higgins, Ms. Veronica Raineiri.

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 Fergus Healy, Sergeant Michael McNamara.

Assisted Admissions Committee

Mr. Padraig Heverin (Chair), Mr. Brendan Byrne, Dr. Eamonn Moloney, Mr. Ronan Browne, Ms. Catherine Bourke, Ms. Bríd Clarke.

Mental Health Services Committee

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

Committee on Scheme for Mental Capacity Bill

Dr. Mary Keys (Chair), Mr. John Saunders, Mr. John Redican, Ms. Vicki Somers, Mr. Martin Rogan, 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 first Chief Executive Officer of the Mental Health Commission, Ms. Bríd Clarke retired from the Mental Health Commission in December 2009 on completion of her 7 year contract.

Mr. Hugh Kane, was appointed as the second Chief Executive Officer of the Commission and began his term in December 2009.

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 2009 (END OF YEAR)

Chief Executive Officer:
Mr. Hugh Kane

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 Development:
Ms. Rosemary Smyth

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

Senior Administrator Office of CEO:
Ms. Marina Duffy

Mental Health Information Officer:
Ms. Deirdre Hyland

Senior Administrator Inspectorate Division:
Ms. Colette Ryan

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

Assistant Inspectors:
Dr. Susan Finnerty
Ms. Maeve Kenny
Mr. Paul Collins
Dr. Fionnuala O'Loughlin
Ms. Patricia Doherty
Mr. Sean Logue

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

Systems/Project Manager – Corporate Services:
Ms. Marie Higgins

CHAPTER 2

Strategic Plan 2009–2012

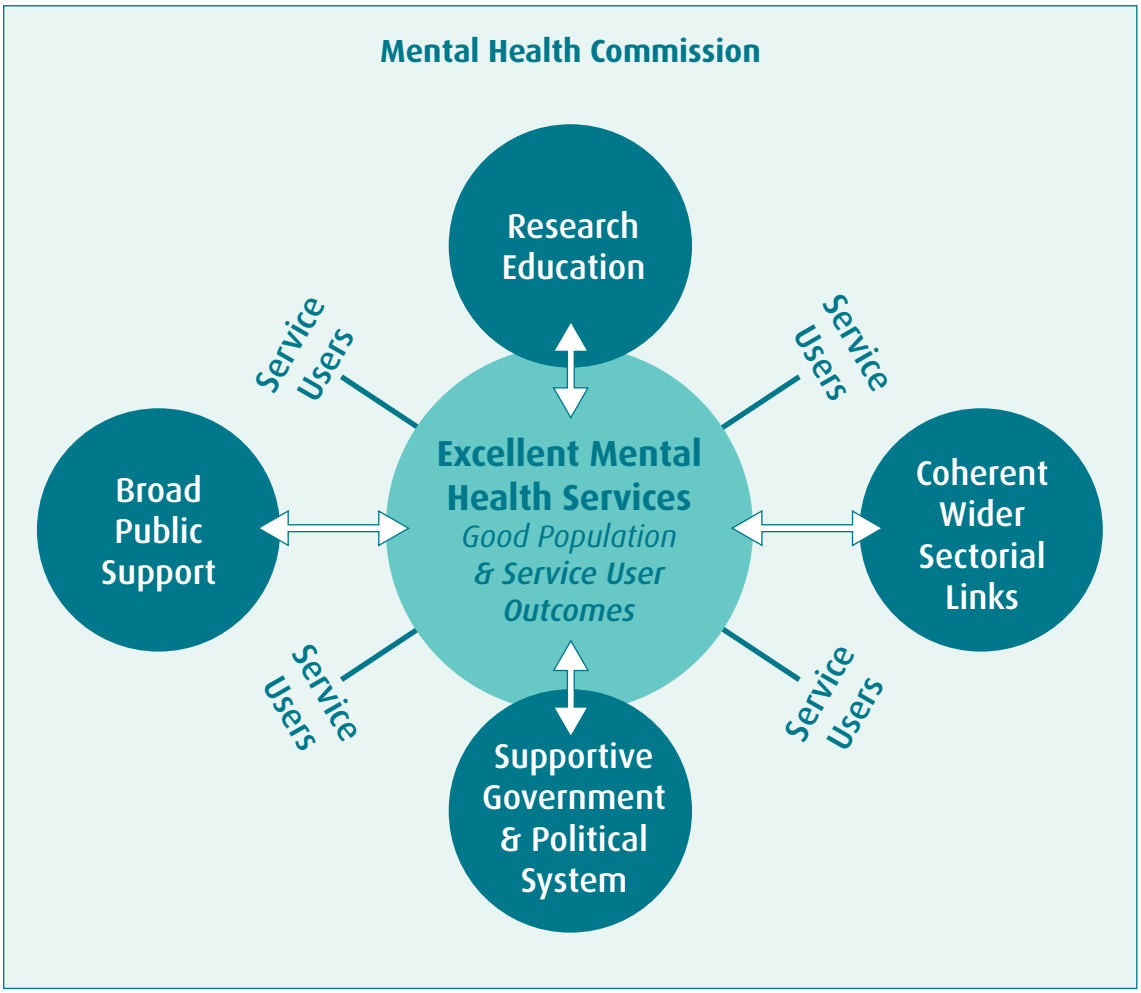
Strategic Plan 2009-2012

The Mental Health Commission published its third Strategic Plan in 2009. This plan builds upon the work undertaken during the timeframe of the Commission's two earlier strategic plans. These earlier plans focused on the actions required prior to commencement of the Mental Health Act 2001. The current plan defines the strategic direction of the Mental Health Commission for the period 2009-2012. The Strategic Plan has six interconnected strategic priorities which translate into goals, and actions the mandate of the Mental Health Commission, pursuant to the Mental Health Act 2001.

The Commission consulted with key stakeholders in preparing the Strategic Plan, and their views informed the development of the plan. Within the organisation all staff of the Commission also had the opportunity to offer their input to the plan. The Strategic Plan sets ambitious targets for the Mental Health Commission. Striving for continuous quality improvement is one of the core values of the Commission. With the continued support and commitment of all stakeholders these strategic priorities can be achieved.

The Strategic Plan is guided by our Vision of the Mental Health System, that is the system that we aspire to having in place in Ireland by the year 2020. This plan contains objectives and prioritised actions for the period 2009–2012 that will deliver significant progress on the journey to first class mental health services and legal protection.

Figure 1: The Irish Mental Health System – 2020



2020 Vision – Service Users and their Families and Carers Are Active Participants in the Care Process

Strategic Priority One (2009-2012) – Service Users, Families and Carers

- Policy and Planning: service users and their families and carers are involved in a significant way, locally and nationally.
- Individual Care Planning: service users and their families and carers are actively involved in planning the care required to meet each individual service user's assessed needs.

2020 Vision – The Human Rights and Best Interests of All Persons Who Use Mental Health Services Are Respected and Protected

Strategic Priority Two (2009-2012) – Human Rights and Best Interests

- A commitment to Human Rights is embedded in all aspects of the Commission's and mental health service providers' policy and practice.
- The Commission will continue to arrange reviews of involuntary admission in compliance with the 2001 Act.
- Promote and support advances in legislation to protect the human rights of vulnerable people.
- The Commission will continue to monitor Rules and Codes of Practice issued pursuant to the provisions of the 2001 Act.

2020 Vision – The Quality of Mental Health Services Is Consistent with Best International Standards

Strategic Priority Three (2009-2012) – Quality Mental Health Services

- To facilitate and support implementation of the quality improvement standards for mental health services in Ireland. (*Quality Framework for Mental Health Services in Ireland*, MHC 2007).
- To continue to support mental health services research to build knowledge that leads to practical ways of improving services.
- The scope and process of inspection and reporting is effective in enhancing both compliance and commitment to continuous quality improvements and is a catalyst for change.
- To promote and support the development of a national mental health information system.

2020 Vision – The Needs and Rights of People with Mental Illness Are Addressed in an Integrated and Cohesive Manner within the Wider Mental Health Domain

Strategic Priority Four (2009-2012) – Wider Mental Health Domain

- The work of relevant state agencies and other organisations within the wider mental health domain is informed by the Commission's strategy and national government policy on mental health, *A Vision for Change*.

2020 Vision – Public Understanding of Mental Illness Is Enhanced, Stigma Is Diminished and Public Attitudes Are Increasingly Respectful

Strategic Priority Five (2009-2012) – Social Inclusion and Active Citizenship

- To challenge the barriers experienced by people with a mental illness to social inclusion and active citizenship.

2020 Vision – The Mental Health Commission Is Viewed as an Efficient Organisation with the Interests of People with Serious Mental Illness or Mental Disorder at the Forefront of All Our Activities

Strategic Priority Six (2009-2012) – MHC as an Organisation

- To maintain and enhance the Mental Health Commission's systems and processes to ensure the provision of a quality service by the Mental Health Commission.
- To continue to promote a culture within the organisation which reflects deep commitment to the Commission's stated values.
- To ensure that the Mental Health Commission is staffed by well trained, competent and committed people.
- To foster widespread understanding of the role and functions of the Mental Health Commission.

Guiding Principles and Values of the Mental Health Commission

The work of the Commission is guided by the principles enunciated in the following international conventions/declarations:

- 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
- 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
- United Nations Convention on the Rights of Persons with Disabilities
- WHO Mental Health Action Plan for Europe, Helsinki 2005.

Specific legislative provisions which inform the work of the Mental Health Commission include;

- Mental Health Act 2001
- European Convention on Human Rights Act 2003
- Disability Act 2005
- Health Act 2004
- Health Act 2007 (Part 14)
- Freedom of Information Act 1997 and Freedom of Information Amendment Act 2003
- Data Protection Act 1988 and Data Protection (Amendment) Act 2003
- Criminal Law (Insanity) Act 2006
- Equal Status Acts 2000-2004.

Values:

The core values which define the Commission's ethos and culture and underpin the delivery of services by the Commission are:

Accountability and Integrity: The Commission operates at all times with probity and in a transparent manner.

Efficiency and Effectiveness: The Commission is committed to exercising good stewardship over the resources allocated to the organisation.

Equality and Diversity: The Commission respects the dignity of those in contact with us and values people for their unique contribution.

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 improving through ongoing partnership, consultation and teamwork.

CHAPTER 3

Mental Health Commission
Progressing the Strategic Plan 2009–2012

Progressing the Strategic Plan 2009–2012

2020 Vision – Service Users and their Families and Carers Are Active Participants in the Care Process

Strategic Priority One (2009-2012) – Service Users, Families and Carers

- Policy and Planning: service users and their families and carers are involved in a significant way, locally and nationally.
- Individual Care Planning: service users and their families and carers are actively involved in planning the care required to meet each individual service user's assessed needs.

Service User Empowerment / Involvement

The Mental Health Commission recognises the importance of service user involvement in mental health care and treatment and has identified this as one of its strategic priorities for 2009–2012. In line with this priority, the Commission produced several service user information resources in 2009. The Commission also set up a new service user information section on its website in 2009 to reflect the new resources available. Details of these new resources are given below.

Service User Guides

In 2009, the Commission produced two service user guides to accompany new codes of practice. We produced a guide to the code of practice on admission, transfer and discharge. This guide was developed in conjunction with the National Adult Literacy Agency (NALA) and was approved for the use of plain English by NALA.

The Commission also produced an easy read guide to the code of practice for those working with people with intellectual disabilities and mental health problems, which was developed in conjunction with MENCAP in the UK and was kindly tested by the People First Advocacy Group in Monasterevin, Co. Kildare.

"Headspace Toolkit" for Young People

The Commission developed a rights and self advocacy toolkit for young people availing of inpatient mental health services entitled the *"Headspace Toolkit"*. The toolkit promotes a self advocacy and rights based approach to mental health care and treatment, providing young people with information on being an inpatient, knowing their rights, what the law says and how to speak up and get others to listen. The toolkit was developed in partnership with Advocacy in Somerset, a UK mental health advocacy charity, who developed a similar toolkit for use in the UK. The views of young people, mental health professions and organisations with an interest in young peoples' mental health and rights also informed the development process. The toolkit was published in December 2009. A website version of the toolkit was also developed which can be accessed at: *www.headspaceireland.ie*. The Commission intends to officially launch the toolkit in the Base Youth Centre in Ballyfermot in early 2010.

Information Leaflets

The Mental Health Commission published four new service user information leaflets during 2009. The four leaflets provide service users with information on the recently revised Rules Governing the Use of Electro-Convulsive Therapy, Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients and the revised Code of Practice on the Use of Physical Restraint in Approved Centres, which came into effect on 1st January 2010.

The four leaflets are as follows:

- What you need to know about the Rules and Code of Practice on Electro-Convulsive Therapy;
- What you need to know about the Rules on Seclusion;
- What you need to know about the Rules on Mechanical Restraint; and
- What you need to know about the Code of Practice on Physical Restraint.

All four documents have been written in an accessible manner and have been approved for the use of plain English by NALA.

Publication of these leaflets reflects a commitment on the part of the Mental Health Commission to empower service users by providing them with information on their rights and addresses Standard 3.1 of the Quality Framework for Mental Health Services in Ireland – "Service users are facilitated to be actively involved in their own care and treatment through the provision of information".

National Mental Health Services Collaborative

In the 2008 annual report, the Commission stated that in order to address poor compliance with the requirement for individual care and treatment plans to support recovery, a joint proposal for implementation of standard 1.1 of the Quality Framework for Mental Health Services in Ireland (Mental Health Commission, 2007) had been developed by the Commission in partnership with the Health Service Executive for implementation 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."

There are 24 standards in total. The attainment of the standard on individual care and treatment planning (standard 1.1) 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.

The Institute for Healthcare Improvement (IHI), based in the United States, seeks to improve health care by supporting change. The IHI innovated collaborative learning for improving quality in healthcare by developing the 'Breakthrough Series' in the mid 1990's (IHI, 2003). The genesis of the 'breakthrough' collaborative approach was that the IHI was looking at developing an approach that would go beyond their traditional training on the essentials for quality. Their aim was to "provide a structure for learning and action that would engage organizations in making real, system-level changes that would lead to dramatic improvements in care (IHI, 2003. p.2).

The Commission and HSE proposed the development of a National Mental Health Services Collaborative (NMHSC) which adopts the IHI breakthrough collaborative methodology. This inclusive approach ensures service users and carers are central and involved in all aspects of the project. During 2009 St Patrick's University Hospital and St John of God Hospital Ltd expressed an interest and joined the partnership. The NMHSC commenced with the assignment of a project manager on 31 October 2009 and involves the participation of representative sites from the Health Services Executive, St Patrick's University Hospital and St John of God Hospital over a period of 18 months. An integral component of the NMHSC is the development of a sustainability plan that will be commenced during the project to ensure that the gains made are retained and built upon over the coming years after the project is terminated.

Framework for Public and Service User Involvement in Health and Social Care Regulation

The Mental Health Commission is a member of the Health and Social Care Regulatory Forum. This Forum was established in 2008 to provide a mechanism for exploring opportunities to harmonise certain business processes, share best practice and facilitate coordination where appropriate between regulatory bodies in the area of health and social care. It also aims to share knowledge and expertise on matters of common interest with a view to enhancing the overall practice of health and personal social services regulation in Ireland for the benefit of public health.

In response to the recently published recommendations of the Commission for Patient Safety and Quality Assurance that *'robust and validated patient and public involvement should be a requirement for all health care oversight, scrutiny, quality control and other accountability mechanisms'* (Commission on Patient Safety and Quality Assurance, 2008, R4.4), the Forum published a Framework for Public and Service User Involvement in Health and Social Care Regulation in Ireland. The framework aims to encourage greater service user involvement in the work of regulatory bodies. The framework was developed by a subgroup of Forum members chaired by Ms. Bríd Clarke, the then Chief Executive Officer of the Mental Health Commission and it is due to be published in January 2010. It is intended that the framework will be available on the websites of all regulatory forum members.

NSUE (National Service User Executive)

During 2009 representatives from the National Service User Executive and Mental Health Commission met on four occasions. These quarterly meetings are held to facilitate the exchange of information and views and to aid joint working between both organisations.

2020 Vision – The Human Rights and Best Interests of All Persons Who Use Mental Health Services Are Respected and Protected

Strategic Priority Two (2009-2012) – Human Rights and Best Interests

- A commitment to Human Rights is embedded in all aspects of the Commission's and mental health service providers' policy and practice.
- The Commission will continue to arrange reviews of involuntary admission in compliance with the 2001 Act.
- The Commission will continue to monitor Rules and Codes of Practice issued pursuant to the provisions of the 2001 Act.
- Promote and support advances in legislation to protect the human rights of vulnerable people.

Mental Health Tribunals

Process for Involuntary Admission (Adults)

The Mental Health Act 2001 Act introduced provisions for a system of free legal representation for adults and independent reviews during their episode of involuntary admission[1]. This is performed by a mental health tribunal during each period of detention. This part of the 2001 Act was commenced on 1 November 2006. The Commission now has three complete years of data relating to involuntary admissions activity. This section of the report provides analysis of 2009 involuntary admissions and their review by mental health tribunals, and some comparisons with previous years.

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. A person may be admitted to an approved centre and detained there on the grounds that or she is suffering from a mental disorder as defined in the Act.

Involuntary Admission (Adults) 2009

Analysis was completed on the number of adults who were involuntarily admitted using the provisions of sections 9, 10, & 14 of the Act in 2009. 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 1,434 Form 6 Admission Orders notified to the Commission in 2009.

Detention Of A Voluntary Patient; Section 24 Mental Health Act 2001 (2009)

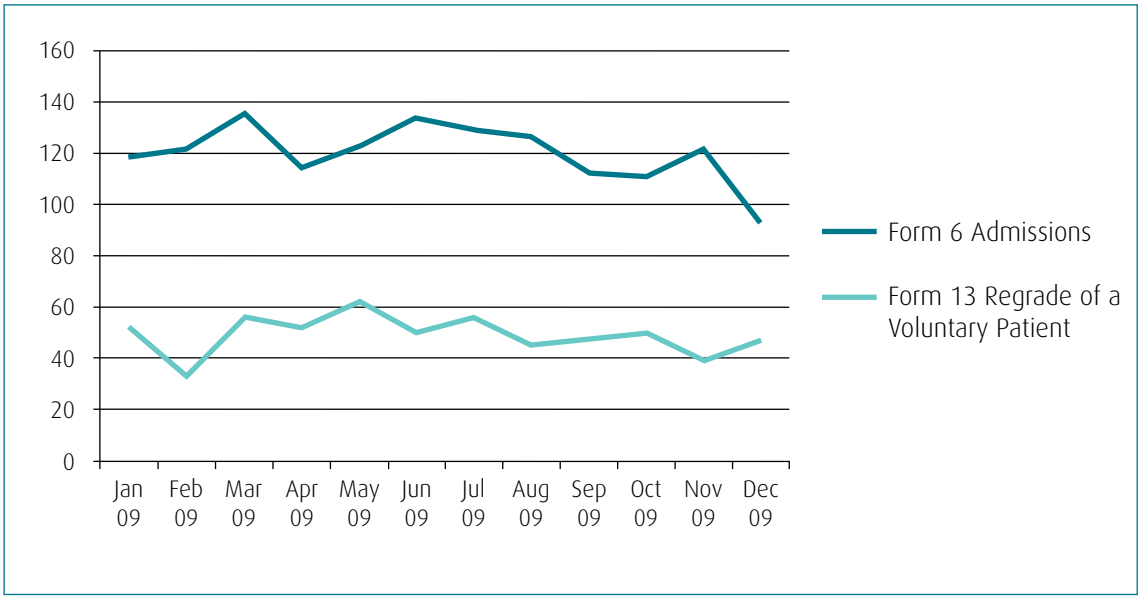
Section 24 Mental Health Act 2001 outlines the procedures relating to a decision to re-grade a voluntary patient to involuntary status. In such admissions the admission order is made on statutory form, Form 13 Certificate & Admission Order to Detain a Voluntary Patient (Adult), signed by two consultant psychiatrists. There were 590 such admissions notified to the Commission in 2009.

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

Comparisons 2007-2009

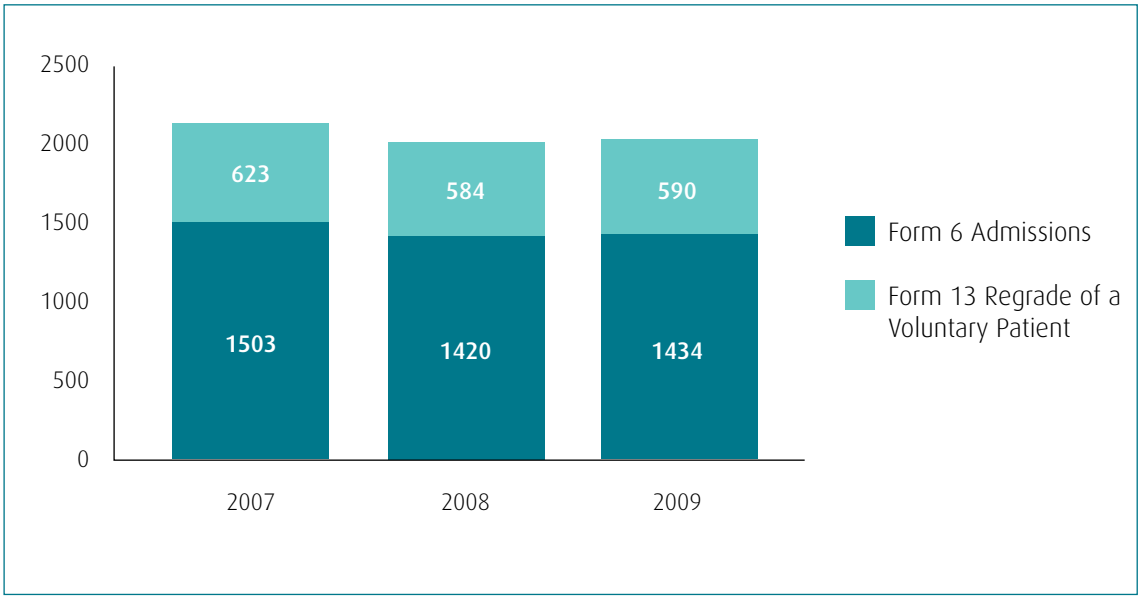
Figure 2 below summarises on a monthly basis both the above categories of involuntary admission for 2009, i.e. – Form 6 *Admission Orders*, and Form 13, *Certificate & Admission Order to Detain a Voluntary Patient (Adult)*. The number of Form 6 orders fall within a range from 93 to 135 per month, and the number of Form 13 orders fall within a range from 33 to 62 per month.

Figure 2: Monthly Involuntary Admissions 2009: Form 6 Admission Orders, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)



Comparison was made of 2009 involuntary admission activity with that for a number of previous years. Figure 3 below summaries these comparisons on an annual basis and shows a decrease of 6% from 2007 to 2008 and an increase of 1% from 2008 to 2009.

Figure 3: Comparisons of Total Involuntary Admissions 2007-2009



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

Comparison of 2008 with 2007 shows the decrease in activity is accounted for by a 6% falls in both the categories Form 6 *Admission Order*, and Form 13, *Certificate & Admission Order to Detain a Voluntary Patient (Adult)*. Further comparison of 2009 with 2008 shows the increase in activity is accounted for by a 1% increase in both the categories Form 6 Admission Order, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult).

Tables 1(a)-1(e) provide further analysis of involuntary admission orders in 2009 by approved centre, by HSE region, and for the independent sector.

Table 1(a): Involuntary Admissions by HSE Regions 2009 (Adults)

HSE WEST	County	Form 6[a]	Form 13[a]	Total
Ballytivnan Sligo/Leitrim Mental Health Services	Sligo	33	22	55
St. Conal's Hospital Letterkenny	Donegal	1	0	1
Acute Psychiatric Unit Carnamuggagh Letterkenny	Donegal	83	22	105
Department of Psychiatry County Hospital Roscommon	Roscommon	19	8	27
St. Brigid's Hospital Ballinasloe	Galway	24	11	35
Psychiatric Unit University College Hospital	Galway	54	21	75
Acute Psychiatric Unit 5B Midwestern Regional Hospital	Limerick	82	18	100
St. Joseph's Hospital	Limerick	0	1	1
Tearmann Ward & Curragour Wards St. Camillus Hospital	Limerick	0	3	3
Acute Psychiatric Unit Midwestern Regional Hospital Ennis	Clare	31	10	41
Adult Mental Health Unit Mayo General Hospital Castlebar	Mayo	51	7	58
An Coillin Castlebar	Mayo	0	2	2
TOTAL HSE WEST		**378**	**125**	**503**

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

Table 1(b): Involuntary Admissions by HSE Regions 2009 (Adults)

HSE SOUTH	County	Form 6[a]	Form 13[a]	Total
St. Finan's Hospital Killarney	Kerry	2	0	2
Acute Mental Health Admission Unit Kerry General Hospital Tralee	Kerry	59	14	73
South Lee Mental Health Unit, Cork University Hospital	Cork	69	28	97
St. Michael's Unit Mercy Hospital	Cork	56	36	92
St. Stephen's Hospital Glanmire	Cork	12	7	19
Carraig Mor Centre	Cork	7	5	12
Acute Psychiatric Unit Bantry General Hospital	Cork	16	5	21
Department of Psychiatry St. Luke's Hospital	Kilkenny	18	13	31
St. Luke's Hospital Clonmel	Tipperary	1	0	1
St. Michael's Unit South Tipperary General Hospital Clonmel	Tipperary	60	11	71
St. Senan's Hospital Enniscorthy	Wexford	38	11	49
Department of Psychiatry Waterford Regional Hospital	Waterford	41	20	61
St. Otteran's Hospital	Waterford	4	1	5
TOTAL HSE SOUTH		**383**	**151**	**534**

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

Table 1(c): Involuntary Admissions by HSE Regions 2009 (Adults)

HSE DUBLIN NORTH EAST	County	Form 6[a]	Form 13[a]	Total
Acute Psychiatric Unit Cavan General Hospital	Cavan	18	6	24
St. Davnet's Hospital Monaghan	Monaghan	11	4	15
Department of Psychiatry Our Lady's Hospital Navan	Meath	22	13	35
St. Brigid's Hospital Ardee	Louth	48	14	62
St. Vincent's Hospital Fairview	Dublin North	65	29	94
St. Ita's Hospital Mental Health Services Portrane	Dublin North	51	14	65
Acute Psychiatric Unit, St. Aloysius Ward Mater Misericordiae Hospital	Dublin North	12	9	21
St. Brendan's Hospital	Dublin North	30	11	41
Department of Old Age Psychiatry Sycamore Unit Connolly Hospital	Dublin North	1	0	1
Department of Psychiatry Connolly Hospital	Dublin North	27	10	37
TOTAL DUBLIN NORTH EAST		**285**	**110**	**395**

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

Table 1(d): Involuntary Admissions by HSE Regions 2009 (Adults)

HSE DUBLIN MID LEINSTER	County	Form 6[a]	Form 13[a]	Total
Jonathan Swift Clinic	Dublin South	38	25	63
Acute Psychiatric Unit AMNCH	Dublin South	56	28	84
Elm Mount Unit St.Vincent's University Hospital	Dublin South	49	9	58
Lakeview Unit Naas General Hospital	Kildare	52	19	71
Department of Psychiatry Midland Regional Hospital Portlaoise	Laois	29	10	39
St. Loman's Hospital Mullingar	Westmeath	44	5	49
Newcastle Hospital	Wicklow	35	8	43
TOTAL HSE DUBLIN MID LEINSTER		**303**	**104**	**407**

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

Table 1(e): Involuntary Admissions by HSE regions 2009 (Adults)

INDEPENDENT SECTOR	County	Form 6[a]	Form 13[a]	Total
St. John of God Hospital Stillorgan	Dublin South	60	62	122
St. Patrick's Hospital Dublin	Dublin South	26	36	62
St. Edmundsbury Hospital Dublin	Dublin South	0	1	1
TOTAL INDEPENDENT SECTOR		**86**	**99**	**185**

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

Table 2 below shows Total Involuntary Admission Rates for 2009 (Adult) by HSE region and independent sector, with rates per 100,000 of total population.

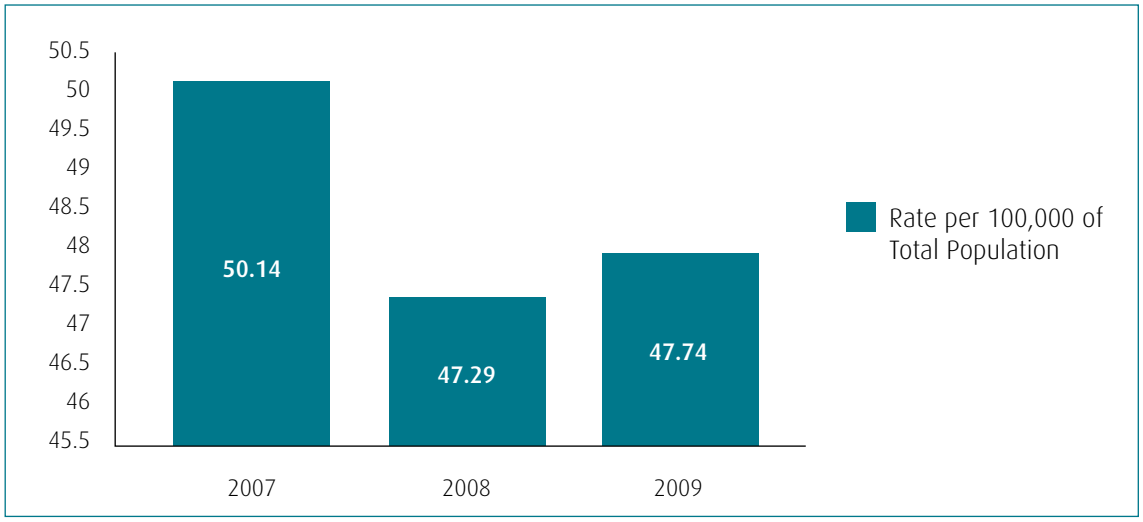
Table 2: Total Involuntary Admission Rates for 2009 (Adult) by HSE region & independent sector

	Total Involuntary Admission Rate 2009 (ADULT)	Population[A]	Involuntary Admission Rate per 100,000 total population
HSE WEST	503	1,012,413	49.68
HSE SOUTH	534	1,081,968	49.35
HSE DUBLIN NORTH EAST	395	928,619	42.54
TOTAL HSE DUBLIN MID LEINSTER	407	1,216,848	33.45
INDEPENDENT SECTOR	185	N/A	N/A
TOTAL (Exclusive of Independent sector)	**1,839**	**4,239,848**	**43.37**
TOTAL (Inclusive of Independent sector)	**2,024**	**4,239,848**	**47.74**

[A] Population figures taken from CSO census 2006.

Analysis of Ireland's involuntary admission rates per 100,000 of total population, including involuntary admissions to independent sector approved centres, is shown in Figure 4 below for the years 2007 to 2009.

Figure 4: Ireland's Involuntary Admission Rates per 100,000 of total population[6] for the years 2007 to 2009.



[6] Population figures taken from CSO census 2006.

Age and Gender

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2009. Tables 3 and 4 below summarise these findings.

Table 3: Analysis by Age – Involuntary Admissions 2009 (Adults)

AGE	FORM 6	FORM 13	TOTAL	%
17–18	1	0	1	0%
18–64	1,190	515	1,705	84%
65 and over	243	75	318	16%
TOTAL	**1,434**	**590**	**2,024**	**100%**

Table 4: Analysis by Gender – Involuntary Admissions 2009 (Adults)

GENDER	FORM 6	FORM 13	TOTAL	%
Female	629	292	921	46%
Male	805	298	1,103	54%
TOTAL	**1,434**	**590**	**2,024**	**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 2009. Table 5 below summarises this analysis.

Table 5: Analysis of Applicant: Involuntary Admissions 2009 (Adults)

Form Number	Type	Number	%
1	Spouse/Relative	886	61.8%
2	Authorised Officer	84	5.8%
3	Garda Síochána	324	22.6%
4	Any other Person	140	9.8%
	TOTAL	**1,434**	**100%**

Comparison of the 2008 figures for type of applicant with the 2009 figures shows the number of applicants by spouse/relative has fallen from 63.9% to 61.8%, authorised officer risen from 4.6% to 5.8%, Garda Síochána fallen from 22.8% to 22.6% and any other person risen from 8.7% to 9.8%. An authorised officer is an officer of the HSE who is of a prescribed rank or grade and who is authorised to exercise the powers conferred on authorised officers by section 9 of the Act.

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 2009 are summarised in Table 6 below.

Table 6: ICD 10 Diagnostic Groups Coded at Close of Episode (Adults) 2009

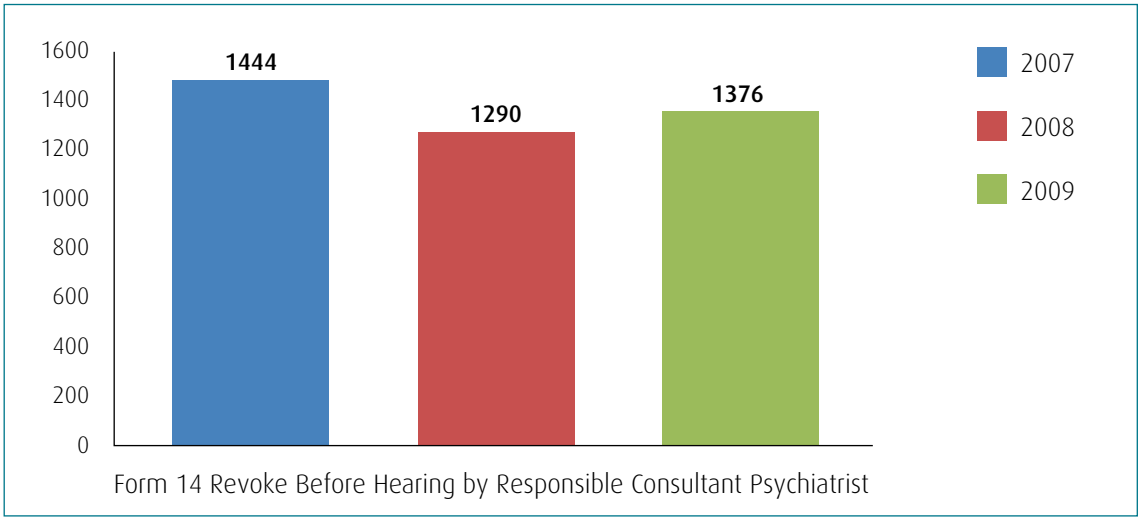
ICD-10 diagnostic groups	ICD-10 Code	Total Number of Episodes	Number of Episodes (%)
1. Organic Disorders	F00-F09	115	6.8%
2. Alcoholic Disorders	F10	32	1.9%
3. Other Drug Disorders	F11-F19, F55	57	3.4%
4. Schizophrenia, Schizotypal and Delusional Disorders	F20-F29	811	48.2%
5. Depressive Disorders	F31.3, F31.4, F31.5, F32, F33, F34.1, F34.8, F34.9	152	9.0%
6. Mania	F30, F31.0, F31.1, F31.2, F31.6, F31.7, F31.8, F31.9, F34.0	435	25.9%
7. Neuroses	F40-F48	30	1.8%
8. Eating Disorders	F50	3	0.2%
9. Personality and Behavioural Disorders	F60-F69	29	1.7%
10. Intellectual Disability	F70-F79	10	0.6%
11. Development Disorders	F80-F89	3	0.2%
12. Behavioural and Emotional Disorders of Childhood	F90-F98	See children sections	
13. Other Diagnosis	F38, F39, F51-F54, F59, F99	5	0.3%
TOTAL		**1,682**	**100%**

It is of interest to note that the diagnostic group with the highest rates of involuntary admission is the grouping *"Schizophrenia, Schizotypal & Delusional Disorder"*s followed by that for *"Mania"*. This is similar to the findings for 2007 and 2008.

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 1,376 such instances in 2009. The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis. Figure 5 below shows the number of orders revoked by responsible consultant psychiatrists under the provisions of section 28 for years 2007 to 2009.

Figure 5: Number of Orders Revoked by Responsible Consultant Psychiatrists under the Provisions of Section 28 for Years 2007 to 2009



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 an other 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 1,882 hearings in 2009.

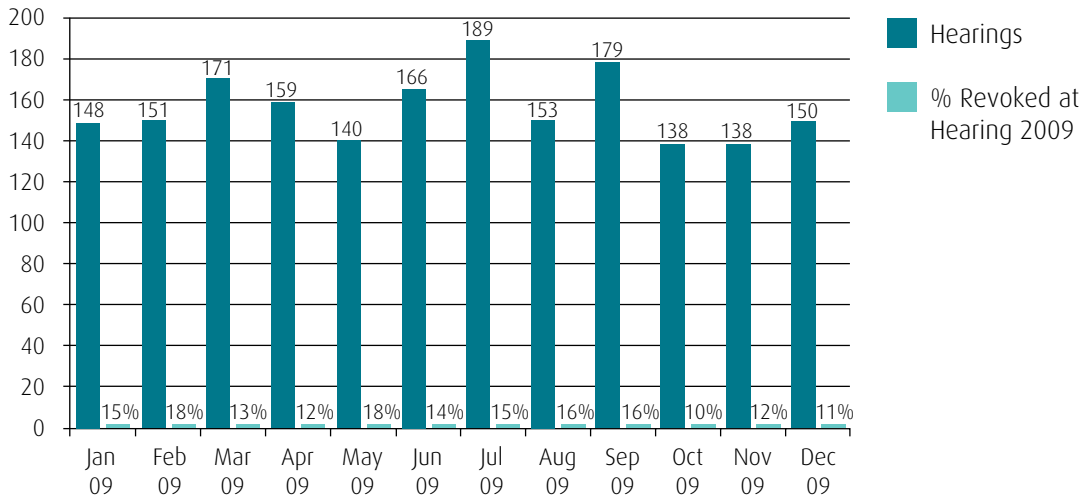
Section 17 Independent Medical Examinations

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.

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 2009 and the number of orders revoked (%) in each month. Overall, 9% of orders were revoked at a mental health tribunal in 2009.

Figure 6: Number Hearings & % of Orders Revoked at Hearing 2009



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 mental health 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 46 Circuit Court appeals filed in the period from 1st January to 31st December 2009. Some of these cases were withdrawn due to orders being revoked by the responsible consultant psychiatrist 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 2009 there were 3 Article 40.4 cases brought that involved the Commission and/or a mental health tribunal. Of these 1 was appealed to the Supreme Court. In the Supreme Court judgment 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 a discretionary remedy. There were 2 Judicial Review cases issued in 2009 that involved the Commission and/or a mental health tribunal. None of those cases are ongoing.

Training and Development

A number of induction programmes for mental health tribunal panel members were delivered in 2009 as preparation for their specific role.

- Induction training for Mental Health Tribunal Consultant Psychiatrists and Section 17 Independent Medical Examinations in February 2009.
- Following the Mental Health Tribunals recruitment process, induction training for Mental Health Tribunal Panel Members was delivered throughout August and September 2009.

All programmes were accredited by their relevant professional bodies.

Panel members were kept updated by the distribution of information and materials throughout the year.

The Mental Health Commission and the Law Society in collaboration developed a Continuous Professional Development seminar for solicitors. The programme was hosted and accredited by the Law Society. The presentations focused on legal representatives and best interests. It was attended by seventy five practitioners, who indicated that the seminar was of an extremely high standard.

The Mental Health Commission and the College of Psychiatry of Ireland jointly developed and delivered a training programme on Mental Health Tribunal Skills for responsible Psychiatrists' working in approved centres. The aim of the programme was to equip consultant psychiatrists who are responsible for detained persons with the skills required to perform competently at Mental Health Tribunals. Thirty five consultants attended the course which was accredited by the College of Psychiatry of Ireland. There was a very high demand for the course; it is intended to repeat this programme in 2010.

Rules and Codes of Practice

Rules issued by the Commission are statutory requirements that must be implemented in approved centres[2]. The '2001 Act' does not impose a legal duty on persons working in the mental health services to comply with codes of practice, but best practice requires that codes be followed to ensure that the 2001 Act is implemented consistently by persons working in mental health services. A failure to implement or follow a code of practice could be referred to during the course of legal and/or disciplinary proceedings. The provisions of Commission codes of practice are not designed to set out a prescriptive model of the ideal service or to replace clinical judgment but rather to provide guidance to enable all professionals working with mental health service users to make decisions which are in keeing with the best interests of the person and are in line with international best practice.

The Mental Health Commission issued several revised rules, revised codes of practice and new codes of practice in 2009 details of which are provided below. A summary of rules and codes of practice developed is provided in Table 1.

Revised Rules Pursuant to the Mental Health Act 2001 – Published during 2009

The Mental Health Commission must make rules providing for the use of electro-convulsive therapy (ECT) on a patient as per Section 59(2) of the Mental Health Act 2001. Section 69(2) of the Mental Health Act 2001 obliges the Commission to make rules providing for the use of seclusion and mechanical means

[2] "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). An approved centre is a centre that is entered on the Register of Approved Centres maintained by the Mental Health Commission in accordance with Section 64, Mental Health Act 2001).

of bodily restraint on a patient. Both sets of rules came into effect on 1st November 2006 with the full commencement of the 2001 Act. At this time, the Commission indicated that it would keep the rules under periodic review and review them no later than two years after their commencement.

Prospectus Consultants carried out a review of the Rules Governing the Use of ECT and a review of the Rules Governing the Use of Mechanical Restraint and the Code of Practice on the Use of Physical Restraint on behalf of the Commission between September and December 2008. The review exercise included an extensive stakeholder consultation. Following consideration by the Commission of the review recommendations, the Commission issued two sets of revised Rules in October 2009.

The revised Rules are effective from 1st January 2010 and inspections by the Inspectorate of Mental Health Services in 2010 will include inspection of compliance with these Rules.

Codes of Practice – Published During 2009

Admission of Children under the Mental Health Act 2001 – Addendum

The Commission issued an addendum to the Code of Practice on the Admission of Children under the Mental Health Act 2001 in July 2009. The aim of the amendment is to reflect and clarify the Commission's policy on the admission of children pursuant to the Mental Health Act 2001.

The amendment to the Code of Practice is as follows:

1. Section 2.4 is amended to read as follows:

2.4 The Commission will review the number of admissions of children to approved centres for adults from time to time.

2.4.1 In respect of the admission of a child to an approved centre for adults, the following applies:

a) No child under 16 years is to be admitted to an adult unit in an approved centre from 1st July 2009;

b) No child under 17 years is to be admitted to an adult unit in an approved centre from 1st December 2010; and

c) No child under 18 years is to be admitted to an adult unit in an approved centre from 1st December 2011.

2.4.2 If, in exceptional circumstances, the admission of a child to an adult unit in an approved centre occurs in contravention of the above, the approved centre is obliged to submit a detailed report to the Mental Health Commission outlining why the admission has taken place. This report should be in the form specified by the Mental Health Commission as per Section B of the Notification to the Mental Health Commission of the admission of a child to an adult unit in an approved centre.

2. Section 2.5m) is amended to read as follows:

2.5m) The Commission should be notified of all children admitted to an approved centre for adults within 72 hours of admission and also notified of the discharge of all children from an approved centre for adults within 72 hours of discharge using the associated clinical practice forms. Procedures should be in place to identify the person responsible for notifying the Commission.

Admission, Transfer and Discharge

The Mental Health Commission published a code of practice on admission, transfer and discharge to and from an approved centre in September 2009. The code of practice is in line with the first theme of the Quality Framework for Mental Health Services in Ireland, which is the provision of a holistic seamless service, and the full continuum of care provided by a multi-disciplinary team. Many of the principles and values in a *Vision for Change* are reflected within the code, such as the importance of involving service user and carers, adopting a recovery approach, liaising with primary care and ensuring co-ordination of services and continuity of care.

One of the primary aims of this code is to create a more positive journey to recovery for service users through inpatient mental health services by improving the continuity and co-ordination of the care and treatment provided. The code is relevant to all partners involved in the delivery of mental health care and treatment. The code of practice is operational from 1st January 2010. The Inspector of Mental Health Services will commence inspections using this code in 2010.

Mental Illness and Intellectual Disability

The Commission published a new code of practice for persons working in mental health services with people with intellectual disabilities in October 2009.

The code adopts a human rights approach to the delivery of mental health services. The key principles that underpin the code are the best interests of the person, adopting a person-centred approach to care and treatment, employing the least restrictive intervention and the presumption of capacity. The code provides guidance on the area of decision-making and capacity, until such time as much needed capacity legislation is enacted.

The code of practice is effective from 1st January 2010 and inspections by the Inspectorate of Mental Health Services in 2010 will include inspection of compliance with this code.

The Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

The Rules Governing the Use of ECT apply only to the use of ECT on a person involuntarily admitted to an approved centre in accordance with Section 69, Mental Health Act 2001. The Mental Health Commission's mandate relates to the quality of service provision to all persons in receipt of mental health services irrespective of whether their legal status is voluntary or involuntary. As a consequence, the Commission issued a code of practice on the use of electro-convulsive therapy for voluntary patients in approved centres in January 2008. This code, in many respects, mirrored the provisions set out under the Section 59(2) rules.

Following the review of the Rules Governing the Use of Electro-Convulsive Therapy and the revision of these rules, the Code of Practice on the Use of ECT was similarly revised and re-issued in October 2009. The revised code of practice is effective from 1st January 2010.

The Use of Physical Restraint in Approved Centres

A code of practice on the use of physical restraint was first published by the Mental Health Commission on 1st November 2006. Prospectus Consultants carried out a review of the Code of Practice on the Use of Physical Restraint in Approved Centres along with a review of the Rules Governing the use of ECT and a review of the rules governing the use of mechanical restraint between September and December 2008. The review exercise included an extensive stakeholder consultation. Following a consideration by the Commission of the review recommendations, the Commission issued a revised code of practice in October 2009.

The revised code is effective from 1st January 2010.

Table 7: Rules and Codes published in 2009

Rules	
Rules Governing the Use of ECT	R- S59(2)/01/2009 Version 2
Rules Governing the Use of Seclusion & Mechanical means of Bodily Restraint	R- S69(2)/02/2009 Version 2
Codes of Practice	
Addendum to Code of Practice relating to Admission of Children under the Mental Health Act 2001	COP-S33(3)/01/2006
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	COP-S33(3)/01/2009 Version 1
Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	COP-S33(3)/02/2009 Version 1
Code of Practice on the Use of ECT for Voluntary Patients	COP-S33(3)/03/2009 Version 2
Code of Practice on the Use of Physical Restraint	COP-S33(3)/04/2009 Version 2

Activity Data

Code of Practice Relating to the Admission of Children under the Mental Health Act 2001

Voluntary and Involuntary Admissions

There are specific 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*[3]. The Mental Health Commission, since its establishment, has consistently highlighted the lack of sufficient Child and Adolescent in-patient and day hospital facilities. Whilst the Mental Health Commission continues to hold the view that the provision of age appropriate mental health services for children and adolescents must be addressed as a matter of urgency, it acknowledges the registration of three additional child and adolescent approved centres in 2009. In situations where 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.

To reflect and clarify the Commission's policy on the admission of children pursuant to the Mental Health Act 2001 an Addendum to the Code of Practice was issued on 01 July 2009. The addendum prohibited the admission of children under 16 years of age to adult units in approved centres from 1 July except in exceptional circumstances.

The Commission was of the view that the addendum was required due to the increase in child admissions under 16 years of age to adult units in 2008 in comparison to 2007 as illustrated in Table 8. The Commission was notified of one admission of a child under 16 years of age from 1st July to 31st December 2009.

Notification of the Admission of Children

Approved centres for adults are requested to notify the Commission of the admission of a child within 72 hours of the child's admission subject to provision 2.5(m) of the code. Child units in approved centres are also requested to send a monthly report on admissions. In 2009, the Commission was notified of a

[3] The Mental Health Act 2001 Section 2(1) defines a "child" as a person under the age of 18 years other than a person who is or has been married.

total of 365 admissions of children to approved centres[4]. This represents a 7% decrease compared to the number of admissions for 2008 (n= 392) although it is similar to 2007 (n= 352).

Admissions by Unit Type and Service Provider

Table 8 provides a breakdown of activity on admissions of children in 2007, 2008 and 2009. It includes the number of units and type of units that admitted children and the number and percentage of admissions by service provider (HSE Area or Independent Sector). The number of child units that admitted children in 2009 increased from three in both 2007 and 2008 to five in 2009. In 2009, there were three new approved centres for children and adolescents entered on the register of approved centres pursuant to Section 64 of the Mental Health Act 2001. The Child Adolescent In-patient Unit, St Vincent's Hospital Fairview had its first admission in March 2009, while the Child & Adolescent Mental Health In-patient Unit, St. Stephen's Hospital had its first admission in December 2009. The Haven Children's Residential Unit was registered in September 2009 and there were no admissions in 2009.

In terms of service provider, HSE Dublin Mid Leinster had the highest number of admissions in 2009 (n=92) followed by the Independent Sector (n=83), HSE West (n=79) and HSE South (n=68). HSE Dublin North East continues to be the provider with the lowest number of child admissions (n=43).

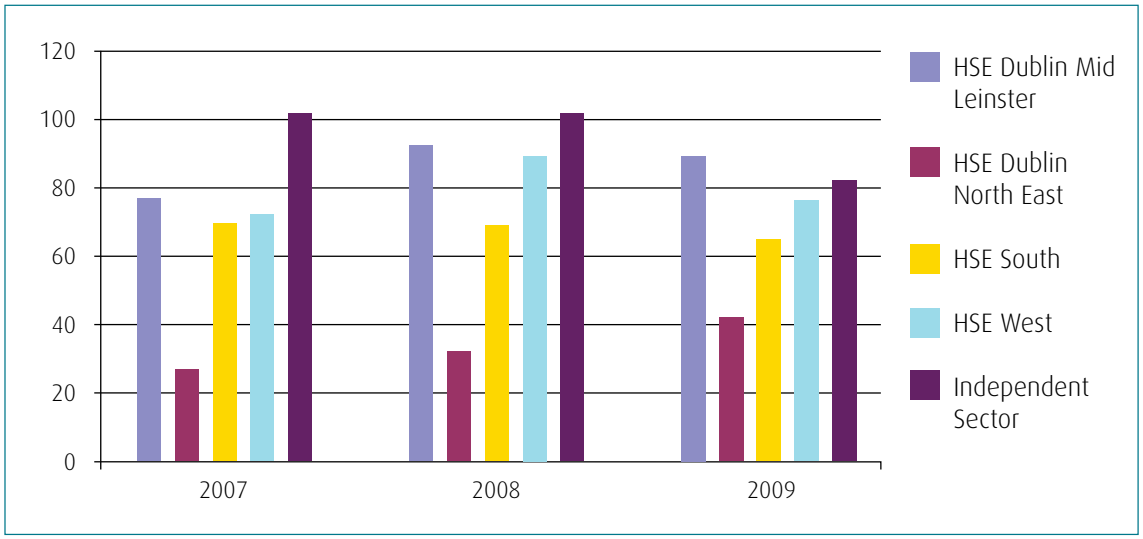
Table 8: Number and Type of Units. Number and Percentage of Admissions by Service Provider.

	2007			2008			2009		
Service Provider	Number and Type of Units	Number of Admissions	% of 2007 Admissions	Number and Type of Units	Number of Admissions	% of 2008 Admissions	Number and Type of Units	Number of Admissions	% of 2009 Admissions
HSE Dublin Mid Leinster	7 adult units 1 child unit	78	22.1%	7 adult units 1 child unit	95	24.3%	7 adult units 1 child unit	92	25.2%
HSE Dublin North East	6 adult units	28	8.0%	8 adult units	33	8.4%	7 adult units 1 child unit	43	11.8%
HSE South	10 adult units	71	20.2%	9 adult units	71	18.1%	8 adult units 1 child unit	68	18.6%
HSE West	7 adult units 1 child unit	73	20.7%	8 adult units 1 child unit	91	23.2%	8 adult units 1 child unit	79	21.6%
Independent Sector	2 adult units 1 child unit	102	29.0%	1 adult unit 1 child unit	102	26.0%	1 adult unit 1 child unit	83	22.8%
TOTAL	**35 units**	**352**	**100.0%**	**36 units**	**392**	**100.0%**	**36 units**	**365**	**100.0%**

[4] 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).

Figure 7 compares the number of admissions in 2007, 2008 and 2009 by Service Provider. There was a decrease in admissions of 27 for 2009 in comparison to 2008, with 19 less admissions in the Independent Sector, a decrease of 12 admissions in HSE West and a decrease of three admissions in HSE South and HSE Dublin Mid Leinster. There was an increase of ten admissions in HSE Dublin North East between 2008 and 2009. This may have been influenced by the opening of a new child unit in the region in early 2009.

Figure 7: Number of Admissions in 2007, 2008 and 2009 by Service Provider.



Age and Unit Type

Table 9 summarises the number of admissions by age and unit type in 2007, 2008 and 2009. In 2009, 55% percent of admissions (n=200) were to adult units; 94% of these admissions (n=188) were 16 and 17 years of age and the remaining 6% (n=12) were 15 years of age or under. 45% of admissions (n=165) were to child units. Of these admissions, 54% (n=89) were 15 years of age or under and the remaining 46% (n=76) were 16 and 17 years of age. There was one admission of an adult who was 18 to a child unit in 2009.

There was a substantial decrease in the number of children under the age of 15 admitted to an adult unit in 2009 (n=12) compared with the previous year (n=24). This is likely influenced by the addendum to the code of practice introduced by the Commission in July 2009. Eleven of these admissions were before 1st July with only one child under the age of 15 admitted to an adult unit in an approved centre for the remainder of the year.

Table 9: Numbers of Admissions by Age and Unit Type for 2007, 2008 and 2009

	2007		2008		2009	
Age	Adult Unit	Child Unit	Adult Unit	Child Unit	Adult Unit	Child Unit
≤15 years of age	14	99	24	90	12	89
16 and 17 years of age	203	36	223	55	188	76
Total (Admissions by Unit Type)	**217**	**135**	**247**	**145**	**200**	**165**

Gender

In 2009 there were more females, 55% (n=202), than males, 45% (n=163), admitted to approved centres. This is very similar to previous years. In 2008, 58% of those admitted were female (n=229) and 42% of those admitted were male (n=163). In 2007, 59% of those admitted were female (n=207) and 41% of those admitted were male (n=145).

Involuntary Admission

There were ten[5] involuntary admissions of children to approved centres in 2009. One was made under Section 18(1) of the Child Care Act 1991; the remainder were under Section 25 of the Mental Health Act 2001.

This represents a slight increase in involuntary admissions from 2008 (n=8) and a notable increase from 2007 (n=4). Seven of these involuntary admissions were to adult units and three were to child units. In 2008 there were six admissions to adult units and two were admitted to child units. In 2007, all involuntary admissions were to adult units.

Additional Information Regarding Child Admission Data

The Commission validates child admissions data received from approved centres by cross referencing it with provisional data received from the Health Research Board (HRB). If any discrepancies arise, approved centres are contacted for clarification and validation.

The number of admissions of children in 2008 and 2009 reported here may differ from those reported by the HRB for the following reasons:

- The HRB reports on the legal status of children on admission, whereas the Commission captures change in legal status from voluntary to involuntary throughout the period of admission and reports on such admissions once as an involuntary admission.
- 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 irrespective of their current or previous marital status.

Training & Development – Child & Adolescent

In 2009 a presentation was delivered on request by the Clinical Director of St. Joseph's Adolescent Inpatient Unit, St. Vincent's Hospital. The presentation focused on admission of children under the Mental Health Act 2001, which was part of the induction programme for the multidisciplinary team.

Notification of Deaths

Approved Centres

Approved Centres are required to notify the Commission *of the death of any resident* of an approved centre in accordance with Article 14(4) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Section 2.2 of the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. In 2009, 45 approved centres notified the Commission of a total of 173 deaths. The Inspector of Mental Health Services is advised of all such notifications received and subsequently follows

[5] Includes two occasions where a child's legal status was re-graded from voluntary to involuntary during the same admission period. In these instances the admission was recorded once as an involuntary admission.

up on the information provided as deemed appropriate. The breakdown of death notification information by service provider is provided in Table 10 below.

Table 10: Number of Approved Centres and Number of Death Notifications by Service Provider in 2008 and 2009.

	2008		2009	
Service Provider	Number of Approved Centres that notified deaths	Number of death notifications	Number of Approved Centres that notified deaths	Number of death notifications
HSE Dublin Mid Leinster	7	21	6	22
HSE Dublin North East	8	45	9	39
HSE South	13	54	13	65
HSE West	8	32	11	23
Independent	6	27	6	24
TOTAL	**42**	**179**	**45**	**173**

Day Centres, Day Hospitals, 24-Hour Staffed Community Residences

All sudden, unexplained deaths of persons attending a day hospital, day centre or currently living in 24 hour staffed community residences should be notified to the Commission as soon as possible and in any event within 7 days of the death occurring (Section 2 (b) Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting).

In 2009 the Commission was notified of 78 deaths in this category.

Based on the information provided, it was not apparent in all instances that a sudden unexplained death had occurred.

All death notifications received were forwarded to the Inspector of Mental Health Services in accordance with standard operating procedures within the Commission. Table 11 provides a breakdown of this information by HSE administrative region.

Table 11: Number of Death Notifications Submitted by Day Hospitals, Day Centres and 24-Hour Staffed Community Residences in 2009

Service Provider	Day Hospitals	Day Centres	24 hour staffed community residences	Not specified[1]
HSE Dublin Mid Leinster	5	2	6	6
HSE Dublin North East	0	1	7	0
HSE South	4	2	8	7
HSE West	3	8	17	2
TOTAL	**12**	**13**	**38**	**15**

[1] Not specified – the returns received indicated that a 'sudden unexplained death' had occurred but did not specify if the deceased person was attending a day hospital, day centre or residing in a 24 hour community residence.

Inspector of Mental Health Services

The Inspector of Mental Health Services examines all death notifications and in cases suggestive of suicide or violent death requests a review be carried out by the service and a copy sent to the Inspectorate. These reviews are analysed with a view to identification of opportunities for improvement in patient safety, care and treatment and form part of the ongoing dialogue between the Inspectorate and the service.

Incident Reporting

In accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, approved centres provide the Mental Health Commission with six-monthly summary reports of all incidents occurring in the centre. The reports received are available to the Inspectorate to inform subsequent inspections.

Due to the wide variation in reporting systems currently in use throughout mental health services national aggregate data is currently unavailable. The Commission on Patient Safety and Quality Assurance was established by the Minister for Health and Children in 2007 to develop clear and practical recommendations to ensure that safety and quality of care for patients is paramount within our healthcare system. Their report – Building a Culture of Patient Safety – was published in 2008 and approved by Government in January 2009. The report contains 134 recommendations including 18 which address the reporting, managing and learning from adverse events. An Implementation Steering Group and a number of working groups were established to implement the recommendations of this report. The Director of Standards and Quality Assurance represents the Commission on the Adverse Events Working Group.

Other Approved Centre Data

Use of ECT, Seclusion, Mechanical Restraint and Physical Restraint

Approved Centres are required to return aggregate data on the use of ECT, seclusion, mechanical means of bodily restraint and physical restraint under the respective Rules and Codes of Practice issued in accordance with the Mental Health Act 2001.

In November 2009, the Commission published national reports on the use of electroconvulsive therapy; seclusion; mechanical means of bodily restraint and physical restraint in approved centres in 2008. Theme 8 of the Quality Framework for Mental Health Services in Ireland states that *"Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services".* The Commission monitors and reports on the above data activity to provide a current picture of activity both within individual services and at national level in order to inform the quality improvement process. The national reports are available in the Publications Section of the Commission's website *www.mhcirl.ie.*

The Commission has requested the relevant data activity for 2009 and will validate and publish it in 2010.

Scheme of Mental Capacity Bill 2008

The Mental Health Commission welcomed the publication of the Scheme of the Mental Capacity Bill and the opportunity for the Commission to make a submission. In April 2009 the Commission furnished its submission to the Department of Justice, Equality and Law Reform. The Commission has on numerous occasions highlighted the urgent need for capacity legislation in Ireland. The Committee established by the Commission re-convened in September 2009 to consider the amended Heads to the Scheme of the Mental Capacity Bill and the matter was considered at the Mental Health Commission meeting which took place in September 2009. The work of the Commission's Committee on this matter was still ongoing at year end.

2020 Vision – The Quality of Mental Health Services Is Consistent with Best International Standards

Strategic Priority Three (2009-2012) – Quality Mental Health Services

- The scope and process of inspection and reporting is effective in enhancing both compliance and commitment to continuous quality improvements and is a catalyst for change.
- To facilitate and support implementation of the quality improvement standards for mental health services in Ireland. (Quality Framework for Mental Health Services in Ireland, MHC 2007).
- To continue to support mental health services research to build knowledge that leads to practical ways of improving services.
- To promote and support the development of a national mental health information system.

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 board spectrum of mental health services in Ireland.

Inspector of Mental Health Services

Section 51, Mental Health Act 2001 specifies the functions of the Inspector of Mental Health Services. In 2009, 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 sector) and senior clinical staff. The Inspectorate visited a number of Day Hospitals and 24-Hour supervised residences during 2009 and held two National Overview meetings with senior clinical and managerial staff of both Child and Adolescent Mental Health Services and Mental Health Services for Persons with an Intellectual Disability. The Inspectorate also carried out a survey of mental illness in the homeless population. The 2009 Inspectors annual review of mental health services in Ireland is reported in Part 2, Book 1. The detailed approved centre inspection reports are contained in books 2-7 on CD Rom and are published on the Mental Health Commission 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:

(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.

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 report was considered by the Mental Health Commission at its meeting held in January 2009 and given further consideration at the Commission's February meeting. The report was adopted by the Commission at the February meeting. The report of inquiry was published on 3rd April, 2009 and is available on the Commission's website at *www.mhcirl.ie*

Subsequently, meetings were held between HSE managers and clinicians and the Mental Health Commission and Inspectorate with a view to facilitating improvements and rectifying the deficits exposed by the inquiry.

A local project team was established in consultation with an external review group and an expert in change management. A set of priorities was identified and short-term and long-term goals specified.

Recent inspections have shown that the short-term goals of achieving compliance with statutory requirements are being accomplished.

Funding to move to a more community-oriented service has been allocated.

The overall quality of the service and progress toward long-term goals continue to be monitored and encouraged.

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[6] 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.

Under the provisions of the 2001 Act, a centre's period of registration shall generally be 3 years from the date of registration. Where the registered proprietor of a centre proposes to carry on the centre immediately after the period of registration expires, he/she must apply to the Commission for registration.

The period of registration of 2 approved centres expired during 2009. These approved centres were Department of Psychiatry, Connolly Hospital and Warrenstown Child & Adolescent In-patient Unit. Both approved centres applied for registration in accordance with Section 64(9) of the 2001 Act and both were entered in the Register of Approved Centres on 7th December 2009 and 14th December 2009 respectively.

Kylemore Clinic closed during 2009 and was removed from the Register of Approved Centres in accordance with Article 36 (Closure of an Approved Centre) of the Mental Health Act 2001 (Approved Centres) Regulations 2006. The residents of Kylemore Clinic were transferred to the approved centre in Bloomfield Care Centre.

[6] "'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)

Three new centres were entered in the Register of Approved Centres during 2009:

- Adolescent In-patient Unit, St Vincent's Hospital, Fairview, Dublin 3. This centre was entered in the Register on 29th January 2009.
- The Haven Children's Residential Unit, Kilcoon, Co Meath. This centre was entered in the Register on 17th September 2009 and a condition was attached to the registration.
- Child & Adolescent Mental Health In-patient Unit, St Stephen's Hospital, Glanmire, Co Cork. This centre was entered in the Register on 16th October 2009 and a condition was attached to the Registration.

The total number of Approved Centres at 31st December 2009 was 66. A list of all approved centres entered in the Register of Approved Centres is available in the Registration of Approved Centres section of the Commission's website, *www.mhcirl.ie*.

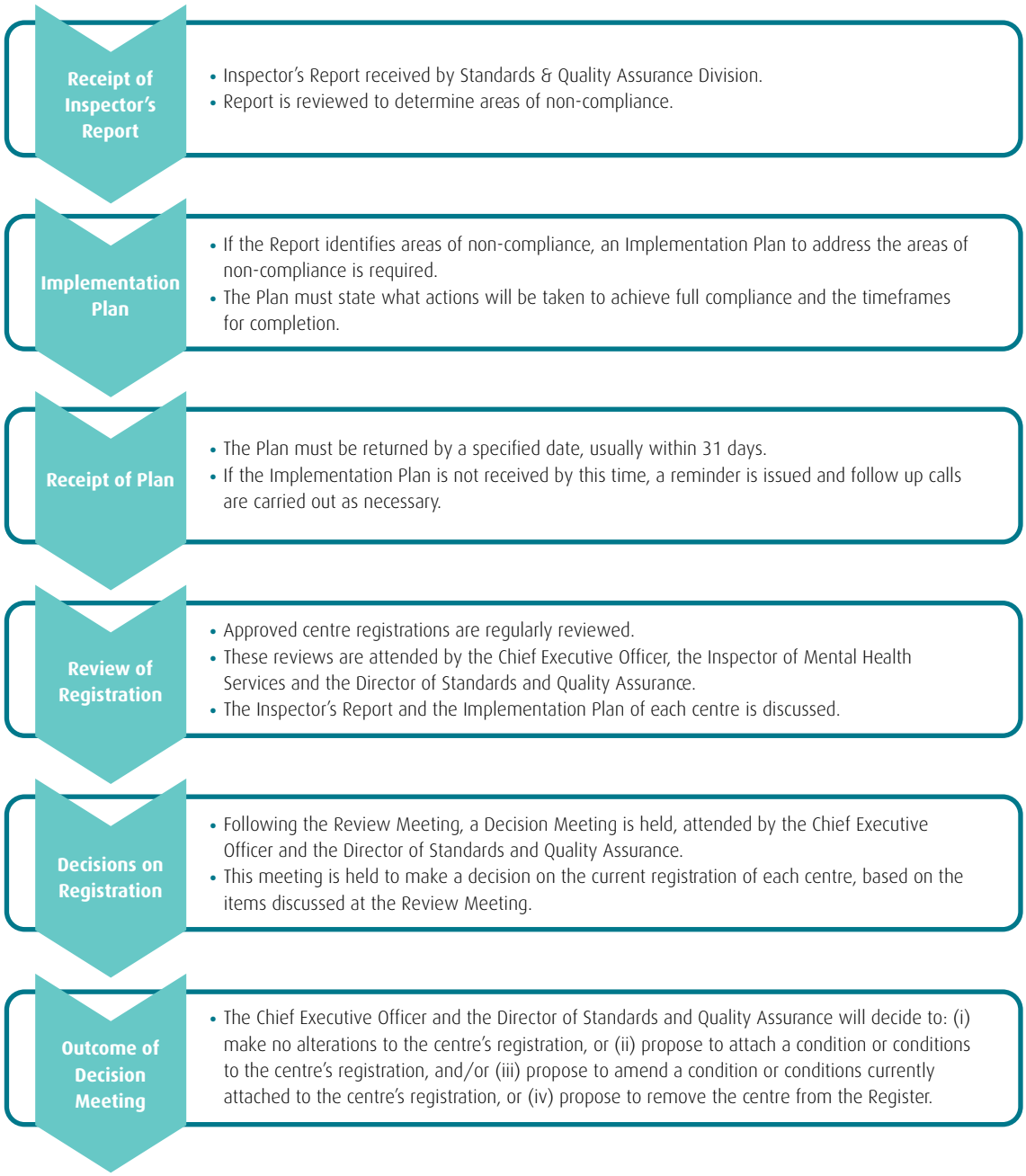
To maintain awareness of the legal requirement for facilities that meet the definition of 'centre' to register with the Commission, advertisements were placed in three national newspapers in March and September 2009.

Continuous Quality Improvement

As part of the Commission's continuous quality improvement approach to developing the quality of service provision, the Standards and Quality Assurance Division requested each approved centre to provide an implementation plan to address the areas of non-compliance with the Articles of the Regulations, Rules and Codes of Practice identified by the Inspector of Mental Health Services.

The Implementation Plan must include the actions that will to be taken to fully address the areas of non-compliance identified in the Inspector's Report and the time-frame(s) for completion. The process involved is outlined in Figure 8 below.

Figure 8: Approved Centre Review Process



Based on the learning from previous years, a Standardised Implementation Plan Template was devised by the Standards & Quality Assurance Division and issued to each approved centre in 2009 to assist the above process.

During 2009, Inspector's Reports for 64 approved centres were received by the Standards & Quality Assurance Division. Out of this number, 63 Reports identified areas of non-compliance with the Articles of the Regulations, Rules, or Codes of Practice.

St Stephen's Hospital in Glanmire, Co. Cork was the only approved centre deemed fully compliant with the regulations, rules and codes of practice by the Inspector of Mental Health Services in 2009.

The Mental Health Commission (MHC) and the Inspector of Mental Health Services have consistently commented upon the unacceptable continuation of provision of mental health services in in-patient settings, that are no longer 'fit for purpose', ie the older psychiatric hospitals/asylums. In January 2009, the HSE was requested to provide copies of closure plans for the older psychiatric hospitals. Reminder letters were issued in March, April and May. Nineteen closure plans were received by the end of June. The quality of information provided in the plans was variable with none of them identifying the person(s) responsible and accountable for actioning the various components of the plans. Following a review of the plans received by the Chief Executive Officer, Inspector of Mental Health Services and Director Standards and Quality Assurance a proposal regarding next steps was approved by the Commission at its meeting on 30 September and implementation is ongoing.

Conditions Attached to the Registration of Approved Centres

In 2009, the Commission attached conditions to the registration of 4 approved centres. These approved centres were:

- St Luke's Hospital, Clonmel
  The conditions attached required full compliance to be achieved with:
  - Articles 15, 16, 18, 20, 22, 26 and 32 of the Regulations,
  - The Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint,
  - The Code of Practice Relating to the Admission of Children under the Mental Health Act 2001, and
  - The Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting

  These conditions were attached with effect from 14th May 2009.

- St Michael's Unit, South Tipperary General Hospital, Clonmel
  The conditions attached required full compliance to be achieved with:
  - Articles 15, 16, 18, 20, 21, 22, and 26 of the Regulations,
  - The Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, and
  - The Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting.

  These conditions were attached with effect from 14th May 2009.

- The Haven Children's Residential Unit, Kilcloon, Co Meath
  The condition attached related to the provision of educational facilities for children.
  The condition was attached with effect from the centre's date of registration, 17th September 2009.

- Child & Adolescent Mental Health In-patient Unit, St Stephen's Hospital, Glanmire, Co. Cork
  The condition attached related to the provision of educational facilities for children.

The condition was attached with effect from the centre's date of registration, 16th October 2009.

Where a proposal was made to attach a condition to a centre's registration, or to enter a centre in the Register with a condition attached to its registration, correspondence was issued to the Registered Proprietor in accordance with the provisions of Section 64(11) and Section 64(12) of the Mental Health Act 2001.

These sections afford the Registered Proprietors of the centres to make representations to the Commission within 21 days of receipt of the correspondence and the Commission must take these representations into consideration before making a decision. Under Section 65, the registered proprietor may also appeal the Commission's decision to the District Court within 21 days of receiving notification of the decision.

National Levels of Compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006

The Mental Health Act 2001 (Approved Centres) Regulations 2006 came into effect on 1 November 2006. Compliance with the regulations is linked with registration as an approved centre. Therefore approved centres are obliged to comply.

This report provides a comparison of compliance in 2009 with 2007.

In 2009, full compliance[7] was 90% or more for the following 12 articles:

- Article 10 – Religion (100%)
- Article 30[8] – Mental Health Tribunals (100%)
- Article 34 – Certificate of Registration (100%)
- Article 4 – Identification of Residents (98%)
- Article 33 – Insurance (97%)
- Article 14 – Care of the Dying (97%)
- Article 7 – Clothing (95%)
- Article 8 – Residents' Personal Property & Possessions (95%)
- Article 12 – Communication (94%)
- Article 13 – Searches (94%)

[7] In 2007 inspector graded compliance as follows: compliant yes or no and in 2009 inspector graded compliance as follows: fully compliant, substantially compliant, compliance initiated, not compliant.

[8] The levels of compliance with Article 30 is based on 56 approved centres in 2007 and 55 approved centres in 2009. The Inspector's Reports stated that Article 30 was not applicable in 5 approved centres in 2007 and 9 approved centres in 2009.

- Article 25[9] – Use of Closed Circuit Television (92%)
- Article 18 – Transfer of Residents (92%)

In 2007, compliance[10] was 90% or more for the following 6 articles:

- Article 10 – Religion (100%)
- Article 30 – Mental Health Tribunals (100%)
- Article 4 – Identification of Residents (100%)
- Article 33 – Insurance (95%)
- Article 34 – Certificate of Registration (92%)
- Article 9 – Recreational Activities (92%)

In 2009 full compliance[11] was less than 50% for the following four articles:

- Article 26 – Staffing (27%)
- Article 16 – Therapeutic Services & Programmes (27%)
- Article 15 – Individual Care Plan (33%)
- Article 22 – Premises (44%)

This compares to 2007, where compliance[12] was less than 50% for the following eight articles:

- Article 15 – Individual Care Plan (18%)
- Article 17[13] – Children's Education (21%)
- Article 20 – Provision of Information to Residents (38%)
- Article 6 – Food Safety (39%)
- Article 16 – Therapeutic Service & Programmes (41%)
- Article 28 – Register of Residents (41%)
- Article 32 – Risk Management Procedures (48%)
- Article 19 – General Health (48%)

[9] The levels of compliance with Article 25 are based on 33 approved centres in 2007 and 36 approved centres in 2009. The Inspector's Reports stated that Article 25 was not applicable in 28 approved centres in 2007 and 2009.
[10] See footnote 5
[11] Ibid
[12] Ibid
[13] The levels of compliance with Article 17 are based on 34 approved centres in 2007 and 36 approved centres in 2009. The Inspector's Reports stated that Article 17 was not applicable in 27 approved centres in 2007 and 28 approved centres in 2009.

The largest improvements in compliance in 2009 are as follows:

- Article 17 – Children's Education (21% in 2007, 78% in 2009)
- Article 13 – Searches (52% in 2007, 94% in 2009)
- Article 28 – Register of Residents (41% in 2007, 81% in 2009)
- Article 20 – Provision of Information to Residents (38% in 2007, 73% in 2009).

However disimprovement in compliance in 2009 is noted as follows:

- Article 26 – Staffing (79% in 2007, 27% in 2009)
- Article 16 – Therapeutic Services and Programs (41% in 2007, 27% in 2009)
- Article 9 – Recreational Activities (92% in 2007, 81% in 2009)
- Article 21 – Privacy (72% in 2007, 61% in 2009)
- Article 22 – Premises (54% in 2007, 44% in 2009)

In relation to article 15 (Individual Care Plan) compliance in 2007 was 18%. This improved to 33% in 2008 and remained at 33% in 2009.

Full national compliance data comparing 2009 with 2007 is provided in Figures 9(a)–(d) inclusive.

Figure 9(a): Comparison of the National Levels of Compliance with Articles 4 to 14 of the Regulations for 2007 and 2009

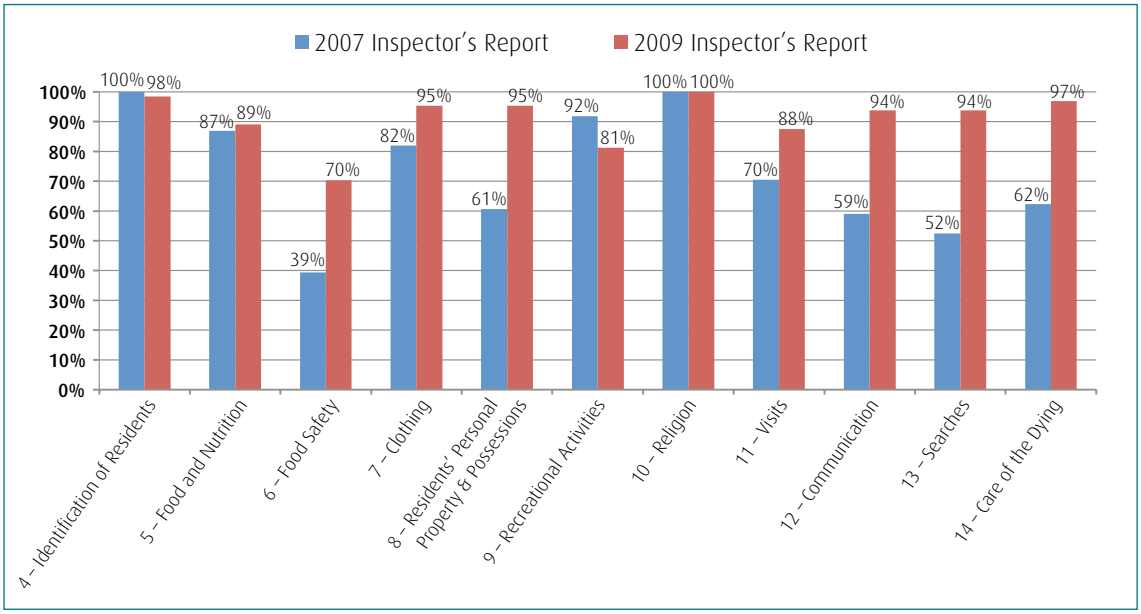


Figure 9(b): Comparison of the National Levels of Compliance with Articles 15 to 20 of the Regulations for 2007 and 2009

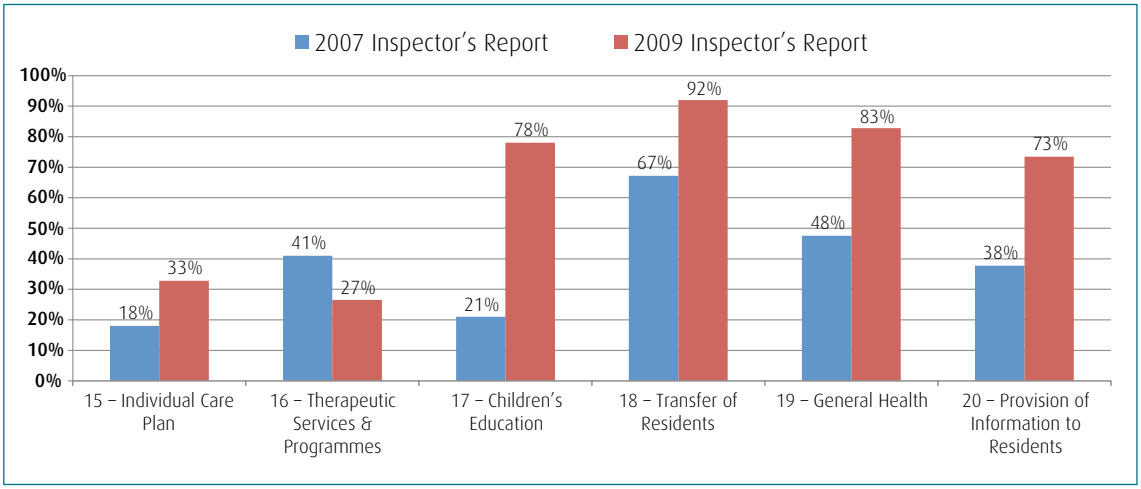


Figure 9(c): Comparison of the National Levels of Compliance with Articles 21 to 26 of the Regulations for 2007 and 2009

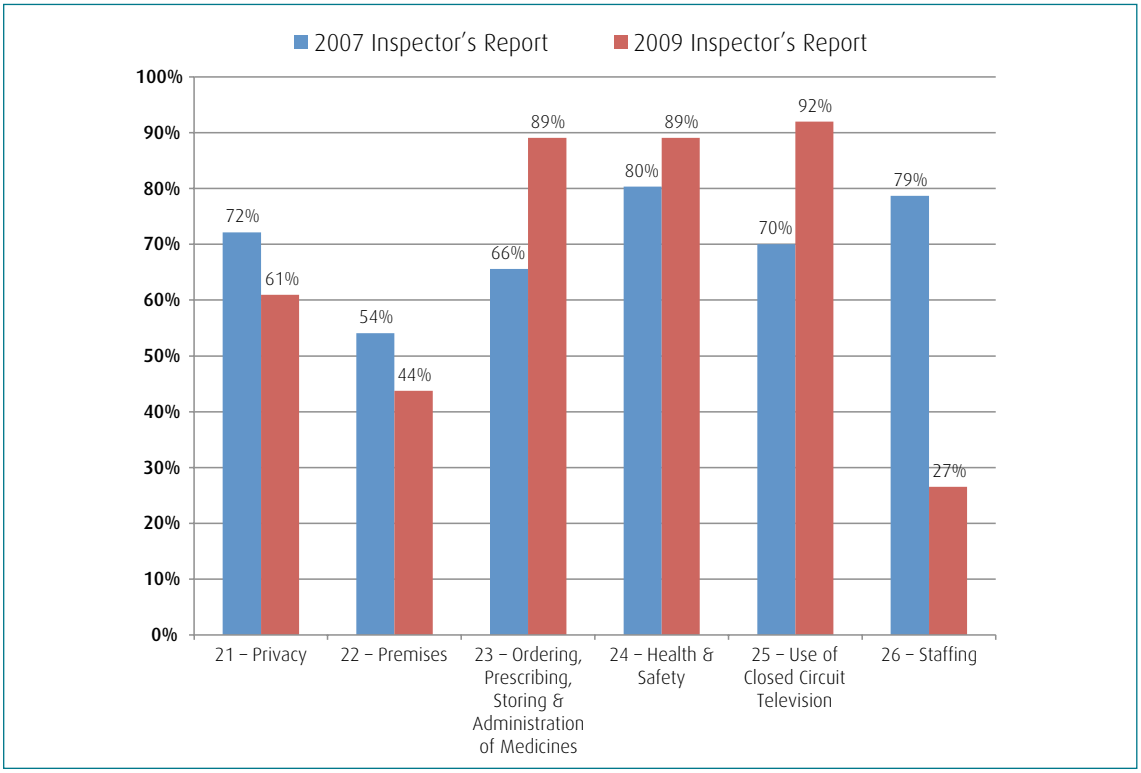
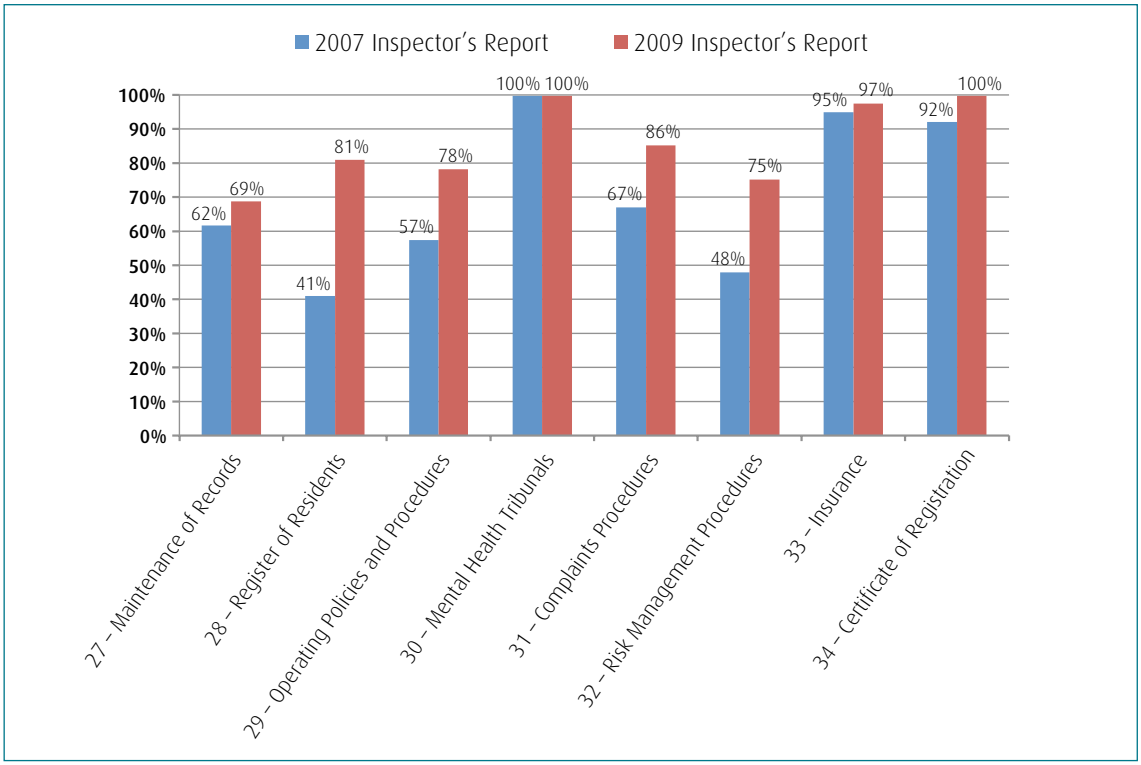


Figure 9(d): Comparison of the National Levels of Compliance with Articles 27 to 34 of the Regulations for 2007 and 2009



National Levels of Compliance with Rules and Codes of Practice

Pursuant to Sections 59(2), 69(2) and 33(3)(e) of the Mental Health Act 2001, the Commission has published a number of rules and codes of practice.

In 2009, the Inspectorate inspected compliance with 2 sets of rules and 4 codes of practice. This report provides an overview of the national levels of compliance with those rules and codes.

The levels of full compliance (i.e. where the Inspector's Report stated that the centre was fully compliant) were as follows:

- Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting – 50 approved centres.
- Code of Practice on the Use of Physical Restraint in Approved Centres – 21 approved centres.
- Rules Governing the Use of Mechanical Means of Bodily Restraint – 20 approved centres.
- Code of Practice on the Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients – 16 approved centres.
- Rules Governing the Use of ECT – 11 approved centres.
- Rules Governing the Use of Seclusion – 6 approved centres.
- Code of Practice on the Admission of Children Under the Mental Health Act 2001 – 5 approved centres.

The levels of non-compliance (i.e. where the Inspector's Report stated that the centre was not compliant) were as follows:

- Code of Practice on the Admission of Children Under the Mental Health Act 2001 – 22 approved centres.
- Code of Practice on the Use of Physical Restraint in Approved Centres – 7 approved centres.
- Rules Governing the Use of Seclusion – 6 approved centres.
- Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting – 4 approved centres.
- Code of Practice on the Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients – 1 approved centre.
- Rules Governing the Use of Mechanical Means of Bodily Restraint – 1 approved centre.
- Rules Governing the Use of ECT – No approved centre.

Full national compliance data is provided in Figures 10(a) to 10(g).

Figure 10(a): Levels of Compliance in 2009 with the Rules Governing the Use of Seclusion (n=64).

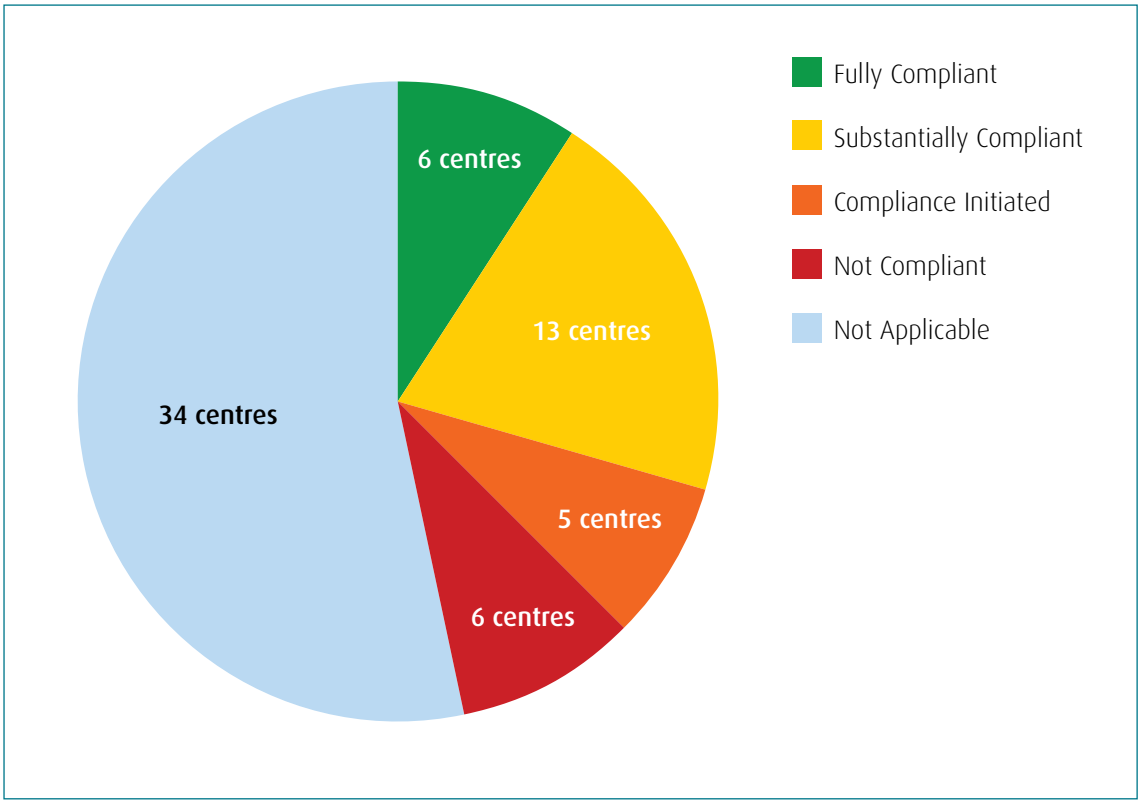


Figure 10(b): Levels of Compliance in 2009 with the Rules Governing the Use of Mechanical Means of Bodily Restraint (n=64).

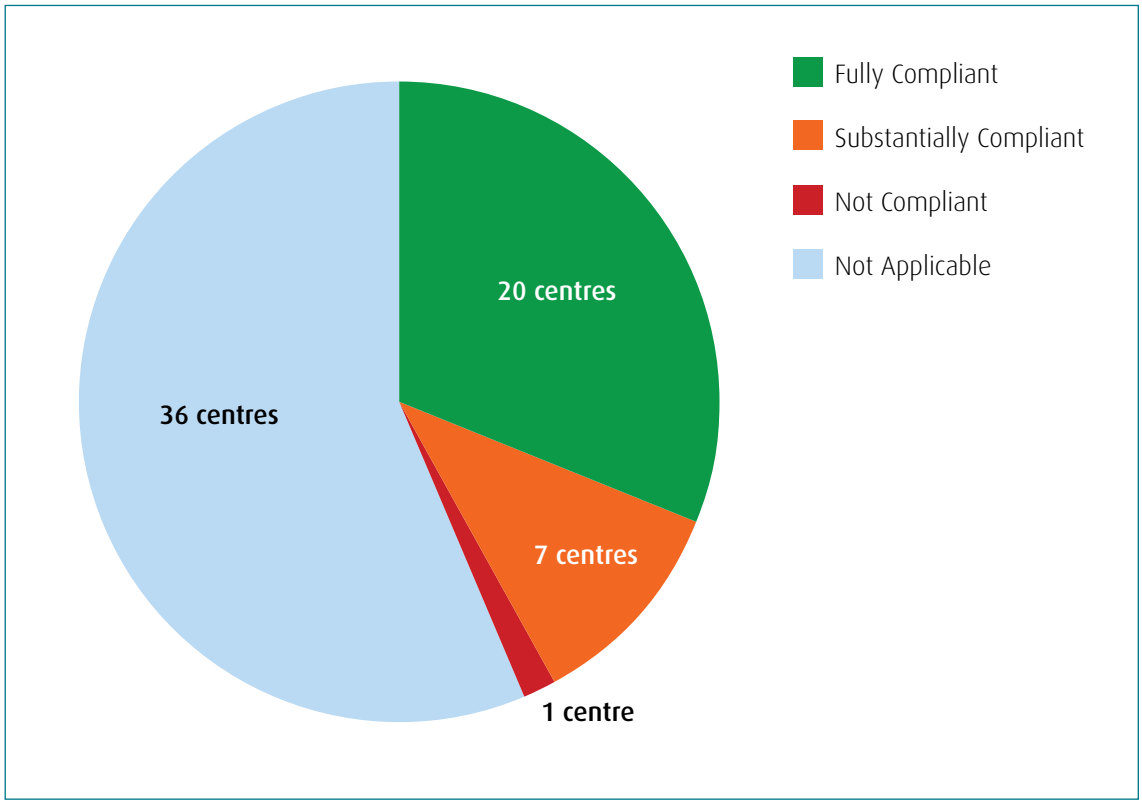


Figure 10(c): Levels of Compliance in 2009 with the Rules Governing the Use of ECT (n=64).

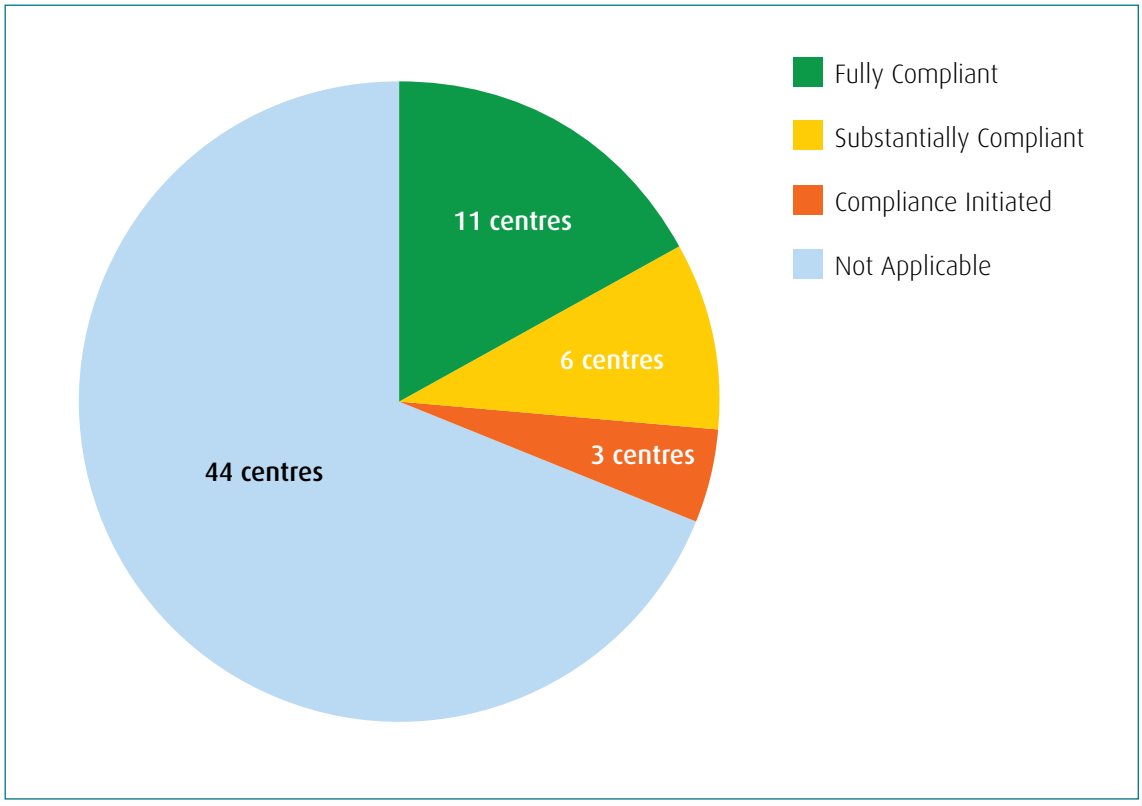


Figure 10(d): Levels of Compliance in 2009 with the Code of Practice on the Use of ECT for Voluntary Patients (n=64).

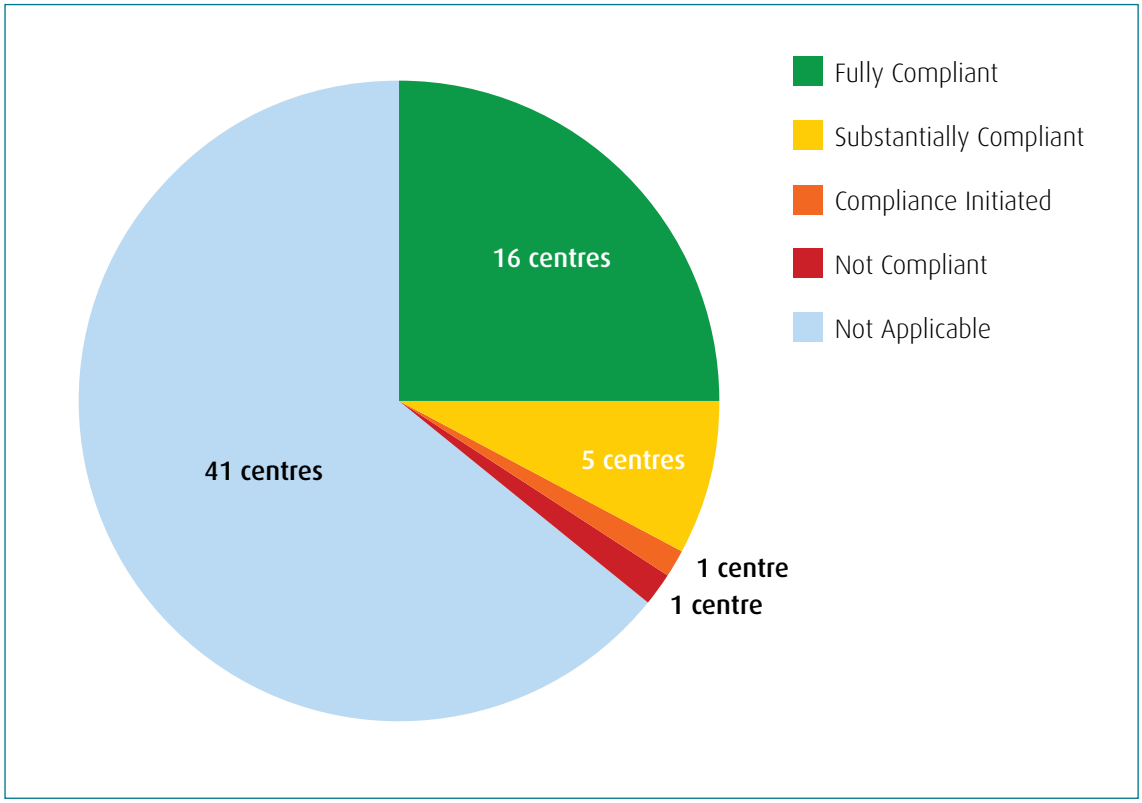


Figure 10(e): Levels of Compliance in 2009 with the Code of Practice on the Use of Physical Restraint in Approved Centres (n=64).

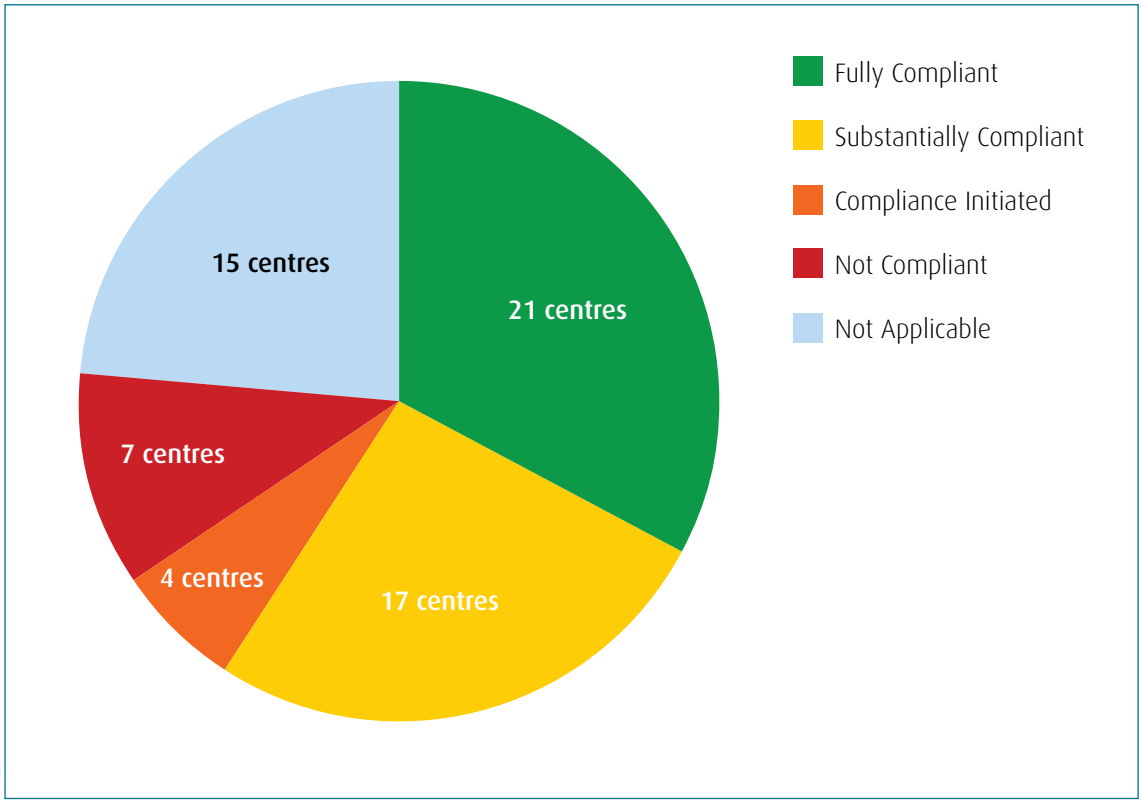


Figure 10(f): Levels of Compliance in 2009 with the Code of Practice on the Admission of Children Under the Mental Health Act 2001 (n=64).

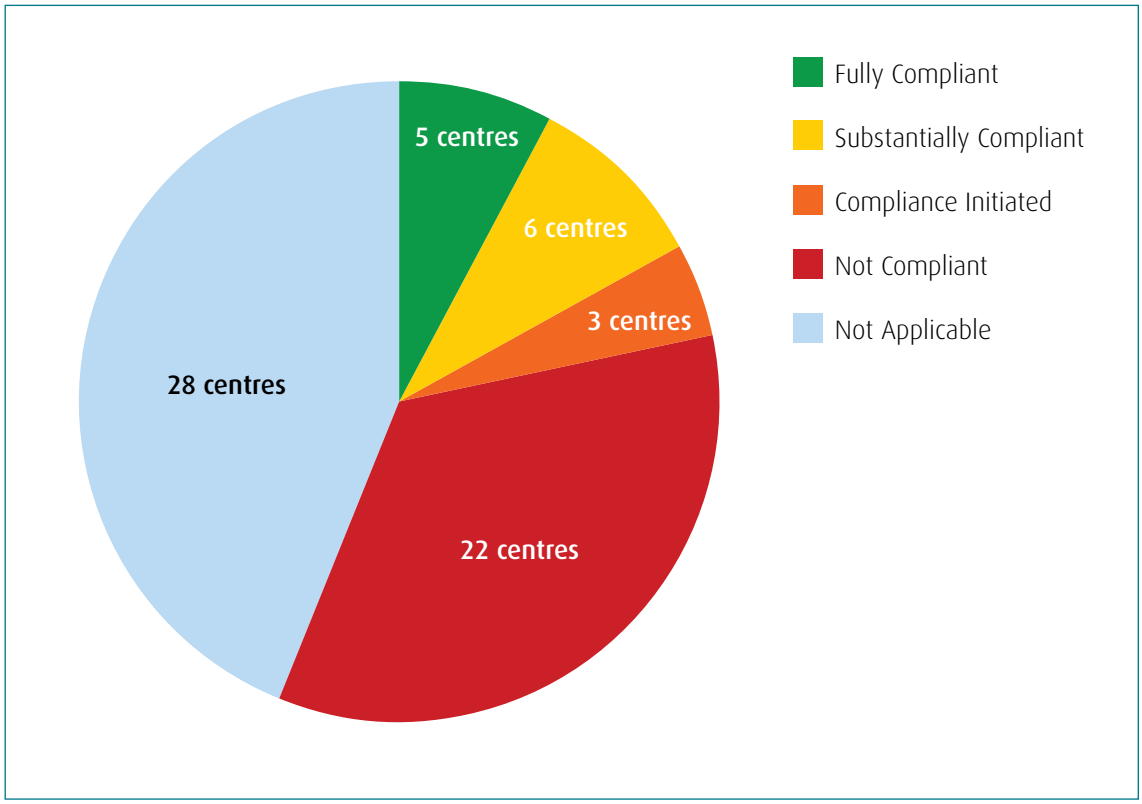
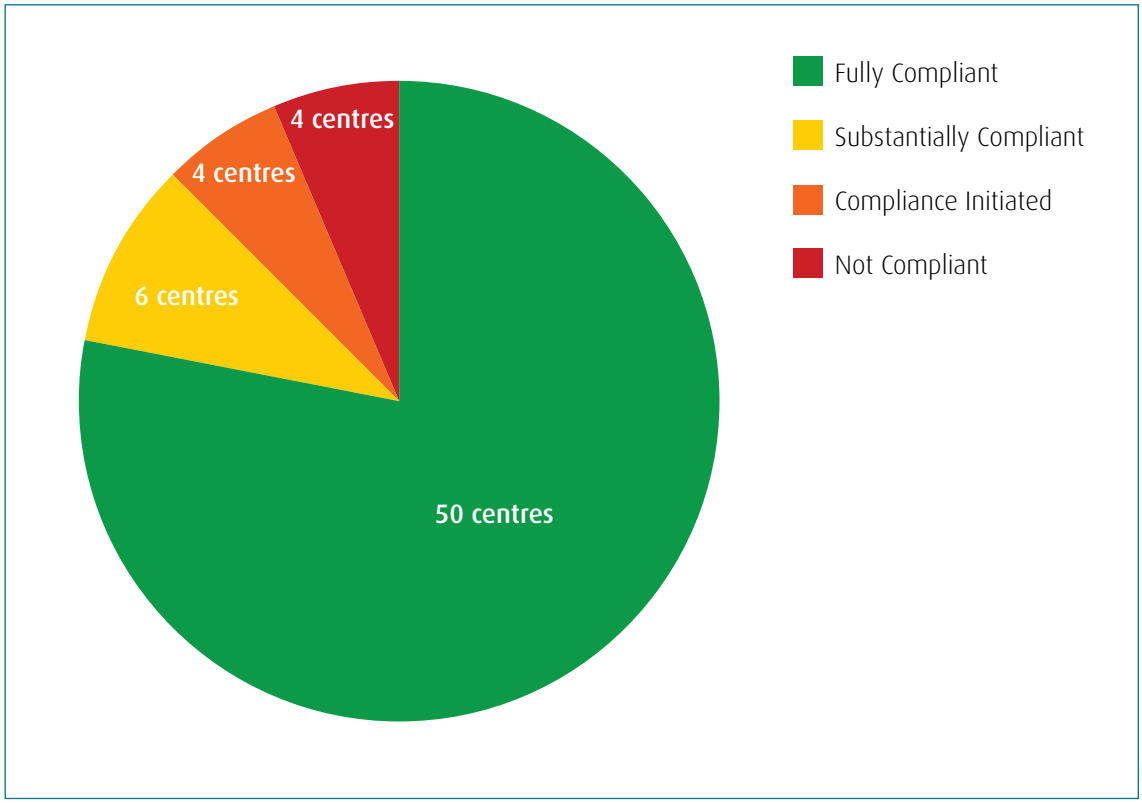


Figure 10(g): Levels of Compliance in 2009 with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting (n = 64).



Tables 12 and 13 detail each approved centre's compliance levels with the rules and the codes of practice respectively.

In these tables, the levels of compliance are abbreviated as follows:

- Full = Inspector Report states the level of compliance is 'Fully Compliant'.
- Substantial = Inspector Report states the level of compliance is 'Substantially Compliant'.
- Initiated = Inspector's Report states the level of compliance is 'Compliance Initiated'.
- Not = Inspector's Report states the level of compliance is 'Not Compliant'.
- N/A = Inspector's Report states that the rule or code in question does not apply.

Table 12: Levels of Compliance in 2009 with the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint and the Rules Governing the Use of Electro-Convulsive Therapy.

Approved Centre Name	Seclusion	Mechanical Restraint	ECT
Approved Centres in the Child & Adolescent Sector			
Adolescent In-patient Unit, St. Vincent's Hospital	Full	N/A	N/A
St. Anne's Children's Centre	Full	N/A	N/A
Warrenstown Child & Adolescent In-patient Unit	N/A	N/A	N/A
Approved Centres in the Health Service Executive (HSE) Dublin Mid Leinster Area			
Acute Psychiatric Unit, AMNCH	Substantial	N/A	Substantial
Central Mental Hospital	Substantial	Full	N/A
Department of Psychiatry, Midland Regional Hospital, Portlaoise	Substantial	Full	Full
Elm Mount Unit, St. Vincent's University Hospital	N/A	N/A	Substantial
Jonathan Swift Clinic	N/A	N/A	Substantial
Lakeview Unit, Naas General Hospital	Not	N/A	Full
Newcastle Hospital	Substantial	Full	Full
St. Fintan's Hospital	N/A	N/A	N/A
St. Loman's Hospital, Mullingar	Not	Full	Full
St. Loman's Hospital, Palmerstown	N/A	N/A	N/A
Approved Centres in the HSE Dublin North East Area			
Acute Psychiatric Unit, Cavan General Hospital	N/A	Full	N/A
Acute Psychiatric Unit, St. Aloysius Ward, Mater Misericordiae Hospital	Initiated	Not	Initiated
Department of Psychiatry, Connolly Hospital	N/A	N/A	N/A
Department of Psychiatry, Our Lady's Hospital, Navan	Full	N/A	N/A
St. Brendan's Hospital	Not	N/A	N/A
St. Brigid's Hospital, Ardee	Not	Substantial	N/A
St. Davnet's Hospital – Wards 4, 8 and 15	N/A	Full	N/A
St. Ita's Hospital – Mental Health Services	Substantial	Full	N/A
St. Joseph's Intellectual Disability Services, St. Ita's Hospital	Full	Full	N/A
St. Vincent's Hospital	Substantial	Full	N/A
Sycamore Unit, Connolly Hospital	N/A	N/A	N/A

Approved Centre Name	Seclusion	Mechanical Restraint	ECT
Approved Centres in the HSE South Area			
Acute Mental Health Admission Unit, Kerry General Hospital	Substantial	N/A	N/A
Acute Psychiatric Unit, Bantry General Hospital	N/A	N/A	N/A
Carraig Mór Centre	Initiated	N/A	N/A
Department of Psychiatry, St. Luke's Hospital, Kilkenny	Full	Full	N/A
Department of Psychiatry, Waterford Regional Hospital	Full	N/A	Full
South Lee Mental Health Unit, Cork University Hospital	N/A	Substantial	Substantial
St. Canice's Hospital	N/A	Full	N/A
St. Dympna's Hospital	N/A	Full	N/A
St. Finan's Hospital	Substantial	Substantial	N/A
St. Finbarr's Hospital	N/A	N/A	N/A
St. Luke's Hospital, Clonmel	N/A	Full	N/A
St. Michael's Unit, Mercy Hospital	N/A	N/A	Substantial
St. Michael's Unit, South Tipperary General Hospital	Substantial	N/A	Full
St. Otteran's Hospital	N/A	N/A	N/A
St. Senan's Hospital	Initiated	Full	Full
St. Stephen's Hospital	N/A	N/A	N/A
Approved Centres in the HSE West Area			
Acute Psychiatric Unit 5B, Midwestern Regional Hospital	N/A	N/A	Initiated
Acute Psychiatric Unit, Carnamuggagh	N/A	N/A	N/A
Acute Psychiatric Unit, Mid Western Regional Hospital, Ennis	Substantial	N/A	Substantial
Adult Mental Health Unit, Mayo General Hospital	Substantial	N/A	Full
An Coillín	N/A	Full	N/A
Ballytivnan Sligo/Leitrim Mental Health Services	Substantial	N/A	N/A
Cappahard Lodge	N/A	Full	N/A
Department of Psychiatry, County Hospital, Roscommon	Not	N/A	N/A
Orchard Grove	N/A	N/A	N/A
Psychiatric Unit, University College Hospital Galway	Substantial	N/A	Initiated
St. Anne's Unit, Sacred Heart Hospital	N/A	Substantial	N/A
St. Brigid's Hospital, Ballinasloe	Initiated	N/A	Full
St. Conal's Hospital	N/A	N/A	N/A
St. Joseph's Hospital	N/A	Full	N/A
Teach Aisling	N/A	Full	N/A
Tearmann Ward & Curragour Ward, St. Camillus' Hospital	N/A	Full	N/A
Unit 9A, Merlin Park University Hospital	N/A	N/A	N/A
Approved Centres in the Independent or Private Charitable Sectors			
Bloomfield Care Centre – Bloomfield, Kylemore, Owendoher & Swanbrook Wings	N/A	Substantial	N/A
Hampstead Private Hospital	N/A	Substantial	N/A
Highfield Private Hospital	N/A	Substantial	N/A
Palmerstown View, Stewart's Hospital	Not	N/A	N/A
St. Edmundsbury Hospital	N/A	N/A	N/A
St. John of God Hospital Limited	Initiated	N/A	Full
St. Patrick's Hospital	N/A	Full	Full

Table 13: Compliance Levels in 2009 with the: (i) Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, (ii) Code of Practice on the Use of Physical Restraint in Approved Centres, (iii) Code of Practice for the Admission of Children Under the Mental Health Act 2001, and (iv) Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting.

Approved Centre Name	ECT	Physical Restraint	Admission of Children	Deaths & Incident Reporting
Approved Centres in the Child & Adolescent Sector				
Adolescent In-patient Unit, St. Vincent's Hospital	N/A	Full	Full	Initiated
St. Anne's Children's Centre	N/A	Full	Full	Initiated
Warrenstown Child & Adolescent In-patient Unit	N/A	Not	Substantial	Full
Approved Centres in the Health Service Executive (HSE) Dublin Mid Leinster Area				
Acute Psychiatric Unit, AMNCH	Substantial	Substantial	Not	Initiated
Central Mental Hospital	N/A	Substantial	N/A	Full
Department of Psychiatry, Midland Regional Hospital, Portlaoise	Full	Substantial	Substantial	Full
Elm Mount Unit, St. Vincent's University Hospital	Full	Substantial	Initiated	Full
Jonathan Swift Clinic	Full	Full	Full	Full
Lakeview Unit, Naas General Hospital	Full	Not	Not	Not
Newcastle Hospital	Full	Full	Not	Full
St. Fintan's Hospital	N/A	N/A	N/A	Full
St. Loman's Hospital, Mullingar	Full	Not	Not	Full
St. Loman's Hospital, Palmerstown	N/A	Not	N/A	Full
Approved Centres in the HSE Dublin North East Area				
Acute Psychiatric Unit, Cavan General Hospital	N/A	Full	Full	Full
Acute Psychiatric Unit, St. Aloysius Ward, Mater Misericordiae Hospital	Not	Substantial	Not	Full
Department of Psychiatry, Connolly Hospital	N/A	Substantial	Not	Full
Department of Psychiatry, Our Lady's Hospital, Navan	N/A	Full	Substantial	Full
St. Brendan's Hospital	N/A	Substantial	Not	Full
St. Brigid's Hospital, Ardee	N/A	Substantial	N/A	Full
St. Davnet's Hospital – Wards 4, 8 and 15	N/A	Full	Not	Full
St. Ita's Hospital – Mental Health Services	N/A	Full	Not	Full
St. Joseph's Intellectual Disability Services, St. Ita's Hospital	N/A	Full	N/A	Full
St. Vincent's Hospital	N/A	Full	Not	Full
Sycamore Unit, Connolly Hospital	N/A	N/A	N/A	Not
Approved Centres in the HSE South Area				
Acute Mental Health Admission Unit, Kerry General Hospital	Full	Substantial	Not	Substantial
Acute Psychiatric Unit, Bantry General Hospital	N/A	Initiated	Not	Substantial
Carraig Mór Centre	N/A	Initiated	N/A	Full
Department of Psychiatry, St. Luke's Hospital, Kilkenny	Full	Full	Not	Full
Department of Psychiatry, Waterford Regional Hospital	Full	Full	Not	Full

Approved Centre Name	ECT	Physical Restraint	Admission of Children	Deaths & Incident Reporting
South Lee Mental Health Unit, Cork University Hospital	Substantial	Not	Not	Substantial
St. Canice's Hospital	N/A	N/A	N/A	Full
St. Dympna's Hospital	N/A	N/A	N/A	Full
St. Finan's Hospital	N/A	Substantial	N/A	Substantial
St. Finbarr's Hospital	N/A	N/A	N/A	Full
St. Luke's Hospital, Clonmel	N/A	N/A	N/A	Full
St. Michael's Unit, Mercy Hospital	Substantial	Substantial	Substantial	Full
St. Michael's Unit, South Tipperary General Hospital	Full	Full	Not	Full
St. Otteran's Hospital	N/A	N/A	N/A	Not
St. Senan's Hospital	Full	Not	Not	Initiated
St. Stephen's Hospital	N/A	Full	N/A	Full
Approved Centres in the HSE West Area				
Acute Psychiatric Unit 5B, Midwestern Regional Hospital	Substantial	Substantial	Not	Full
Acute Psychiatric Unit, Carnamuggagh	Full	N/A	Substantial	Full
Acute Psychiatric Unit, Mid Western Regional Hospital, Ennis	Substantial	Initiated	Not	Full
Adult Mental Health Unit, Mayo General Hospital	Full	Substantial	Not	Full
An Coillín	N/A	Full	N/A	Full
Ballytivnan Sligo/Leitrim Mental Health Services	N/A	Substantial	Not	Full
Cappahard Lodge	N/A	Full	N/A	Full
Department of Psychiatry, County Hospital, Roscommon	N/A	Not	Not	Full
Orchard Grove	N/A	Substantial	N/A	Full
Psychiatric Unit, University College Hospital Galway	Initiated	Substantial	Initiated	Substantial
St. Anne's Unit, Sacred Heart Hospital	N/A	N/A	N/A	Full
St. Brigid's Hospital, Ballinasloe	N/A	Full	Substantial	Full
St. Conal's Hospital	N/A	N/A	N/A	Full
St. Joseph's Hospital	N/A	Full	N/A	Full
Teach Aisling	N/A	Full	N/A	Full
Tearmann Ward & Curragour Ward, St. Camillus' Hospital	N/A	N/A	N/A	Full
Unit 9A, Merlin Park University Hospital	N/A	N/A	N/A	Full
Approved Centres in the Independent or Private Charitable Sectors				
Bloomfield Care Centre – Bloomfield, Kylemore, Owendoher & Swanbrook Wings	N/A	N/A	N/A	Full
Hampstead Private Hospital	N/A	N/A	N/A	Full
Highfield Private Hospital	N/A	N/A	N/A	Full
Palmerstown View, Stewart's Hospital	N/A	Substantial	N/A	Not
St. Edmundsbury Hospital	Full	Full	N/A	Full
St. John of God Hospital Limited	Full	Initiated	Initiated	Substantial
St. Patrick's Hospital	Full	Full	Full	Full

E-Learning

An extensive learner survey on the e-learning programme on the Mental Health Act was conducted in 2009. A number of revisions to the e-Learning programme were suggested to facilitate a better way of learning about specific processes to adhere to the provisions of the Mental Health Act, 2001. This feedback will be used to improve the overall learning experience and promote a more accelerated learning approach to learning about the Mental Health Act, 2001.

Supporting Mental Health Services Research

A Research Strategy for the Mental Health Commission was published in 2005. 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 actions 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

During 2009 the Mental Health Commission was funding four research projects.

- 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 2009 the Commission advertised a Research Programme Grant Scheme which replaced the Research Scholarship Scheme.

The aims of the research programme grant scheme were to:

- Produce outputs which will address questions of direct relevance to mental health services and the mandate of the Mental Health Commission;
- Produce high quality mental health services research;
- Support the creation of research partnerships between mental health services , service users and third level institutions (TLIs);
- Support multidisciplinary, collaborative research which involves service users at all stages;
- Support the long-term development of research capabilities in mental health services research both in TLIs and mental health services.

Focus of the Research Grants

The focus of the scheme was to support the creation of research partnerships to carry out innovative, high quality, multi-disciplinary mental health service research in Ireland. The Mental Health Commission identified two priority areas for research in this Grant scheme.

Theme A: Research on quality in mental health services

Theme B: Research related to the impact of Part 2 of the Mental Health Act 2001

The closing date for submissions to the Scheme was 30th October, 2009 and at the end of 2009 submissions received were being evaluated for alignment with the objectives of the Scheme.

Research Studies Commissioned by the Commission

During 2009 a scoping study on 'Current Education and Training for Professionals Working in the Mental Health Services in Ireland' was conducted by Trinity College Dublin, on behalf of the Mental Health Commission. The recommendations of the study are to be advanced by commencing discussions with the Higher Education Authority.

Research Committee

The Commission's Research Committee held three meetings in 2009. In line with the committee's terms of reference it guided and advised the Mental Health Commission on the organisation's research agenda for the year.

Mental Health: The Case for a Cross-Jurisdictional Approach Combining Policy and Research on the Island of Ireland

During 2009, in collaboration with the Centre for Cross Border Studies, the Mental Health Commission continued to examine the feasibility of establishing an all-island mental health research centre. As part of this programme Dr. Patricia Clarke was the author of a report which looked at the case for a cross jurisdictional approach combining policy and research efforts on the island of Ireland. The report built on previous interest in researching all-island efforts.

The report set out the context, challenges and approach to transformation of mental health services and related research on the island of Ireland. It compared the two main mental health policy documents (Bamford Review in the North and *A Vision for Change* in the South) and identified similarities and differences in policy approach across the border. The report also highlighted areas of common concern, joint priorities for research and gaps which exist. The Report is available to download from the Commission's website at *www.mhcirl.ie*.

The Commission received very positive feedback to Dr. Clarke's report and subsequent to its publication the Chief Executive Officer of the Commission met with representatives from the North South Ministerial Council on two occasions to help highlight and progress matters.

2020 Vision – The Needs and Rights People with Mental Illness Are Addressed in an Integrated and Cohesive Manner within the Wider Mental Health Domain

Strategic Priority Four (2009-2012) – Wider Mental Health Domain

- The work of relevant state agencies and other organisations within the wider mental health domain is informed by the Commission's strategy and national government policy on mental health, *A Vision for Change*.

"A Vision for Change"

In January, 2006, *A Vision for Change* the national government policy on mental health services in Ireland was published. This policy was widely welcomed and embraced by all parties as the framework for developing mental health services in Ireland. The policy proposed the reorientation of the delivery of mental health services away from the old style model of institutional care and envisages specialist community care and treatment that addresses the biological, psychological and social factors that may contribute to a person's mental illness.

During 2009 the fundamental changes to mental health services as recommended in *Vision for Change* had still not taken place. However, in November 2009 the Commission warmly welcomed the commitment made by the Minister of State with Responsibility for Mental Health Mr. John Moloney T.D. to a core element of this policy – the closure and sale of the State's old psychiatric hospitals and the ring-fencing of the proceeds of those sales for the development of new mental health services, and the transfer of patients from the old institutions to community based settings.

In December 2009 the Commission made a submission to the Independent Monitoring Group for *A Vision for Change* and a presentation to the group was planned for early 2010.

Vision into Action Report

In November 2009 the Commission published a paper giving an analysis of the progress towards implementation by the Health Service Executive of *A Vision for Change*.

The paper acknowledged that implementation of a complex policy with many recommendations in a system that is undergoing significant change is a challenging process. The paper outlines what works in implementation and discusses the extensive literature on effective implementation processes. This requires co-ordinated change at system, organisation, programme and practice levels.

In the paper the Mental Health Commission acknowledged the appointment of the Assistant National Director Mental Health Services as a positive indicator of the Health Service Executive's response to *Vision for Change*. However, evidence based requirements for successful implementation are largely missing from the HSE implementation plan. The paper states that the implementation plan from the HSE should include:

- an overall sense of the HSE vision for mental health services;
- a statement of specific outcomes;
- a map of the steps needed to achieve these outcomes with real targets, timelines, resources and responsible agents clearly described;

- and finally an outline of the measurable benefits arising from the implementation including the monitoring of the outcomes as they are being achieved.

The above report is available to download from the Commission's website at *www.mhcirl.ie*

Report of Joint Working Group on Police and Mental Health Services

In September 2009 the Mental Health Commission and An Garda Síochana jointly published the Report of the Joint Working Group on the Police and Mental Health Services. The recommendations of the report require a multi-faceted approach from a number of agencies including, An Garda Síochana, the Health Service Executive and service user organisations. The recommendations emphasise the importance of collaboration and joint working while respecting the different areas of expertise and responsibilities of those involved. Following discussions with the key stakeholders involved it was agreed to progress initially with actioning Recommendation 6 of the report and work was ongoing at year end. A copy of the report is available to download on the Commission's website at *www.mhcirl.ie.*

Resource Paper – Teamwork Within Mental Health Services in Ireland

Given its potential benefits for service users, the development of more effective teamworking within the mental health services in Ireland remains a prime concern for the Mental Health Commission. In late October 2009 the Commission approved the publication of a Resource paper on Teamwork Within the Mental Health Services in Ireland. This paper followed on from the Discussion paper on Multidisciplinary Teamworking which the Commission had published in 2006. The Resource Paper will be available in early 2010.

Mental Health Commission Annual Training Symposium 2009

The Mental Health Commission annual training symposium titled 'Promoting Best Interests – Mental Health Act 2001' took place in November 2009. Over 300 delegates attended the symposium. The guest speakers and the title of their presentations were:

Professor Terry Carney
Professor of Law, University of Sydney
Best Interests or Legal Rectitude? Australian mental health tribunal stakeholder & case-flow implications

Professor Phil Fennell
Professor of Law, Cardiff University Law School
Current Issues in Mental Health and Human Rights

Ms. Patricia Rickard Clarke
Law Reform Commissioner
Development of Capacity Legislation in Ireland

Dr. Margo Wrigley
Consultant Psychiatrist/Clinical Director, North Dublin Old Age Psychiatry Service
Capacity: Clinical Decisions and Dilemmas

Professor Elyn R. Saks
Orrin B. Evans Professor of Law, Psychology, & Psychiatry at the University of Southern California Gould School of Law
My Journey through Madness

The feedback on the symposium was extremely positive. All of the presentations are available in PowerPoint, audio and video on the Mental Health Commission website at *www.mhcirl.ie*

MHC Submission to the Expert Group on Resource Allocation and Financing in the Health Sector

In July 2009 the Mental Health Commission made a submission to the Expert Group on Resource Allocation and Financing in the Health Sector.

The Commission's submission focused on:

- Prevalence and Economic Costs of Serious Mental Ilness/Mental Disorder
- Strengths and Weakness of the Current System of Resource Allocation
- Proposals for Change

Other Stakeholder Meetings/Consultations

During 2009 the Commission held meetings with representatives from Amnesty International Ireland and the Irish Human Rights Commission to discuss issues of mutual concern and interest.

The Commission participated in the consultation on the Law Reform Commission's paper on 'Children and the Law: Medical Treatment' which was published in December 2009. The Commission will also be making a submission in response to this consultation paper in early 2010.

The Commission also contributed to the following external consultations by way of written submissions or membership of advisory groups:

- An Bord Altranais: Guidance standards for the care of older persons;
- Helath Research Board, Disability Databases Unit: draft Research programme 2009-2011;
- Denmark, National Board of Health: Pan European Questionnaire – Using coercive measures in psychiatry;
- OECD: EU 15 Review of Rgulatory Capacity
- HIQA/ESRI Health Information Project
- HIQA: National Standards for Quality an Safety Advisory Group.

2020 Vision – Public Understanding of Mental Illness Is Enhanced, Stigma Is Diminished and Public Attitudes Are Increasingly Respectful

Strategic Priority Five (2009-2012) – Social Inclusion and Active Citizenship

- To challenge the barriers experienced by people with a mental illness to social inclusion and active citizenship.

Irish Mental Health Recovery Education Consortium

The Training and Development division represented the Mental Health Commission on the Advisory group of the Irish Mental Health Recovery Education Consortium (IMHREC). The purpose of the consortium was to develop and deliver a facilitated learning programme on Mental Health Recovery and WRAP (Wellness Recovery Action Plan). The role of the MHC was to advise and support the consortium in the design, delivery and evaluation of the mental health recovery and wrap education programme.

World Mental Health Day 2009

World Mental Health Day is an international event which is annually held on 10th October. Each year there is a different theme which raises awareness about mental health and wellbeing. The 2009 World Mental Health Day campaign focused on *"Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health."*

The Mental Health Commission marked the event by hosting an event on October 10th in the Mansion House.

Speakers at the 2009 event included:

Mr. Pádraig Ó Morain, Counsellor and Journalist,
"Takeaway course in Mindfulness – Exercises to enhance your daily life"

Dr. Antonia Lehane, General practitioner,
"Encouraging Good Mental Health"

Carol Hunt, Journalist and Mental Health Advocate,
"Not all in the Mind: A Personal and Holistic Approach to Mental Health"

Ms. Paula Mee, Consultant Dietician,
"Nutrition: A Positive Contribution to Mental Health"

Mr. Padraig Murphy, Strength and Conditioning Specialist,
"Improving Wellbeing Through Exercises"

A number of stakeholder organisations provided information stands on the day. The event received very positive feedback with over 160 people in attendance.

International Initiative for Mental Health Leadership

The International Initiative for Mental Health Leadership (IIMHL) is a "Government-to-Government" initiative with seven participating Governments. The purpose of the initiative is to work towards improving mental health services by supporting innovative leadership processes. IIMHL will hold its annual Exchange & Network meeting in Ireland in May 2010. The Mental Health Commission is one of the partners in supporting the exchange and conference. The MHC is planning to host a leadership exchange and a number of visiting leaders have signed up to attend the programme.

Mental Health Awareness

The Mental Health Commission was represented on the "Mental Health Awareness Campaign Steering Group", established by the National Suicide Office for Suicide prevention. The work in 2009 focused on continuing and progressing with the young person's campaign.

Medication Safety Forum

The Mental Health Commission was one of the stakeholder groups of the Medication Safety Forum which was set up and facilitated by HIQA in 2008. The terms of reference of the group was to provide those with an interest in the medication use process or in medication safety in Ireland an opportunity to come together to discuss relevant national issues and developments.

In keeping with the recommendation of the Commission on Patient Safety and Quality Assurance (CPSQA), regarding the establishment of clear communication structures between all bodies with a stake in the medication use process or medication safety, it was agreed that the Medication Safety Forum could be harnessed to assist with the implementation of the medication safety project's objectives. The terms of reference of the Medication Safety Forum evolved to allow the group to actively contribute to the implementation of the CPSQA report recommendations.

Recruitment, Induction, Education, Training and Development Project Group

A Recruitment, Induction, Education, Training and Development Project Group was established in 2009 as a sub group of the Health and Social Care Regulatory Forum. The purpose of the group is to consider and scope the areas around recruitment, induction, training and development across the members of the Health and Social Care Regulatory Forum. In 2009 a questionnaire was developed by the Project Group and circulated to the regulatory organisations. Results from the questionnaire highlighted potential areas where these organisations could collaborate in particular around the area of training and development.

National Disability Advisory Committee

The Department of Health and Children established a National Disability Advisory Committee, representative of people with disabilities and other key stakeholders, which includes the Mental Health Commission. The purpose of the committee is to:

- Provide a forum to inform policy at national level in relation to services for people with disabilities;
- Form part of the overall monitoring mechanism in relation to the implementation of the National Disability Strategy in so far as it relates to the health services; and
- Advise the Minister for Health and Children on progress in the implementation of the Disability Act 2005 within the health services.

2020 Vision – The Mental Health Commission Is Viewed as an Efficient Organisation with the Interests of People with Serious Mental Illness or Mental Disorder at the Forefront of All Our Activities

Strategic Priority Six (2009-2012) – MHC as an Organisation

- To maintain and enhance the Mental Health Commission's systems and processes to ensure the provision of a quality service by the Mental Health Commission.
- To continue to promote a culture within the organisation which reflects deep commitment to the Commission's stated values.
- To ensure that the Mental Health Commission is staffed by well trained, competent and committed people.
- To foster widespread understanding of the role and functions of the Mental Health Commission.

Expenditure

The non-capital allocation to the Mental Health Commission for 2009 was €19,012,000. 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. This was in part due to the impact on the Commission of the Moratorium on recruitment in the public sector. The provisional outturn for 2009 is €17,950,000.

Key areas of expenditure included Mental Health Tribunals, staff salaries, legal fees, office rental, I.T technical support and development and research projects. The accounts for 2009 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 2009 to conduct its business. Issues addressed by the Audit Committee included the report on the internal audit review of internal financial controls, risk management, 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 2009 the Mental Health Commission received nineteen requests under the Freedom of Information Acts (1997 and 2003). Of these fifteen were granted, three were withdrawn and one request was refused.

Data Protection

Six requests for information were received under the Data Protection Act in 2009, five of which were granted and one request was withdrawn.

Information Communication Technology

During 2009 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 incident the Mental Health Commission relocated its Disaster Recovery site to a more secure and resilient facility. All systems were successfully tested following this move.

An invitation to tender was issued for a proposal for IT Managed Services which resulted in a subsequent change of supplier based on results of tender. The Commissions project to replace out of warranty servers and replace them with a virtualised environment in 2009 has entered its final stage.

The Commission has utilised the national procurement network to source equipment through the ICT framework during the year.

Health & Safety

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

- Personal Evacuation Egress Plans (PEEP) are made available to staff;
- Ergonomic workstation assessments are available to all staff as are VDU eyesight test and eye tests;
- Manual handling training and Emergency Evacuation procedures are carried out on a regular basis and staff feedback is obtained to measure effectiveness.

The Mental Health Commission also has a number of proactive measures in place to protect staff health and wellbeing such as seasonal Flu vaccination and vaccination against the H1N1 virus. In addition occupational First Aid training carried out during 2009 has raised the awareness of Health and Safety issues in the workplace.

Staff Development and Training

In line with its strategic plan the Mental Health Commission continues to support staff and ensure maximum staff engagement by supporting staff training and development in areas that are related to their work and encouraging learning and professional development.

The Study Assistance Scheme applies in cases where the need to complete a course in part-time study has been identified as necessary to enable the individual to increase effectiveness in their job or increase their potential for future development.

The personal development and training plans, developed under the Performance Management and Development System, are the primary mechanism for considering training funding requests. In 2009 37.5% of Commission staff received some assistance in their studies.

Support for Staff with Disabilities

The Mental Health Commission is committed to providing a positive working environment and, in line with equality legislation, promotes equality of opportunity for all staff of the Commission. A census on the number of staff with a disability employed by the Commission was undertaken in 2009. The survey was based on self-disclosure and all staff members were requested to participate. The Department's Disability Monitoring Committee co-ordinate the survey results in respect of the public bodies under the aegis of the Department and reported directly to the National Disability Authority (NDA). The census results were included in a report published by the NDA.

When necessary the Commission has provided specialist equipment and /or measures to staff that require assistance to perform their duties. It is the policy of the Mental Health Commission to ensure that relevant accessibility requirements for people with disabilities are included in all stages of the tendering process.

Under the Disability Act 2005, the Commission is required to have in place Access Officers to provide assistance and guidance for people with disabilities in accessing services and procedures in relation to the making and investigation of complaints from people with disabilities. Access Officer training was carried out in 2009.

MENTAL HEALTH COMMISSION
ANNUAL REPORT 2009

Including The Report of The Inspector of Mental Health Services

Book 1

Part 2

CHAPTER 4

National Review of Mental Health Services 2009

National Review of Mental Health Services 2009

Mental Health Act, 2001, Section 51:

The principal functions of the Inspector shall be:

(a) to visit and inspect every approved centre at least once in each year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate, and

(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 (The Mental Health 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 sixth report of the Inspectorate of Mental Health Services as established under the Mental Health Act, 2001, and the third year in which approved centres were inspected against the rules, regulations and codes of practice.

2009 was a year in which there was limited change of a positive nature on the ground. No major improvements in the quality of care and treatment were discerned on a systemic basis, although there were individual examples of improvements. Overall, approved centres appeared to understand and to have come to terms with the reality of abiding by the rules, regulations and codes of practice and this was reflected in improved compliance. Disappointingly, though, "slippage" was noted in a number of centres where compliance had previously been achieved.

Discerning changes in the quality of care and treatment on a national basis is difficult on a year on year comparison. The National Mental Health Services might be compared to a rusty old tanker, the change in direction of which may only be measured over a long period. Changes may only be noticed in decades rather than years.

And, there is no doubt that we have seen improvements in the past decade with respect to numbers of patients hospitalised, occupancy levels in old psychiatric centres, new professionalism of mental health staff, concepts such as governance and recovery gaining credence and the increasing awareness of the centrality of the service user/patient in the delivery of mental health services.

2009 also saw a number of positive, hopeful developments. If even some of this hope is realised, we may well see in a decade's time a National Mental Health Service of international quality based on the principles of recovery and respectful of the dignity and human rights of all service users/patients.

2. Inspection 2009

The Mental Health Act, 2001, imposes a minimum standard on the Inspectorate to inspect all approved centres annually.

Prior to the introduction of the rules, regulations and codes of practice in 2007, the Inspectorate had gone beyond this minimum requirement by visiting and inspecting community centres and meeting with catchment area management teams. However, the addition of these regulatory requirements, on an unphased basis, meant that much time and effort was now redirected at educating and familiarising approved centre staff with all aspects of these requirements.

The inspection reports of 2007 and 2008 showed a disappointing level of compliance and understanding of the principles behind the requirements and of the logistical aspects. In 2009, in an effort to further educate centres, self-assessment forms were sent to each centre. These self-assessments were then compared with Inspectorate findings in discussions following each inspection.

Additionally, we had noted in previous years, the expressed disappointment of centres at "all or nothing" compliance scores. For this year's inspection, we devised a 4-point scale of compliance. Centres reported satisfaction with this measure as it allowed them to have progress measured and credited.

It is somewhat ironic that while the "gold standard" of mental health service is one based primarily in the community, the Inspectorate was spending most of its time focusing on approved centres. However, it is in approved centres where the human rights of committed patients may be at risk with respect to autonomy, dignity, liberty and bodily integrity.

In order to reflect the Inspectorate's encouragement of community-based mental health services, we also inspected a number of community services.

The following is a listing of engagements with services outside of Approved Centre inspections:

1. 32 catchment area management meetings (including 1 meeting held with the Sligo/Leitrim services by video link). Attendees included clinical and administrative management as well as representatives of all clinical disciplines and local service user/patient advocates;

2. Inspection of ten day hospitals chosen on a regional basis and then at random;

3. Inspection of thirteen 24-hour residences chosen at a regional level and then at random;

4. Cloverhill Prison Mental Health Service - Prison Inreach Court Liaison Service (PICLS);

5. Survey of homeless mental health services;

6. National meeting of Child and Adolescent Mental Health Services (CAMHS)—organised and facilitated by the Inspectorate;

7. National meeting of Mental Health Services for Persons with an Intellectual Disability (MHID)—organised and facilitated by the Inspectorate;

8. A number of approved centres received more than one inspection during 2009 (including a night time visit to Clonmel). This occurred when areas of particular concern were noted during the first inspection;

   - St. Luke's Hospital, Clonmel—2 additional inspections
   - St. Michael's, Clonmel—2 additional inspections
   - Cappahard Lodge—1 additional inspection
   - Central Mental Hospital—1 additional inspection
   - St. Ita's Hospital—1 additional inspection

9. A number of community mental health services were visited and the Inspectorate met with staff on an informal basis to garner valuable background information;

10. Self-assessments were sought from CAMHS and MHID services.

3. Encouraging Developments in 2009

3.1 We welcome the *appointment of a HSE Assistant National Director* with responsibility for the implementation of *A Vision for Change*. While the job description falls short of previous calls for a National Directorate with strong executive and budgetary powers, nevertheless, we anticipate that a number of reforms can still be achieved. The most urgent of these reforms are:

- The establishment of a primarily community-based service;
- The equalisation of resources across regions;
- The improvement of information systems so the performance data can be collected and compared across regions;
- The improvement of clinical and financial governance;
- Measurement of quality outcomes.

3.2 *The establishment within the HSE of a Directorate of Clinical Care and Quality.* It is anticipated that Mental Health Services will be an integral part of the deliberations of this Directorate whose initial aim is to audit services against practice guidelines on a national basis.

3.3 *The response of the HSE and local management to the Section 55 Inquiry Report into the quality of care and treatment at St. Luke's and St. Michael's Hospitals, Clonmel.*

A local project team, professionally mentored, was established as well as an advisory team of outside specialists. A rigorous, project-managed, time-line specified and action-oriented schedule of improvements was drawn up.

This work was facilitated and monitored during discussions with representatives of the Inspectorate and the Commission over a series of four meetings in 2009.

As a result, three inspections of the Clonmel approved centres in 2009 reveal significant and, so far, sustained improvements in adherence to rules, regulations and codes of practice.

The manner and content of this project could well serve as a model for other services wishing to move to a more patient-centred, community-focused and modern culture.

3.4 2009 saw the *appointment of 14 "Executive Clinical Directors" (ECD's),* 13 of whom will have clinical responsibility for "super catchments" of approximately 320,000 and one of whom is the National Executive Clinical Director for Forensic Mental Health Services. The hope is that with this arrangement, services within the now enlarged "super catchment" can be rationalised and appropriate, specialised services provided. The ECD's will work closely with the Assistant National Director and regional directors to implement performance and quality improvement measures. Hopefully, the result will be sustained adherence to high standards and less variation in clinical practice.

3.5 *HSE transformation*

The integration of former hospital and Primary Community and Continuing Care (PCCC) divisions should have positive implications for mental health services. The 2008 Inspector's Report was concerned at the "lumping" of mental health services into primary care and community services. During 2009, we saw many examples of "raiding of the monasteries" with respect to leakage of mental health resources to other services. Concern was also expressed at the perception that mental health services could be almost exclusively delivered at a primary care level.

It is to be hoped that, in the new integrated system, especially with the influence of an Assistant National Director for Mental Health, these concerns will be addressed and a more coherent and transparent funding stream for mental health services will be established.

3.6 Another positive sign is the increasingly frequent *service-user reports* of nursing staff increasingly espousing and practicing the principles of recovery and patient-centeredness. We are aware that these areas are increasingly central in undergraduate nursing training. The principles appear to be taking hold in centres throughout the country.

3.7 We welcome the *survey* conducted by the National Service User Executive of over 500 service users of their views on various aspects of the mental health services. The growth of the service user and advocacy movements is encouraging and should help to drive improvement.

3.8 2009 also saw the publication of the *first audit of HSE Child and Adolescent Mental Health Services.* The audit was a measure of activity levels in services throughout the country for the month of November 2007 and provided a "snapshot" of practice in domains such as waiting lists, hospitalisation rates, age profiles and diagnostic categories.

We are aware that another audit was conducted in November 2009 and we look forward to the increasing sophistication and usefulness of this development.

3.9 We welcome the *recent budgetary provision* that money from the sale of psychiatric lands will be re-invested into the modernisation of mental health services. Although the value of such property has reduced in recent times, so also will the cost of acquiring alternative property for community nursing units and community mental health centres.

3.10 We have been encouraged by the *attitudinal change* of approved centre staff who have engaged meaningfully with the Inspectorate around the achievement of compliance, in particular in the area of individual care planning.

3.11 The roll-out of *new beds for children* in Cork, Galway and Dublin and the provision for community teams deserves credit. To obtain maximum benefit from these beds, national coordination is vitally important.

3.12 In previous Inspectorate Reports, much emphasis was laid on the importance of a wide-spread system of information technology. We are pleased to see that the WISDOM pilot in Co. Donegal is nearing completion and hopefully now a modern efficient system can be put in place across the country.

3.13 Another interesting development in 2009 has been the coming together of a *consortium of independent mental health service providers* offering their services and assistance to the HSE in the implementation of *A Vision for Change*. In these straitened financial times, it might be appropriate for the HSE to enter into dialogue with this group with respect to the provision of services for more specialised areas such as eating disorder, borderline personality disorder, secure care and forensic services for the intellectually disabled.

4. Areas of Concern

4.1 *Buildings* – While the number of people residing in old, unsuitable, dilapidated buildings has continued to reduce, the fact that vulnerable people still reside in these conditions is deplorable.

In 2008, the Inspectorate encouraged the Mental Health Commission to seek project-managed, time-lined specified, action-oriented and continuously updated plans for the closure of the older buildings and their replacement by appropriate alternative accommodation. The Commission sought such plans and the majority of those received were disappointing in their lack of specificity.

Whatever (weak) justification can be made for maintaining in unsuitable settings those individuals who have been residing on a long-term basis in these institutions and have acquired a degree of familiarity with their surroundings regarding them as "home", there can be no justification whatsoever in admitting for the first time an individual in acute crisis to such surroundings.

A first step to the closure of these types of buildings may be to cease new acute admissions. The Inspectorate have recommended to the Commission that by 01 January 2011, all such acute admissions should cease to St. Ita's Hospital, St. Brendan's Hospital and St. Senan's Hospital.

Whereas the key ingredient in the concept of recovery is the encouragement of hope, admission to these units is more akin to the abandonment of hope as described by Italian poet Dante.

4.2 *Staffing* – It is estimated that approximately 10% of psychiatric nursing staff have left the mental health services in 2009. This precipitous decline in numbers associated with delays in recruiting health and social care professionals adversely impacts on the delivery of high quality care and treatment. Unfortunately and ironically, when cuts are made, it is the progressive community services which are culled, thus causing reversion to a more custodial form of mental health service.

Multidisciplinary community mental health teams are still deficient in numbers and where they exist, in staffing.

4.3 *Rules, Regulations and Codes of Practice* – While some improvements have been noted, the level of compliance overall, after three years, is still disappointing. One staff member reported to the Inspectorate, "We'd be doing well if it wasn't for the regulations..."

It is now time that an Assistant Director of Nursing (ADON) or other senior professional be appointed Compliance Officer in each approved centre. This need not be a full-time position, but such an officer would be the point person in each centre and would have responsibility for ensuring compliance with all statutory requirements.

Compliance Officers of all approved centres would be in a position to liaise with each other to streamline and coordinate required policies obviating the need for much resource-sapping last-minute panic and chaos.

In addition, because of the slippage noted, there is a need for ongoing training and re-training in the provisions of the Mental Health Act, 2001, which might be a further role for Compliance Officers.

4.4 *Inconsistencies of Mission and Service Delivery* – Again in 2009, wide variations were noted across the country.

There is an urgent need for professional bodies of all clinical categories to establish norms and guidelines for practice. These, in association with stricter operational standards as elaborated by the Executive Clinical Director Group, should reduce variation which has been called "the enemy of quality".

Often, problems with excessive admissions to approved centres arise earlier in the patient care pathway at outpatient clinics populated by many with minor mental illness which should be dealt with at primary care level. In addition, many day hospitals function as drop-in or day centres and do not deal with an appropriate level of acuity. These matters need to be addressed urgently.

4.5 *Governance* – Governance has been defined as a system of accountability ensuring patient safety, high quality of patient experience and high quality of care and treatment. Governance at its essence may be described as ethical practice where the interests of the patient are placed above any other.

In terms of patient safety, while incident recording takes place, it is not clear that sufficient aggregation or monitoring of patterns takes place at management level.

Quality of patient experience is only rarely solicited and few systematic measures are in place.

Quality measurement and assurance are still far-off realities.

4.6 We are still concerned at the *continuing inappropriate placement of individuals with intellectual disability* (ID) in large approved centres without access to specialist intellectual disability mental health services.

Indeed, on a national level, the funding of ID Mental Health Services "by default" and apparently "ex-gratia" by generic ID services, appears to be a common practice. There is a need to clarify, on a national basis, what specific aspects of care for the intellectually disabled constitute Mental Health Services and then to adequately ring-fence resource these services preventing duplication.

4.7 *CAMHS* – We are concerned by the occupation of scarce CAMHS beds by individuals with no diagnosable mental disorder often with social problems with "nowhere else to go". This is inappropriate and potentially damaging to these individuals as well as depriving others of needed beds.

The practice of admitting children to adult approved centres continues. Recent HSE CAMHS audit has shown, interestingly, that a large percentage of these admissions are for 16 and 17-year olds, an age group with a traditional pattern of short-term crisis admissions to adult units.

Notwithstanding the traditional expertise of general adult psychiatrists in dealing with the 16 and 17-year old age group, it is still inappropriate that these individuals be admitted to general adult approved centres even on a crisis basis.

We have been informed by those CAMHS services which have taken on the care of 16 and 17-year olds, that their waiting lists for the more traditional child and adolescent mental illnesses have increased such that the majority of their work now is in dealing with crises in the older adolescent age group.

In addition, a number of CAMHS services have identified a lack of training in dealing with the problems associated with the 16 and 17-year old age group.

In the light of recent suggestions from Professor Patrick McGorry, University of Melbourne, that services be organised around the 14-25-year old age group, it is now time for the general adult and CAMHS services to sit down and creatively resolve this issue.

4.8 *Resource Allocation* – We are grateful for figures provided by the Assistant National Director for Mental Health Services showing the gross imbalance in the regional allocations of funds. Even allowing for the new aggregations in "super catchments", there is still a wide discrepancy in fund allocation. The whole funding issue for mental health services was criticised in a recent Indecon Report and is byzantine, opaque and almost incomprehensible.

If the time has come for clarity of mission with respect to the delivery of services, the time must surely also have come for clarity of funding.

4.9 *Community Detention* – Although the Mental Health Act, 2001, has made no provision for committal orders relating to individuals residing in the community, this practice is being followed on a de facto basis by a number of services.

Under the Mental Treatment Act, 1945, a patient could be discharged "on trial" and continue under a detention order for up to 90 days.

The Mental Health Act, 2001, allows patients under detention orders to be allowed into the community with specific written conditions. The purpose of this provision would appear to have been to gradually re-integrate the patient into the community on a controlled basis facilitating appropriate discharge.

However, it appears that certain Consultant Psychiatrists, at the end of the period of detention under the order, are renewing the order while the patient is still in the community. Furthermore, it is known that some Tribunals have affirmed these orders.

The net effect is that patients, subjected to this stratagem, can be returned to the hospital without the same procedural safeguards which would have applied if they had been discharged. This has significant implications for the liberty interests of the individual.

While other jurisdictions have legal provision for such community orders, there is, by no means, widespread agreement that these measures improve the quality of community care.

If such measures are to be introduced in Ireland, they should be property debated and the evidence for and against formally weighed.

5. Other Important Issues Impacting on Quality of Care and Treatment

5.1 *Recovery* – In *A Vision for Change,* the ethos of recovery was to imbue all aspects of planning and practice with respect to mental health services.

Although the concept was first most powerfully enunciated by Bill Anthony in 1993, mental health practitioners still appear to have an imperfect understanding or grasp of the concept as it applies in operational terms in their daily work.

A recent Sainsbury Centre publication, *"Making Recovery a Reality"*[1], (contained in the Mental Health Commission comprehensive information pack on recovery[2]), as well as providing an excellent overview of the topic, grasps the nettle of consideration of "obstacles to its implementation". The report recommends a recovery-oriented "policy implementation guide to provide simple guidelines for practice at an individual team and service level". This is a matter that might be addressed by the Executive Clinical Director Group and by the Assistant National Director for Mental Health Services.

Bill Anthony has given the following definition of recovery:

"It is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness..."[3]

While individual practitioners, almost universally at a start of a career in the mental health services, would have no difficulty in espousing these values, often the system of processing mental illness tends to overcome this early idealism and enthusiasm.

It is encouraging, however, that a significant number of pockets exist within the Irish Mental Health Services where these values are practiced on a daily basis and groups of like-minded idealistic individuals have established the culture of recovery. It is significant that these types of services tend to have lower admission rates, less relapses, more connections with community services, more emphasis on service user/patient and family/carer involvement in services and more focus on vocational and social issues.

Also of significance, is the current emphasis in undergraduate nurse training on these principles now beginning to be reflected in patient experiences.

5.2 *Role of the Pharmaceutical Industry* – In the recently published 7th Edition of the Guide to Professional Conduct and Ethics for Medical Practitioners[4], the Medical Council states:

"You are advised not to accept gifts (including hospitality) from pharmaceutical, medical devices or other commercial enterprises....You should be aware that even low-value promotional materials are offered by commercial enterprises with the intention of influencing prescribing and treatment decisions".

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1 Shepherd, G., Boardman, J., Slade, M., Making Recovery a Reality.
2 Recovery Approach within the Mental Health services – Translating Principles into Practice, 2008.
3 Anthony, WA, 1993, Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990's. *Psychosocial Rehabilitation Journal*, 16, 11-23.
4 http://www.medicalcouncil.ie/_fileupload/misc/171109%20Final%20Version%20Ethics%20Guide%20Update%20For%20Printer.pdf

We note that the Medical Council also intends to develop further comprehensive guidelines on the relationship between doctors and commercial enterprises and we welcome this approach.

In addition, we have received from St. Patrick's University Hospital a copy of a policy dealing with the relationship of clinical staff and the pharmaceutical industry. In preparing the policy, research was undertaken on the literature reflecting international best practice.

The policy lays down for all clinical staff the requirement of maintaining a log of all pharmaceutical industry (Pharma) support received for Continual Professional Development (CPD), research or payment for attendance at advisory meetings. Attendance at non-CPD Pharma-sponsored meetings is prohibited. Clinical staff are not permitted to receive gifts or to have papers ghost-written by the industry. Conferences under the auspices of the hospital do not accept industry funding.

The purpose of these policy requirements is to prevent the perception by service user/patients or carers of any potential conflict of interest between the primary objective of patient care and any obligation to use a specific industry's product.

It is well established that trust and confidence of the service user/patient in the treatment team is paramount in establishing a beneficial therapeutic relationship. Where this trust can be put in doubt and where opportunities exist to eliminate all doubt, these should be seized. St. Patrick's University Hospital should be congratulated on this progressive policy and it is recommended that other mental health services also address the matter.

The above is not to suggest that the pharmaceutical industry in general does not make a valuable contribution to the delivery of mental health services. Medication is regarded, in the most serious mental illnesses, as a necessary, though not sufficient, condition for treatment and recovery.

The role of Pharma in supporting CPD of clinicians is of value. However, it might be preferable if contributions of different companies were pooled and a less direct connection between the CPD and a specific company with a specific drug were established. This is a matter which might be further discussed by the professional bodies and Pharma.

5.3 *"Friends"* – We have been impressed by the work of volunteers belonging to groups such as the "Friends" at Newcastle Hospital, The St. Joseph's Association for the Intellectually Disabled, Portrane and other similar groups. That local volunteers take an interest in the local approved centre, not just provides increased comfort for patients, but is also important in reducing the local stigma of the approved centre and providing some degree of informal oversight or inspection of the centre. Historically, almost all mental health residential centres received visiting committees through the former health board or local health authority system. Management at the centres were obliged to present reports to the visiting committee. This was an important discipline and opportunity for management to address governance issues.

With the disbandment of the health boards and the special hospital programme committees ceasing to visit centres, a valuable opportunity has been lost.

It is recommended that the office of the Assistant National Director for Mental Health Services consider this issue with a view to re-implementing some form of visiting/oversight committee comprised of HSE management staff and local volunteers and representatives.

6. Recommendations

6.1 The role of the Assistant National Director for Mental Health Services should be augmented to that of a Directorate with executive and budgetary powers.

6.2 The Executive Clinical Director Group along with the Mental Health Service Directorate and the Director of Clinical Care and Quality should agree a number of robust quality outcomes to facilitate meaningful comparisons between "super catchment" areas.

6.3 To facilitate proper governance, information systems should be in place and relevant performance and outcome data should be collected.

6.4 Needs-based resources should be equalised across regions.

6.5 A coherent and transparent system for the funding of mental health services should be established.

6.6 A system of ongoing training in the principles of recovery and those underpinning the Mental Health Act, 2001, along with logistical aspects of implementation of the Mental Health Act, 2001, should be established for all professionals involved in patient care and treatment.

6.7 Child and Adolescent Mental Health Services should be coordinated at a national level.

6.8 Mental Health Services for Persons with an Intellectual Disability should be coordinated at a national level and have ring-fenced funding.

6.9 Intellectually disabled patients in approved centres should be provided with specialist mental health care and treatment.

6.10 Funding from the sale of psychiatric lands should be protected and redirected towards the provision of community nursing units and community mental health centres.

6.11 Community mental health centres should be adequately staffed with multidisciplinary teams.

6.12 Creative ways of involving the independent/private sector in public sector projects should be explored.

6.13 Patients should no longer be housed in unsuitable buildings.

6.14 As a first step, no new acute admissions should be made to St. Ita's Hospital, St. Brendan's Hospital or St. Senan's Hospital from 01 January 2011.

6.15 Deployment of staff should be more flexible than at present.

6.16 Each approved centre should appoint a Compliance Officer.

6.17 Compliance officers should meet on a national basis to coordinate and streamline policies.

6.18 The ECD Group should examine clinical practices with respect to priorities, communitisation of services, recovery and proper demarcation and coordination between primary and secondary mental health services.

6.19 Children should not be admitted to adult units.

6.20 The management of 16 and 17-year old patients should be negotiated between the CAMHS and the general adult services.

6.21 The issue of de facto community orders should be debated taking into account human rights concerns.

6.22 The relationship of clinical staff and the pharmaceutical industry should be monitored by services and appropriate policies put in place.

6.23 The practice of visiting committees to approved centres should be re-established.

6.24 A recovery-oriented policy implementation guide should be established at national level.

7.Conclusions

7.1 Ireland's Mental Health Services have shown limited improvement over 2009.

7.2 However, taking a longer-term view, services have improved over the previous decade.

7.3 Improvements have occurred in the general area of attitudes and acceptance of the need for regulation and governance.

7.4 A number of significant areas of concern still exist with respect to buildings, staffing, resource inequities, residual custodial attitudes and in the treatment of children and those with intellectual disability.

7.5 Cause for optimism exists in the appointment of a National Director for Mental Health Services and the establishment of a number of HSE structures which will allow the introduction of much-needed governance of our mental health services.

7.6 Although an antiquated system continues to overpower the idealisation of many individuals, pockets of rebelliousness in terms of embracing the principles of recovery and patient-centeredness prevail in certain quarters and should be encouraged.

The major task of completion of the 2009 Inspector of Mental Health Services Report was only achieved by the dedication and commitment of all members of the Inspectorate team, inspecting and administrative, whose contribution is greatly appreciated. Thanks are also due to all staff members of mental health services both clinical and administrative without whose cooperation this report would not have been achieved.

Particular thanks are due to Colette Ryan, Senior Administrator of the Inspectorate.

Dr. Patrick Devitt
Inspector of Mental Health Services

APPENDICES

Appendix 1: Psychiatry of Old Age: Resource and Activity Data 2007 (Irish Association of Consultants in Psychiatry of Old Age)

I) Resource data per service Jan – Dec 2007

Service	Date Est'd	Pop≥65	Con	NCHD		ACNO	CMHN	Sec	Other[1]	Acute Psych Beds	Day Hosp	L/S Beds	
				SR	SHO							Psych	Non Psych
NAHB Area 6&7	1989	32,500	3.5	1	2	1(DON)	3	2	1	6	√	33	67
SWAHB Areas 3&½ 4	1991	20,228	2.5	1	2	0.5	2	2	3	9	√	X	X
ECAHB Area 1&2	1996	30,000	2	1	3	1	6	3	5	10	√	X	67
MWHB Limerick	1996	19,000	2	1	1	X	2	2	1.5	6	1 day/wk	X	21
SWAHB Area 5&½ of 4	1998	18,500	1.5	1	1	0.5	2	1.5	7	X	√	X	X
MHB Laois-Offaly	1999	14,036	11.5	1	1	1	4.2		2.2	2	6	50	14
NEHB Cavan-Monaghan	2000	14,289	1	1	1	1	8	2	6	7	1	26	X
SEHB Waterford	2000	14,800	1	1	1	0.3	2	1	2.75	6	X	23	X
SEHB S. Tipperary	2000	10,200	1	X	1	0.2	2	1	1	4	X	23	X
MWHB Clare	2000	13,500	1	X	1	1	2	1	1	5	X	34	X
SEHB Wexford	2001	15,000	1	X	1	X	4	1	1.5	8	X	14	X
MHB Lf/Wm	2001	13,000	1.5	X	2	0.5	4	1.5	1	Access	√	40	X
SHB South Lee	2001	18,500	1	X	2	PT	3	1	3.6	Access	X	X	X
NWHB Donegal	2002	17,300	1	X	1	1	5	1.5	2.5	Access	X	X	X
NWHB Sligo/Leitrim	2002	14,600	1	1	1	1	4	1.5	1	4	√	X	X
NAHB Area 8	2002	18,600	2	1	3	1	3.5	1.5	3	7	X	56	55
SEHB Kilkenny	2002	14,000	1	X	1	X	2	1	1	Access	X	24	X
WHB Mayo	2002	17,000	1	1	1	0.5	3	1.2	3	5	X	14	X
NEHB Meath	2003	13,000	1	1	1	X	2	1	1	Access	X	X	X
Galway West	2004	25,500	1	1	0.5	X	1	0.5	1.25	4	X	X	X
Louth[2]	2007	14,200	1	X	1	X	1	1	X	X	X	X	X

X Resources not provided to the service.

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

[2] Service started September 2007.

II) Activity data per service for the year Jan – Dec 2007

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	961	655	306	29	110	1578	3	17	3141	Carers group
SWAHB Areas 3&½ 4	628	172	456	42	140	2553	5	13	1930	OPD
ECAHB Area 1&2	845	600	245	64	71	1025	12	30	4173	-
MWHB Limerick	486	253	233	22	11	209	7	97	1697	-
SWAHB Area 5&½ of 4	487	245	242	X	36	1250	X	X	1257	Outreach team
MHB Laois-Offaly	516	454	62	38	73	838	6	12	3267	Carers group
NEHB Cavan-Monaghan	439	329	110	23	25	1270	2	0	3828	-
SEHB Waterford	377	225	152	50	X	X	7	18	1932	OPD
SEHB S. Tipperary	316	229	87	36	X	X	4	0	1255	OPD
MWHB Clare	281			19	X	X	3	21	860	OPD
SEHB Wexford	334	208	126	61	X	X	5	0	2704	Anx Mn Gps
MHB Longford/Westmeath	334	256	78	33	52	1383	0	2	2761	
SHB South Lee							X	X		
NWHB Donegal	590	420	170	22	X	X	X	X	3900	OPD
NWHB Sligo/Leitrim	486	306	180	31	63	1254	X	X	2700	OPD
NAHB Area 8	943	443	500	38	X	X	9	29	2508	-
SEHB Kilkenny	353	215	138	20	X	X	4	0	1860	-
WHB Mayo	310	255	55	16	X	X	1	0	1506	-
NEHB Meath	212	165	47	5	X	X	X	X	748	-
Galway West	212	88	124	7	X	X	X	X	505	OPD
Louth	53	13	40		X	X				-

X Resource not available so service cannot be provided.

Appendix 2: Individual Care Plan

Seán Logue, Assistant Inspector of Mental Health Services

Introduction

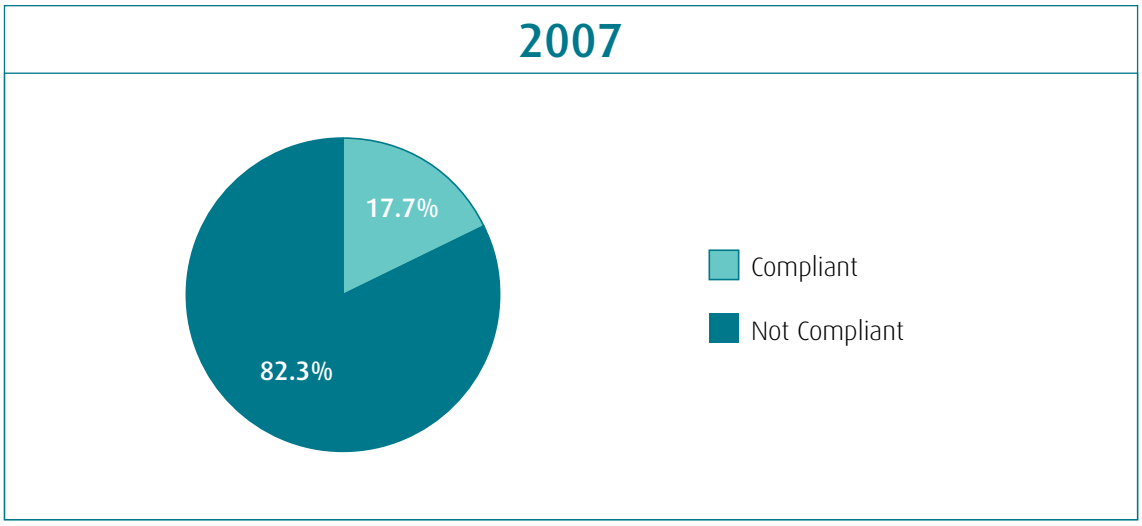
Article 15 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No.551 of 2006) places an obligation on the registered proprietor of an approved centre to *"ensure that each resident [of the approved centre] has an individual care plan."* The Regulations define an "individual care plan" as,

"a documented set of goals developed, regularly reviewed and updated by the resident's multidisciplinary team, so far as is 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."

Compliance with Article 15 of the Regulations

Compliance with Article 15 of the Regulations was first inspected during the 2007 inspection process. During the 2007 and 2008 inspections, approved centres were deemed either compliant or not compliant with all Articles of the Regulations. Figure 1 below, gives an indication of the level of compliance of approved centres with Article 15 following the 2007 inspection process.

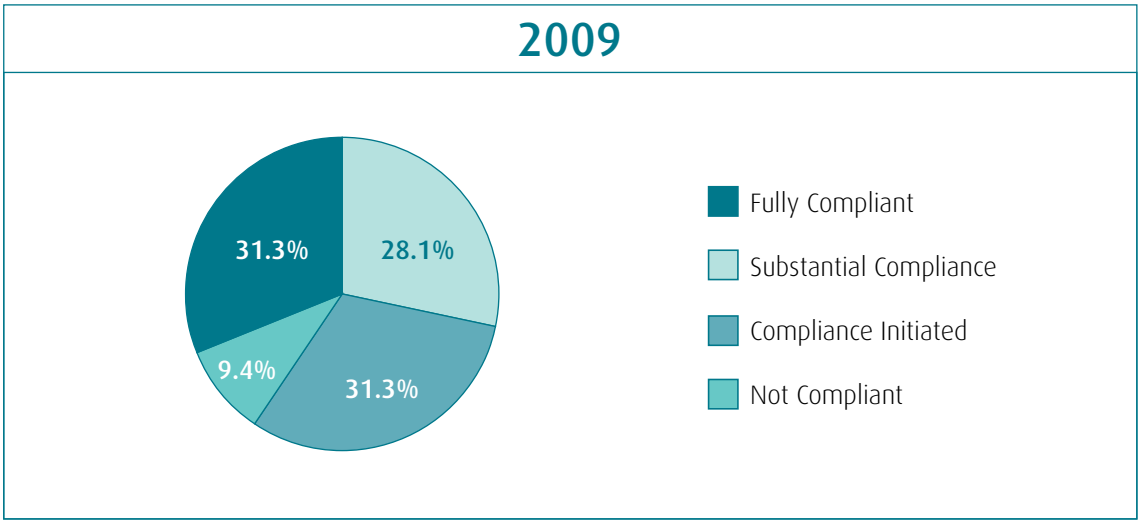
Figure 1



Prior to the 2008 inspection process self-assessment documentation was forwarded to all approved centres. Following return of these self-assessments, 83.6% of approved centres indicated compliance with Article 15. In order to assist approved centres and staff to reach compliance with all Articles of the Regulations, a four-stage rating scale comprising: Fully Compliant, Substantial Compliance, Compliance Initiated and Not Compliant was introduced in the Inspection process of approved centres in 2009. In determining compliance, following the inspection, a draft report was written which was then forwarded to the relevant service for factual correction. Following receipt of factual corrections and following editing, reports were presented to the Mental Health Commission. The reports were then placed on

the Mental Health Commission's website. The Mental Health Commission publishes an annual report that includes the Report of the Inspector of Mental Health Services. There were 66 approved centres registered in 2009. 64 approved centres were inspected as two had not been declared operational, that is, they had not yet admitted service users to in-patient beds. Of the 64 approved centres inspected, only 31.3% (n=20) were fully compliant with Article 15. See Fig. 2.

Figure 2



Following inspections of every approved centre over three years: 2007-2009, the level of compliance with this Article is disappointing. During the 2009 inspection process the Inspectorate found that doubt, uncertainty, confusion, lack of motivation and disregard for the law were factors that impacted on compliance in relation to this Article. The following, therefore, is written as an aid to those approved centres that have yet to reach full compliance with Article 15 of the Regulations. It does not purport to offer expertise in the area of care planning.

Service Users: Partners in Their Own Care

A Vision for Change (2006) declares that, at an individual level, *"the most immediate way that a service user or carer can be involved in mental health care is through the development of their own care plan, in conjunction with a multidisciplinary team."*[1] One of the key recommendations of *A Vision for Change* is that *"service users should be partners in their own care. Care plans should reflect the service user's particular needs, goals and potential and should address community factors that may impede and support recovery."*[2] The key phrase is **"partners in their own care"**. Only the service user can have full knowledge of their personal experiences. No one can ever know another person's experience although mental health professionals often act as though they know a service user better than the service user knows him or herself.[3] Likewise, it is important to note that many service users, particularly residents of old institution-type hospitals, may express satisfaction with their quality of life, but many may have very low expectations in this regard.[4] *The Quality Framework – Mental Health Services in Ireland* (2007) (Quality Framework), is the Mental Health Commission's response to the stakeholder consultation on quality in mental health services entitled *Quality in Mental Health – Your Views*, which was published by the Mental Health Commission in 2005. Theme 1, Standard 1.1 of the Quality Framework provides that, *"each service user has an individual care and treatment plan that describes the level of support*

1 *A Vision for Change*, p25, 3.2.1.
2 *A Vision for Change*, p9.
3 Buchanan-Barker, P. and Barker, P.J. (2008) The Tidal Commitments: extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing* 15, 93-100.
4 Wolfe, J. and Associates, (2009) Report on the Quality of Life Survey of South Tipperary Mental Health Services. Findings 4.1.2.

and treatment required in line with his/her needs and is coordinated by a designated member of the multidisciplinary team." There are seven associated criteria with this standard. It is important that service providers, at all levels, have a good understanding and working knowledge of the Quality Framework.

What Is a Care Plan?

Apart from the statutory obligation, when a service user is receiving the services of a number of different disciplines there is a need for a care plan. The individual care plan puts on paper the needs and goals of the service user and also irons out or streamlines the care being delivered by each discipline. Thus, a care plan may be regarded as a recovery map which guides the service user from a point in their life towards recovery. In turn, each discipline can see the care and treatment being delivered by a colleague of a different discipline which has the overall result of making the care plan more streamlined and avoiding duplication.

Traditionally, the care plan has been almost exclusively associated with nursing. Because of the statutory obligation to have an individual care plan, this is no longer the case. The purpose of an individual care plan is to assist the service user, all providers of care and treatment and the family member or chosen advocate, where appropriate, to steer in the direction where optimal outcomes may be attained for the service user.

No plan of care can be undertaken without first undergoing an assessment process. If assessment proves difficult, for one reason or another, following the admission of a resident (service user who is resident in an approved centre) to an approved centre, a pre-assessment care plan or emergency care plan should be formulated in conjunction with an evidence-based risk assessment to ensure the health, safety and well-being of the resident over the initial 24/72-hour period until a more thorough assessment can be completed. In setting up a care plan, *"the needs of each service user should be discussed jointly by the [multidisciplinary] team, in consultation with [service] users and carers, in order to construct a comprehensive care plan. Care plans should be written and agreed between all parties, and include a time frame, goals and aims of the [service] user, the strategies and resources to achieve these outcomes, and clear criteria for assessing outcome and [service] user satisfaction."*[5]

The Component Stages of a Care Plan

(1) Assessment – the data collection step

The key worker assigned to a resident should carry out a complete and holistic assessment of the resident's needs in partnership with the resident. During the development of the individual care plan, when it is being discussed with the service user by the key worker, the pen might be offered to the service user as a gesture of genuine empowerment.[6] Problems and/or potential strengths are now identified.

(2) Planning – the goal setting step to improve outcomes for the service user

During this stage, the resident and the key worker identify ways of overcoming any problem or problems that have been identified. For each problem identified a measurable goal should be set. It is important that goals are realistic. The method or methods by which these goals are to be achieved should be recorded, preferably in the residents own words and not in complex professional terminology.

[5] *A Vision for Change* (2006), p.81,9.6.
[6] Barker, P. and Buchanan-Barker, P. (2005) *The Tidal Model: A Guide for Mental Health Professionals*. Brunner-Routledge.

(3) Implementation – setting the plans in motion

Goals are set out as a means of overcoming identified problems or building on potential strengths. If no problem can be identified then one must question what the service user can hope to gain from his or her contact with the mental health service. Outcomes are documented. The care planning process only ceases when the individual is no longer receiving care or treatment from the service whether hospital or community based. The care planning process will be continued by the community mental health team if appropriate.

(4) Evaluation – analysing the success of the care plan and examining the need for adjustments

Progress towards achieving identified goals is evaluated. If progress towards achieving desired goals is slow then the care plan can be tweaked accordingly. If goals are achieved then in-patient care and treatment may cease and care and treatment may continue in the community. New problems that were not apparent may also crop up and may need to be resolved. This requires the entire care plan process to be repeated.

Elements of a Good Care Plan

Because one problem may abate and a wholly different problem or problems may emerge, care planning should be an evolving process which facilitates adaptation and change. In other words, care plans should involve a high level of fluidity. Prescheduled evaluation should take place frequently in collaboration with the service user and the necessary adjustments agreed, documented and signed by the member of the multidisciplinary team and the service user. In certain cases, unscheduled evaluation will be necessary when perhaps unforeseen circumstances, for example, the service user having a setback while on leave at home, may occur. Criterion 1.1.3 of the *Quality Framework* advocates that the care and treatment plan should reflect the assessed needs of the service user, not from any one professional group but from the perspective of the multidisciplinary team. Care and treatment should be developed, implemented and reviewed in a timely manner, signed by the multidisciplinary team member who is the allocated key worker and the service user, and a copy of the care plan kept by the service user unless there is a documented reason for not doing so. The response of the service user to support from the key worker and interventions from the multidisciplinary team should be evaluated. Progress towards meeting desired outcomes should be clearly documented. Any area of unmet need should also be documented in the individual care plan.

Benefits of a Care Plan

Problems can be identified and realistic goals can be set and achieved. Service users and service providers become more focussed on individual needs. Service users become involved in the care planning process, thus fostering a sense of commitment and responsibility in achieving their personal health gain and social gain. Continuity of care among the relevant disciplines becomes more streamlined.

Role of the Key Worker

The key worker is, "*the person who co-ordinates the delivery of the individual care and treatment plan. The key worker is responsible for keeping close contact with the resident, family/carer and chosen*

advocate and for advising other members of the multidisciplinary team of changes in the service user's circumstance."[7]

The key worker is a vital coordinating role undertaken by any member of the multidisciplinary team. So important is the key worker role that its absence may hinder care planning. **The key worker is a source of support for the service user and a link with all other disciplines within the multidisciplinary team**. The key worker is responsible for working with the service user, other members of the multidisciplinary team and family member or chosen advocate where appropriate, in ensuring the coordination of an effective plan of care. **The role of "key worker" is not a job title but a series of functions** to be undertaken to ensure the effective coordination of appropriate care and treatment based on the individual needs of the service user. The key worker acts as a single point of contact for the service user with whom they can assist in navigating their way through the mental health system and engage in effecting real choices and change towards recovery. **The main role of the key worker is to coordinate the delivery of outcomes agreed in the multidisciplinary team review and to ensure that they are recorded in the individual care plan and that they are regularly reviewed**. Being an effective key worker involves a degree of personal organisation. Effective time management is a prerequisite and ensuring the involvement and commitment of other members of the multidisciplinary team is not always clear-cut. It cannot be assumed that all members of the multidisciplinary team will be available all the time. In order to ensure the coordination of care planning and review, multidisciplinary teams will find it helpful to schedule a regular time slot for this purpose.

Conclusion

The business of any mental health professional is relatively straight forward. Mental health care professionals are in the business of helping the individual service user to lead a more dignified and fulfilling life. A full compliance rate of 31.3% nationally in respect of Article 15, three years following the introduction of the Regulations, is reflective of the need for attitudinal, cultural and educational change. There are many human resources available within each mental health service and affiliated third level education centre to put in place an individual care plan to meet the requirements of the Regulations. The process must also involve meaningful engagement and partnership between service users, carers and professionals. The process outlined clearly in Standard 1.1 of the *Quality Framework* should be followed throughout. **Having an individual care plan does not necessarily mean having reams of paperwork**. Some approved centres have achieved full compliance using one or two sheets of paper. In conjunction with this, an evidence-based assessment and risk assessment should be used. Four examples of individual care plans that achieved full compliance in 2009 were posted on the Mental Health Commission website.

The following is a list of the twenty approved centres that were fully compliant with Article 15 in 2009.

Central Mental Hospital, Dundrum

Newcastle Hospital, Co. Wicklow

St. Loman's Hospital, Palmerstown

Acute Psychiatric Unit, Bantry General Hospital

Department of Psychiatry, St. Luke's Hospital, Kilkenny

St. Dympna's Hospital, Carlow

St. Stephen's Hospital, Cork

[7] Mental Health Commission (2009). Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre.

Highfield Hospital

Hampstead Hospital

Palmerstown View, Stewart's Hospital

Department of Psychiatry, Our Lady's Hospital, Navan

St. Vincent's Hospital, Fairview

Sycamore Unit, Blanchardstown

Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis

Orchard Grove, Ennis

St. Conal's Hospital, Letterkenny

St. Joseph's Adolescent In-patient Unit, St. Vincent's Hospital, Fairview

St. Anne's Children's Centre, Galway

Warrenstown Child and Adolescent In-patient Unit

St. Luke's Hospital, Clonmel

Appendix 3: Overview of 24-Hour Nurse-staffed Community Residences

Seán Logue, Assistant Inspector of Mental Health Services

Introduction

Thirteen 24-hour nurse-staffed community residences (community residences) were inspected in 2009. This was part of the continuing monitoring of the role and function of these community residences in the provision of mental health services and is the third report on this theme. In 2005, all 127 community residences were inspected. In 2007, each community residence was asked to complete a self-assessment from which data was collated and reported. Finally, in 2008, data was again collated and analysed. At the end of 2008 there were 132 residences with 1,664 places. It was reported that service users had limited access to rehabilitation teams in different parts of the country and that the skill mix on teams was predominantly medical and nursing. Another key finding was that many of the residences were large, with service users asked to share accommodation with between 10 and 32 other people. There are no statutory regulations governing the provision of care and treatment in community residences.

Aim of the Report

The aim in 2009 was to inspect the largest residences providing full time care in each of the proposed super catchment areas, to establish the access service users had to rehabilitation and to assess the quality of care and treatment provided to them. The Inspectorate also examined the level of integration within the local community, the condition of the physical structure and the overall physical environment of each premises and the level of privacy afforded to residents.

Methodology

Based on the information available to the Inspectorate, thirteen residences with the highest number of places were selected from each of the proposed super catchment areas. An inspection template was developed based on the self-assessment tool used in 2007. All residences were notified in advance of the inspection and it was reported by the services that all service users were afforded the opportunity to be present and meet with the Inspectorate. Following the inspection a draft report was written which was then forwarded to the relevant service for factual correction. Of the thirteen draft reports sent by the Inspectorate, three were not returned. These three reports, following a stated timeframe, were deemed to have been factually corrected after 1 December 2009.

Overview of Residences Inspected

Residence	Number of places	Number of residents on day of inspection	Age profile of residents	Team responsible	Care Plan type
HSE South					
Ard na Deise	14	13	27-72	Rehabilitation	Nursing
Owen na Corra	32	31	42-93	General Adult	Nursing
Perrott House	23	23	Average age 67	General Adult	MDT
Kelvin Court	17	17	33-71	General Adult	MDT
HSE West					
O'Connell House	25	23	20s-90	Rehabilitation	Nursing
Toghermore	23	23	32-80	General Adult	MDT
Cleary House	20	12	28-75	Rehabilitation	MDT
Dublin Mid Leinster					
Erkina House	17	16	41-69	Rehabilitation	MDT
St. Columba's	17	17	36-75	Rehabilitation	MDT
Ellerslie House	15	11	26-78	General Adult	Nursing
Dublin North East					
An Solasán	16	16	67-88	General Adult	Nursing
Kilrock	12	12	34-88	Rehabilitation	MDT
St. Elizabeth's Court	26	23	51-95	Rehabilitation	Nursing

Each of the above thirteen community residences were inspected in 2009 and more detailed information is available in the relevant individual inspection report.

Discussion

Profile of Residents

Many of the residents had enduring mental illnesses and had spent considerable periods of their lives in long-stay wards of psychiatric hospitals from where they had been transferred or discharged. It is evident from the above table that the age profile of residents varied considerably except in An Solasán in Dundalk and Perrott House in Skibbereen where there were similar age profiles. The gender mix was balanced across all services with one or two exceptions.

Service User Interviews

Overall, the majority of residents who requested to speak to the Inspectorate during this series of inspections were generally pleased with the service provided and with the staff who offered care and treatment. In Kelvin Court, one resident stated that he/she had not seen a doctor since his/her arrival at the residence.

Access to Rehabilitation

All thirteen community residences provided on-going care with varying degrees of rehabilitation. Emphasis was mostly on the provision of a safe and homely environment. Only seven of the thirteen residences were under the care of specialised rehabilitation teams, all of which were inadequately staffed and fell far short of recommendations in *A Vision for Change* (2006). This limited the amount of exposure of residents to active rehabilitation and reintegration into local communities. Despite the

increase in the number of residences using multidisciplinary team (MDT) care plans, the skill mix of staff on the rehabilitation or community mental health teams under whose care the community residences fell, continued to remain mostly limited to medical and nursing personnel. Access to health and social care professionals such as occupational therapy was limited, access to social work was even more limited and access to clinical psychology services was either non-existent or special arrangements had to be made on behalf of the resident. Eight of the thirteen community residences inspected, offered respite places. In all thirteen community residences inspected, nursing staff were found to be proactive and dedicated in the provision of a caring service.

The Level of Integration with the Local Community

A number of residences encouraged active participation in their local community. In six of the residences a small number of residents were attending either Vocational Education Colleges, catering college, studying for college diplomas or undertaking supported employment. The Inspectorate found that staff were positive and supportive of residents attending courses and employment and proactive in assisting residents in achieving their maximum potential. The majority of residents either shopped in their community alone or were accompanied by staff, depending on their physical ability and/or level of capacity. A small minority were involved in local community organisations or groups.

Psychiatric Review

Many reviews by the residents' consultant psychiatrist occurred fortnightly or once a month. In most cases the NCHD attended weekly and as such, was available to review any resident upon request. In Kelvin Court, in Carlow, although the residents had been discharged from St. Dympna's Hospital on 13 February 2009, upon inspection on 10 September 2009, no psychiatric review had been entered into any of the resident's clinical files or care plans examined during the inspection despite the fact that all residents continued to be under the care and treatment of a consultant psychiatrist. Since that inspection, it was reported that a schedule of regular psychiatric reviews had been implemented. It is positive to note that in other residences there was evidence of regular and systematic review of planned care and regular MDT review, although as already indicated, such MDT reviews were being carried out by mostly medical and nursing staff.

Physical Care and Treatment

The Inspectorate received a number of enquiries into the matter of physical examinations with regard to residents of community residences. It is the view of the Inspectorate that in cases where individuals are under the care of Mental Health Services and where clinical responsibility lies with the community mental health teams (CMHTs), there is a duty of care to ensure that, in the best interests of each resident, access to all available health care is afforded. This duty of care extends to physical care. The NCHD attached to each CMHT should be the delegated professional accountable for ensuring that the physical health needs of all residents are being met. In all services, a general practitioner (GP) either attended the residence or residents attended their own GP. Physical health examinations occurred annually in most cases, some occurred six-monthly, and in one case, O'Connell House in Limerick, there was no documentary evidence that physical examinations had occurred in regard to five residents. In many situations, where the practice was for the resident to attend their GP, the Inspectorate had difficulty finding records of these examinations. While such documentation of physical examinations might remain within the GP practice, at the very least, staff of community residences should have a system in place to ensure that records of attendance of a resident at his or her GP are maintained. In Ard na Deise, in Waterford, the residents' clinical files were forwarded to the GP when the resident attended for physical examination for the purpose of documenting the examinations and were then returned to the residence. Notwithstanding the right of a resident to confidentiality in dealings with his or her GP, in many instances, there was no documentary evidence of liaison between the GP practices and staff based at the community residences regarding identified follow-up care. In one example, in Toghermore, Tuam, dates were noted in the diary when each resident was due a visit to their GP, and although it was

reported that the GPs liaised with the service on the findings of these physical examinations, no record of liaison could be found in any care plan or record confirming that the resident actually attended. Whereas, a resident with capacity has a right to refuse to attend for physical examination, a record of such non-attendance should be documented and such an eventuality discussed amongst the multidisciplinary team and agreed action taken and documented in the resident's care plan. At the very least, attendance or non-attendance for physical examination should be recorded in each resident's care plan.

Therapeutic Services and Programmes

It was positive to note that all services had a programme of therapeutic activities, albeit limited in some cases, or access to such was available if required by the resident. In the majority of cases, the residents of each service attended a day centre for limited periods. In two cases: Cleary House in Letterkenny and Ellerslie House in Bray, all residents attended the day centre with no access to their residence during the working day. In Cleary House, residents had access to a range of therapeutic programmes in accordance with their individual care plans. Again, it must be noted here that access to therapeutic services was restricted by limited numbers of health and social care professionals.

Medication

Although there is no statutory requirement for such, there were no policies on the ordering, prescribing, storage and administration of medicines. In most cases medications were prescribed by three different parties: the consultant psychiatrist, NCHD and GP. Each service should have an up-to-date written operational policy on the ordering, prescribing, storage and administration of medicines. Residents reported that there was a lack of information available to them regarding the medicines they were receiving. Staff reported that the information contained within medicine boxes was used to relay information to residents and that such information could be elaborated on and discussed in more detail with the resident upon request to the consultant psychiatrist, NCHD or nurse. However staff need to be proactive in assembling a system of information on various frequently-used medications so that residents may peruse it easily and then ask questions if they wish to do so. A small number of community residences reported that a number of residents were managing their own medication.

Staffing Levels

The paucity of health and social care professionals such as occupational therapists, social workers and psychologists across all teams has already been highlighted. Night staffing levels were inadequate in two of the thirteen community residences inspected: Ard na Deise, Waterford, and Ellerslie House, Bray, Co. Wicklow. The staffing level of one registered psychiatric nurse on night duty is inadequate to facilitate the care of residents in these community residences. Staffing levels at night should comprise at least two members of staff, one of whom should be a registered psychiatric nurse. Night staffing levels in the remaining eleven community residences were adequate.

The Condition of the Physical Structure and the Overall Physical Environment of the Premises

The mean number of places available in the thirteen community residences inspected was 20. The physical structure of these residences varied from period houses dating back to pre-Victorian times to converted convents built 130 years ago and from previously used buildings in the grounds of hospitals to modern purpose-built single-storey developments. All residences, with one exception, were located in urban or suburban settings. Toghermore was three kilometres from the town of Tuam, including a distance of one kilometre from the premises to the main gate. Residents were restricted to undertaking this walk during daytime only as the area was unlit at night and the path surface uneven. In the majority of cases it was reported that maintenance was generally adequate. Many staff reported that because the residences were some distance away from maintenance departments based at main hospitals, it was difficult sometimes to acquire routine maintenance. In emergency situations, maintenance was reported

to be generally, very good. In Ard na Deise, Waterford, there was evidence of damp in some of the rooms; St. Columba's, Crumlin, was an old building, poorly maintained; and Toghermore, in Tuam, a large period residence, reported serious problems with the structure of the premises, both inside and outside and problems obtaining necessary maintenance. These issues are reported separately in the individual reports.

The Level of Privacy Afforded to Residents

Although many residences accommodated residents at night in single and twin rooms, in some cases, residents were living in accommodation affording them little or no privacy, sometimes with up to five or even six people sleeping in the one room as in the case of Toghermore House, Tuam, and O'Connell House, Limerick respectively. For many years now, the Inspectorate has recommended that in bedrooms with two or more beds, residents should be afforded some degree of privacy through the use of privacy curtains and satisfactory privacy of bedroom windows from car park, garden and public access areas. In most of the residences inspected, in bedrooms with two or more beds, the Inspectorate found that insufficient resources had been allocated to provide for the privacy rights of residents as individuals. Measures to address these privacy issues should be expedited. Any proposed new community residence should afford each resident a high degree of privacy.

Quality Initiatives and Improvements

It was positive to note that all areas had quality initiatives and improvements to report, most areas had a ready and lengthy list of items that had been undertaken in recent times. These were many-varied and service specific. Rather than duplicating these in this overview report, individual services' initiatives and improvements may be read in each of the individual inspection reports for the community residences.

Financial Arrangements

All thirteen community residences were owned by the HSE. Each resident paid a set amount of money on a weekly basis towards rent. The reports on these thirteen community residences found that most residents had their own bank, post office or credit union accounts. This was a positive development as it lessened the need for nursing staff to handle residents' monies, reduced the risk of retaining relatively large cash sums on site and enhanced the autonomy of residents. This practice should be replicated by all community residences. Financial arrangements were backed by a written operational policy in seven residences. It is recommended that all residents of community residences should have a personal bank/post office or credit union account and that each service has a written operational policy and procedures on local financial arrangements.

Leisure/Recreational Activities

It was reported in the majority of cases that residents had access to a wide range of leisure and recreational activities. Leisure outings occurred regularly either for day trips or for trips to the cinema, swimming and shopping. Access to local libraries was also reported in a number of cases. Many areas had occasional Sunday lunches at local restaurants and hotels. Local sporting events were also well attended in a number of areas. Residents' birthdays were always celebrated.

Conclusion

There were 1,805 places in 24-hour nurse-staffed community residences reported to the Inspectorate through the catchment reports of 2009. With the anticipated imminent closure of remaining Victorian institutions, future plans for newly commissioned buildings for use as community residences need to be reviewed and planned carefully. What is not needed in place of Victorian institutions is an emergence of "mini-institutions" or "wards in the community" dotted about rural and urban communities. The planners of our mental health services must exercise a vision and identify purposeful housing for residents in

need of round the clock care. Indeed, in the present era of falling property prices, the climate may be right for embracing this vision of residential care in our communities at all levels of support. Defenders of the larger community residences such as Toghermore in Tuam point to kind, caring and well-meaning staff, and a sense of camaraderie amongst residents and staff. However, such facilities can only deepen an individual's sense of detachment from community life, increase attachment to a more paternalistic philosophy of care and smother any hope of ever reaching their full potential as individuals. This can give rise to caution on the part of residents towards co-operating with moves to objectively more desirable settings. Such cautiousness should not be underestimated as it is a genuine concern. But this concern can only be remedied by the provision and utilisation of fully-staffed specialist rehabilitation teams as recommended in *A Vision for Change*. In the absence of specialist rehabilitation teams, new residents to the service who are experiencing severe and enduring mental illnesses, long-stay residents in community residences and medium and low support housing, will not get the specialist care and treatment and essential ongoing interventions to assist them in reaching their maximum potential.

Appendix 4: Individual Inspection Reports – 24-Hour Nurse Staffed Community Residences

HSE Dublin North East

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Dublin North Central/North West Dublin
Mental Health Service Inspected	North West Dublin
Residence Inspected	St. Elizabeth's Court
Total Number of Beds	26
Total Number of Residents	24
Number of Respite Beds (if applicable)	0
Team Responsible	Rehabilitation
Date of Inspection	3 November 2009

Description

Service Description

St. Elizabeth's Court was a 24-hour community staffed residence located on the North Circular Road in Dublin. The residence opened in its current form in 2001 and prior to that it was composed of self-catering bed-sits owned by Dublin Corporation. It was a two-storey building with bedroom accommodation on both floors, with day areas located on the ground floor. It provided continuing care to older people in the catchment, many of whom had moved there from other services because of increased physical needs. On occasion the residence provided respite for older people.

The bedrooms were a mix of single and double rooms and were in good decorative order. The residence was clean and well maintained throughout. A new accessible shower room had been installed downstairs, making this the only residence in the catchment that was wheelchair accessible. The upstairs accommodation was not suitable for residents with limited mobility. The residence had a chef and all meals were cooked on site. There was a kitchen, dining room and sitting room on the ground floor, and a laundry room was attached. There was a spacious enclosed garden with a gazebo that was used as a smoking place. This area of the garden was overlooked by more recently built apartments. Staff reported that on occasion there was disturbances and littering of the garden arising from parties in certain apartments.

There was a day centre adjacent to St. Elizabeth's Court and many of the residents attended it. The residence was also located close to local amenities and most residents made use of these. The residents were well known in local businesses and staff reported a good and supportive relationship with local businesses, shops, pubs and pharmacies.

Profile of Residents

The residence could accommodate 26 residents and on the day of inspection there were 23 residents. The average age of residents was 67 years; their ages ranged from 51 to 95 years. The average length of stay was 6.4 years. There were 14 male residents and 9 female residents. St. Elizabeth's Court catered for older people with a history of severe and enduring mental illness who by and large required continuing care. Most of the residents had significant physical dependency needs.

Quality Initiatives and Improvements in the Last Year

- Residents meetings were facilitated regularly.
- Residents were being facilitated to open bank accounts with Postbank to avail of direct debit payments of community residence contributions.
- Ordering from the pharmacy had been streamlined. New forms had been developed in conjunction with a local pharmacy to reduce incidents of errors.
- All clinical and bathing areas were equipped with liquid soaps and hand towel dispensers. Alcohol-based hand sanitisers had been installed.
- New showering facilities and a wheelchair accessible toilet had become operational in the past year.
- Half of the residents were reviewed in St. Elizabeth's Court by the community component of the rehabilitation team. This removed their need to attend a clinic and improved communication of health care information between resident, nursing and medical staff.
- New medication card indexes were being implemented in St. Elizabeth's Court and across the community residences as part of a medication management standard.
- Home voting was being organised to facilitate residents vote on site.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

All residents had an up-to-date nursing care plan and had regular mental health and physical health reviews. Residents were involved in their own care and treatment plan. Many residents, because of their advanced age and physical needs, had regular outpatient appointments in the nearby Mater Hospital. The rapid access clinic in Smithfield was available for anyone over 65.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

1. As far as possible residents were encouraged to access services provided locally outside the residence and within their community.
2. The service had embarked on a detailed needs assessment of all residents in community residences. A number of specific standardised assessments had been used and the results for the entire service area were due to be analysed to provide information to inform care planning.

3. Residents could attend the Aird Nua and New Century House, which were vocational rehabilitation services provided by EVE Holdings. The Cabra day hospital, the day centre and Goirtín sheltered workshop were nearby on the North Circular Road. Their proximity was particularly attractive for residents of St. Elizabeth's Court who had mobility issues.

How are residents facilitated in being actively involved in their own community, based on individual needs?

1. Residents needs were being formally assessed.

2. Residents had substantial links with the neighbourhood and were encouraged to maintain links with their families and friends. Families and friends often visited the residents and this was welcomed and encouraged by staff.

3. Residents regularly availed of the shops, coffee-shops, pubs, hairdressers and churches in the locality. Many walked or took taxis to their destinations.

4. All residents attended their own GP in the area.

5. A day centre was located next door to St. Elizabeth's Court and many residents attended a number of times per week. Amongst the local social services available to residents were the Basin Club (Shine) in Blessington Street and the befriending service hosted by Goirtin. The Alexian Brothers also offered a community group for people who use services. Some residents were involved in local community groups. Goirtín also hosted a number of community groups such as AA.

6. St. Elizabeth's Court was home to a number of cats that some residents had taken to looking after.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

1. Although the residence was large, with 26 beds, all the rooms were either single or double and were private. Each resident had a wardrobe and locker and the rooms were individualised with personal belongings.

2. The service had invested in improving the bathrooms and making them accessible.

3. Residents were offered downstairs rooms where indicated by their physical health needs.

4. Many residents liked to share rooms with other residents and the maintenance of friendships was respected in the choice of room-mate. Some residents did not like to share and this option was respected and facilitated as much as possible.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
CNM2	1	0
CNM1	0	0
Nurse	1	1
Household	2.5	0
Care staff	1	1
Chef	1	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1
NCHD	1
Occupational therapist	0
Social worker	0
Clinical psychologist	0

Team input

Most residents in St. Elizabeth's Court were under the care of the rehabilitation service, which was run by two consultant psychiatrists and comprised a St. Brendan's Hospital component and the new North West Dublin community rehabilitation service. The community component of the service comprised a consultant psychiatrist and NCHD. Efforts were being made to extend the multidisciplinary staff to cover the entire North West Dublin service. Progress towards this end was steady and already a common placement team had been established to conduct multidisciplinary assessment of placement referrals to the North West Dublin community residence network. Similarly, the needs assessment project, which was ongoing at the time of the inspection, was a joint initiative.

The community component of the rehabilitation service held weekly team meetings nearby at its base in Whitepoint on the North Circular Road. Community residences from the catchment, including St. Elizabeth's Court, were represented at the meeting. Four of the residents were under the care of the St. Brendan's Hospital rehabilitation component of the service. Other teams with residents in St. Elizabeth's Court held their clinics in nearby Conolly Norman House and their weekly team meetings at their team bases.

Liaison was maintained with the residents' GPs regarding physical health and medication changes.

Medication

The service had a policy with regard to prescription card indexes. The prescription card indexes were reviewed during the inspection and they were up to date and clearly written.

Many residents received assistance with their medications, e.g. heparin and insulin injections.

Self-medication programmes were encouraged as much as practicable, but on the day of inspection none of the residents were deemed suitable for self-medication programmes. The service had developed a policy for self-medication programmes.

Tenancy Rights

Residents paid a contribution of 75 euro towards their living and care expenses. It was hoped that in the future this would be achieved through a direct debit from bank accounts, which were being set up.

The residence facilitated regular meetings of residents.

There were few house rules and these were included in the information leaflet that described the residence and the facilities provided.

Financial Arrangements

The HSE policy regarding residents' finances was in place. Most residents were in receipt of state or occupational pensions. Five residents had their pensions collected by staff because of infirmity. There were arrangements in place for the safe-keeping valuables.

Residents were encouraged to shop for clothes and toiletries and often requested the assistance of staff with these tasks.

Leisure/Recreational Opportunities Provided

Residents were facilitated in remaining involved in the community for leisure opportunities. Residents used local pubs, coffee shops and local shops.

Within the residence there were regular celebrations, for example, birthday parties and seasonal celebrations.

Residents were encouraged to develop and maintain their pastimes for example, some residents enjoyed jig-saw making and crochet.

Residents also availed of the day centre next door where there was bingo, opportunities to keep up to date with the papers and to enjoy one another's company.

Service User Interviews

A number of residents were spoken to during the inspection. They all expressed positive views about the quality of their care and treatment and their relationships with staff. A number commented on the range of recreational activities that they availed of in the day centre or in the locality.

Conclusion

Although this was a large residence with 26 beds, the bedrooms were either single or double and had been individualised by the residents. The building was spacious and had a large outdoor enclosed garden. Access to local amenities and day centres was made easy by the central location of St. Elizabeth's Court. The residence was clean and well kept. Importantly the residents who spoke to the Inspectorate reported a positive experience of living there. The residents all looked well cared for and a good rapport was observed during the inspection between residents and staff.

The residence was catering for older people in the service. As the only residence that was wheelchair accessible in the catchment area, the demand for places was likely to grow, putting particular pressure on ground-floor accommodation. While it was positive to see joint initiatives between the St. Brendan's Hospital and the community-based rehabilitation teams, the issue of staffing needed to be addressed. The community-based rehabilitation team comprised a consultant psychiatrist and NCHD. With this level of staffing it was difficult to see how progress could be made in providing a community-based rehabilitation service that would support service users in the community, foster links with local housing authorities and perhaps shift the focus from residential provision and facilitate a reduction in the number of beds provided in St. Elizabeth's Court in line with *A Vision for Change*, which of 10 places.

Recommendations and Areas for Development

1. *The rehabilitation team should be fully resourced.*

2. *Consideration should be given as to how best to use the vacant space upstairs in St. Elizabeth's Court so that it does not become dilapidated.*

3. *Consideration should be given to developing more day rooms or sitting areas on the ground floor so that residents have a choice of space where they can sit and relax rather than all gathering in the one large sitting room.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	HSE Dublin North
Mental Health Service Inspected	North Dublin
Residence Inspected	Kilrock House, Howth
Total Number of Beds	12
Total Number of Residents	12
Number of Respite Beds (if applicable)	0
Team Responsible	Rehabilitation
Date of Inspection	30 July 2009

Description

Service Description

Kilrock House was a large red-brick period house built in 1875 with large mature landscaped gardens. It was situated in Howth, with seascape views of Howth Harbour and Irelands Eye. Kilrock House was a high support residence which provides accommodation for 12 residents under the care of the community rehabilitation team. The house was also the headquarters of the rehabilitation team which covers area 8 in North Dublin. New referrals were directed to the rehabilitation team which meets on a weekly basis.

Kilrock House was a three-storey house with bedroom accommodation both upstairs and downstairs. There was a day room, kitchen and conservatory downstairs. The staff offices that housed the multidisciplinary rehabilitation team were on the second floor. Bedroom accommodation comprised four male rooms with one single room, two double rooms and one with three beds. There were two female rooms with two beds in each room. None of the shared bedrooms had a curtain separating the room in half to provide residents with privacy. There were six toilets in the house and two bathrooms. A bathroom was being redecorated on the day of inspection. There was one toilet and shower room downstairs, two male toilets and two female toilets and one bathroom and shower room upstairs with access to a laundry room. The dining room was attached to a kitchen where all the meals were delivered from St. Ita's Hospital from Monday to Friday. Residents prepared meals on site at weekends and on bank holidays as part of their programme.

There was a well-maintained, spacious and private landscaped garden to the front of the house. At the back of the house there were spacious grounds and a vegetable garden that had been developed and maintained by staff and residents. This facility provided a choice of activities and was particularly popular with some of the men who were not interested in some of the other activities offered. There were plans to redevelop the gardens to the rear of the house to facilitate therapeutic activities for residents.

The philosophy of care was to support and encourage residents with mental health problems so that they can participate in all aspects of daily living and take an active role in the decisions that affect their lives. The resident's right to choose not to participate was also acknowledged.

Profile of Residents

The current age range of residents was from 34 years to 88 years, the majority with a diagnosis of schizophrenia. On the day of inspection, there were eight male and four female residents. Seven of the residents had been resident in the house for more than ten years. With the increasing age profile of residents, the layout of the house may provide difficulties for the less able-bodied residents in the future. The residents were involved in various activities. Most of the residents attended the Vocational Training

Programme, Clubhouse, National Learning Network college, or Suaimhneas on a daily basis and one resident was employed by the local butcher.

Quality Initiatives and Improvements in the Last Year

- The proposed development of the occupational therapy service in Kilrock House.
- An analysis report to identify the needs of clients with a view to establishing an appropriate vocational training programme.
- A service development plan was instigated to develop a rehabilitation occupational service.
- A gardening programme, including the development of a sensory garden, rose garden together with a vegetable patch.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

All residents had a rehabilitation team assessment and care plan completed. These were reviewed approximately every week or more or less frequently if required. The rehabilitation consultant was based in Kilrock House and each resident was discussed with the multidisciplinary team on a monthly basis.

All of the residents were registered with a local GP and staff reported a close relationship with the GP. There was good access to specialist consultants and clinics through the GP.

The rehabilitation team had no clinical psychologist.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

The services and programmes included the following:

- gardening programme.
- personal hygiene programme.
- budgeting programme.
- cookery programme (weekends).
- smoking cessation programme.
- domestic chores around the house.
- resident meeting (weekly). Notes taken by resident each week – shopping for household groceries, healthy food shopping, and food preparation.
- one resident attended Delvin Sheltered Workshop.
- one resident attended Coláiste Dhúlaigh and attained a diploma in Art and Design.

- one resident attended a catering course in Phibsboro.
- three residents attended Suaimhneas Sheltered Workshop.
- all residents used local shops/cafes/farmers market as part of their social programme and integration into the local community.
- there was access to voluntary agencies, e.g. GROW and Mental Health Association, Friends of Kilrock.

How are residents facilitated in being actively involved in their own community, based on individual needs?

The premises was located near the centre of Howth village with easy access to a range of local facilities including the town library, pubs, harbour and shops. There was good access to bus services which served North Dublin and a local DART station. Residents were encouraged to attend local events held throughout the year. Residents were invited to community functions through their close links with local social services. Some of the residents used the local shops and library and there was access to other social activities.

The local community was invited to attend both Christmas and summer parties at Kilrock House.

The service had built and was actively maintaining good links with the local community by participating in local events and inviting the community in for special occasions.

Some residents were engaged in Vocational Training Programmes of Delvin, National Learning Network and Roslyn Park. One resident was independently employed by a local butcher.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

Kilrock House was located in a quiet suburban area. The house was well maintained, bright and comfortably furnished. There was good access to repair and maintenance staff. Residents' placement was determined by proximity to family support and vocational training. Residents shared accommodation based on gender, age and social background.

Living quarters were personalised with photographs and residents' belongings. Curtains were not provided around bed areas and each resident was provided with their own storage space.

Meals were cooked at St. Ita's Hospital from Monday to Friday and on site at weekends and on bank holidays by the residents. The kitchen was Hazard Analysis and Critical Control Points (HACCP) compliant. A choice of meals was provided for residents and special diets were catered for. The dining room was bright and spacious.

Fire inspections were carried out routinely. Pastoral care was available on request. A representative of the Irish Advocacy Network visited the house on request.

Staffing Levels

Full Time in Residence

staff Discipline	Day WTE	Night WTE
CNM2	1	0
CNM 1	0	0
Staff nurse	2	1
Cook	0	0
Care staff	1	1

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	2-3 sessions weekly (12 hours)
NCHD	2-3 sessions weekly (12 hours)
Occupational therapist	3 sessions (12 hours)
Social worker	On a need to see basis
Clinical psychologist	None
Research fellow	2 sessions (8 hours)

Medication

Medications were sourced in the local pharmacy and paid for by St. Ita's Hospital. Depot medications were given in the residence. Written information on medications was provided by means of the information leaflet in the medication pack. Medications were stored in a medication room. They were ordered from the community pharmacy on a weekly basis unless otherwise required.

Tenancy Rights

The house was owned outright by the HSE. Residents do not have a tenancy agreement. The Inspectorate was informed that residents were involved in all aspects of life in the house. Residents signed a contract agreeing to no consumption of alcohol or illegal substances. The contract also included a no smoking policy in the residence. Community meetings were weekly.

Financial Arrangements

There was a HSE policy and local guidelines in place regarding financial arrangements for residents. All were in receipt of social welfare payments. Residents' money dealt with by staff was recorded in a book and signed by staff and the resident. The majority of residents managed their own finances through their post office savings book.

Leisure/Recreational Opportunities Provided

Residents had access to a good range of recreational activities. There were regular outings to the cinema, drives, swimming, Sunday lunch and shopping. Birthday parties for significant birthdays were held in the house.

Service User Interviews

Residents were informed of the inspection visit and invited to speak with the Inspectorate. One resident spoke in depth and expressed overall satisfaction with the house.

There were two service users groups residing in Kilrock House. The first being those who were resident in the house prior to the rehabilitation service and the second service user group were individuals admitted from the Community Mental Health Services. Each resident was involved in their own rehabilitation team assessment and care plan. Residents had signed their care plans.

Conclusion

Kilrock House was a bright well-maintained facility for both men and women with a mixed age range who were referred by the psychiatric rehabilitation services. Many of the residents had been there for many years and had developed strong ties with the service and the other residents. The atmosphere in the house was warm and welcoming and residents seemed pleased with the service. It was under the care of the rehabilitation team which was under-resourced and without a clinical psychologist. Residents had good access to facilities outside the house and it was clear that they were encouraged by staff to be as independent as possible.

Recommendations and Areas for Development

1. *Arrangements should be put in place to ensure privacy in the shared bedrooms.*

2. *The rehabilitation team should be fully resourced with health and social care professionals.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Cavan/Monaghan, Louth/Meath
Mental Health Service Inspected	Louth/Meath
Residence Inspected	An Solasán
Total Number of Beds	16
Total Number of Residents	15
Number of Respite Beds (if applicable)	1
Team Responsible	General adult
Date of Inspection	7 May 2009

Description

Service Description

An Solasán was built in 2002 and was a purpose-built residence situated in the grounds of Louth County General Hospital. It was a single-storey building and had 15 beds, including one respite bed. On the day of inspection, there were 15 residents and one additional resident who was a patient in St. Brigid's Hospital in Ardee.

The residence was under the care of two general adult psychiatry teams which provided continuing care to the elderly residents.

Profile of Residents

The age range of residents was between 67 and 88 years. Referral for admission was through a hostel referral committee which had recently been set up to consider all referrals to supervised residences in the catchment area. In view of the age profile of the residents, it was reported that residents required a lot of physical nursing care. It was expected that most residents would remain in the residence as long as their physical requirements could be met.

There was one respite bed in the residence and respite of one week's admission was available.

Quality Initiatives and Improvements in the Last Year

- A patient satisfaction survey was conducted.
- A clinical learning audit was conducted for An Bord Altranais.
- A health promotion grant was secured in 2008 and a fish aquarium was installed in the residence.
- A HSE quality and risk group had been set up and a representative from the staff of An Solasán was on the committee.
- There was ongoing mandatory training for staff in relevant areas, e.g. elder abuse.
- Integrated files for residents had been introduced.
- A number of infection control initiatives had been developed.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Residents had a nursing care plan that was reviewed every three months. The consultant or a member of the treating team visited the residence weekly and full reviews were conducted every six months. In addition, reviews were carried out as required. The senior nurse on duty in the residence attended the weekly team meeting.

There was no provision to conduct regular six-monthly physical health reviews. The physical health care of residents was attended to by the local GPs.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

Nurses carried out assessments on residents. There was no access to an occupational therapist. Activities were nurse led and included activities of daily living, newspaper groups, bingo sessions and outings.

How are residents facilitated in being actively involved in their own community, based on individual needs?

Residents had open access to the day centre which was located in the grounds of the hospital, and residents could attend daily if they wished. There was also good links with the local Alzheimer's Centre.

Residents frequently went shopping in the area or in the town, either accompanied by staff or independently.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

The residence was well maintained and well furnished. The decor reflected the permanent nature of the residence, which residents regarded as their home. There were 16 bedrooms, all single with adequate bathroom facilities. Residents had access to a pleasant paved outdoor area and there was an activities room where nurses facilitated therapeutic activities.

Staffing Levels

Full Time in Residence

staff Discipline	Day WTE	Night WTE
CNM 2	1	0
CNM 1	1	1
Nurse	2	1
Household staff	2	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1 a week
NCHD	1 a week, or more frequently as required
Occupational therapist	0
Social worker	Access to social worker
Clinical psychologist	Access to psychologist

Team Input

Team meetings were held weekly and were attended by a member of staff and the consultant psychiatrist visits the residence weekly. NCHDs also visit the residence as required. Six-monthly psychiatric reviews were conducted by the psychiatrist on all residents. Hospital appointments were facilitated for the residents; a chiropodist attended every two months and residents had access to a physiotherapist when required. The residence was self-staffing in terms of nursing staff.

Medication

Medications were supplied on a weekly basis from the pharmacist in St. Brigid's Hospital. Medication was dispensed by the nursing staff but there was a plan to introduce self-medication to some residents. Additional medication such as antibiotics, prescribed by the GP, was obtained through the medical card system.

Tenancy Rights

The residence was owned by Louth/Meath Mental Health Services. Community meetings for the residents were held every few months. There was a complaints box in the entrance hall for residents but it was reported that very few complaints had been received. The complaints procedure was outlined in the information leaflet which was given to each resident.

Financial Arrangements

There was a policy in place regarding financial arrangements for residents. A number of different systems were in place for collection of pensions. In some instances, family members or staff collected the pension for the resident. One resident managed their own financial affairs, and in the remaining cases, pensions were collected by staff in St. Brigid's Hospital. Residents had access to their own money once the pension has been collected and two staff members witnessed any financial transaction.

Leisure/Recreational Opportunities Provided

Residents had daily access to the day centre, which was also located in the grounds of the General Hospital. There was some interaction with the local Alzheimer's Centre. Residents were taken on regular outings and shopping excursions. The residence hosted an annual Family Day in the residence.

Service User Interviews

The residents had been informed of the Inspectorate visit and they were invited to speak with the inspector, but no resident availed of the opportunity on the day.

There was information on advocacy services in the residence, but there were no regular visits from an advocate.

Conclusion

An Solasán was a bright, well-maintained and spacious residence providing continuing care to 16 residents. It was situated in a pleasant area of the grounds on the Louth County General Hospital, and was under the care of two general psychiatrists who visited the residence weekly. Because of the age profile of the residents, a lot of physical nursing care was required. Psychiatric reviews were conducted six-monthly, but there was no system in place to conduct similar physical health reviews. The service has been involved in a number of initiatives and residents could avail of a number of nurse-led activities.

Recommendations and Areas for Development

1. *Residents should have the benefit of occupational therapist input into their care plans.*
2. *A system should be implemented for six-monthly physical health reviews of residents.*

HSE Dublin Mid Leinster

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Dun Laoghaire, Dublin South East and Wicklow
Mental Health Service Inspected	Wicklow
Residence Inspected	Ellerslie House, Bray
Total Number of Beds	15
Total Number of Residents	11
Number of Respite Beds (if applicable)	2
Team Responsible	General adult
Date of Inspection	11 June 2009

Description

Service Description

Ellerslie House was a three-storey period residence taken over for use as a 24-hour supervised residence by the then Eastern Health Board in 1986. The facility had 15 beds, including 2 respite beds, and was situated in a leafy suburban area of Bray facing a public park. On the day of the inspection, there were 11 residents: five male and six female. The residence was under the care of the general adult team.

The aim of Ellerslie House was to promote and encourage the rehabilitation of its residents through retraining in life skills and restore them back into the community, to the service's three low support houses, or to the family home. It was reported that a homely ambience was the main philosophy of the residence.

Referrals were made from the general adult team and were discussed at team meetings with the CNM2 responsible for the residence, who it was reported had the final say on the appropriateness and suitability of the admission.

Profile of Residents

The age range of residents, on the day of the inspection, was between 26 and 78 years. Length of stay depended on the individual resident but was broadly reported to be from four to five years. The residence was not appropriate for any resident who was in need of intensive or enduring physical care.

Quality Initiatives and Improvements in the Last Year

- A hygiene audit had taken place in March and April of 2009, with a follow-up due to happen in the autumn.
- A bathroom had been upgraded to a purpose-built shower room.
- A sitting room had recently been refurbished.
- A side gate had been included to the garden side entrance for privacy reasons.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

The residents' clinical files were maintained at Lincara day centre and were not accessible to the Inspectorate for examination. The care plan in Ellerslie House was a nursing care plan. This care plan remained at the residence and was evaluated every six months. Each resident was fully reassessed every six months. Progress reports were maintained twice daily on each resident. Each resident had a social functioning summary record and related nursing interventions, which were highlighted in graphic format on a performance analysis chart. It was subsequently reported that all residents had a multidisciplinary care plan.

Each resident attended their own general practitioner selected by them and records of attendance were maintained at the residence to ensure regular physical reviews.

The multidisciplinary team met at Lincara day centre each week. It was reported that each resident was reviewed at least monthly by the team. Records of these monthly reviews were maintained at the day centre. The CNM2 from the residence attended this meeting.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

Most residents attended Lincara day centre on a daily basis. Lincara provided a structured activity programme. Others attended New Dawn, a step-up training centre for work-training skills such as computers, cookery, purchasing skills, and physical education. Two residents were currently enrolled in Bray Adult Education Centre: one was studying computer science, while another was studying geography.

A programme of life-skills training was conducted at the residence, placing responsibility on each resident for their individual activities of daily living. A shared internal duty roster for residents to take ownership of housekeeping responsibilities was also in place, for example putting out and bringing in bins, setting tables for meals, garden maintenance, dishwasher emptying, washing up and cleaning dining room.

How are residents facilitated in being actively involved in their own community, based on individual needs?

The residence was a period house in a suburban part of Bray with similar style houses set out along a tree-lined road and facing a public park that had a large grassy area where during the summer time, picnics were held by the residents and staff. It was reported that private residences on the road were friendly and supportive towards Ellerslie House. On New Years Eve each year, a party was held which was attended by the neighbours on the road and staff and residents. It was reported that the residence had excellent contacts with the community and were kept updated on upcoming local events such as church fetes etc.

Residents went frequently into town either accompanied by staff or unaccompanied. One resident, who had a good ear for music, was a member of Ceoltas. It was reported that all residents were members of the local library where they attended each Saturday.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

The residence was a large three-storey period residence but was well-maintained, bright and well-ventilated and in a good state of decor. A conservatory had been built overlooking the large rear garden, which had two apple trees and a pear tree. A sitting room and shower room had recently been upgraded to a high standard. It was reported that the response rate from the maintenance department at Newcastle Hospital was good. There were two sitting rooms, each with a TV set and a conservatory. During the summer, meals were eaten outdoors, weather permitting. The laundry area off the kitchen was large and functional, with a rear entrance leading to the garden.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
Nursing	1 CNM2 + 1 staff	1 staff
Care assistant	2	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	Once a week at day centre
NCHD	Daily
Occupational therapist	0
Social worker	0
Clinical psychologist	Access upon referral

Team Input

The multidisciplinary team met at Lincara day centre each week. It was reported that each resident was reviewed at least monthly by the multidisciplinary team. Records of these monthly reviews were maintained at the day centre. The CNM2 from the residence attended this meeting. The staff nurse at night time could contact the night CNM3 at Newcastle Hospital if required.

The staff level of one nurse on night duty was inadequate to facilitate the care of 15 residents in a high support community residence.

Medication

Prescriptions were written by the consultant psychiatrist or NCHD. With regard to physical illness, the resident's GP was called. The GP then wrote a prescription. All prescriptions were filled by the local pharmacy and collected by staff.

Depot medications were administered at Lincara day centre and recorded in the clinical file that remained there. The administration of the depot was also recorded in the residence's diary.

Information on medication was provided by the medical and nursing teams.

It was reported that two residents were self medicating.

Tenancy Rights

Rent was paid by residents on a weekly basis. Groceries were purchased by staff on a weekly basis using a procurement card that had been issued to three staff.

Utilities were paid by Newcastle Hospital.

Financial Arrangements

Each resident had their own post office or bank account. Most residents managed their own finance. The financial arrangements of three residents were managed by staff. In these cases the bank/post office books for each three residents were maintained in the office and two staff signatures were required on individual notebooks for accountability purposes.

Leisure/Recreational Opportunities Provided

The library was visited each week. There were two TV rooms to facilitate a choice of programme. A quiet area could be availed of in the conservatory that overlooked the side and rear gardens. A selection of books was available. Two broadsheet newspapers were delivered to the residence each morning. On the Sunday of each bank holiday weekend, all staff and residents went to a local restaurant for an evening meal. Regular pancake nights were held in the residence. Main meals were taken in the garden during the summer depending on the weather. Picnics were also taken in the park across the road during the summer. On the day of inspection, a resident's sixtieth birthday party was being arranged.

Service User Interviews

Most residents had left the building by the time of the inspection. Normally, the staff followed the residents to Lincara day centre. No resident had asked to speak to the Inspectorate. A number of residents were greeted by the Inspectorate.

Details of the local advocacy service were displayed.

The residents collaborated in the development of their care plans and co-signed them.

Conclusion

Ellerslie House was integrated into the community and was indistinguishable from other houses along the road. Neighbours were reported to be supportive of the residence and much community information reached the residents living within. From the nursing care plans, and evidence garnered during the inspection, there was evidence that the philosophy of the residence, which was to promote and encourage the independence of each resident so as to live meaningful lives in the community, was being practiced. The staff level of one nurse on night duty was inadequate to facilitate the care of 15 residents in a high support community residence.

Recommendations and Areas for Development

1. *Staffing levels at night should be increased.*

2. *Each resident's clinical file should be accessible on a twenty-four hour basis.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Kildare/West Wicklow, Laois/Offaly, Longford/ Westmeath
Mental Health Service Inspected	Laois/Offaly
Residence Inspected	Erkina House, Rathdowney
Total Number of Beds	17
Total Number of Residents	16
Number of Respite Beds (if applicable)	1 male
Team Responsible	Rehabilitation
Date of Inspection	25 August 2009

Description

Service Description

This 24-hour community staffed residence first opened in 1996 and was located in the heart of Rathdowney village. The house was built approximately 130 years ago and functioned as a convent prior to opening as a community residence. It was a two-storey house with bedroom accommodation upstairs and day rooms downstairs. At the top of the first flight of stairs, bedroom accommodation comprised two male rooms with four beds in each, with a curtain separating the room in half with two beds either side of the curtain. Up another few steps, there were 9 single rooms, 1 male toilet and separate bathroom and 1 female combined toilet and bathroom. There was a new toilet and accessible shower downstairs and a number of other toilets and a laundry room. The dining room was attached to a kitchen where all the meals were made on site.

There was a well-maintained, spacious and private landscaped garden to the back of the house. To one side there was a vegetable garden that had been developed and maintained by staff and residents. This facility provided a choice of activities and was particularly popular with some of the men who were not interested in some of the other activities offered.

The premises also housed a day centre that catered for up to 25 service users. The Birr sector team held an outpatient clinic there every two weeks and two rooms were also used by team members to schedule appointments in between clinics. One of the rooms was also used by a number of voluntary agencies to facilitate meetings. A nearby refurbished house had been converted to house the day centre and there was accommodation for the Birr team to hold clinics and appointments. The opening of these premises was awaiting staffing. The newly refurbished premises were of a very high standard. The new day centre and sector offices were due to free up more space for use by the residents. This also meant that residents who were able to attend the day centre would be going off site.

The philosophy of care was to support and encourage residents with mental health problems so that they can participate in all aspects of daily living and take an active role in the decisions that affect their lives. The resident's right to choose not to participate was also acknowledged.

Profile of Residents

Two men and two women were over 65 years and the other six men and six women were under 65 years. The youngest resident was aged 41 years and the oldest was aged 69 years. Seven of the residents had been accommodated there since Erkina House opened in 1996 and the remaining nine had been there between five months and five years.

Quality Initiatives and Improvements in the Last Year

- A new information booklet was introduced describing the residence and services provided. This was given to service users who were considering accommodation in Erkina House.
- A statement of purpose document had been developed that positioned Erkina House within the overall rehabilitation service provision of Laois/Offaly Mental Health Services, outlined the accommodation provided, the philosophy of care, mechanisms in place for consultation with service users, organisation of care, interventions offered, input from voluntary organisations, referral and admission criteria, staffing input and the model of care.
- Client and staff surveys in the Laois/Offaly service had been completed in relation to new care plans and information was being analysed. The residents and staff of Erkina House were due to receive feedback when the analysis was completed.
- Successful liaison with Laois Co. Council resulted in provision of a new boundary wall to the front of the building and a pedestrian crossing adjacent to the premises to enhance residents' safety.
- The furniture in the sitting room had been upgraded and rooms had been repainted.
- A gardening group had been established.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

All residents had a rehabilitation team assessment and care plan completed. These were reviewed approximately every six to nine months, or more or less frequently if required. The rehabilitation consultant attended Erkina House every week and each resident was discussed with nursing staff; residents were seen as required.

All of the residents were registered with a local GP and staff reported a close relationship with the GP and practice nurse. There was good access to specialist consultants and clinics through the GP.

The rehabilitation team had no health and social care professionals, so access to clinical psychology, social work and occupational therapy in mental health was limited to what could be provided through negotiation with the heads of discipline. There was some access to community occupational therapy and social work through the GP service.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

The activation area offered services to residents and day attendees. This was available five days a week and was run by a CNM1 and there was input from the occupational therapist from the Birr team and a social skills instructor from the rehabilitation team.

An art therapist from the rehabilitation team facilitated art and pottery classes and arranged visits to art exhibitions.

Although there were no health and social care professionals on the rehabilitation team, limited access was facilitated by heads of discipline in the Laois/Offaly mental health services where possible. There was also some access to these professionals through the GP.

There was a gardening group that residents could participate in.

There was access to voluntary agencies, e.g. GROW and the Mental Health Association.

Two of the residents were seeking supported employment through the Midland Employment Support Agency (soon to be renamed as EmployAbility Service).

How are residents facilitated in being actively involved in their own community, based on individual needs?

The premises were located in the centre of the village with easy access to a range of local facilities including the town library, pubs and shops. Residents could go to local cabarets and dances.

Residents were invited to all community functions through their close links with local social services. Some of the residents used the local library and there was access to local GAA events and golf club social activities.

The local community were invited to attend Christmas parties and sale of works in Erkina House.

One of the residents, an artist, had a local artist as mentor and exhibited his work at community exhibitions.

The local community were involved in fundraising for Erkina House through the Mental Health Association and the Laois Hunt.

The service had built and was actively maintaining good links with the local community by participating in local events and inviting the community in for special occasions.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

CCTV was used to monitor the external areas of the front and back door for security.

The premises were well maintained and there was good access to repair and maintenance staff. The decor was in very good condition and was sympathetic to the style of the building. All the rooms were bright and fresh, with the exception of one downstairs toilet that was in need of refurbishment.

The two male bedrooms required further work to ensure the privacy of each resident.

The house had a number of day rooms along with a spacious garden for the use of residents. It was anticipated that more space would become available to residents when the day centre and Birr team moved to the new day centre.

There was a health and safety statement in place.

Erkina House was ideally located in the centre of the town to facilitate ease of access for residents to local facilities.

Staffing Levels

Full Time in Residence

staff Discipline	Day WTE	Night WTE
CNM 2	2	0
CNM 1	0	0
Nurse	1	1
Household staff	2	1

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1
NCHD	0
Occupational therapist	0
Social worker	0
Clinical psychologist	0

Team Input

Weekly rehabilitation team meetings were held in Portlaoise. Due to resource issues, staff from Erkina House did not attend weekly but they reported to the meeting about any concerns or developments and there was close communication between the nursing team. Every quarter there was a full meeting of the rehabilitation team. The consultant psychiatrist attended every week and saw residents as required. The team had an art therapist and social skills instructor who had input to the day centre where some of the residents attended.

Medication

None of the residents were on self-medicating programmes at the time of the inspection.

Medication was included in the resident's care plan and card index reviews were carried out. The consultant psychiatrist carried out weekly reviews in Erkina House. Medication was supplied by a local pharmacy and included the manufacturer's patient information sheet. A number of residents on specific antipsychotic medication had access to an information video.

Tenancy Rights

The residence was owned by the Laois/Offaly Mental Health Services.

Generally the house rules were flexible but could be negotiated on an individual basis with staff. This was indicated in the booklet given to residents. Residents were asked to inform staff when they were entering and leaving the building. Drugs were not permitted.

Community meetings for the residents were facilitated as required when issues arose. There was a key worker system in place through which most issues were addressed.

The complaints procedure was outlined in the information booklet given to residents.

Financial Arrangements

There was a HSE policy and local guidelines in place regarding financial arrangements for residents.

All residents had a post office account. Four to five residents also had bank accounts. All were in receipt of social welfare.

Residents' money dealt with by staff was recorded in a book and signed by staff and the resident.

Leisure/Recreational Opportunities Provided

The day centre facilitated a range of recreational activities.

Swimming was accessible in Monasterevin.

Individual and group outings were available. Residents had an annual holiday with staff. There was access to a people-carrier vehicle, which was solely for the use of Erkina House.

Residents accessed the local library, pubs and shops.

At night there was access to cabarets, dances, pubs and residents socialised with staff and locals.

Service User Interviews

A number of residents were in Erkina House on the day of inspection. One of the residents had access to a workshop which he used as a studio for his art. He informed the Inspectorate that he had been involved in several exhibitions and was planning a further exhibition soon. He was very pleased with his accommodation as it had this added benefit for him. He was facilitated and encouraged by staff to pursue his artistic work and had teamed up with a local artist who was mentoring him and they accompanied each other to exhibitions.

Each resident was involved in their rehabilitation team assessment and care plan. Residents had signed their care plans.

The Irish Advocacy Network was active in the area and residents could access this service if required.

Conclusion

Erkina House was a bright, well-maintained and spacious residence providing high support accommodation for continuing care and rehabilitation to 16 residents of the service. It was situated in the centre of Rathdowney and local facilities were easily accessible. It was under the care of the rehabilitation team, which was under-resourced having no health and social care professionals.

There was no low support accommodation in the vacinity and residents had to move on to Portlaosie or Tullamore, which was very different to the rural small town environment provided in Erkina House. While this suited some, it did not suit others. Some residents had been able to access social housing through the local social services and remained in the community.

Seven of the residents had been there since the accommodation opened and it was unlikely that they would progress elsewhere in the service. This population had originally been moved from St. Fintan's Hospital and were an ageing group. This may pose some difficulties in the future as the house was not accessible to those with limited mobility and at present the only options were to move to high supported single storey accommodation in Tullamore or back to St. Fintan's Hospital, involving upheaval for the residents affected.

Recommendations and Areas for Development

1. *Alternative arrangements should be put in place to ensure privacy in the shared male bedrooms.*

2. *The number of residents in Erkina House (17 beds) was high and consideration should be given to lowering these to enhance the quality of life of the residents.*

3. *The day centre should open as soon as possible so that residents who can avail of this service have somewhere off site to go during the day.*

4. *The rehabilitation team should be fully resourced with health and social care professionals.*

5. *More formal time frames should be put in place to ensure regular mental and physical reviews of all residents.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	HSE Dublin Mid Leinster
Mental Health Service Inspected	Dublin West/Dublin South West Mental Health Services
Residence Inspected	St. Columba's, Crumlin
Total Number of Beds	17
Total Number of Residents	17
Number of Respite Beds (if applicable)	0
Team Responsible	Rehabilitation
Date of Inspection	1 October 2009

Description

Service Description

St. Columba's was situated in the top floor of a large box-like building in its own grounds in a suburban area of Crumlin. As a former monastery it had an institutional appearance. The grounds which until recently were overgrown, were currently being renovated by horticultural students.

The downstairs part of the building housed a day centre and community outreach team. Upstairs the residence catered for an ageing population with varying degrees of physical disability, but there was no lift. Plans to develop a purpose-built residence appeared to be shelved, although staff were somewhat confused about future plans for the service and the ownership of nearby sites. The emphasis was on continuing care because of the difficulty of moving people on to alternative accommodation.

Staff also had responsibility for managing the medium support hostel nearby.

Profile of Residents

The residence catered for seven male and ten female residents, aged from 36 to 75 years, who had been with the service for from 2 to 20 years. Most had been moved from in-patient hospital care. As well as a primary psychiatric diagnosis, five residents also had intellectual disability. Most had significant physical ill health and were in the older age group. Five residents were ready for discharge to nursing home care but this was not possible because of funding issues. Some residents presented with challenging behaviour and upset other residents by harassing or shouting at them. These people sometimes availed of respite beds in Lorrha Unit in St. Loman's Hospital.

Quality Initiatives and Improvements in the Last Year

- As a result of flooding in July, 10,000 euro was spent in repairing the roof.
- The medical team had reviewed patient medication. As a result, all medication regimes had been simplified and one resident had had medication discontinued without adverse effect.
- The team had worked with the local Mental Health Association to develop a housing project which will help accommodate some residents.
- Draft multidisciplinary care plans had been introduced.

- Case files with multidisciplinary care plans accompanied residents when they attended outpatient clinics with their sector team doctors, minimising the likelihood of poor communication leading to bad decision making. Community mental health nurses who knew the patients were also present.
- A daily communication sheet facilitated good communication between staff members and was kept in the patient notes.
- One room had been adapted as a smoking area.
- The service had been reduced by two beds in the last year, in an effort to increase space for residents.
- Heating had been introduced to a shower room and a basic pump had been installed.
- Staff could avail of ongoing training.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Draft multidisciplinary plans were in place and for review in November. Monthly multidisciplinary team meetings took place with the full team attending. However, the range and effectiveness of these plans was limited by shortage of multidisciplinary team members. The occupational therapist visited once a week and there was no psychologist attached to the rehabilitation team. The social worker time was shared with other parts of the service.

Physical health needs were addressed by the visiting GP who attended the service weekly. Staff reported that he was very supportive. An out-of-hours medical service was provided by the Dubdoc agency. Routine physical examinations were not being conducted. The service could link with the public health nurse in Primary Community and Continuing Care (PCCC).

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

An art therapist attended on a weekly basis. Staff reported that residents value this contribution, and had taken part in exhibitions and enjoyed their work being displayed around the unit. An annual exhibition of residents' art was held and relatives were invited. Some money for the art project had been lost because of financial cutbacks.

A dancing programme had been introduced for residents who could not leave the unit.

Residents had access to TV in their rooms where they provided this themselves. Otherwise access to TV was in the living area.

An occupational therapist visited the service for a half day each week.

A chiropodist and beautician visited.

Staff reported that the time spent on social activities had been reduced because of the level of demand on staff for nursing care.

How are residents facilitated in being actively involved in their own community, based on individual needs?

The service user group met monthly. It had an independent chair and staff attend. Outside agencies attended and gave talks on a variety of topics, e.g. advocacy, social welfare, and housing.

Residents who could, took part in activities and socials organised by the Crumlin district branch of the Mental Health Association every second week. This group also organised pub quizzes.

Some people could leave to visit local shops or go into town. People who need it, could be accompanied.

The PINEL project facilitating social skills training, organised by the Kimmage, Walkinstown, Crumlin, Drimnagh (KWCD) Partnership, had been discontinued due to cutbacks.

Transport was shared with Tallaght for outings and the Christmas party.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

The building was old and poorly maintained. The Inspectorate was informed that money had now been allocated for some improvements. The interior of the building was being painted on the day of inspection, but there was evidence that this had not been done for some time previously. Although there were two toilets and two baths and a shower with a toilet, only the latter was fully in use. The baths could not be used as they were too inaccessible for people with physical disabilities. There was therefore only one shower for all the residents. These facilities were located at one end of the building so that elderly or sick people had to walk a considerable distance to access them by day and by night. The Inspectorate was informed that a tendering process was in hand for two wet rooms.

The sluice room was old and in poor repair.

Most residents had their own bedrooms but there were four double rooms. These did not have curtains to facilitate privacy. Some beds were divan type, which was not conducive to hygiene control. More suitable beds had been requested but funding had not been forthcoming. The ceiling in some rooms had evidence of damage inflicted by the floods earlier in the year. Most rooms had their own wash-hand basins, but some did not. There were appropriate curtains on the windows. Over-sink mirrors were provided but no full-length mirrors.

Much of the furniture was old and needed to be replaced. One resident had bought their own bedroom furniture. The family of another had paid for the redecoration of their room.

Residents had a choice of diet and their suggestions had been listened to with regard to choice. Main meals were supplied by the Ballyfermot resource centre. At weekends and at night residents could avail of the house kitchen.

Staff reported that an environmental health officer visits every 6 months and improvements suggested had been met e.g. food was now probed for temperature control. Staff were Hazard Analysis and Critical Control Points (HACCP) trained.

There was one domestic staff member charged with daily cleaning of the premises. While generally the unit was clean, this could be better in some instances. Nursing staff reported that there was a need for more staff.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
CNM2	1	1
Staff nurse	1	1
Attendant	1	1
Domestic staff	1	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1 every 4 weeks or as needed
NCHD	Daily from day centre downstairs
Occupational therapist	1 half day per week
Social worker	By appointment
Clinical psychologist	As per sector team

Team Input

Multidisciplinary team meetings were held monthly by the rehabilitation team. Management of individual patients was decided by agreement between the sector and rehabilitation teams. Decisions were recorded in notes and the draft care plans, which accompanied residents to outpatients clinics. In addition residents' needs were discussed with their sector team when their team meetings were held in the day centre downstairs. Because of the number of teams involved, preference was expressed for the strengthening of the ties between one sector team and the rehabilitation team. It was felt the transfer of all residents to the care of the Crumlin sector team would facilitate tighter case management.

Medication

The medical team reviewed all residents' medications during the year, resulting in simplification of the medication regime for most residents, while one resident's medication had been discontinued without ill effect.

Information on their medication was provided to residents, based on what was available with medication packs. Where residents identified difficulty in understanding this, staff members reported they give information verbally.

No self-medication programmes were in place as staff believed this would result in poor adherence.

Tenancy Rights

Rent of 90 euro was paid to the HSE. No lease agreement was available to residents.

The user group, which met monthly, could comment on issues arising. At the user group's suggestion, greater food choice was introduced and a choice of holiday was decided. Members attended the Irish Advocacy Network conference two years ago.

Financial Arrangements

Rent was paid by monthly direct debit to the HSE from residents' bank accounts. Where residents were not able to access these accounts written permission was obtained from residents for staff to do so on their behalf. Small sums of money were kept on the unit for day-to-day expenditure. On admission,

house rules were presented to residents and signed by them. This was in accordance with the policy document which was signed and dated.

The HSE paid household bills and allowed 5,000 euro a month for shopping.

Issues of capacity were referred to the consultant psychiatrist.

Leisure/Recreational Opportunities Provided

The service was asked to forward information to the Inspectorate but did not do so.

Service User Interviews

Two service users interviewed reported they were happy with the service.

Conclusion

This service was provided in an old building which was unfit for the provision of a modern mental health service. It was physically deficient in basic facilities which should be available to adults sharing accommodation, particularly where these people were elderly or disabled, e.g. appropriate bathrooms and a lift. The lack of move-on accommodation had resulted in the service operating as a continuing care rather than a rehabilitation facility. All concerned were to be congratulated on the degree to which links to the local community had been encouraged. However, the increasing need for physical care for the ageing population meant less time was spent in rehabilitation-related activities by the nursing staff. The discontinuation of local community projects due to cutbacks impacted negatively on residents' quality of life.

Recommendations and Areas for Development

1. *The future of the service should be decided and the decision conveyed to staff.*
2. *The physical deficits of the building should be addressed to bring it into line with modern requirements.*
3. *Appropriate furnishings should be obtained.*
4. *Every effort should be made to facilitate the transfer of those residents who need it to more appropriate accommodation.*
5. *The rehabilitation team staffing should be completed in line with the recommendations of A Vision for Change.*
6. *The arrangements for sharing care between rehabilitation and sector teams should be reviewed.*
7. *Six-monthly physical reviews should be conducted and a record that this has been done should be entered into the patients' notes.*
8. *Future developments should facilitate single room occupancy for all residents.*

HSE South

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Waterford/Wexford
Mental Health Service Inspected	Waterford
Residence Inspected	Ard na Déise
Total Number of Beds	14
Total Number of Residents	13
Number of Respite Beds (if applicable)	1
Team Responsible	Rehabilitation
Date of Inspection	18 May 2009

Description

Service Description

Ard na Déise was a large residential house with 14 resident beds and 1 respite bed that opened as a 24-hour supervised residence in 1993. The house was laid out over three floors and had a very large garden. It was under the care of the rehabilitation team. Referrals came predominately from St. Otteran's Hospital and the aim of staff was to facilitate placement in independent accommodation for appropriate residents.

Profile of Residents

The current age range of residents was from 27 to 72 years. Some residents had been living at the residence since it opened in 1993. On the day of inspection, there were eight male and five female residents. With the increasing age profile of residents, the layout of the house may provide difficulties for the less able-bodied residents in the future. The residents were involved in various activities. Four of the residents attended the activation unit in St. Otteran's Hospital daily. This was an occupational therapy based activities centre. One resident was employed in St. Otteran's in the hospital laundry.

Quality Initiatives and Improvements in the Last Year

- Staff were implementing the Solution to Wellness programme for residents.
- All staff had participated in a music therapy programme in conjunction with the Waterford Healing Arts Group.
- Care plans for residents based on the Camberwell Assessment of Need (CAN) had been introduced.
- All staff had received regular training in cardio-pulmonary resuscitation (CPR).

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

A weekly team meeting was held in St. Otteran's Hospital and was attended by a member of staff from the house. The Camberwell Assessment of Need based care plan had been introduced but had not yet been drawn up for all residents. The key worker system was in place and residents were familiar with their key worker. Current care plans were updated monthly, and included risk assessments. Residents signed their individual care plans.

Six-monthly physical health reviews, including routine blood tests, were conducted by the resident's GP. Records of all GP and outpatient visits were recorded in the resident's file.

The consultant psychiatrist visited the house every two months, or more frequently if necessary.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

Five residents attended the activities centre in St. Otteran's Hospital daily, by public transport or in the residence's own minibus. One resident went to the day centre, and some residents helped with the household chores.

Residents in the house could attend music therapy, facilitated by staff.

How are residents facilitated in being actively involved in their own community, based on individual needs?

Residents frequently visited the nearby local shops. One or two residents assisted with the weekly shopping for the house in a local supermarket. Some of the residents also visited the local pub on occasion.

Staff had established a link with the Waterford Healing Arts Trust and Waterford Mental Health Association. Two members of the house met regularly in town with members of the Waterford MHA.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

The house was a large one with adequate living space. There was a large sitting room and dining room. Residents had easy access to a large garden, which was maintained by gardeners from St. Otteran's. Bedrooms were mostly double, with one triple room and three single rooms. There was evidence of damp in some of the rooms and staff reported that there was no contractor for cleaning of the outside windows of the house.

There was CCTV monitoring at the front door and around the front of the building, for security reasons.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
CNM/Staff nurse	2	1
Household staff	1	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1
NCHD	1
Occupational therapist	Access
Social worker	1

Medication

Medications were sourced in the local pharmacy and paid for through the medical card system. Depot medications were given in the residence. Written information on medications was provided by means of the information leaflet in the medication pack.

Tenancy Rights

Each resident paid, on average, €70 rent per week. Collectively, the house then pays rent of €1,100 per month to St. Otteran's. Beyond that, the residence was self-sufficient, paying for its own groceries, electricity, fuel, and diesel for its minibus.

Financial Arrangements

With a couple of exceptions, staff collected pensions for the residents. Residents then had access to their money in the residence as required. Two members of staff witnessed all financial transactions with residents.

Leisure/Recreational Opportunities Provided

Residents had access to a good range of recreational activities. There were regular outings to the cinema, drives, swimming, Sunday lunch and shopping. Birthday parties for significant birthdays were held in the house. Two residents were participating in a photography course run by Mental Health Ireland. There was no internet access in the house, which was felt to be a disadvantage for both residents and staff.

Service User Interviews

The service in Ard na Déise had produced an information leaflet on the house with details of the ethos, staff and recreational activities. An advocate from the Irish Advocacy Network (IAN) visited the house about every six weeks. Two residents attend a weekly peer support group.

Residents were informed of the visit and invited to speak with the Inspectorate. A number of residents spoke briefly around the house during the course of the inspection. One resident spoke in more depth and expressed overall satisfaction with the house. However, the resident indicated that they would like some more activities in the house, for example painting.

Conclusion

The residence at Ard na Déise was a comfortable house which easily accommodated the number of residents. There was evidence that some structural matters needed to be addressed. Residents had good access to facilities outside the house and it was clear that they were encouraged by staff to be as independent as possible. There appeared to be good links with the commercial agencies locally but interaction with neighbours in the locality seemed limited. Staff reported good access to the rehabilitation team and were keen to continue the implementation of the new collaborative care plans. Physical health needs were well monitored, with the clear cooperation of the local GPs. The staff level of one nurse on duty at night would seem to be inadequate for a residence catering for 13 residents.

Recommendations and Areas for Development

1. *The house should be maintained in a good state of repair and current problems with damp should be addressed.*

2. *Internet access should be made available for staff and residents.*

3. *An occupational therapist should attend the house on an intermittent basis and implement a programme of activities for those residents who are unable to attend outside activities.*

4. *Staff levels at night should be increased.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Carlow/Kilkenny/South Tipperary
Mental Health Service Inspected	Carlow/Kilkenny
Residence Inspected	Kelvin Court
Total Number of Beds	17
Total Number of Residents	17
Number of Respite Beds (if applicable)	None
Team Responsible	General adult
Date of Inspection	10 September 2009

Description

Service Description

Kelvin Court was a newly constructed unit for persons with an intellectual disability opened in February 2009, and was situated in the grounds of St. Dympna's Hospital in Carlow town. It consisted of four self-contained bungalows in a gated complex, surrounding a central garden area. Three of the houses contain five bedrooms with en suite facilities, a day room, dining room, and ancillary rooms for storage. The fourth house was designed to provide accommodation in two separate one-bedroom apartments. Residents in this house took their meals with the residents in one of the other houses. There were 17 residents in Kelvin Court and no resident was confined to bed on the day of inspection.

The houses were very clean, well-maintained, and bright. Each resident had their own spacious room, with adequate wardrobe facilities. Some of the rooms displayed personal items belonging to the residents, but this was absent in other rooms. All of the rooms had TV sets and DVD players, and had beds that could be adjusted by remote control. Communal areas were comfortably furnished. Each house had its own garden at the back of the house.

Profile of Residents

All the residents were in long-term care and had been transferred from St. Dympna's Hospital in February 2009. They included both male and female residents.

Quality Initiatives and Improvements in the Last Year

- The unit had only been opened since February 2009.
- Staff were receiving ongoing training specific to the area of intellectual disability, e.g. regulation of sensory interventions, multi-element behavioural support and use of multisensory equipment.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Psychiatric reviews: Although not an approved centre, all the residents were under the care of a consultant psychiatrist. However, it was reported that no psychiatrist visited the unit on a regular basis. A number of residents' files were examined. No psychiatric notes had been entered in the files since the discharge from St. Dympna's Hospital dated 13 February 2009. In the case of one resident, there were a couple of entries relating to physical complaints only. A few residents had multidisciplinary care plans drawn up in November 2008, but no further entries were noted. The service had drawn up a list of multidisciplinary care plans to be completed over the following months. Since the inspection, a schedule of psychiatric reviews had been implemented.

The file of one resident who had been the subject of an incident in the previous month was not available for examination on the day of inspection.

Physical reviews: A GP attended to the physical complaints of residents and it was reported that this service was very satisfactory. Physical health examinations had been carried out within the previous twelve months and were documented in the files. The service had established a system of alerting staff to the need for physical reviews.

Nursing: Night nursing reports were written weekly, and it was reported that day reports were written about three times a month.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

Most of the residents attended activities for part of the day in the activities centre that was adjacent to the houses. Residents who had difficulty in attending with others were given individual programmes. Residents were also taken on weekly outings by the nurses in the unit's dedicated wheelchair-accessible minibus.

How are residents facilitated in being actively involved in their own community, based on individual need?

Social outings to local community facilities took place regularly.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

The accommodation provided to residents was extremely good. Each resident had their own room, and there were communal rooms for watching TV.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
CNM 2	1	–
Staff nurses	4	–
Health care assistants	1	1

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	As required
NCHD	As required
Occupational therapist	0
Social worker	0
Clinical psychologist	0

Team Input

The unit was self-staffing. There were no staff assigned to the house with the two apartments during the day, but a health care assistant was on duty at night. Other health professionals rarely attended the houses.

All residents were under the care of a consultant psychiatrist. However, it was reported that the psychiatrist rarely attended the unit. A GP attended every three weeks to deal with physical ailments, and also attended as requested. Nursing staff praised the commitment of the GP in attending the unit.

Medication

Medication was provided from the community pharmacy.

Tenancy Rights

The building was owned by the HSE.

Leisure/Recreational Opportunities Provided

Residents had TV sets in their rooms and in communal sitting rooms. Staff took residents on outings in the unit's minibus.

Service User Interviews

Residents were greeted during the visit. Residents who could, expressed their satisfaction with the unit. One resident asked to speak in more detail. The resident reported not having seen a doctor since arriving in the unit, and wished to speak to a doctor.

Conclusion

Kelvin Court provided far superior accommodation for residents than previously experienced in Kelvin Grove, where these residents lived prior to their move to interim accommodation in St. Anne's Ward in St. Dymphna's. Residents attended activities in the activities unit in the grounds of the hospital. Physical health needs were met by a local GP.

It was unclear whether the primary treatment being provided to the residents was a psychiatric one, under the clinical direction of a consultant psychiatrist, or whether the primary nature of the service was to provide residential care to persons with a mental disorder, in this instance, intellectual disability. The unit was currently not registered as an approved centre with the Mental Health Commission.

Recommendations and Areas for Development

1. *A consultant psychiatrist in mental health of intellectual disability should be appointed.*

2. *Residents should be reviewed regularly by the psychiatric team, and multidisciplinary care plans should be completed for each resident.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	North Lee/North Cork
Mental Health Service Inspected	North Lee
Residence Inspected	Owenacurra, Midleton
Total Number of Beds	32
Total Number of Residents	31
Number of Respite Beds (if applicable)	2
Team Responsible	General adult
Date of Inspection	1 September 2009

Description

Service Description

Owenacurra 24-hour residence provided long-term care to residents admitted under the care of the community mental health team. It was a single-story building, built in the 1960s. It began admitting residents in 1988. It was the first residence to admit patients from Our Lady's Hospital in Cork when that institution began to transfer its patients to community residences. A number of the current residents were transferred from Our Lady's. The residents had a variety of mental illnesses.

Profile of Residents

On the day of inspection, there were 31 residents ranging in age from 42 years to 93 years. There were 14 male and 17 female residents. Half of the residents were over 65 years of age, and approximately 16 residents had been transferred from Our Lady's Hospital in Cork in 1988. The majority of residents were long stay, but the two most recent admissions were in 2008.

Quality Initiatives and Improvements in the Last Year

- Since the last inspection, the service had replaced the Roper nursing care plans with a more collaborative Tidal care plan.
- A hygiene audit was conducted in 2008 in the kitchen. Its recommendations were followed up, which resulted in some changes in the practice of food preparation.
- Three nurses had completed a degree course in nursing, and one nurse had completed a master's degree.
- Two nurses completed a hand hygiene course and subsequently trained the remainder of nursing staff.
- Four residents participated in, and completed a National Learning Networks course.
- Other nurses did courses on medication in the elderly and on geriatric nursing.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Over the past two years, the nursing care plans had changed to the Tidal model of nursing care. This was a collaborative model which involved the resident in the formulation of their individual care plan, and which was signed by them. The multidisciplinary team met twice monthly, and was attended by the consultant, NCHD, social worker and nursing staff. Each resident had a psychiatric review carried out twice a year, and a full physical health review done yearly, including routine blood tests. In addition, a monthly record of weight was kept.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

Activities in the residence were provided by the nursing staff, and include newspaper readings, relaxation tapes, outings, assistance with personal shopping, and one-to-one talks with residents.

About six residents attended the psychiatric day centre that was situated across the road from the residence. In addition to attending occupational therapy activities in the day centre, residents had access to psychology services there. From time to time, the occupational therapist on the community team carried out assessments on residents of the residence. The social worker attended the residence three days a week, and was also available on other days.

Access to physiotherapy was through the community service, although arrangements could be made for private appointments. A chiropodist attended every three months and residents were facilitated in attending dental, optician and hearing test appointments.

Over the previous two years, four residents had completed courses in the National Learning Network centre in the town.

How are residents facilitated in being actively involved in their own community, based on individual needs?

The 24-hour residence was very well situated in Midleton town, at the end of the main street. Able-bodied residents could easily access the amenities of the town and visit shops, banks, and cinema with little difficulty. Residents attend the local Christmas old age party, and St. Patrick's Day parade.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

The residence was well maintained and clean. There were 15 single rooms, and the remainder of rooms were 2-bed or 3-bed. In addition, two single rooms were assigned as respite beds. Many of the single rooms were homely and personal memorabilia were displayed. The 2-bed and 3-bed rooms all had curtained partitions, affording privacy to residents. There were two sitting rooms, a dining room and a multifunctional room which also served as a visitors' room. The building itself was more reminiscent of an institution in layout, rather than a house. It had a pleasant enclosed garden.

Food was prepared on site in the kitchen.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
ACNO	1	–
CNM 2	1	1 (acting)
Staff nurse	3	2
Contract cleaner	2	
Kitchen staff	3	
Secretarial staff	1	

All nursing staff had psychiatric training and a number were dual qualified in psychiatric and medical nursing. Student nurses were attached to the residence as part of their training.

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	Fortnightly
NCHD	2 days a week
Occupational therapist	Access
Social worker	On site three days a week
Clinical psychologist	Access

Team Input

The consultant psychiatrist attended the residence fortnightly, and the NCHD was in the residence two days a week. Reviews of residents were held six monthly.

Medication

Psychiatric reviews, including review of medication were conducted six-monthly. Medications were charted in the residents' card index by the consultant or NCHD, which had then to be brought to the local GP who issued a prescription for the resident. This prescription was then filled in the local pharmacy and dispensed. Medications were administered by the nursing staff.

Tenancy Rights

The residence was owned by the HSE.

Financial Arrangements

Residents paid maintenance of 152 euros a week. The remainder of their pension income was either held in the nurses' office in the residence, where the resident could access it, or was deposited in a bank or post office according to the wishes of the resident. Administration staff managed patients' private property on behalf of the patient.

Leisure/Recreational Opportunities Provided

The residence had two TV sets and a DVD player. Staff had access to transport from the day centre and were able to bring residents on outings and trips.

Service User Interviews

Residents were greeted by the Inspectorate during the inspection, but none requested an interview.

Conclusion

Owenacurra was a large 24-hour residence in Midleton town which provided long-term care for 32 residents. It was well maintained and offered pleasant accommodation for its residents. The recent introduction of a different plan of nursing care had resulted in residents being more involved in their own care plan. Residents had a good plan of care for physical health, but would also benefit from input from occupational therapy. While nursing staff clearly provide activities for residents of a non-institutional nature, the size of the unit and the number of residents make it difficult to get away from the appearance of a small institution; this was perhaps contributed to by staff wearing nursing uniforms. It was clear from the level of engagement by nursing staff in the educational process that staff were committed to providing a good quality service to the residents. The arrangement relating to medication seemed cumbersome and resulted in duplication of service from both medical and nursing staff.

Recommendations and Areas for Development

1. *A computer and internet access should be provided for staff to enable ready access to information on blood tests, medications, etc.*

2. *The team attending the residence should be resourced to provide a better staff skill mix, particularly in occupational therapy.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	South Lee/West Cork/Kerry
Mental Health Service Inspected	West Cork
Residence Inspected	Perrott House
Total Number of Beds	23
Total Number of Residents	23
Number of Respite Beds (if applicable)	0
Team Responsible	General adult
Date of Inspection	1 September 2009

Description

Service Description

Perrott House was located in the grounds of the community hospital in Skibbereen. It opened in 1996 and was previously an acute mental health admission unit. Most of the residents moved to Perrott House following the closure of Our Lady's Hospital in Cork and the residence was regarded as their home. However a number had moved to Solas Nua, a residence that had a more dedicated rehabilitation focus.

The residential service had recently been reconfigured in order to accommodate service users according to their assessed need.

Profile of Residents

Most of the residents were elderly and had been in the residence since it opened in 1996. There were 15 men and 8 women residents. The average age was 67 years and the average length of stay was 13 years.

Quality Initiatives and Improvements in the Last Year

- The service had been reconfigured as a result of an ongoing residential review.
- Each resident had an individual care plan.
- A questionnaire was currently being rolled out from the West Cork Cooperative Learning Leadership Group.
- A carers pack had been developed.
- There was an excellent garden consisting of a relaxation and therapeutic area and a vegetable garden.
- Pet-assisted therapy was available to residents.
- There was music therapy and art therapy available.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Each resident had a multidisciplinary care plan. There were monthly multidisciplinary team meetings and a key worker system was in place.

Physical examinations were completed by the GP every 6 months. The GP attended once a week or more often if required.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

- There was a staff member dedicated to therapeutic activities.
- There were garden projects in place. This included an annual plant sale.
- There were regular relaxation and reflexology sessions.
- Regular story-telling and music therapy took place.
- Art therapy took place and this included an annual art exhibition.
- A music in healthcare programme was due to start in September 2009.
- Cookery classes took place.
- VEC tutors attended on a weekly basis to provide the art, relaxation and gardening.

How are residents facilitated in being actively involved in their own community, based on individual needs?

The residence was situated about 1.5 km outside the town of Skibbereen and most residents were unable to travel into town independently. There was no public transport. There was a people-carrier vehicle belonging to the residence and social outings to the town took place at least three times a week.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

Perrott House was originally an acute unit and the structure reflected this. Most residents did not have single rooms but curtains were provided around the beds. Each sleeping area was personalised. Each resident had a locked box for private possessions.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
Nursing	3	2 x 12 hours 1 x 2 hours
Care assistants	1	0
Activities staff	1	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	Once a month
NCHD	Once a week
Occupational therapist	On request
Social worker	On request
Clinical psychologist	0
Physiotherapist	On request

Team Input

Multidisciplinary team meetings took place once a month and all disciplines attended. Care plans were completed at these meetings. The GP attended once a week, or more often if required. A nurse attended all outpatient appointments with the resident.

Medication

Medication was reviewed once a week by the GP. No resident was self-medicating. Information on medications was on request.

Tenancy Rights

The premises was owned by the HSE and the residents paid weekly rent and upkeep of 120 euro. Each resident had a means assessment completed prior to any changes and on an annual basis.

There were written house rules about smoking and eating in the dining room. There was a regular community meeting.

Financial Arrangements

A local policy on financial arrangements was in draft form, awaiting sign-off. Each resident had their own bank or post office account and receive regular statements. Assistance was provided where necessary with regard to withdrawals and lodgements.

Leisure/Recreational Opportunities Provided

Recreational and leisure activities included yoga, walking, TV, gardening, and social outings.

Service User Interviews

A peer advocate visited Perrott House every week. Details of contact for the advocate were displayed in the residence. There were also other relevant information leaflets displayed. The advocate took part in policy making and development issues on behalf of the residents.

Residents stated that they were very happy with their care and treatment. They also liked Perrott House as a residence and regarded it as their home.

Conclusion

Perrott House was part of a large complex of HSE facilities and a community hospital. It was situated at some distance from the nearby town and community integration was therefore limited. There was good psychiatric, multidisciplinary and medical input. Each resident had a multidisciplinary care plan, there were monthly multidisciplinary meetings and a wide range of therapeutic activities and leisure activities. There were regular physical reviews and a GP visited weekly.

The population was elderly with limited potential to live independently. However a more rehabilitative accommodation was available if necessary. The premises were old and quite institutional. However there were plans to build an extension which will address some of these difficulties.

Recommendations and Areas for Development

1. *The local financial policy should be signed off as soon as possible.*

2. *Renovations to the residence should take place as soon as possible.*

HSE West

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Donegal, Sligo/Leitrim, West Cavan
Mental Health Service Inspected	Donegal
Residence Inspected	Cleary House, Letterkenny
Total Number of Beds	20
Total Number of Residents	12
Number of Respite Beds (if applicable)	4
Team Responsible	Rehabilitation
Date of Inspection	13 October 2009

Description

Service Description

Cleary House was a purpose-built single-storey residence opened in 2000. The facility had 20 beds, including four respite beds, and was under the direction of the rehabilitation and recovery service. It was reported that the residence was in transition to facilitate the closure plan for St. Ciaran's Ward in St. Conal's Hospital. The aim of Cleary House was to provide a quality service for residents, holistic in approach, which promoted the rehabilitation of residents while assisting them to achieve maximum independence. It was reported that the residents had input into developing the service's mission statement, ethos and philosophy. Cleary House closed each day between 1130h and 1630h. During this period, staff and some residents were based in the day centre at St. Conal's Hospital. It was reported that most residents attended their programmes or employment during this period and only attended the day centre for meals and medication management. There were ten low support houses attached to the service with no medium support residence. It was planned to reconfigure three low support houses in close proximity to one another and develop these into a medium support cluster with increased staffing available at evenings and over weekends.

Profile of Residents

There were ten male and two female residents on the day of the inspection. The individual length of stay currently varied from six months to nine years. The age profile of residents was between 28 and 75 years. The service had an admission policy that also incorporated discharges.

Quality Initiatives and Improvements in the Last Year

- A pin-point alarm system had been installed.
- Each resident's intellectual disability profile was posted on their clinical file.
- Residents' medications were stored in individual compartments in the medication cupboard.
- The multidisciplinary team documented clinical reviews in a single composite clinical file for each resident.

- The STEER Ireland independent advocacy service now attended the residence twice a month.
- A new conservatory and patio area had been developed.
- An automatic emergency defibrillator (AED) machine was now provided on site and staff had undergone training in its use.
- The fire doors were now automated.
- New pine beds and wardrobes – built in the workshop in St. Conal's Hospital – had been provided to each resident.
- Funding had been accessed from the local VEC for classes in the day centre.
- Two new flat-screen TV sets had been purchased, funded by the Lotto and by a generous donation from the family of a recently deceased resident.
- New leather furniture, selected by the residents, had been placed in the communal areas.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Each resident, with the exception of a number of residents who had refused, had a multidisciplinary care plan called Client's Assessment of Strengths, Interests and Goals (CASIG). These care plans were regularly reviewed and evaluated at review meetings by the rehabilitation and recovery team. It was reported that the residents who had refused the CASIG care plans had done so as they had perceived them to be an initial step to leaving the residence to lower support housing. All residents had nursing care plans based on the Orem Leninger model. Three clinical files were examined by the Inspectorate and all had six-monthly physical reviews carried out by the NCHD attached to the service and regular psychiatric reviews. There was evidence of multidisciplinary input from all members of the rehabilitation and recovery team into the composite clinical files. All residents had their own GP. The consultant psychiatrist visited weekly.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

It was reported that the residents of Cleary House were supported and encouraged to maximise their potential. This was evidenced by the quality of each resident's multidisciplinary team assessment and the input of the team into continuous review. Most residents, apart from those residents who refused for reasons indicated above, had a key worker from the rehabilitation and recovery team, for example a CNS, occupational therapist, or health care assistant. Individual assessment programmes included daily living skills, household skills, personal hygiene, budgeting skills, concordance training (medication education and management), horticulture training, alcohol and drug relapse prevention, the Steps programme through Worklink, and attendance at Cara House Family Resource Centre, which supported health, well-being and quality of life of families and individuals in Letterkenny through social, recreational and educational activities. Two residents were employed through a VEC-supported scheme.

It was reported that residents of Cleary House did not have access to the kitchen facilities due to Hazard Analysis and Critical Control Points (HACCP) regulations and that a request had been made by

the rehabilitation and recovery team for a training kitchen to develop more independent living skills programmes for suitable residents.

How are residents facilitated in being actively involved in their own community, based on individual needs?

Cleary House was situated in Knocknamona, a residential suburb on Letterkenny's east side. It was serviced by a public bus route but it was reported that this service was irregular. The residence had its own vehicle for the purposes of transporting individuals. The CASIG care plans identified each resident's strengths, interests and goals. Some residents were attending an Autumn Programme in Cara House. There was good participation at groups such as the walking group, cinema group and dance, voice and movement group. Social outings also took place, whether for small groups for Sunday lunch, or larger groups for day trips away. It was reported that the annual Cleary House Christmas party was well-attended by neighbours, family, friends and staff.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

Cleary House was a well-decorated, well-maintained, clean, modern, purpose-built single-storey residence opened in 2000. The bathroom areas and shower and bathing areas were very clean and in a good state of decor. All residents were cared for and treated in a setting that was safe. There were eight double rooms and four single rooms. The beds looked comfortable and wardrobe space was good. The beds in the double rooms were without privacy curtains.

All areas within Cleary House were wheelchair accessible.

Meals using the cook-chill method were delivered from the main kitchen in St. Conal's Hospital. The main meal of the day was provided at the day centre. At weekends, Cleary House bought in the services of a chef from Letterkenny General Hospital. It was reported by staff and residents that the meals during the weekend were of a better standard and quality than the cook-chill meals served in the day centre on weekdays.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
Nursing	2 staff nurses and 1 CNM2	2 staff nurses
Health care assistant	0.8	0
Household	1	0
Secretarial support	4 hours a week	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1 session a week
NCHD	1 session a week
Occupational therapist	As required following MDT review
Social worker	0
Clinical psychologist	As required following MDT review

Team Input

The rehabilitation and recovery team held a case review every Tuesday morning in the Willows day centre. All members of the multidisciplinary team could request an appointment slot in advance for discussion. Minutes were kept of this meeting. The service user attended the review and care plan meetings, which were held every Tuesday afternoon. The key worker could book an appointment and invite all stakeholders that the service user requested to attend. Cleary House held out-patient clinics by the consultant psychiatrist and NCHD once a week.

Medication

Medications were reviewed whenever required and at least every three months. Medication management training was carried out with service users by the key worker in preparation for the step down to independent living. No resident self-medicated. The process of prescribing, storage and administration of medication appeared satisfactory.

Tenancy Rights

Cleary House was owned by Donegal Mental Health Services. Residents contributed financially towards rent and housekeeping by their individual financial assessment forms which were kept separate to their clinical file in Cleary House. The house rules detailed in the resident information booklet were reasonable.

Financial Arrangements

Each resident had their own individual account within the service and also their own individual credit union account. The financial arrangements of each resident were overseen and managed by an administrator within the health service but separate to Cleary House. These financial arrangements were examined by the Inspectorate and appeared in order. Cleary House used the HSE's national policy on financial management in community residences.

Leisure/Recreational Opportunities Provided

The residence had two large flat-screen TV sets in two communal areas. There was also a conservatory area for residents who wanted to avail of silence or who wished to read. There was an exercise room with a treadmill and an exercise bike. A computer with internet access was also available to residents. The walking group, cinema group and dance, voice and movement group were well-attended. There were many areas where visits by relatives and friends could be accommodated. Residents also took part in social outings and attended many local sporting events. The garden had a smoking shelter. Seating areas were also available in the garden.

Service User Interviews

Cleary House had a resident information booklet that outlined the mission statement and philosophy of the residence, the team members, daily routines, house rules, facilities and services available. Access to information was excellent. There was information on many different clinical diagnoses. Information on STEER and contact telephone number was available, as was information on many voluntary and support groups. Residents who had a CASIG care plan had input into this plan of care and co-signed it with their key worker.

Conclusion

It was evident from the inspection of Cleary House that the residents were participating actively in rehabilitation and recovery. There was much evidence of excellent multidisciplinary team working through the key worker system and the regular multidisciplinary team reviews. The CASIG care plans were ideal for the cohort of residents at Cleary House and it was unfortunate that a small number of residents had refused to participate in these assessments and care plans.

Recommendations and Areas for Development

1. *All beds in dormitories should have privacy curtains installed.*

2. *The plan to develop the medium support houses should be expedited.*

3. *The development of a training kitchen for independent living skills programmes for suitable residents should be expedited.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Limerick, North Tipperary, Clare
Mental Health Service Inspected	Limerick
Residence Inspected	O'Connell House
Total Number of Beds	25
Total Number of Residents	23
Number of Respite Beds (if applicable)	1
Team Responsible	Rehabilitation
Date of Inspection	10 July 2009

Description

Service Description

O'Connell House was a square-shaped single storey building opened in 1989, situated in a suburban area of Limerick. It provided continuing care for an older population. Within the building was a well maintained garden that was used to facilitate residents and visitors who wished to smoke. A separate smoking room was provided. An independent day centre was situated in the building which some residents attended.

Staff reported that many residents regarded the unit as a home and the people there as family. They were proud of the fact they had recently been able to provide palliative care to a long stay resident who had died a few days previously. She had been waked in the residence. Residents had attended her funeral and they had gone to a hotel for a meal afterward at the resident's request.

Families of some residents provided support to others who did not have access to family members.

A question mark lies over the future development of the service as it may apply for designation as an approved centre for the use by the psychiatry of later life team, whose patients were situated in St.Camillus Ward in Limerick at present. Plans were being developed by service management to move residents to community facilities in preparation for the change.

Profile of Residents

On the day in question, there were 11 men and 12 women in residence, with ages ranging from late twenties to 90 years old. Most were in the older age group. Many of the residents were transferred from St. Joseph's Hospital. Some residents had been living there for more than 20 years.

Quality Initiatives and Improvements in the Last Year

- Two shower rooms were refurbished.
- In-service training was held in June in diabetic care. Four nurses attended.
- A self-medication management programme had been initiated to facilitate the discharge of residents.
- Palliative care was provided for one resident who had lived in O'Connell House for many years, with the aid of the nearby Milford Hospice Service.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

General medical care was provided by the local GP who called as required. He was affiliated with the Shannondoc medical service which provided cover out of hours.

Physical health reviews were carried out annually in most instances. However, on the day of the inspection, five of these reviews had not been completed. No copies of the reviews or notes that they had been done were entered in the residents' files.

Multidiscipinary team meetings were held monthly.

There was no psychology service and one resident's family were engaging a psychologist privately.

Nursing care plans were in place.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

Nurse therapists trained in cognitive behavioural therapy were available to help residents deal with hearing voices.

There were newspaper and relaxation groups. Reminiscence groups had recently been temporarily discontinued because of service demands.

Some residents attended the independent day centre which was next door and availed of the snoezelen multisensory room.

There were two visiting rooms and visitors could also use the garden. Staff reported there were many visitors, especially on Sundays. Children were welcome.

How are residents facilitated in being actively involved in their own community, based on individual needs?

Some residents attended the Desmond community complex for the elderly, which was situated next door to the residence. One resident worked there on a FÁS community employment scheme. Residents attended social activities there in the evenings, e.g for films. They also were free to go into town and shop for themselves. For those residents not able to do this, a local shop brought a selection of clothing to the house and residents could buy their clothing in this way.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

O'Connell House was provided in a quiet suburban area. The house was well maintained, bright and comfortably furnished. Maintenance was provided by the maintenance department, St. Ita's Hospital.

There were four 3-bed rooms, a 6-bed room, and single rooms with their own sinks. Two of the three separate shower rooms had recently been refurbished. One existing shower room had been retained at the residents' request. Better extractors were needed for this room, which was affected by condensation on the day of the inspection.

Living quarters were personalised with photographs and residents' belongings. Curtains were provided around bed areas and each resident was provided with their own storage space.

A kitchenette that was originally used for teaching activities of daily living had more recently been used as a diabetic kitchen, due to the demands of the current population. Staff liaised with a CNS with regard to diabetic care. Meals were cooked on the premises. The kitchen was Hazard Analysis and Critical Control Points (HACCP) compliant. A fish alternative was provided to the main meat dish for those who wished it. Special diets were catered for. The dining room was bright and spacious.

Fire inspections were carried out annually. The last report was for 5 December 2008. Recommendations made had been carried out. Fire alarms were checked every three months by Siemens.

Medications were stored in a medication room. They were ordered from the community pharmacy on a three-monthly basis unless otherwise required. On the day of inspection, one of the floor tiles was loose and dangerous. However, this was to be repaired later in the day.

There was good access to St. Ita's geriatric hospital, which was next door. Their ambulance, physiotherapist and pastoral care service were available on request.

A representative of the Irish Advocacy Network visited the training centre regularly and on request visited the community residence.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
CNM2	1	–
CNM1	1	–
Staff nurse	2	2
Cook	1	–
Household staff	1	–

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	1 monthly
NCHD	1 monthly
Occupational therapist	1 monthly (nurse therapists run groups)
Social worker	0
Clinical psychologist	0
Other	0

Medication

Six-monthly psychiatric medication review schedules were kept by nursing staff.

These reviews were conducted by the psychiatrist. However, three sets of notes examined by the Inspectorate showed no evidence of specific scheduled reviews taking place.

There was no evidence in the notes that scheduled annual reviews by the GP had taken place, except where this had been entered by nurses in the nursing notes.

The only written information for residents on medication was that provided with medication packs. Staff said verbal information was given, but this was an area that should be improved.

Medication was blister packed, as a self-medication programme had commenced in anticipation of residents moving to nursing homes.

Tenancy Rights

Residents paid 25 euro a week to Limerick Mental Health Services for rent, a further 25 euro was paid for food and general upkeep of the house and 10 euro was kept for comforts. Residents did not have a tenancy agreement. The HSE paid for larger bills, e.g. oil and telephone. There were no house rules but residents were asked to let staff know if they were going out. There were no formal house meetings, but informal meetings tended to take place around meal times. The Inspectorate was informed that residents were involved in all aspects of life in the house, e.g. the recent funeral.

Financial Arrangements

All residents had their own pension books. Nursing staff collected the money for those not able to do so themselves. The balance of their pension, kept in their own post office account, was accessible by themselves or on request. A petty cash account could be kept in the office at the resident's request. The register for this was audited annually and spot checks were done. Procedures and protocols were in place.

Leisure/Recreational Opportunities Provided

Bingo, TV, yoga, films were available in the nearby Desmond complex.

Service User Interviews

The service users interviewed expressed themselves happy with their care.

Conclusion

O'Connell House was a bright well-maintained facility for mostly older people who were referred by the psychiatric rehabilitation services. Many of the residents had been there for many years and had developed strong ties with the service and the other residents. The atmosphere in the unit was warm and welcoming and residents seemed pleased with the service.

Recommendations and Areas for Development

1. *A record of medication reviews should be entered into the notes by the psychiatrist.*
2. *All physical reviews should be done at least annually.*
3. *A record of annual physicals performed should be entered into the notes by the GP.*
4. *Written information on mental illnesses, treatment, medication and recovery should be provided.*
5. *Condensation in the shower area should be addressed.*

Mental Health Services 2009
Inspection of 24-Hour Community Staffed Residences

Executive Catchment Area	Galway, Mayo and Roscommon
Mental Health Service Inspected	East Galway Mental Health Services
Residence Inspected	Toghermore
Total Number of Beds	23
Total Number of Residents	23
Number of Respite Beds (if applicable)	3
Team Responsible	General adult
Date of Inspection	30 September 2009

Description

Service Description

Toghermore House was an old period residence of unknown age but which featured on the Ordnance Survey maps of 1836. A large extension had been added in the early 1980s. The house, set in the midst of wood and park land of about 10 hectares (25 acres), was presented to a Trust to have it used as a charitable institution. The house was subsequently handed over to the then Western Health Board in 1974. Adjacent to the house was Toghermore Training Centre, a coffee shop, pitch and putt course and three Bocce courts with adjacent covered stand for spectators. The house provided two lunch sittings for residents, staff and attendees of the training centre, which amounted to about 100 people.

It was reported that the purpose of Toghermore House was to provide safe and comfortable surroundings to residents with the aim of meeting their current needs, plan for future needs and to provide meaningful age-appropriate and resident-appropriate occupation to improve quality of life and encourage independence and personal development. The training centre provided work and training facilities for persons with mental health problems, physical disabilities and intellectual disabilities.

Toghermore House was under the clinical direction of a general adult team and cared for persons with a history of enduring mental heath problems in the Tuam/Headford sector of East Galway.

Profile of Residents

On the day of inspection, the age profile of residents was from 32 to 80 years. There were a total of 23 residents: 12 female and 11 male. Length of stay depended on the individual. There were a number of community houses located in the town of Tuam which provided varying degrees of support: two high support houses, two medium support houses and six low support houses. Residents of Toghermore moved on to these facilities following assessment. In other cases, residents from low and medium support houses moved into Toghermore following continual assessment based on individual need.

Respite beds were also available for residents of private dwellings who were known to the service to facilitate family and carers. It was subsequently reported that in other cases, residents from low and medium support houses could avail of respite in Toghermore House following clinical assessment.

Quality Initiatives and Improvements in the Last Year

- An annual hygiene audit had recently been completed.
- The multidisciplinary team care plan had recently been modified.

- A six-week smoking cessation group took place once a year.
- BreastCheck, through the Marie Keating Foundation, had provided a service in Toghermore House.
- Five nurses had undergone training in phlebotomy.
- Monthly meetings were held to discuss issues such as menu planning and social and living conditions.

Care Standards (Based on MHC Quality Framework and 2008 Inspection Self-Assessments)

Individual Care and Treatment Plan

Each resident had an individual multidisciplinary care and treatment plan, called a Multidisciplinary Management Plan. All residents were reviewed by the multidisciplinary team twice yearly and this review was documented in the individual care and treatment plan.

A daily nursing assessment and nursing care plan was also maintained.

It was reported that an attempt had been made by nursing staff to introduce individual risk assessments, which were present but blank in each clinical file. It was reported that for operational reasons these had not been commenced.

It was reported that each resident had their own GP. It was also reported that each resident had a full physical examination carried out by their GP annually. However, the GPs maintained these records at their practices and, although it was reported that the GP liaised with the service on the findings of these physical examinations, it was difficult for the Inspectorate to find records of these GP visits in the residents' clinical files.

Therapeutic Services and Programmes Provided to Address the Needs of Service Users

The majority of residents attended the training centre adjacent to the house.

A programme of activities available for residents who didn't go to the training centre was outlined on the house groups timetable. These included Solutions for Wellness, relaxation, current affairs, a smoking cessation group, gentle exercise, music appreciation, monthly chiropody visit, and a weekly visit by the hairdresser.

Two service user-led groups, the garden group and the walking club, were regularly attended.

How are residents facilitated in being actively involved in their own community, based on individual needs?

Toghermore House was located in a rural setting within lands of about ten hectares, approximately three kilometres from the town of Tuam. The tree-lined drive from the gate to the house was approximately one kilometre in length, of uneven surface and unlit at night. It was reported that some residents enjoyed the walk into town but most were driven to the town centre by taxi or by the service's minibus. It was reported that many of the residents were from a rural background and enjoyed living in this rural setting. It was reported that many of the residents had expressed no wish to live closer to the town.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy?

Toghermore House was last inspected in 2005. It was then reported that the residence *"was in need of extensive refurbishment, e.g. to the electrical system and the roof. The toilets and bathroom area were inadequate and not suitable."*

On the day of inspection, it was reported that the electrical system had undergone a complete overhaul and that the entire house had been rewired.

The roof had not been attended to and it was reported that there were many leaks into various areas such as bedrooms, offices and corridor areas.

While the downstairs toilet, bathroom, and shower areas had been completely upgraded, this upgrade had not extended to the upstairs male and female toilet, bathroom, and shower areas which, on the day of inspection, were very clean but unfit for purpose. There were seven steps leading to the upstairs female toilet, bathroom, and shower area and these were quite steep although hand rails had been provided.

It was reported to the Inspectorate that it was difficult for staff to acquire essential ongoing maintenance of the house except in cases of emergency. The Inspectorate examined and acquired photocopies of maintenance requests that had been submitted over the previous five months and that had not been attended to. These included: holes in walls in two male dormitories, light fittings loose over beds, toilet seats missing, cisterns in toilets without covers, toilet-paper holders missing, faulty door handles on bedroom doors, loose lino on steps outside the female toilet, a number of windows having broken latches, ceiling leaking on the male corridor, a bar spanning a stairway needing to be assessed, and the house needing to be painted throughout.

Accommodation in the female section consisted of one 2-bed dormitory, two 3-bed dormitories and one 4-bed dormitory. Accommodation in the male section of the house consisted of: three single rooms, three 2-bed dormitories, one 4-bed dormitory and one 5-bed dormitory.

Most dormitories had no privacy curtains around the bed spaces, which resulted in residents having little or no privacy.

Staffing Levels

Full Time in Residence

Staff Discipline	Day WTE	Night WTE
RPN	4 including 1 CNM2 and 1 CNM3	2
Multitask attendant	1	0
Social care leader	1	0

Sessional

Discipline	Number of Sessions
Consultant psychiatrist	When required
NCHD	1 weekly
Occupational therapist	Sessional
Social worker	Access
Clinical psychologist	Access

Team Input

Each resident had a named key worker. It was reported that a team meeting occurred each week. This team review was attended by the NCHD, nurses, occupational therapist and social care leader. This review was documented in the multidisciplinary management plan.

It was reported that the consultant psychiatrist called whenever requested by staff. It was reported by staff that the weekly medical cover by the NCHD was adequate.

Weekend and night medical cover pertaining to mental health issues was provided by the NCHD at St. Brigid's Hospital, Ballinasloe, which was approximately 55 kilometres distant.

Medication

The process of administration of medication within Toghermore House appeared to be satisfactory. Three medication card index prescriptions were examined. Regular reviews of prescribing of medications were maintained. A signature bank was maintained.

Some residents self-medicated with planned intervention by a CNM2 who also supervised self-medication with residents from the other community residences. Each resident's key worker also played a role in this function.

Medications were ordered on a monthly basis by five GPs. Two residents of Toghermore received their prescription directly from their GP and collected their own medications from the pharmacy in the town.

Tenancy Rights

All residents paid the rent of 153 euro per week. This was maintained by an administrator. All residents had a swipe social welfare card.

Staff and residents met once a month for an in-house community business meeting.

Financial Arrangements

Each resident maintained their own individual bank account,set up on admission to Toghermore. For residents who lacked capacity, their individual account was maintained by the administrator with transactions requiring the signature of two RPNs, which was entered on transaction documentation. This was examined by the Inspectorate and appeared satisfactory.

The service had no local policy on financial arrangements.

Leisure/Recreational Opportunities Provided

There were two TV sets available to residents. Books and board games were also available. Many residents had a private TV and music system in their own bedroom. There was a pool table and an air hockey table available to residents. Many residents availed of outdoor pursuits such as pitch and putt, Bocce, walking and gardening.

It was reported that the Mental Health Association had provided pilgrimages to Rome and Lourdes. They now focused on midweek breaks in Ireland for the residents.

Residents attended the annual ploughing championships, GAA matches, pilgrimages to Knock and individual social outings of their choice.

Service User Interviews

One resident asked to speak to the Inspectorate. The resident was happy with the care and treatment. All residents who were present during the inspection were greeted by the Inspectorate.

All residents signed their multidisciplinary care and treatment plan.

The East Galway Mental Health Service User Group met regularly with residents in the Toghermore Training Centre.

The Irish Advocacy Network (IAN) representative called to the house when required.

An information leaflet on Toghermore House was available to residents.

A suggestion box was located on site.

It was reported that the service had received no written complaints.

Conclusion

Toghermore House was an old period house whose purpose was to provide safe and comfortable surroundings to residents with enduring mental health problems. The house was situated in a rural setting approximately three kilometres from the town of Tuam.

Although many good practice developments had commenced since the last inspection in 2005, including the introduction of multidisciplinary care planning and more service user focused decision making, for example service user input into choice of menu, the physical conditions inside the house were very poor. In its present state of disrepair, it was not fit for purpose and needed complete and total refurbishment.

There were a number of serious outstanding maintenance requests that required urgent attention. There was also an occupational therapy environmental assessment report on Toghermore House, updated on 18 July 2007, the contents of which needed to be addressed.

Recommendations and Areas for Development

1. *A record of attendance of each resident at their GP should be maintained by the service.*
2. *Each resident should be risk assessed and records maintained by the service.*
3. *The service should have a local policy on financial arrangements.*
4. *All beds in dormitories should have privacy curtains.*
5. *The upstairs male and female toilet, bathroom and shower areas are not fit for purpose and require immediate upgrading. This was a recommendation in the 2005 Report of the Inspector of Mental Health Services.*
6. *The roof of Toghermore House needs to be upgraded. This was a recommendation in the 2005 Report of the Inspector of Mental Health Services.*
7. *The interior walls of Toghermore need redecorating.*
8. *Areas of the walls in two of the male bedrooms need to be replastered immediately and redecorated.*
9. *The exterior walls of the house need to be repainted.*
10. *The recommendations in the occupational therapy environmental assessment report on Toghermore House updated on 18 July 2007 should be addressed in full.*
11. *The outstanding maintenance work which has been requested and submitted by staff since May 2009 must be attended to immediately.*

Appendix 5: Mental Health Services 2009 Inspection of Mental Health Day Hospitals

Dr. Fionnuala O'Loughlin, Assistant Inspector of Mental Health Services

In 2009, the inspectorate undertook inspections of some community facilities in addition to the inspections carried out in the approved centres. As part of this process, a number of Day Hospitals were inspected. One day hospital in each catchment area was selected for inspection, and in all, ten day hospitals around the country were inspected. *A Vision for Change* (2006) stated that the community mental health centre should include a day hospital, which could *"offer an alternative to in-patient admission for some service users"* (p.96), and recommended that *"high quality day hospitals should be provided"* (p.98).

Day hospitals in the following locations were inspected: **Athlone**; **Sligo** town; **Galway** city; **Carlow** town; **Raheny**, North Dublin; **Clondalkin**, West Dublin; **Ballincollig**, Co. Cork; **Tralee**; **Nenagh** and **Enniscorthy**.

Using the conclusions of the document *"Psychiatric Day Care – An Underused Option?"* (2003) as a guideline for day hospitals, a template was drawn up to examine some of the issues highlighted by the authors which included factors such as the location of the day hospital, opening hours, the nature of illnesses of service users and numbers of service users attending.

Aspects of Day Hospitals

Location: All but one day hospital was located in a building separate from a psychiatric hospital. The day hospital in Carlow was part of St. Dympna's hospital. The sector headquarters were located in the day hospital in seven cases. It was recommended that sector headquarters are located in the day hospital as this provides ease of access for staff to meet and discuss management of clients.

Opening Hours: Only two of the day hospitals offered a seven days per week service. Enniscorthy was open from 0900hrs to 1700hrs daily, and in Carlow, the day hospital was open from 0830hrs to 2000hrs. The remainder operated essentially a 0900hrs to 1700hrs service, Monday to Friday.

Facilites: Four of the day hospitals were able to provide a hot meal for service users. The majority had two or three activity rooms available (with the exception of Carlow), and one service had twelve rooms for activities (Nenagh). In some instances, these rooms were multifunctional and the activity rooms in Ballincollig, for example, were bright and spacious.

The day hospitals provided a range of therapeutic services: anxiety management, 'Wellness' groups, psycho-education groups, relaxation therapy, addiction counseling, stress management and goal-setting groups. One-to-one counselling was available in most of the day hospitals. Service users in Carlow and Tralee attended the day hospital for medication management.

Out-patient clinics were held in four day hospitals: Carlow, Enniscorthy, Clondalkin and Ballincollig.

All services, except Ballincollig and Carlow, carried out domiciliary or outreach visits.

Numbers of Attendees: There was a very large variation in the numbers of service users attending. Some day hospitals focused on individual therapies while others provided interventions in the form of group activities. The numbers of attendees ranged from eight to ten in Clondalkin and Wexford, to around 500 in Carlow and Nenagh and 380 in Ballincollig. Clearly, not all service users attended regularly, and it was recommended that services aim to review their caseload.

All of the day hospitals had discharge policies and all but one (Athlone) had admission policies. In view of the very large caseloads in some centres, it was recommended that day hospitals implement their discharge policy in order to avoid these facilities becoming blocked.

Care Plans: It was encouraging to see that many of the service users attending day hospitals had individual care plans drawn up by their multidisciplinary teams. This was the case in seven of the day hospitals inspected. The remaining centres (Enniscorthy, Carlow and Raheny) used nursing care plans.

Diagnoses: Information on diagnoses was not available in three of the day hospitals inspected (Carlow, Tralee and Wexford), and full information was not available in all services. Available statistics on the diagnoses of service users in the other day hospitals were requested: Affective disorders, Psychoses, Anxiety disorders, Addiction disorders, Personality Disorders and 'Other'. The information is contained in the table below:

	Affective Disorders	Psychotic Disorders	Anxiety Disorders	Addiction Disorders	Personality Disorders	Other	Serious M/I
Nenagh	10%	14%	55%	0	10%	0	24%
Sligo	41%	36%	7%	6%	5%	4%	77%
Clondalkin	25%	42%	8%	17%	8%	0	67%
Ballincollig	55%	35%	10%	0	0	0	90%
Tralee	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Athlone	39%	46%	Incl. in Affective	0	11%	4%	85%
Galway	45%	19%	13%	13%	6%	4%	64%
Enniscorthy	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Carlow	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Raheny	68%	26%	0	0	5%	0	94%

(Serious M/I = Serious mental illness)

The figures above illustrate the nature of the diagnoses of service users attending day hospitals. In two of the services (Clondalkin and Athlone), the most common diagnosis of those attending was a psychotic disorder; affective disorder was the most common diagnosis in four centres (Sligo, Ballincollig, Galway and Raheny). In one centre, Nenagh, anxiety disorder was the commonest diagnosis. It was interesting to note that Addiction disorder was the diagnosis in service users attending three of the seven day hospitals (Sligo, Clondalkin and Galway).

Grouping the diagnoses of affective and psychotic disorders together, the figures show that serious mental illness account for a significant majority,(i.e.> 75%) of the caseload in four of the day hospitals (Sligo, Ballincollig, Athlone and Raheny). Information on the duration of illness was not sought during the inspections, and it was therefore not possible to assess the chronicity of illness.

Summary

During 2009, the inspectorate carried out a number of inspections of day hospitals in catchment areas throughout the country. The number of places provided ranged greatly between services and some day hospitals had very large numbers of service users on its books. A variety of services were provided in the day hospitals and a number of centres offered domiciliary visits. The most common presentations were of affective and psychotic disorders, but information on duration of illness was not sought during the inspection. Most day hospitals had a substantial sector presence in that team members spent a considerable amount of time in the day hospitals, and in most cases, people referred for assessment were discussed by the multidisciplinary team.

Conclusion

The report on the use of day hospital care in two Health Board areas, *"Psychiatric Day Care – An Underused Option?"* (2003) recommends that 11 day hospital places per 35,000 population should be provided. Using this figure, some of the day hospitals inspected in 2009 have insufficient places whereas others have an excessive number of places. It was surprising, in some of the day hospitals, to see little activity being conducted in view of the recommendation that day hospitals should provide an alternative to hospital admission for acutely ill patients. In their study on the use of day hospitals in two health board areas, the authors of the report *"Day Care – An Underused Option?"* (2003) found that most attendees had relatively minor illnesses, a substantial number were chronically ill and only 6% of attendees were suffering from an acute illness. In 1998, a study of ten day hospitals in the U.K. (Myba P., Creed,F. & Tomenson,B.) found that only 13% of day hospitals were used as an alternative to in-patient admission. These findings would suggest that day hospitals are not being fully utilised as a real alternative to hospital admission.

Many of the services available were generic in nature and group meetings were not available in all day hospitals. The inclusion of service users with a diagnosis of addiction disorders in three day hospitals was surprising, given the recommendation in *A Vision for Change* (2006) that *"the major responsibility for care of people with addiction lies outside the mental health system"*(p.146), and the availability of services for addiction in some areas in local drugs task forces.

Despite these shortcomings, it was encouraging to see that in many of the day hospitals, assessments were conducted by the multidisciplinary teams and individual care plans for service users were drawn up and reviewed. However, it was disappointing to note that, despite all services having a policy on the discharge of patients, many service users remained 'on the books' for a relatively long period of time, thereby reducing the effectiveness of a day hospital service.

Recommendations

1. *Greater use should be made of day hospitals to divert acute admissions from acute psychiatric units.*

2. *Services should carry out regular reviews of their attendees to ensure service users move to more suitable facilities when the initial acute phase of their illness has abated.*

3. *Sector headquarters should be located in day hospitals.*

References:

A Vision for Change, (2006), Government Publications Office, Dublin.

Hickey T., Moran R., Walsh. D. *Psychiatric Day Care-An Underused Option?* 2003, Health Research Board.

Myba P.,Creed F.,Tomenson,B. *The different uses of day hospitals*. Acta Psychiatrica Scandinavica 1998 :98:283-287.

Appendix 6: Individual Inspection Reports – Day Hospitals

HSE Dublin North East

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	St. Francis Day Hospital
HSE Area	HSE North Dublin
Executive Catchment Area	North Dublin
Catchment Population	80,000
Location	Raheny
Total Number of Places	30
Date of inspection	2 July 2009

Details

Service Description

St. Francis day hospital, opened in 1978, was located in an old friary building. The building consisted of two floors. There were two large group rooms on the ground floor and a number of small offices on the first floor.

Two sector teams had access to the day hospital and it was a five-day service during office hours. The building was located close to local public transport. The HSE was currently renting the premises but the lease was not due to be renewed after 2011. There was also a clubhouse located in the sector. The service did not provide a day centre service.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	No
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	Yes
How many activity rooms are there for service users?	3
How many service users are attending?	30
Is there a facility for providing hot meals?	Yes

Referral Procedure

All referrals had to be processed through the multidisciplinary team weekly team meeting. Referrals were mainly from the outpatient clinic. A number of service users were referred during their in-patient stay. Referrals could be assessed within one working day.

On arrival at the day hospital, each service user was orientated to the building and staff, and to the group programme. The clinic file followed the service user from the outpatient clinic. An assessment was completed by medical and nursing staff. There was a centralised computer database and clinical notes system in place.

Referrals to other disciplines and therapies were discussed at the team meetings.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	2	15 hours each
Nursing staff	4	Full time
NCHD	3	As required
Occupational therapist	2	4
Psychologist	1.7	2
Social worker	1	As required
Art therapist	1	1
Psychotherapist	2	2
Art teacher	1	1

Range of Services Provided

The day hospital provided a group programme and individual sessions in psychotherapy. The group programme was facilitated by the nursing staff and had a wide range of groups, from stress management to cookery to psycho-education. A number of other groups were provided by sessional staff. Attendance was based on clinical need. There was no home care team but domiciliary visits were provided by the community mental health nurses.

A new centralised psychotherapy service had commenced using the facilities upstairs. A clinical nurse specialist coordinated all referrals. A number of rooms upstairs had been painted and refurnished to facilitate the service. A number of the disciplines had additional training in various cognitive therapy and psychotherapy approaches.

Care planning was discipline based. The nursing staff document a care plan for each service user. All disciplines record in a single case file in the computer data base. There was no individual multidisciplinary care plan but the team met weekly.

Service User Input

The Irish Advocacy Network (IAN) representative attended the day hospital twice a month. This was a new initiative. The service had used a questionnaire to obtain feedback on the group programme.

A carers group had been established recently. It was to be facilitated by a nurse and a social worker and it was planned to have monthly meetings.

A number of voluntary agencies had links with the service. They included GROW, citizens information, and KLEAR (an adult literacy programme).

Quality Initiatives in 2009

- The psychotherapy service had commenced.
- A questionnaire was used to improve service user feedback to staff.

- The Mental Health Information System (MHIS) computer system had been modified and updated. There were plans to extend it to the acute unit.

Diagnoses (All Attendees in Past Month)

Diagnosis and Duration	Number
Affective disorders	13
Psychotic illness	5
Anxiety disorders	0
Addiction disorders	0
Personality disorders	1
Other	0
Average length of stay (number of days)	3 months to 2.5 years

Operational Policies

There were no set criteria for referral to the day hospital or discharge to other agencies following treatment or intervention. There was no waiting list in operation. It was reported that each service user had a risk assessment completed before attending the day hospital. The majority of service users remained in the day hospital for a maximum of three months. Two service users had been there for over two years. It was reported that they were awaiting an appointment with the rehabilitation team.

There was a system in place for recording risks and incidents. Staff reported that the number of incidents reported was very low.

Staff had access to general in-house and HSE training. Local records were maintained by each discipline.

Planning

A management team meeting had recently been recommended. Its objective was for the multidisciplinary team to review strategic plans and operating policies. The exact terms of reference were not in place.

The service must vacate the building in 2011. It was planned that the new primary care centre would incorporate a mental health centre, including a day hospital. A design brief had been developed and was under discussion. A building had been identified in Baldoyle and was to be progressed using the public private partnership funding model.

Conclusions

The service had been established for over 30 years in its current location. The building was no longer fit for purpose, many of the rooms were small, and the building was not accessible. The site had been made smaller over the years and there was now a high wall surrounding it. It was encouraging to hear the plans were well advanced to move to a new primary care site.

Clinically the team had worked at developing a group programme and providing a range of cognitive therapies. Many of the staff had acquired additional training in specialist areas. This was an asset for service users in the area.

Recommendations and Areas for Development

1. *The day hospital relocation plan should continue.*
2. *The team should document its criteria for referral to the day hospital.*
3. *Each service user should have an individualised care plan developed with the team.*

HSE Dublin Mid Leinster

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Athlone
HSE Area	HSE Dublin Mid Leinster
Executive Catchment Area	Kildare/West Wicklow, Laois/Offaly, Longford/ Westmeath
Catchment Population	27,000
Location	Athlone
Total Number of Places	10 full-time places
Date of inspection	28 May 2009

Details

Service Description

The Athlone Day Hospital served the Athlone sector of the Longford/Westmeath catchment area. It provided acute interventions for service users, alternative treatments to admission to hospital and acted as a step-down facility for residents in the acute hospital setting.

The hospital was situated in the centre of Athlone in the grounds of St. Vincent's Hospital, which provided continuing care to the elderly and hospice care.

The day hospital was open Monday to Friday, from 0900h to 1700h. It had 10 places, but as most service users did not attend on a full-time basis, it could accommodate many more people. On the day of inspection, 30 service users were availing of the facility on a weekly basis. While the average length of stay was three to six months, one service user had been attending for more than two years. The day hospital had good links with the day centre which was located across town.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	No
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	Yes
How many activity rooms are there for service users?	2
How many service users are attending?	30
Is there a facility for providing hot meals?	No
Is a record of attendance kept?	Yes

Referral Procedure

Athlone day hospital accepted referrals only from the Athlone sector and referrals were made by members of the multidisciplinary team. Referrals were discussed at the weekly multidisciplinary team meeting, and minutes were kept of these meetings. There was no specific referral form, and there was virtually no waiting list for admission to the day hospital.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	1	6
Nursing staff	1	Full-time
NCHD	1	4
Occupational therapist	1	5
Psychologist	1	Access as required
Social worker	1	Access as required
Activities therapist	0	
Nurse therapist	2	Access as required

Range of Services Provided

The Athlone sector had a full multidisciplinary team which met weekly. Individual multidisciplinary care plans were being introduced on a phased basis to all service users. There were a number of nurse-led groups, including groups for goal-setting, anxiety management, relaxation and medication concordance. A Solution for Wellness group provided gym and swimming passes for service users. Individual sessions were also provided by the nurse and occupational therapist.

The occupational therapist had recently been involved in a number of session-planning groups and had planned to begin four regular group sessions a week in the day hospital, which were to include a relapse prevention group. In addition, the occupational therapist conducted home visits.

The social worker had recently conducted a six-week parental group in the day hospital.

Service User Input

There was a weekly service user support group meeting. The management team included a user consultative member in its group and the management team met the user consultative group regularly.

Service users were involved in their own care planning and service users facilitated some groups.

Quality Initiatives in 2009

- The occupational therapist had conducted a survey of service users and planned to use the information gathered to develop specific groups.
- A number of staff had Mental Health and Deafness training and were now able to conduct consultations with deaf service users using sign language.
- Individual multidisciplinary care planning was being gradually introduced to the service.
- The staff had been running a collaborative project with local GPs for a number of years.

Diagnoses (All Attendees in Past Month)

Diagnosis or duration	Number
Affective disorders	11
Psychotic illness	13
Anxiety disorders	Included in affective group
Addiction disorders	0
Personality disorders	3
For observation	1
Average length of stay (number of days)	3–6 months

Operational Policies

The day hospital operated according to Longford/Westmeath Mental Health Services' policies. It operated the complaints procedure of the HSE. Local policies included a referral policy. Staff were aware of the policy of the Mental Health Commission on incident reporting and stated that no deaths or incidents had been recorded.

Planning

The plan for the day hospital included a scheme to develop an outreach service in the sector. The Inspectorate was informed that there was a plan to relocate the day hospital to a purpose-built building nearby which was to incorporate a full Primary Community and Continuing Care (PCCC) facility and which will allocate space for a day hospital and sector headquarters.

Conclusions

The day hospital in Athlone provided a service for the population of the Athlone sector. It was centrally located in the town and could accommodate up to 30 service users. The sector had a full multidisciplinary team and provided a range of primarily nurse-led group and individual sessions for service users. The occupational therapist also provided some individual sessions and domiciliary visits and there was access to a psychologist and social worker as required. As the sector headquarters was located in the day hospital, staff reported ready access to members of the team on a daily basis.

Recommendations and Areas for Development

1. *All members of the multidisciplinary team should be involved in providing therapeutic sessions for service users in the day hospital.*

2. *All service users should have an individual multidisciplinary care plan.*

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Clondalkin Day Hospital
HSE Area	HSE Dublin Mid Leinster
Executive Catchment Area	Dublin West/Dublin South West, Dublin South City
Catchment Population	55,000
Location	Clondalkin Village
Total Number of Places	8
Date of Inspection	11 August 2009

Details

Service Description

Clondalkin day hospital was opened 20 years ago and served an urban population of 55,000. It was open from 0900h to 1700h, Monday to Friday. It had eight places and the duration of stay averaged about three weeks. The day hospital was located upstairs in a small shopping arcade. It was very cramped and consisted of two small rooms (a kitchen and a sitting room) and a number of offices and waiting area. The day centre was located nearby and a home care team and a sector team occupied the same premises as the day hospital. There was a seamless service between the in-patient service, the home care team, the day hospital, the day centre and the outpatients.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	No
Is the premises purpose built?	No
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	Yes
How many activity rooms are there for service users?	2
How many service users are attending?	8
Is there a facility for providing hot meals?	Yes

Referral Procedure

External referrals from GPs and the Emergency Department were to the multidisciplinary team and there was a weekly new patient clinic. Internal referrals to the day hospital were through the multidisciplinary team meeting, which was held twice a week.

Occasionally patients attended the day hospital prior to discharge as part of their discharge plan.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	1	Not provided
Nursing staff	2	Not provided
NCHD	1	Not provided
Occupational therapist	1	Not provided
Psychologist	1	Not provided
Social worker	1	Not provided
Activities therapist	0	Not provided
Art instructor	0	Not provided
Psychology trainee	1	Not provided

Range of Services Provided

There were multidisciplinary team meetings twice a week. A nursing care plan and a multidisciplinary care plan was in operation. The home care team carried out domiciliary visits. Although it was not structured, a number of activity-orientated and educational groups were held depending on the needs of the service users and individual sessions were facilitated by the nursing staff. There were also individual sessions with the multidisciplinary team members as required.

Service User Input

Service users took part in the formation of their individual care plan, signed their care plans and received a copy of their care plan if they wished.

Quality Initiatives in 2009

- A number of groups were held, including a walking group, a carers group, a Stay Well group that was rehabilitation based, and a group for children of service users.
- Liaison between the service and various voluntary bodies such as addiction services, suicide prevention organisations and family support groups had been enhanced.
- All multidisciplinary team members carried out new patient assessments.
- Educational programmes such as cognitive behavioural therapy, in-house training and external training and seminars continued.
- A case summary for GPs on discharge of service users and for outpatient reviews had been developed.
- A working group had been set up to consider a triage system for queries and referrals to the team.
- An open day for GPs and voluntary bodies was held annually.

Diagnoses (All Attendees in Past Month)

Diagnosis and duration	Number
Affective disorders	3
Psychotic illness	5
Anxiety disorders	1
Addiction disorders	2
Personality disorders	1
Average length of stay (number of days)	19.7

Operational Policies

The service had policies relating to admission and discharge, risk management, incident reporting. In addition there were numerous other relevant policies that reflected local practice.

Planning

A report was prepared annually.

A move to a new health premises with primary care teams was planned within the next two years.

It was planned to expand the working relationship with the rehabilitation team and to obtain accommodation for individuals with enduring mental illness.

Conclusions

Clondalkin day hospital was part of a cohesive community service. This was a well-established seamless service incorporating home care, day hospital, day centre and outpatients. The day hospital itself was very small and cramped, and this limited the scale of therapeutic activities that could take place. Each service user had a care plan and there was good multidisciplinary team working. The day hospital service was engaged with local voluntary agencies and this had allowed ease of referral and educational opportunities.

Recommendations and Areas for Development

1. *The new purpose-built premises for the day hospital should be advanced as quickly as possible.*

2. *To reduce duplication, the multidisciplinary care plan should be a summary of team goals and interventions rather than a detailed replication of the nursing care plan.*

HSE South

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Ballincollig Resource Centre, Co. Cork
HSE Area	HSE South
Executive Catchment Area	South Lee/West Cork/Kerry
Catchment Population	40,110
Location	Ballincollig
Total Number of Places	25
Date of inspection	5 October 2009

Details

Service Description

The day hospital in Ballincollig was situated at the entrance to a retail and technology park on the outskirts of Ballincollig. The building, which opened in 2001, was a single-storey purpose-built building adjacent to a medical clinic. It was in a good state of repair and was bright and quite spacious.

The day hospital served two sectors, Bishopstown and Ballincollig, with a combined population of 43,000. It was open from 0900h to 1700h, Monday to Friday. There were two large activity rooms and three interview rooms. The service had a full-time administration officer in the centre.

Each sector held review clinics once a week and one new-patient clinic was held weekly at the day hospital.

Between 20 and 25 service users were seen daily. Medication was not administered at the day hospital.

The day hospital had established good links with a near-by centre which ran a Social Focus Programme, which was a national training programme for persons with a mental health difficulty. A number of clients from the day hospital had attended the programme there.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	Yes
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	Yes
How many activity rooms are there for service users?	2
How many service users are attending?	380
Is there a facility for providing hot meals?	No

Referral Procedure

The day hospital served two sectors. Referrals were primarily from GPs, and involved mostly new referrals. Urgent referrals were usually seen within one or two days, and the waiting time for non-urgent referrals was up to six weeks. Other referrals came from the liaison service in Cork University Hospital and some service users were referred following discharge from the acute unit.

Following referral, each case was discussed by the multidisciplinary team and an individual multidisciplinary care plan was drawn up for the person. A copy of the care plan was given to the service user. The Tidal model of assessment was carried out by the designated nurse.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	1.3	6
Senior registrar	1.2	9
NCHD	0.8	2
Nursing staff	1 CNM2 2 staff nurses	Full-time
Community mental health nurse	2	Full-time
Occupational therapist	0	–
Psychologist	0.7	8
Social worker	Access	–
Art therapist	0.2	2

Range of Services Provided

Multidisciplinary team reviews were carried out on a regular basis, and as required. Individual programmes were designed for each service user in collaboration with the individual. The service was in the process of compiling a multidisciplinary care plan for each individual attending the day hospital.

The service offered a range of therapeutic interventions. Most interventions were on a one-to-one basis and service users were given appointments that generally lasted 1 to 1.5 hours. The psychologists saw clients for cognitive behavioural therapy and had run programmes in social anxiety and self acceptance.

Group therapies in depression management, anxiety management and relaxation were conducted from time to time when demand exists. A six week relaxation rrogramme was also offered. A wellness programme and a walking group were also accessible.

Through collaboration between nursing staff and the psychologists, educational programmes in depression, psychosis and bipolar disorder were held from time to time. The family educational group also ran a ten-week course for families of service users.

Yoga and art therapists from the local VEC provided classes until recently, when funding problems caused this service to be discontinued.

Service User Input

Service users were involved in the development of their care plan. Family members were also included in multidisciplinary team reviews, with the individuals' consent.

Only one service user was seen by the Inspectorate in the unit during the visit, which took place in the afternoon.

Quality Initiatives in 2009

- An audit of the individual care plans done to date was carried out.
- A service user questionnaire was conducted.
- An outpatient satisfaction survey was conducted, with generally favourable results for the service.
- A liaison service with the local primary care unit was established to afford better links with primary care. As a result of this liaison, one member of the day hospital staff was carrying a mobile phone to facilitate access between the services.

Diagnoses (All Attendees in Past Month)

Diagnosis and duration	Number
Affective disorders	55%
Psychotic illness	35%
Anxiety disorders and personality disorders	10%
Addiction disorders	0
Average length of stay (number of days)	Varies

Although the service was conscious of not retaining service users beyond a time of therapeutic benefit – 80 to 90 clients had been attending for less than one year – some service users had been attending since the opening of the service in 2001.

Operational Policies

The operational policies in place were those of the South Lee catchment area. These were in the process of being reviewed. The service had a policy on discharge of service users from the day hospital, as part of their care plan.

There was no training at the present time. All staff nurses had completed the Higher Diploma in Acute and Enduring Mental Illness, and one CPN had recently completed a master's programme in nursing.

Planning

Current plans included a plan to extend the opening hours to 1900h. There was also a plan to develop phlebotomy services at the day hospital to facilitate a Clozaril clinic there. The psychology service were planning to run groups in emotional skills training and to conduct research workshops.

In the longer term, it was hoped to further develop links with the primary care service in the area.

Conclusions

The day hospital at Ballincollig provided day services to two sectors in the South Lee catchment area. The service was in the process of developing individual multidisciplinary care plans for all service users, a welcome feature in the provision of day care for service users. A variety of therapies were available from medical, nursing and psychology staff. It appeared that the majority of therapies were delivered on an individual basis. There was evidence of an interest in auditing and a survey of service users that will be useful in informing the service when considering future plans.

Recommendations and Areas for Development

1. *The multidisciplinary team should be fully staffed and should include an occupational therapist.*

2. *The review of operational policies should continue and specific policies in relation to the operation of the day hospital should be developed.*

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Caherina House Day Hospital
HSE Area	South Lee/West Cork/Kerry
Executive Catchment Area	Kerry
Catchment Population	139,835
Location	Tralee
Total Number of Places	25
Date of inspection	15 June 2009

Details

Service Description

The original Caherina House day hospital was first established in 1978 by the then Southern Health Board. The present Caherina House Day Hospital, situated around the corner, was opened in March 2002 by the incumbent Minister for Health. It was a red-bricked purpose-built bungalow-style building situated on the west side of the town on a site that was physically well integrated in the community.

The service's opening hours were from 0900h to 1700h, Monday to Thursday, and 0900h to 1600h on Fridays.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	Yes
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	No
How many activity rooms are there for service users?	7
How many service users are attending?	80-120
Is there a facility for providing hot meals?	Yes

Referral Procedure

The Tralee West sector formally admitted referrals to the day hospital but referrals were considered from the Tralee East sector. A standard referral form was completed by the consultant psychiatrist who may receive referrals from general practitioners, in-patient services, outpatients, and the Emergency department in emergency situations. Emergency referrals were reported to be rare. All referrals were discussed at the multidisciplinary team meetings that occurred each Tuesday.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	1	Twice
Nursing staff	2	Full-time
NCHD	1	2–3
Occupational therapist	0.8	Four
Psychologist	0	–
Social worker	0.5	–
Activities therapist	0	–
Art instructor	1	Once (academic year)
Psychology trainee	1	–

Range of Services Provided

Therapies provided were a combination of group and individual. Groups such as the young persons' activity group, schizophrenia group, social skills group, art group, therapy group and the wellness group were all part of the weekly programme. Pastoral care also occured as well as one-to-one therapies and overcoming anxiety and overcoming depression sessions. There was also a regular group for young people who had been newly diagnosed.

The multidisciplinary team consisted of the consultant psychiatrist, psychiatric registrar, CNM2/CNS, occupational therapist and social worker. There was no psychologist attached to the team, although a trainee psychologist carried out sessional work at the day hospital. The multidisciplinary team met each Tuesday. Each member of the multidisciplinary team acted as a key worker for a specific group of service users. An individual care plan was worked out between the service user and the key worker although it was reported that documentation of this care plan was poor, the weekly meetings between service user and key worker resolved this. It was reported that regular chronological progress notes were maintained collaboratively by the key worker with each service user.

Family meetings were also held with the key worker and service user to discuss such items as preventative measures, triggers to avoid and care planning.

Home visits were carried out informally by the social worker or community mental health nurse.

A number of service users attended the day hospital on a daily basis for medication administration and for depot medication.

The CNM2/CNS, who was a qualified psychotherapist, also accepted individual referrals.

Individuals attending the day service were referred onwards to: the National Learning Network, which had a year-long rehabilitation programme called the Focus Programme and gave guidance on personal development and career choice and courses including carpentry and catering; Rehab Care which offered a sheltered workshop; and FÁS, which had a disability advisor and a pathway to the adult education centre.

Service User Input

No peer advocate attended although pertinent information regarding advocacy and many relevant voluntary organisations was readily available. There was also an information booklet about the day hospital and the services it provided.

Quality Initiatives in 2009

- A support group for individuals experiencing the affects of schizophrenia had proven very successful.
- The staff nurse at the day hospital had completed a nurse prescribing course which was expected to be used by the service.
- The service had a goal-directed policy, where the focus was on treatment rather than on passing time, and this was reported to be working well.

Diagnoses (All Attendees in Past Month)

Diagnosis and duration	Number
Affective disorders	unavailable
Psychotic illness	unavailable
Anxiety disorders	unavailable
Addiction disorders	unavailable
Personality disorders	unavailable
Average length of stay (number of days)	unavailable

Operational Policies

Written operational policies from Kerry Mental Health Services were available in the day hospital.

The day hospital had written an operational policy document outlining the admission and discharge policies, the history of the service, the mission statement, the role and function of the day hospital, the service user group, the multidisciplinary team and the different functions within it, team meetings, quality control, incident reporting and the complaints procedure.

Planning

The service's proposal to develop community mental health services called Vision into Action described the piloting of a new referral and assessment system by Caherina House day hospital which had shown promising early results and which had the potential to offer a more community orientated service to avoid the need for hospitalisation. The recommendations of Vision into Action were:

- Build on work done by Caherina Day Hospital in 2007 in conjunction with the community mental health team.
- The operating hours, staffing and function of day hospitals to be revisited in light of changes to service delivery with the development of the community mental health teams.

Conclusions

The original Caherina House day hospital was opened in 1978 and a new building had been in operation since March 2002. Over the past three decades the service had transformed from one providing a day centre for individuals with enduring mental illness who were meaningfully occupied by industrial therapy to one that now focused on treatment and support for individuals with acute and enduring mental health problems. The service embraced a multidisciplinary approach and strove to offer people an alternative to in-patient care and treatment.

Recommendations and Areas for Development

1. *Consideration should be given to using formal multidisciplinary care plans.*

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Carlow
HSE Area	HSE South
Executive Catchment Area	Carlow/Kilkenny/South Tipperary
Catchment Population	52,500
Location	St. Dympna's Hospital
Total Number of Places	On demand
Date of inspection	10 September 2009

Details

Service Description

The day hospital was located in St. Dympna's Hospital, in what was formerly a ward of the hospital. It was a bright area with two rooms for doctors' interviews, a kitchen, a pleasant waiting room, nurses' office and one general interview room. There were no activity rooms.

The day hospital, which served service users from the Carlow North and Carlow South sectors, opened in 2003, and was open from 0830h to 2000h, seven days a week. One nurse operated the day hospital at the weekends.

The main functions of the day hospital were to offer medication management and provide access to assessment of new patients from both sectors. The number of daily attendees varied from about 25 to 43, depending on what clinics, including Clozaril clinics, were being held. Some 561 service users had been attending the day hospital in 2008, and the service was working to reduce this number. Service users attended for medication which was dispensed by the nurses.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	Yes
Is the premises an independent building?	No
Is the premises purpose built?	No
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	No
How many activity rooms are there for service users?	None
How many service users are attending?	561
Is there a facility for providing hot meals?	No

Referral Procedure

All new patient referrals to the two sectors were seen and assessed in the day hospital by the community mental health teams. A new patient clinic was held once a week. Referrals were made by letter from the GPs, but telephone referrals were also acceptable for patients requiring urgent assessment. Referrals were discussed at multidisciplinary team meetings and allocated an appointment in the clinic. Occasionally, self-referrals were also seen. There was no referral form.

Other referrals came from the outpatient clinics, community nurses, and from the Department of Psychiatry in Kilkenny, following discharge of residents. In addition, referrals were made by the teams as an alternative to hospital admission.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	2	4-6
Nursing staff	2 CNM2 2 staff nurses	Full-time
NCHD	2	Full-time, shared with the in-patient service
Occupational therapist	Access when required	–
Psychologist	Access when required	–
Social worker	Access when required	–
Activities therapist	0	–

Range of Services Provided

The primary service offered was medication management, and new patient assessments. There were no group activities. Service users were referred to the skills-based centre which was located in the grounds of St. Dympna's Hospital for activities and training. This centre provided activities in computer skills, horticulture, activities of daily living, art and other activities. Other service users had been referred to Steer, which had links with FÁS.

There were no multidisciplinary care plans in place, but the service was working on adapting the multidisciplinary care plan that was currently in operation in the approved centres to suit day hospital users. The nurses carried out a risk assessment and had nursing care plans for attendees.

While the day hospital team did not include an occupational therapist, psychologist or social worker, service users had access to these services.

Service User Input

Service users in the waiting room were invited to speak with the Inspectorate. One service user spoke very highly of the service and staff, saying the day hospital offered an excellent support service.

Quality Initiatives in 2009

- Two CNM2s were currently participating in a course on self-harm, and were planning to set up a specific programme for service users.
- Two CNM2s completed a course on Clozaril management, and were training other staff members in this management.
- The social worker and systemic therapist in the family education group was about to set up a carers group in the day hospital.
- Staff were being trained in venepuncture.
- Two nurses were currently being trained in cognitive behavioural therapy, with a view to providing it to service users of the day hospital.
- Useful information leaflet about the day hospital had been produced for service users.

- The service was working to introduce the Orchid programme which provided information to service users.

Diagnoses (All Attendees in Past Month)

No record of diagnoses of attendees was kept, although the impression of staff was that the predominant illness was affective disorder.

Diagnosis and duration	Number
Affective disorders	Not provided
Psychotic illness	Not provided
Anxiety disorders	Not provided
Addiction disorders	Not provided
Personality disorders	Not provided
Other	Not provided
Average length of stay (number of days)	Not provided

Operational Policies

There was a policy group on the implementation of the multidisciplinary care plans, which was looking at the suitability of this form of plan for the day hospital. Risk assessments were carried out by the nurses but in an informal way. It was expected that risk assessment Level 1 of the modified Sainsbury Centre for Mental Health risk assessment was to be introduced as part of the multidisciplinary care plans.

Incidents were reported to the hospital manager, although it was stated that incidents occurred infrequently. Although the service did not have an admission policy, it had a referral and discharge policy. The service was in the process of reducing its case load.

Planning

The service was moving away from the medication management model of operation in its day hospital, and was planning to introduce group activities.

There was a tentative plan to relocate the day hospital to a primary care building in the centre of the town, but these plans were at a very early stage of discussion as yet. A database of service users was established, and a steering group had been set up to establish ways of introducing more therapeutic services and group activities.

Conclusions

The day hospital in Carlow was located in St. Dympna's Hospital and was open seven days a week. There was a very large number of attendees on its books but it generally catered for between 25 and 45 service users daily. The primary activity was to provide medication management and some service users attended daily for medication. Referrals were assessed by the multidisciplinary team, and new patient clinics were held weekly. There seemed to be a good working relationship with the local GPs, and the day hospital also provided a service for service users recently discharged from the Department of Psychiatry in Kilkenny. There were no group activities and no designated sessions by associated healthcare professionals.

Recommendations and Areas for Development

1. *There should be designated sessions in the day hospital for the psychology, social work and occupational therapy professionals.*

2. *The role of the day hospital should be expanded to provide therapeutic services, and group activities should be considered.*

3. *A record of diagnoses should be kept.*

4. *The service should continue its policy of reducing the number of attendees on its list.*

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Carn House, North Wexford
HSE Area	HSE South
Executive Catchment Area	Waterford/Wexford
Catchment Population	61,583
Location	St. John's Hospital, Enniscorthy
Total Number of Places	6 to 9
Date of inspection	21 May 2009

Details

Service Description

Carn House, the North Wexford day hospital, was located in the grounds of St. John's Community Hospital near the centre of Enniscorthy. It was a converted convent and as such the rooms were small and clinical space was limited. The day hospital was now open seven days a week from 0900h to 1700h. It was the sector headquarters and also housed the psychiatry of later life team. Outpatient clinics were run four days a week from the day hospital. Service users attend for sessions only. The day hospital served a radius of approximately 30 km and a population of 61,000. The day hospital was owned by the HSE.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	No
Is the premises accessible by public transport?	No
Is the premises the sector HQ?	Yes
How many activity rooms are there for service users?	3
How many service users are attending?	8 to 9
Is there a facility for providing hot meals?	No

Referral Procedure

One sector, North Wexford, admitted to the day hospital. Referrals were by members of the sector team, by the in-patient services and by self-referral. A referral letter or referral form accompanied all referrals to the day hospital.

Referrals to the sector team were from GPs, the liaison service, from the mental health service and from the general hospital services.

All referrals were discussed at the team meeting where management options were agreed.

Emergency referrals were seen immediately.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	2	Full time
Nursing staff	2 CNM2 2 staff nurse 2 CMHN	Full time Full time Full time
NCHD	1	Full time
Occupational therapist	1	Sessional group and individual
Psychologist	1	Sessional individual
Social worker	1	Sessional individual
Activities therapist	0	0
Other	0	0

Range of Services Provided

The multidisciplinary team met weekly and all referrals and issues concerning service users were brought to this meeting. There was a nursing care plan but no multidisciplinary care plan. However the psychiatry of later life service, which was based in the day hospital, used a multidisciplinary care plan. A number of group sessions were available including anxiety management and relaxation groups. As well as an outpatient clinic there were also home visits by most members of the multidisciplinary team.

Family education groups were also provided.

Service User Input

Regular carers groups and family education groups were held. A peer advocate did not come regularly to the unit but access to advocacy was clearly displayed and appointments could be made if required.

There was an excellent information booklet available as well as information about other community services.

Voluntary organisations such as Aware and GROW held regular meetings in the day hospital.

Quality Initiatives in 2009

- Family education groups were held regularly.
- Concordance programmes were held with service users.
- Staff contributed to the mental health module in social care studies in Wexford Education Centre.
- Staff also contributed to the Health Promotion Unit.
- The day hospital had facilitated an open day for local GPs.
- Staff provided a crisis response to the community following serious incidents such as suicide.
- Full clozapine monitoring was provided at the day hospital which allowed service users to be more involved in their treatment.

Diagnoses (All Attendees in Past Month)

Diagnosis and duration	Number
Affective disorders	Not available
Psychotic illness	Not available
Anxiety disorders	Not available
Addiction disorders	Not available
Personality disorders	Not available
Other	Not available
Average length of stay (number of days)	Not available

Operational Policies

There were policies and procedures on referral admission and discharge as well as on non-attendances. There were procedures in the event of fire.

There was an excellent written unit profile which outlined different procedures.

Planning

There was no written plan available in the day hospital. Although there were plans to update the current building and, in the long term, to provide a purpose-built unit these plans were not active due to funding difficulties.

Conclusions

Carn House day hospital is was a well-run service that provided a comprehensive range of services, including outpatient services, individual therapy, group therapy, mental health education and crisis intervention. The service was somewhat limited by the constraints of the building but good use was made of the existing space. The staff were enthusiastic and justifiably proud of the service they offered.

Recommendations and Areas for Development

1. *Should funding become available a purpose-built day hospital should be provided.*

2. *The service should use multidisciplinary care plans.*

HSE West

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Lá Nua Day Hospital, Galway
HSE Area	HSE West
Executive Catchment Area	Galway, Mayo and Roscommon
Catchment Population	121,567
Location	Ballybane Neighbourhood Village, Ballybane, Galway
Total Number of Places	114
Date of inspection	29 September 2009

Details

Service Description

Lá Nua day hospital was a purpose-built day hospital situated on the first floor of a two-storey building that was completed in 2005. The day hospital's floor plan was limited only by the ground floor plan of the public library situated below. The day hospital was located off the Ballybane Road which was a suburban residential area in the east of the city. The day hospital could be accessed by three bus routes which stopped outside the entrance.

The service aimed to provide an alternative to the in-patient service offering short-term admission within a supportive and educational environment.

Four sector teams from within the West Galway Catchment admitted to the day hospital. Service users were referred from in-patient services and outpatient services. The opening hours were from 0900h to 1700h, Monday to Friday.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	Yes
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	No
How many activity rooms are there for service users?	7
How many service users are attending?	114 (average weekly attendance)
Is there a facility for providing hot meals?	No

Referral Procedure

The service had a closed referral policy which had been revised in July 2009. Service users from all four sectors of the West Galway Mental Health Services assessed as suitable for referral to the day hospital were offered an appointment within one week for routine referrals and within one working day for urgent referrals. Referrals were made from in-patient units and outpatient clinics. All urgent referrals

must be discussed with the CNM2/senior registrar prior to admission being offered, in order to prioritise the level of urgency. The referral form incorporated a mandatory risk assessment. If service users did not attend admission or an appointment, an outpatients department appointment was requested, the relevant consultant team was notified and also the community mental health nurse if necessary.

All clinical documentation was maintained in the service user's clinical file, which followed the individual throughout the different mental health services.

Liaison with other agencies was maintained in preparation for discharge, including FÁS, the National Learning Network, adult education centre, VEC, Galway Mayo Institute of Technology, day centres, community employment, learning schemes, college, work and home.

Staffing Levels

It was reported that the service was down a 0.5 whole-time-equivalent nursing post. The holder of the 0.6 occupational therapy post was leaving the service permanently on the day after the inspection. Staff expected this post to be filled.

Post	Number WTE	Sessions per week
Consultant psychiatrist	4.5	Each consultant: one session every three weeks
Nursing staff	3.36 (Incl 0.75 CNM2)	Full time
NCHD	1.5	Full time
Occupational therapist	0.6	–
Psychologist	0.5	–
Social worker	–	Average 0.5 or as needed
Activities therapist	–	4 per week

Range of Services Provided

On admission to the day hospital, a core assessment was carried out by any member of the multidisciplinary team. A key worker was then allocated which was usually from the disciplines of nursing, occupational therapy and psychology. All service users were risk assessed using a Brief Risk Assessment tool; if this indicated a further risk, a Functional Analysis of Care Environment (FACE) assessment was completed and discussed with the multidisciplinary team.

All service users were seen by the NCHD at least once a week. Each multidisciplinary team met once every three weeks. All service users had an individual care plan that was completed at each multidisciplinary team meeting and signed by the key worker and service user.

Individual and group activities occurred including one-to-one sessions and targeted closed groups, including stress and coping, mood disorder, anxiety management and psychosis education.

The provision of hot meals to attending service users had ceased since October 2008 due to budgetary constraints.

Home visits were undertaken when necessary. There had been eight home visits in 2008.

There was a supervised gym on site.

All service users self-medicated. An emergency supply of anticholinergic medication was maintained. Initiation of certain medications such as Clozaril and Antabuse was supervised by nursing staff.

Service User Input

Three-monthly meetings with service users were facilitated to review the programme and to ensure the programme was benefiting them. Appropriate changes to the programme that were suggested by the service users were implemented. Minutes of these meetings were posted on the notice board for service users to read.

A representative from AWARE called weekly. A representative from the Irish Advocacy Network (IAN), who used to call regularly, now called only when requested; it was reported that this service had been restricted by budgetary constraints.

An information booklet on the day hospital and the services it provided was given to all attending service users.

Information on IAN and a contact telephone number was posted throughout the day hospital.

Information on other services such as Shine, GROW and Aware was also available.

Quality Initiatives in 2009

- All attending service users were undergoing a core assessment that was introduced in August 2009.
- The group programmes had been changed to incorporate more individual work.
- Service user satisfaction survey pre- and post-changes to these programmes were in progress.

Diagnoses (All Attendees in Past Month)

Diagnosis and duration	Number
Affective disorders	61
Psychotic illness	25
Anxiety disorders	17
Addiction disorders	18
Personality disorders	8
Intellectual disability/psychosocial stressors	6
Average length of stay (number of days)	8–14 weeks

Operational Policies

The day hospital had a detailed admission policy that had been revised in July 2009, and which declared that the service's aim was to respond to service needs and arrange a prompt and brief assessment for admission to all suitable referrals from West Galway Mental Health Services.

The service had a discharge policy that had been revised in July 2009 which included: service user and family involvement, discharge planning, liaising with community agencies, the arrangement of an outpatients appointment, notifying the community mental health nurse and a discharge letter to the service user's GP.

The service had a "Did Not Attend" policy – in the event that the service user failed to keep an appointment, the referring team was notified, an outpatients appointment was requested and where there were concerns about an individual service user, the staff at the day hospital carried out a home visit, or a community mental health nurse was asked to carry out such a visit if there were staffing issues at the day hospital. If service users did not attend regular appointments they were discharged following consultation with the multidisciplinary team or senior registrar. The relevant GP and consultant

team were notified and the community mental health nurse was also informed if this was deemed appropriate.

Planning

A business meeting held by staff occured once every two or three months to iron out operational and clinical issues. Minutes were kept of these meetings.

Three-monthly meetings with service users were held to introduce changes to and review of the programme. Minutes were kept of these meetings.

The day hospital's service plan was incorporated into the service plan for the West Galway Mental health Services.

Conclusions

Lá Nua day hospital was the only day hospital in West Galway Mental Health Services. It served four sectors, which was the entire area of West Galway, including the Aran Islands. The day hospital was situated on the east side of Galway city. The purpose of the day hospital was to offer short-term admission in a supportive and educational environment as an alternative to acute in-patient admission.

Recommendations and Areas for Development

1. *The 0.6 WTE occupational therapy post should be filled.*

2. *The service should have its own written service plan and operational framework.*

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Markiecvicz House, Sligo
HSE Area	HSE West
Executive Catchment Area	Donegal, Sligo, Leitrim and West Cavan
Catchment Population	99,875
Location	Sligo
Total Number of Places	Not supplied
Date of inspection	20 August 2009

Details

Service Description

This was a five-day service which opens from 0900h to 1700h Monday to Thursday, and from 0900h to 1700h on Fridays. It also sometimes opened for specific groups in the evenings. It was situated in a modern purpose-built building, the other half of which is used by Primary Community and Continuing Care (PCCC) where general health clinics were held and there was a canteen available for use by mental health service users with a voucher system in use. Staff felt the integrated building model facilitated confidentiality and reduced stigma.

Most referrals were made by two of the five consultant teams. Mental health review clinics were held twice weekly by these two teams. Staff identified a problem with feedback to and from other consultant teams who refer to the service. As there were no dedicated community mental health nurses, staff of the day centre also provided an outreach service for people who did not attend. Staff felt this negatively impacted on the service they could provide in the day centre. A family therapy and cognitive behavioural therapy service was provided, with direct referral from GPs attached to the centre. There was a 12-week waiting list for the family therapy service.

At least five people attended the service daily. Staff noted that the nature of the service had changed with the introduction of the cognitive behavioural therapy service. Most service users opted for this rather than attending groups. People attended for a time-limited specific purpose and did not tend to stay in the day centre all day.

Staff were accommodated in a large open plan office on the day of inspection. There was a concern for staff safety as there was only one entrance and one exit from this office. There were plans for staff groups, e.g. family therapists, to move to their own offices within the building. At the time of the inspection, the cognitive behavioural therapy team, which had been housed elsewhere, was due to move into the building within a matter of weeks.

At the time of inspection, clerical staff were on leave and could not be replaced because of the HSE staffing moratorium. As a result, essential typing was not being done and this posed a risk to patient safety.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	Yes
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	Yes (for 2 of 5 sector teams)
How many activity rooms are there for service users?	2
How many service users are attending?	135
Is there a facility for providing hot meals?	Yes

Referral Procedure

Referrals were made either by GPs or consultant psychiatrists. It was reported to the Inspectorate that they were aware of the perception by some psychiatrists that referral was not open to everyone. The Inspectorate was told that this was not the case, and there was confusion among the staff as to why this impression had arisen.

Referral forms were available. All patients discharged from the in-patient service were referred to the day centre from the two consultant teams and, as required, from the outpatient clinics.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	Sector consultants	4.25 sessions per week
Nursing staff	6.4 (5 in post)	
NCHD	1	
Occupational therapist	1	Provides service for Sligo town and day hospital
Psychologist	1	Not assigned to daycentre, had a service wide remit
Social worker	As per sector teams	Limited availability to day centre clients
Activities therapist	0	
Other: - CNS family therapy - CNS cognitive therapy	2.4 3	Based in day hospital, with service wide remit
Pharmacist	1	Pharmacist was available to the day hospital

Range of Services Provided

There were two multidisciplinary team meetings a week, held by the two principal teams that used the service. These were attended by the consultant, NCHD, nursing staff, occupational therapist, social worker and psychologist (as required). All made entries in the case notes.

A multidisciplinary care plan was in use, in line with the practice in the in-patient service.

Addiction counsellors attended on Wednesday mornings. Relaxation groups were held on Wednesdays and Fridays. A leisure group was due to start on the day of the inspection, while a vocational group was due to start shortly, to be run by occupational therapy and nursing staff.

An outreach service was provided for refugees and homeless people. Staff had access to an interpreter service by arrangement. They found diagnoses of post-traumatic stress disorder were common and they could refer to Spiritan Asylum Services Initiative (SPIRASI) as required.

Service User Input

There was no consumer input into the service. There will be consumer input into the planned review. The notice board advertised the availability of a representative of Irish Advocacy Network but the representative had not as yet visited the service.

The consumer panel was discontinued as it was felt to have completed its remit.

There were no service users in the centre at the time of inspection. The Inspectorate were informed that this was not unusual as services were divided between those conducted in-house, and domiciliary visits.

Quality Initiatives in 2009

- A review of the operation of the service was planned and terms of reference were being finalised.
- A dedicated psychology post for mental health services had been filled.
- A vacant occupational therapy post had been filled.
- Two nurses were attending a nurse prescribing course, to be completed later in the year.

Diagnoses (All Attendees in Past Month)

Diagnosis and duration	Number
Affective disorders	56
Psychotic illness	48
Anxiety disorders	10
Addiction disorders	8
Personality disorders	7
Other: - Anorexia nervosa - Acquired brain injury	3 3
Average length of stay (number of days)	Not available
Total case load	135

Operational Policies

Policies were in operation in line with the in-patient service. Operational policies were in place for admission and discharge, risk management, incident reporting and staff training. All policies needed to be appropriately reviewed.

The service was inspected annually for fire safety.

Planning

This will be subject to the forthcoming review.

Conclusions

This day service was provided in a Primary Community and Continuing Care (PCCC) setting. While there were advantages in terms of stigma and confidentiality, there were problems in relation to how it related to the mental health service as a whole. Issues of access, communication and governance had arisen and needed to be addressed. The terms of reference of a service review were being finalised. This should address the future vision for the service and whether the provision of a community mental health nurse at the centre would facilitate its development.

The enhancement of the multidisciplinary team during the year was to be welcomed, but there remains a problem in relation to social work services. The Inspectorate was informed that this was conducted through the sector teams. However, not all teams had a dedicated social worker.

Recommendations and Areas for Development

1. *The service review should be conducted as soon as possible with a view to clarifying issues that have arisen about referral, governance and access.*

2. *The review should address the issue of the deployment of staff in the centre and whether a dedicated community mental health nurse is needed to facilitate centre staff further developing the service there.*

3. *Services should reflect the mental health need of the population at least at a secondary level.*

4. *Access to social work staff should be addressed.*

5. *Policies should be reviewed and dated appropriately.*

6. *The service should have access to a dedicated risk manager.*

7. *Safety issues in regard to the office accommodation should be addressed.*

8. *Service user input should be enhanced.*

Mental Health Services 2009
Inspection of Mental Health Services in Day Hospitals

Day Hospital Inspected	Drommin House Community Mental Health Centre, Nenagh
HSE Area	HSE West
Executive Catchment Area	Limerick, North Tipperary and Clare
Catchment Population	66,023
Location	Nenagh
Total Number of Places	500
Date of inspection	23 July 2009

Details

Service Description

Drommin House Community Mental Health Centre was situated on Drommin Road in a residential area on the outskirts of Nenagh and as such, was physically integrated into the community. It commenced official operations in 2005 following the purchase of the premises, formerly family residence, and following a major extension to the rear of the premises making it fit for purpose. The waiting area consisted of a purpose-built atrium with offices and activity rooms off it. This waiting area was bright and in good decorative order and had adequate seating. Two copies of a daily newspaper were available. There was fresh filtered drinking water and access to toilet areas that were clean and in good order. It was reported that the service had developed strong links with primary care.

The service's hours of opening were from 0900h to 1700h, Monday to Thursday, and from 0900h to 1600h on Friday.

Service users attended for specific clinic appointments, individual one-to-one therapies with members of the multidisciplinary team, anxiety groups, sessional work, supervision of daily medications and administration of depot medications.

Although new referrals were tracked for non-attendance, there were no statistics on non-attendees.

It was reported that adjoining neighbours were very supportive of the service.

World Mental Health Week each October was used as an opportunity to target the general public and specific groups such as Garda members to come and view the workings of the service.

Premises

Checkpoint	Response
Is the premises part of a psychiatric hospital?	No
Is the premises an independent building?	Yes
Is the premises purpose built?	Yes
Is the premises accessible by public transport?	Yes
Is the premises the sector HQ?	Yes
How many activity rooms are there for service users?	12
How many service users are attending?	500
Is there a facility for providing hot meals?	No

Referral Procedure

The Nenagh sector team admitted individuals to the service. Referrals were made by a GP to any member of the multidisciplinary team and subsequently discussed by the team. The service users then automatically came under the care of the sector consultant psychiatrist.

Out of a total of 323 referrals to the service in 2008, 84 were new referrals.

Patients who were discharged from St. Luke's Hospital, Clonmel, or St. Michael's Acute Admissions Unit, Clonmel, and who were resident in the Nenagh sector, were automatically referred to the service and were seen within a week of their discharge.

A community mental health nurse attached to the service attended team meetings of Nenagh sector service users who were resident in St. Luke's Hospital and St. Michael's Unit, so the service was aware of impending discharges back to the Nenagh sector. There was no social worker and psychology input into the Nenagh sector service users who were resident in St. Luke's Hospital or in St. Michael's Acute Unit.

Staffing Levels

Post	Number WTE	Sessions per week
Consultant psychiatrist	1	Full time
Nursing staff	4	Full time
NCHD	2	Full time
Occupational therapist	0	-
Psychologist	2	Full time
Social worker	1	Full time
Activities therapist	0	-
Addiction Counsellor	1	Full time

Range of Services Provided

A new assessment and individual care plan had been introduced by the service. The plan was that all new referrals would begin with this documentation. It was envisaged that regular attendees would be transferred to the new documentation in time. The service user collaborated with the care plan and signed it.

There was a weekly team meeting attended by all members of the multidisciplinary team.

Home visits were carried out by the community mental health nurse, and also by all members of the multidisciplinary team.

Case conferences were held and were attended by the service user concerned.

A liaison nurse linked the service with the hospital to facilitate follow-up for people who deliberately self harm.

Service User Input

The Irish Advocacy Network (IAN) representative had established firm links with the service. Information regarding IAN and other voluntary organisations was displayed prominently on the notice board in the waiting room.

The service user report indicated that staff were helpful and approachable. However, service users also believed there was too much emphasis on medication and some clients had little awareness of their care plans.

The social worker had facilitated the development of a user-led support and information service at Áras Folláin.

None of the service users attending the service on the day of inspection, asked to speak to the Inspectorate.

Quality Initiatives in 2009

- A new community mental health service assessment and recovery care plan had been introduced by the service.
- An audit on nursing documentation based on An Bord Altranais standards had been undertaken by the service and was to be followed by a six-month evaluation and review.
- All members of the multidisciplinary team had received training in prevention and management of aggression and violence (PMAV).

Diagnoses (All Attendees in Past Month)

Diagnosis	Number
Affective disorders	3
Psychotic illness	4
Anxiety disorders	16
Addiction disorders	3
Personality disorders	0
Other	3
Average length of stay (number of days)	Not available

Operational Policies

A policy working group had been established by the service to introduce policies and procedures pertinent to the service provided.

The service had an admission and discharge policy.

Risk assessment had been incorporated into the new assessment tool to be used for all attendees of the service.

All incidents were now fed into the STARS Web tracking system.

A number of staff from the North Tipperary catchment had received PMAV training in the Dundalk Institute of Technology. They, in turn, had provided in-service training to all staff of the service in October 2008. A follow-up training programme was scheduled for October 2009.

All staff of the service had received training in cardio-pulmonary resuscitation (CPR). An automatic emergency defibrillator was located on the premises.

All staff training had now stopped because of cutbacks.

Planning

The plan for separating North Tipperary and South Tipperary mental health services was complete and was made available to the Inspectorate. This did not deal with the closure of in-patient services in South Tipperary. A new committee was now looking at this and the development of alternate in-patient facilities for North Tipperary. It was reported that a decision had been made that no patients from North Tipperary would be admitted to Clonmel after 31 December 2010. Although it was reported that the plan was to extend opening hours possibly to a seven-day service and to further develop the already established links with primary care, Drommin House Community Mental Health Centre had no specific written service plan or operational framework.

Conclusions

Drommin House Community Mental Health Centre was the sector headquarters for the Nenagh sector, one of two sectors in the North Tipperary catchment that was part of HSE West. The catchment was unique in Ireland in that it had no residential beds. Any individual who required in-patient care and treatment was referred to St. Michael's Acute Admissions Unit in South Tipperary catchment, which was part of HSE South.

Drommin House, set discreetly in a residential area, provided a service to approximately 500 service users. It had established strong links with primary care and had received great support from the local community.

Service users attended for clinic appointments, individual one-to-one therapies with members of the multidisciplinary team, specific groups, sessional work, supervision of daily medications and administration of depot medications.

The focus of care and treatment was a multidisciplinary approach, in collaboration with the service user.

Recommendations and Areas for Development

1. *Consideration should be given to extending the service to seven days a week.*

2. *The service should have its own written strategic plan and operational framework to include the provision of in-patient beds and community residences for which it is responsible.*

Appendix 7: Service Users and Carers Involvement in Mental Health Services 2009

Maeve Kenny, Assistant Inspector of Mental Health Services

Introduction

In 2009, the Inspectorate was interested in the views of service users and carers about the quality of mental health services, the availability of peer support and advocacy, and their level of involvement at all levels in mental health services. Service users and carers have unique and valuable perspectives on the service they receive and consequently their views had been incorporated into the inspection process. *A Vision for Change* (2006, p.9) recommends that the *"involvement of service users and their carers should be a feature of every aspect of service development and delivery"*.

Methodology

Approved Centre Inspections

The Inspectorate met with residents during inspections of approved centres and included their comments in individual approved centre inspection reports. Residents represented their own personal issues and concerns to the Inspectorate.

Mental Health Service Inspections

Inspections of mental health services were conducted through local meetings with relevant personnel who provided their perspectives about the quality of local mental health services. Generally, services invited the local or regional Irish Advocacy Network (IAN) or STEER peer advocate and some services also invited service user and carer representatives.

Self-Assessment

This year, as part of the inspection of mental health services, the Inspectorate requested local management to complete a self-assessment. This included an evaluation of the extent of peer support and advocacy, and the level of service user involvement in the local mental health services. Thirty-one catchments and St. Joseph's I.D. service were requested to return self-assessments to the Inspectorate. Thirty-one self-assessments were analysed. All of the services, with the exception of Dublin South East, returned a self-assessment.

The information requested related to theme 3 from the *Quality Framework* (MHC, 2007). Theme 3 states that *"an empowering approach to mental health services delivery is beneficial to both people using the service and those providing it"* (MHC, 2007, p. 29). The specific information sought related to two standards under theme 3, which state that *"peer support/advocacy is available to service users"* and *"that a clear accessible mechanism for participation in the delivery of mental health services is available to service users"* (MHC, 2007, p 32). Each of these standards had 5 criterion against which services were asked to assess themselves. The criterion are reported later in this report.

The information received from services was difficult to collate due to inconsistencies in reporting information and different interpretations of the information being sought. The main issues and concerns from Approved Centre and Catchment reports are presented below. Examples of good or innovative practice are highlighted from the self-assessments completed by services. This is not an exhaustive list of good practices and does not imply that other services were not delivering similar or other good practices.

Service Users' Views from Approved Centre Inspection Reports

A range of issues and concerns emerged in meetings with residents during inspections of approved centres. The Inspectorate intervened where appropriate. Importantly, the Inspectorate noted that most residents stated they were happy with their care and treatment. It was encouraging to note that a number of residents spoke about the high level of involvement they had in their care plan and treatment. However, highlighting inconsistencies across services, other residents reported that they were not aware of their care plan and reported not having enough information about their treatment. Residents were generally positive about improvements in their environment when facilities had been upgraded or decorated. Most residents commented on the helpfulness, warmth and dedication of most staff on the units, in particular, recently qualified nursing staff who they found to be caring and supportive. The practice of protected nursing time to spend with residents was seen as valuable.

Some of the concerns raised by residents included not having enough choice of food and lack of privacy in some approved centres. Residents also commented that there were limited recreational activities provided in the evenings and at weekends.

Service User Representatives' Views from Catchment Inspection Reports

The IAN and STEER peer advocates reported that they were welcomed by local mental health services and supported by staff to carry out their work. In some areas peer advocates attended mental health tribunals at the request of residents and this was valued by service users. There were mixed reports from peer advocates about how satisfied residents were about their level of involvement in their care and treatment and the level of information that had been made available to them in relation to their diagnosis and medication. This indicated that in some services more work is required in this area.

Peer advocates reported that in a number of services they had been invited onto the senior management team and thus they were part of decision making processes within these services. While not all services had expanded their management structure in this way, peer advocates had been asked to participate in a range of local groups facilitating the inclusion of service user views, for example, local *Vision for Change* implementation groups, health and safety, risk management and policy development committees.

The Inspectorate noted that these developments, while welcome, had been gathering pace over the past few years and raised a number of issues. Some services were relying on peer advocate involvement rather than service user and carer involvement. Peer advocates, service users, carers and services also highlighted that there were a limited number of service users and carers available to take up roles within the services. There is an ongoing need for further training and building of capacity among service users and carers to facilitate the development of their roles and their ongoing participation in mental health services.

IAN representatives reported that in most areas, funding for peer advocacy training was limited. The limited resources in terms of numbers of advocates made it impossible for all mental health facilities to be visited on a regular basis. At a minimum, most tried to provide a regular visiting service to the admission units, but were not able to provide the same level of service to other units or community based facilities.

Advocates reported that in some services residents in approved centres were expected to attend team meetings, in other services this option was not provided, while in other services the resident could choose whether or not to attend. While there are logistical issues for some services, it is an example of how services could be reconfigured to facilitate the preferences and choices of residents, thereby enhancing autonomy.

Other issues, highlighted in the 2008 Inspector's report, continued to be of concern, including a perceived over-reliance on medication, and a lack of attention to and information about the side effects of medications. The limited time that service users had to discuss matters with a consultant psychiatrist was criticised. In addition, the limited access to clinical psychologists, social workers, occupational therapists and alternatives to the medical model continued to be highlighted as a concern.

Some services had formal and regular meetings between management and IAN or STEER peer advocates and these were reported generally to be effective in resolving issues. Specific liaison arrangements with a designated staff member on a unit or in an approved centre also helped communication and prompt resolution of specific issues.

Services' Perspectives on Service User Participation

Mental Health Services were asked to assess themselves on a number of questions designed to examine the level of peer support and advocacy provided and the level of participation of service users in the delivery of mental health services. Below is a summary of the information provided and some examples of good or innovative practices from the self-assessments completed by services.

Availability of Peer Advocacy Services to Service Users

Peer-advocacy was available in all services. However, the limited number of trained peer advocates resulted in limited access in some services. For example, in some areas advocates were only able to visit approved centres and did not have the capacity to visit community based facilities, or in the case of some approved centres were unable to provide a service to all the units, for example St. Senan's where there was no provision to continuing care units.

Availability of Peer-Provided Services to Service Users

Peer-provided services were available in all areas. Typically these included Shine, Grow, Aware, A.A., Al-Anon, and Narcotics Anonymous. In some areas, these voluntary organisations delivered services in the approved centres as well as in the community.

HSE Dublin Mid-Leinster

Laois/Offaly: There was a community based 'Finding Your Way to Recovery Group', which was a joint initiative between Shine and mental health and primary care social work. It was led by a service user. There was also a Lighthouse Club, which was an out-of-hours social networking service run by service users in partnership with IAN.

South County Dublin: A user resource and information centre had been established at Burton Hall and was staffed by the Service User Resource Committee (SOURCE) and volunteers.

HSE Dublin North East

Cavan/Monaghan: The Solas drop-in centre provided a link service between statutory and voluntary groups.

Louth/Meath: Client focus groups were facilitated by development officers from local voluntary groups.

St. Joseph's I.D. service: Peer advocacy was not available but Social Inclusion Ireland provided an advocacy service and training in self-advocacy.

HSE West

North Tipperary: Peer provided services were available through Áras Falloin, a community based project in Nenagh.

West Galway: A peer support centre was being established.

Quality Framework Mental Health Services in Ireland – Standard 3.3

3.3.1(a): Adherence to Regulation 20 (Provision of Information to residents)

There was a statutory requirement for compliance with Article 20 of the *Mental Health Act, 2001, (Approved Centre) Regulations*. Seventy-three percent (47) of approved centres were compliant. St. Finan's was the only approved centre that was non-compliant, while other approved centres had either initiated compliance or were substantially compliant.

3.3.1(b): Provision of Clear Written Information on Mental Health Peer Advocacy Services and How to Access Them

Most services provided written leaflets and notices about peer advocacy services. It was not always clear from the self-assessments if this information was available in all mental health facilities in the area or only approved centres. St. Joseph's I.D. services provided plain English booklets incorporating imagery. Ninety-four percent (61) of approved centres were compliant with Article 20 (1) (d) of the regulations which requires that details of relevant advocacy and voluntary agencies be provided to each resident. All other approved centres had either initiated compliance or were substantially complaint.

3.3.2: Provision of Access to Advocacy Training for Service Users

Twenty two services reported access to advocacy training for service users.

HSE Dublin Mid-Leinster

Dublin South City and Dublin West/South West: Service users, carers and staff were sponsored to participate in the Co-operative Learning Leadership Programme, a partnership between the School of Nursing, Dublin City University (DCU), the HSE, IAN and the National Service User Executive (NSUE).

HSE Dublin North East

North Dublin: Advocacy training could be accessed through a referral process from a consultant psychiatrist.

St. Joseph's I.D. service: Training was provided in self-advocacy and the service was working with the School of Nursing, DCU, to support people with an intellectual disability to develop leadership and advocacy skills.

HSE South

West Cork: Service users, carers and staff were sponsored to participate in the Co-operative Learning Leadership Programme, a partnership between the School of Nursing, DCU, the HSE, IAN and NSUE.

HSE West

Donegal: Service users, carers and staff were sponsored to participate in the Co-operative Learning Leadership Programme, a partnership between the School of Nursing, DCU, the HSE, IAN and NSUE.

Limerick: Ten people trained in advocacy.

North Tipperary: Aras Follain and the Citizen's Information Board provided self-advocacy courses and service users had been supported to attend peer advocacy training with IAN.

Sligo/Leitrim: Training was provided for carers.

3.3.3: Policy about Availability of Peer Support and Advocacy to Service Users

HSE Dublin Mid-Leinster

Dublin South City: Reported there was a policy in place.

HSE Dublin North East

St. Joseph's I.D. service: A steering committee had been established to develop a strategy to support the development of peer and self-advocacy.

HSE South

West Cork and North Cork: Reported there was a policy in place.

HSE WEST

Sligo/Leitrim: Reported there was a policy in place.

3.3.4: Ongoing Arrangements to Monitor Peer Support and Advocacy

In all areas, the local or regional peer advocate presented a report at an annual meeting with the Inspectorate. Apart from that forum, 16 services reported additional ongoing arrangements to monitor access to peer advocacy. Most often this involved regular meetings with peer advocates. Three services reported ongoing specific arrangements for monitoring other forms of peer supports.

HSE Dublin Mid-Leinster

South County Dublin: Service user representatives were on the elected committee in Venegas House Members Club.

HSE Dublin North East

Louth/Meath: There were designated groups with responsibility to monitor the progress of client focused groups, relatives and carers' support groups and consumer participation in services.

St. Joseph's I.D. service: A steering committee had been established and monitoring peer support and advocacy was part of its brief.

Quality Framework Mental Health Services Ireland – Standard 3.4

Participation in the Delivery of Mental Health Services

Extent of Service User Involvement in The Planning and Development of Research within the Service

Nine services reported that they included service users in the planning and development of research. Some of the replies to this question highlighted confusion between viewing service users as participants in research, rather than as being involved in the planning and development of it and a further confusion between peer advocates and service user representatives.

HSE Dublin Mid-Leinster

Dublin West/South West and Dublin South City: Engaged in research projects through involvement with the DCU Cooperative Learning Leadership programme. This required the collaboration of service users, carers and staff to develop and implement research projects.

South County Dublin: Two service users were members of the adult mental health research board, which reviewed all proposed research in the service.

Wicklow: The service user representative was a member of the ethics committee.

HSE Dublin North East

Dublin North Central: Service users had requested a research topic on stigma.

HSE South

West Cork: Research projects were established through involvement with the DCU Cooperative Learning Leadership programme. This required the collaboration of service users, carers and staff to develop and implement research projects.

Wexford: The peer advocate was involved in the steering group of the SCAN project, which contained an element of research with the Suicide Research Foundation.

HSE West

Donegal: Research projects were established through involvement with the DCU Cooperative Learning Leadership programme. This required the collaboration of service users, carers and staff to develop and implement research projects.

West Galway: Service users developed the Employment and Social Support Report, a survey of mental health service users in Galway.

Service User Involvement in Staff Training and Education

Thirteen services reported service user or carer involvement in staff training and education.

HSE Mid-Leinster

Longford/Westmeath: There was involvement in NCHD induction training.

South County Dublin: The SOURCE group presented at conferences and third level courses. There was a buddy system in place with service users and nursing students from UCD. Service user representatives attended weekly joint lectures in UCD. Grow were involved in presentations to NCHDs at induction.

Wicklow: Service users were involved in case conferences.

HSE Dublin North East

Louth/Meath: Service users were involved in an assertive outreach induction programme. They were involved in an 11 day recovery workshop. They had input to the training of student nurses in Dundalk Institute of technology and linked with student nurses on placement in the service.

North Dublin: Staff accessed training in DCU, where service users were involved in training and education.

St. Joseph's I.D. service: Service users had ongoing involvement in the education and training of pre-registration students.

HSE South

South Lee: There was involvement in induction programmes for NCHDs and student nurses.

Waterford: Service users were involved in case conferences.

Wexford: There was involvement in NCHD training.

West Cork: Participants in the DCU Cooperative Learning Leadership project had presented the background to their course and their research project to all staff.

Kerry: The peer advocate was involved in undergraduate nurse training and acted in an advisory role in designing community mental health team training and staff development.

HSE West

Mayo: Service users were involved in rehabilitation and recovery training.

North Tipperary: Service users had presented to staff on WRAP, recovery and self-advocacy.

3.4.1: The Ways Service Users Are Active Participants in the Planning, Implementation, Evaluation and Review of Their Own Care and Treatment

Most services indicated that care plans were used for this purpose. The information submitted did not indicate how widespread the use of individual care plans was across the mental health services in any given catchment. It was evident from the approved centre inspection reports that only 31.3% were fully compliant with this requirement (20). Inspection reports on a sample of day hospitals and 24-hour staffed community residences completed this year, and self-assessments commenting on community based facilities, indicated that individual care plans were not consistently used throughout the mental

health services, thereby limiting service user involvement in their own care and treatment. Apart from care plans, there were a number of other ways that services facilitated involvement of service users in their care and treatment.

HSE Dublin Mid-Leinster

Dublin West/South West: A planning and advisory group had been established on carer and service user participation.

Laois/Offaly: The psychiatry of later life team had established a carers' support group.

HSE Dublin North East

Dublin North Central: A cultural clinic had developed a cultural advisory panel that included service users in order to help develop services with appropriate awareness of cultural issues.

Louth/Meath: A pilot project on helping service users to manage future crisis using crisis cards was developed through a client interest group in conjunction with AWARE.

North West Dublin: Focus groups for service users and carers had been initiated to enhance involvement.

HSE South

West Cork: The West Cork Health Forum was an informal network of stakeholders in the area that included community organisations, voluntary sectors and individuals. It provided a channel for service users and carers, identified support for families, engaged with the local community and challenged the stigma of mental health.

HSE West

East Galway: There was a consumer forum and consumer panels.

North Tipperary: There was a family support group.

Roscommon: Mental Health Ireland had established a user group and there was also a relatives' support group.

3.4.2: Mechanisms in Place for Obtaining Feedback at Service and Multidisciplinary Team (MDT) Level from Service Users

All services reported that they had mechanisms in place for obtaining feedback from service users. Many services did not distinguish between feedback at MDT level and feedback at service level. Most services reported that care plans facilitated feedback at MDT level. However, as described above, not all service users had care plans and it was not clear what type of feedback residents gave through their care plans.

HSE Dublin Mid-Leinster

Longford/Westmeath: The Athlone service users' group had designated feedback meetings with the clinical director.

HSE Dublin North East

St. Joseph's I.D. service: Non-verbal feedback was monitored.

HSE West

North Tipperary: There were regular meetings with service users in Áras Falloin.

Roscommon: Focus groups were held in Roscrea.

At service level, all catchments operated a complaints policy and many also proactively sought the views of service users through satisfaction questionnaires. It was not clear from the information submitted whether or not satisfaction questionnaires were used throughout all aspects of the service or in specific areas such as approved centres or day hospitals.

HSE Dublin Mid-Leinster

Dublin West/South West: A carers' council had been established.

South County Dublin: Satisfaction questionnaires had been completed by the service user research committee (SOURCE) and a catering review group planning survey had been completed across the service by service users.

HSE Dublin North East

North Dublin: Focus groups were held.

Louth/Meath: The consumer group fed-back to management. The psychiatry of later life family support group included a feedback mechanism to the team.

St. Joseph's I.D. service: There were regular focus groups between service users and management, as well as informal sessions of service user feedback.

HSE South

West Cork: The Cooperative Learning Leadership project had developed a questionnaire seeking feedback about all aspects of the service from all those who use or work in the services.

Wexford: A consumer panel was developing mechanisms for feedback.

HSE West

Sligo/Leitrim: Mental Health Ireland had initiated a formal survey of the consumer panel.

3.4.3: Involvement of Service Users in the Development and Planning of the Mental Health Service Including Inclusion on MDT Catchment Management Teams

There was significant variation across catchments in terms of the extent of service user and carer involvement on various planning and development committees. Most services had involved peer advocates while some also involved service user and carer representatives, on the local *Vision for Change* implementation groups.

HSE Dublin Mid-Leinster

Dublin South City: The peer advocate attended the heads of department group.

Dublin West/South West: The clinical governance group had been expanded to include service users and carer representatives and they had been involved in the design of a local building project.

South County Dublin: There was service user participation on all planning committees.

HSE Dublin North East

Dublin North Central: The peer advocate attended the heads of discipline management meetings.

Louth/Meath: The regional peer advocate was involved in meetings about the planning and development for a new acute unit in Louth, a replacement facility for a day centre in Meath and amalgamation of units in St. Brigid's and service users had been involved in a service planning session with the management team. Service users were involved in the quality and best practice group.

HSE South

South Tipperary: A service user representative was involved in governance structures, capital projects developments and strategic groups.

West Cork: Service users were represented on the policy committee, the multidisciplinary integrated notes/medical records committee, the residential review committee, the risk management group, and service users and carers were members of the local *Vision for Change* implementation group.

Wexford: The peer advocate was a member of the steering group for the pilot Suicide Crisis Assessment Nurse (SCAN) project.

HSE West

Clare: The peer advocate was on the management steering group, the policy group and the multidisciplinary team care plan development committee.

East Galway: There was involvement in the audit committee.

Limerick: The consumer group facilitated nominations for reviewing multidisciplinary team documentation and the catering standards committee.

Mayo: The peer advocate attended the heads of department meetings, which reported to the management team.

West Galway: The peer advocate attended senior staff meetings, quality/accreditation meetings and all policies were sent for consultation to service user representatives prior to implementation.

Relatively few services had adapted to include service users and carers on the management team. While in all services there was some level of involvement of peer advocates in the development and planning of services, mainly through inclusion on local *Vision for Change* implementation groups, significantly fewer services had formally involved service users and carers.

HSE Dublin Mid-Leinster

Longford/Westmeath: The peer advocate joined the catchment management meeting every three months.

Wicklow: There was a service user on the Newcastle Hospital management team.

HSE Dublin North East

North Dublin: The peer advocate was a member of the management team.

HSE South

North Cork: The peer advocate attended management meetings although this arrangement has not been formalised and the peer advocate was a member of policy and procedure group.

HSE West

Donegal: The peer advocate was on the mental health services management team and chaired the policy review group.

3.4.4: Policy about Service User Involvement at All Levels within the Mental Health Service

Four services reported having a policy about service user involvement.

HSE Dublin Mid-Leinster

Dublin West/South West: The policy was to increase representation at all levels of the service.

South County Dublin: The policy was to encourage all stakeholders to participate in the planning and delivery of services.

Wicklow: There was a policy about service user involvement on management team.

HSE South

West Cork: The policy was to have service users involved at all levels of the service.

3.4.5: Ongoing Arrangements to Monitor Performance with Regard to Service User Involvement at All Levels within the Mental Health Service

Only two services reported ongoing arrangements to monitor its performance with regard to service user involvement.

HSE Dublin North East

St. Joseph's I.D. service: A steering group had designated responsibility for monitoring performance in relation to service user involvement.

HSE South

West Cork: Time was set aside at the end of each *Vision for Change* implementation group to review progress in relation to service user involvement.

Summary

This report highlighted a wide range of variation across mental health services in terms of what residents, peer advocates and services reported about the extent and type of service user and carer involvement at all levels within the mental health services and the availability of peer support and advocacy.

Residents in approved centres generally reported concerns about:

- limited choice of food
- lack of privacy
- limited recreational activities in the evenings and at weekends

Residents in approved centres were generally satisfied with:

- the care and treatment they received while in hospital
- the positive effects of helpful and warm relationships with staff
- recently qualified nursing staff
- protected time for key nurses to spend with residents
- improvements in the physical environment in approved centres

Peer advocates highlighted positive issues including:

- the welcome and support they received from staff when carrying out their work
- the usefulness of having regular meetings with staff in approved centres
- some services had a designated senior staff member who the advocate could liaise with to address concerns promptly
- they were increasingly requested to support detained patients at their MHC tribunal
- the expansion of management structures to include service user representatives

Peer advocates highlighted issues for improvement including:

- limited time service users were afforded to spend with consultant psychiatrists
- restricted or no access for service users to alternate approaches to their recovery apart from the medical model
- lack of information made available to service users about their diagnosis and medication, particularly about the side-effects of medications
- limited involvement of service users in their own care plans
- individual care plans were not used throughout the entire service and may only have been used in approved centres or community facilities, but not in both

- restricted resources and capacity for peer advocates and service user/carer involvement

Self-assessments completed by services indicated:

- significant variation across services in relation to service user and carer involvement
- pockets of services where a significant amount of work had been undertaken in the area of service user and carer participation at all levels
- West Cork, Dublin West/South West, Dublin South City, South County Dublin and St. Joseph's I.D. services all stood out in terms of their collaborative and inclusive approach to service users and carer involvement in the respective services

Conclusion

Overall, there is significant scope for further involvement of service users and carers at all levels within the mental health services. Many of the good and innovative practices described in this report could be incorporated into service delivery without significant expenditure and indeed some of the practices are cost neutral.

Recommendations

1. Funding, training and personnel resources need to be made available as services strive to increase the level of participation of service users and carers in all aspects of delivery and development of mental health services.
2. Formal links between mental health services and third level institutions should continue to be forged to develop capacity for service user and carer involvement.
3. Services should develop a policy about the availability of peer support and advocacy to all service users.
4. Services should develop a policy about service user and carer involvement at all levels within the mental health service.
5. Service users should have an individual care plan regardless of what aspects of the mental health service they use.
6. Formal mechanisms should be implemented in mental health services to obtain feedback from service users and carers about all aspects of the mental health service, including the person's MDT.

References

Department of Health and Children (2001) *Mental Health Act, 2001, (Approved Centre) Regulations*. Dublin: Stationery office.

Department of Health and Children (2006) *A Vision for Change – Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office.

Mental Health Commission (2007) *Quality Framework: Mental Health Services in Ireland*.

Appendix 8: Child and Adolescent Mental Health Services 2009

Dr. Susan Finnerty, Assistant Inspector of Mental Health Services

Information for this report was collected through a self-assessment questionnaire sent to each service and from an overview meeting held with all the services in November 2009.

The quality of the information received through the self-assessment was variable. The majority of services provided detailed information about their service while a small number of services gave minimal information, leaving some questions unanswered.

Description of Services

Linn Dara Mental Health Services (South West Dublin, South Inner City, North West Dublin and Kildare)

The population served by Linn Dara was 1.55 million. It had eight community child and adolescent mental health service (CAMHS) teams and provided a liaison service to The National Children's Hospital in Tallaght. Children were seen to the age of 16. It had a six- bed in-patient unit, Warrenstown House, which was an approved centre. The plans for the service included developing a new base at Cherry Orchard for a day hospital and community teams, and developing the service in Warrenstown. Developments included the appointment of a child psychiatrist and approval for five new staff members. There were a number of ongoing programmes including a project targeting children at risk of early school leaving, parent psycho-education meetings, psychotherapy for adolescent girls and the Dinosaur children's group. There were dedicated ADHD clinics.

Waterford/South Kilkenny Child and Adolescent Mental Health Services

Waterford/South Kilkenny had a catchment population of 120,017 and had one community mental health team. The team was based in Waterford Regional Hospital for which it provided a liaison service. Children were seen up to the age of 18. There were plans to recruit two new community teams. Developments included the recruitment of a speech and language therapist and an occupational therapist and the NCHD allocation had been changed from registrar to senior registrar. There was a dedicated ADHD clinic.

North Lee and North Cork Child and Adolescent Mental Health Services

The North Lee catchment area had a population of 178,692 and North Cork had a population of 80,795. There were three community CAMHS teams. The service assessed and treated children up to the age of 16. Active cases were seen to age 18. There was an interim in-patient unit in St. Stephen's Hospital with six beds. Construction had commenced on a 20-bed unit in Bessboro in Cork which will be a regional in-patient service. Developments included completion of the in-patient unit. Ongoing programmes included Incredible Years Programme for parents, initiation of the Jigsaw Project, Parent's Plus Groups, social skills training, adolescent parents group and speech and language and occupational therapy groups. Children with ADHD were seen both at a dedicated clinic and part of routine referrals depending on sector.

Carlow Kilkenny Child and Adolescent Mental Health Services

Carlow Kilkenny served a catchment area of 120,671. It had one community CAMHS team and provided a liaison service to the St. Luke's General Hospital, Kilkenny. The service sees children to the age of 18. Two consultant psychiatrists have been appointed. A waiting list initiative and an IT data management system had been set up. Parenting course training had been completed and there was an ADHD parenting group. There was an ADHD dedicated clinic.

Kerry Child and Adolescent Mental Health Services

Kerry had a population of 139,565 and one community CAMHS team. The service was delivered by the Brothers of Charity for the HSE. Referrals were accepted up to the age of 16. The service also provided a service to children with intellectual disability who had co-morbid mental health problems. The service was based in Tralee. Recruitment of a consultant psychiatrist had been completed although there was no team. There was also a new occupational therapy post. A number of groups were held including ADHD parenting groups, CBT depression groups and there was participation in the Jigsaw Project. There was a dedicated ADHD clinic.

Donegal Child and Adolescent Services

The population of Donegal was 145,000 and there were two community CAMHS. Referrals were accepted to the age of 18. There were plans to integrate the Donegal and Sligo services at management level. A senior registrar and a psychologist were recruited in 2009 and approval had been granted for a community team. Programmes available included group therapy, a family clinic, parenting groups, behavioural therapy and an attachment clinic. Formal links have been established with the adult mental health service. There were dedicated ADHD clinics.

Sligo/Leitrim/West Cavan Child and Adolescent Mental Health Services

The population of this area was 91,053. There was one community CAMHS team. Referrals were accepted to age 18. A permanent consultant psychiatrist had been recruited (previously filled on a temporary basis). There were plans to integrate services with the Donegal team. Five multidisciplinary posts have been approved as well as a second consultant psychiatrist post. The service ran group therapy, cognitive behavioural therapy and family therapy. Outreach clinics had commenced and there was a dedicated ADHD clinic. The service provided a half day input to the autism service.

Galway, Mayo, Roscommon Child and Adolescent Mental Health Services

The total population of this area was 463,383. There were five community CAMHS teams. There was a 10-bed in-patient unit in St. Anne's Children's Centre in Galway, which was an approved centre. Building was underway for a new 20-bed unit in Merlin Park in Galway which will be completed in 2010. There were plans to redefine boundaries to match Primary Care Networks. A consultant psychiatrist for the in-patient service had been appointed. There had been five additional posts recruited for a team in Mayo. There were groups for young people with eating disorders, community teams liaise with Jigsaw (currently being extended) and new information leaflets were in use. There were dedicated ADHD clinics. There was a Child and Adolescent Mental Health Course at NUIG for nursing staff.

Limerick, Clare and North Tipperary Child and Adolescent Mental Health Services

The population in the service was 361,028. There were four community CAMHS teams. Referrals were to the age of 16 years, although there were some limited provisions to see children up to the age of 18 in Limerick City. There was access to adult psychiatric beds in the Mid-Western Regional Hospital in Limerick. A consultant psychiatrist and five multidisciplinary staff had been recruited. Plans were in place to establish a consumer panel. There were dedicated services for children with ADHD.

North Dublin, Dublin North Central and Part of North West Dublin Child and Adolescent Mental Health Services

The population of this area was 380,856. There were five community CAMHS teams based in the Mater Hospital, an in-patient unit team and a day hospital team. There was a newly opened six bed unit for 16-18 year olds in St. Vincent's Hospital, which was an approved centre, and a day hospital for 13 to 17 year olds. A consultant psychiatrist was appointed in February 2009, as well as a senior psychologist, senior social worker and a senior speech and language therapist in the Mater community service. There were no nurses on the community teams. A psychologist and social worker were appointed to the day hospital team, also there was an increase in medical input. Service users provided formal feedback. There was an updated data collection system in use. There were group therapies, parent training, family therapy and art psychotherapy. Each CAMHS team provided an ADHD service as an integral part of their general work. Quality Network for In-patient CAHMS (QNIC) was used to inform practice in the in-patient unit. There was a specialized ADHD team in National Children's Hospital in Temple Street.

Louth Meath Cavan Monaghan Child and Adolescent Mental Health Services

The catchment population was 392,889 and there were three community CAMHS teams. Referrals were taken up to the age of 16 but services were extended to 18 for active cases. There was a regional day programme in Louth which runs two days a week and a liaison service to Cavan General Hospital, Our Lady's of Lourdes Hospital in Drogheda and Navan General Hospital. A consultant psychiatrist and a community mental health nurse had been appointed, and a senior psychologist and senior social worker were being recruited. Programmes included family therapy, cognitive behavioural therapy, family support for ADHD, psychotherapy for adolescents, early psychosis intervention, the Kerfoot programme, parent support groups, anti-bullying, Crosslinx, groups for adolescents with Asperger's Syndrome and a dialectical Behaviour Therapy group. There were dedicated ADHD services.

South Tipperary Child and Adolescent Mental Health Services

The population of South Tipperary was 83,221. There was one community CAMHS team. Referrals were up to the age of 16. No new teams were planned for South Tipperary. A new patient clinic had been established. No groups or programmes were able to take place due to lack of staff. There were dedicated ADHD clinics.

Wexford Child and Adolescent Mental Health Services

The population of Wexford was 131,000. There was one community CAMHS team. The service took referrals up to 17 years and provided a liaison service to Wexford General Hospital. A new consultant had been appointed and there were plans to recruit a social worker and nurse. There were also plans to provide clinical placement for trainee GPs. A clinical nurse specialist liaised with the schools of children who were attending the service. There were dedicated ADHD clinics

Laois/Offaly/Longford/Westmeath Child and Adolescent Mental Health Service

The population of this area was 250,000 and there were two community CAMHS teams. Referrals were up to the age of 16. A liaison service was provided to the Midland Regional Hospitals in Portlaoise, Tullamore and Mullingar. A social worker was appointed in 2009. A basic grade clinical psychologist post had been replaced by a senior clinical psychologist; the basic grade post was now vacant. Adolescent group therapies were available and focus groups had been held with parents and adolescents. There was active involvement with an anti-obesity programme for children. Programmes included parenting groups, stress management groups, cognitive behavioural programmes, art psychotherapy, Kerfoot programme for attempted suicide, social skills group and family therapy. There was a dedicated 0.5 WTE consultant psychiatrist for ADHD with dedicated clinics.

South Lee and West Cork Child and Adolescent Mental Health Service

Although there were three teams in this area only information on one team was submitted by self-assessment. The population of this team was 86,921. The service was run by the Brothers of Charity for the HSE. The service also provided a service to children with intellectual disability who have co-morbid mental health problems. A mindfulness group for anxiety disorder had commenced, there were psycho-educational sessions to schools, a Parent Plus group, a library service and an ADHD service audit was near completion. There were a number of ongoing clinical audits taking place. A social worker, part-time occupational therapist and a nurse were due to commence work in November 2009. A psychologist was due to commence in 2010. No consultant post had been approved for this team. There was a dedicated ADHD service.

Lucena Child and Adolescent Mental Health Service

Lucena CAMHS covered a population of 600,000. There were eight community CAMHS teams and a day hospital. There were close links to two special schools. There was an effective IT system which was shared with St. John of God Services. Programmes included family therapy and parenting groups.

Summary

One of the most striking features in the information collected was the immensely wide range of services, groups and programmes offered by the child and adolescent mental health services. However, each team provided different programmes; some providing many programmes while others appeared to provide very few. While this was obviously a factor of the availability of resources, it was obvious that the type of programmes on offer varied considerably. The decision as to which service was to be offered and how it was to be offered was made locally. Neighbouring catchments and even adjacent teams often offered very different services. There were no national standards as to what services should be provided and it was unclear whether these programmes had been evaluated.

Programmes for Children and Adolescents

There was a variety of group therapies available for children and adolescents. For example North Lee provided social skills groups. Others such as Laois, Offaly, Longford, and Westmeath provided cognitive behavioural groups as well as the Kerfoot project (for children who have attempted suicide), social skills training and communication, and Locke programme for children with eating disorders. Linn Dara provided Solution Focused Therapy and the Dinosaur group as well as the Londubh project which targeted children at risk of early school leaving.

A number of areas were either in partnership or plan to become partners in the Jigsaw project. This included Galway, North Lee and Kerry. This programme was provided by Headstrong in conjunction with the HSE to provide an early intervention service for young adults as well as access to counselling services. There was crossover with the adult services in each area. It still required full evaluation but the model had been successfully used in other jurisdictions. The Jigsaw project was based outside the mental health service but provided intervention by the mental health services when required.

Parenting Programmes

Many services offered parenting groups. Some services such as those in North Lee in Cork, Laois, Offaly, Longford, Westmeath and Linn Dara provided Incredible Years parenting programme. Carlow, Kilkenny and South Tipperary and the North East provided a programme for parents of children with ADHD. Others provided a Parenting Plus programme. Linn Dara provided a parents psycho-education, crisis intervention and support programme.

Data Collection

Where resources are scarce and services are stretched to provide assessments and interventions, the quality of information for planning was vital. Only three services were able to provided breakdown of assessments of children and adolescents by both age and diagnosis for 2008 for the purpose of this report. In Wexford and South Tipperary and the Mater service, ADHD accounted for the highest percentage of children assessed. In St. Joseph's Adolescent and Family Service depression accounted for the highest percentage of cases seen in adolescents. North Cork provided a breakdown on age only. South Lee & West Cork provided information from one team only. Other services indicated that it was not possible to provide any breakdown by diagnosis or age. Most services do not have computerised data collection systems. This information is minimal in attempting to plan, audit and monitor services, and also to allocate resources and it was incomprehensible that there were not the facilities to collect this data. The vast majority of services had responded to the perceived need for ADHD services by holding dedicated ADHD clinics. Most services provided a consultation services to other agencies for children and adolescents with autism.

The First Annual Report of the Child and Adolescent Mental Health Services compiled by the HSE was published in 2009.

Waiting Lists

There were declared efforts to keep waiting lists at a minimum from most services. However, waiting lists continue to be long in many areas, ranging from six weeks to two and half years for non urgent cases. Emergency and urgent referrals were usually provided with an assessment quickly. Most services could give no information about the length of time waiting for an in-patient bed. This was mainly due to the fact that there were only beds in St. Anne's Centre, Galway (10 beds), Warrenstown (6 beds) and St. Vincent's Hospital, Fairview (6 beds) since March 2009. Where CAMHS were seeing 16-18 year olds this had added to the waiting times.

Table: Waiting Times in Days

	Urgent	Non-urgent	In-patient
Galway, Mayo, Roscommon	1	90	0
Donegal	No information given	No information given	No information given
Sligo, Leitrim	1	912	No information given
Limerick, Clare, N. Tipperary	1	365	0
Kerry	1	450	No information given
S. Tipperary	1	365	No information given
Carlow, Kilkenny	0	630	60
Wexford	1	730	No information given
North Lee	1	570	No information given
North Cork	0	547	No information given
Waterford	1	42	No information given
Laois, Offaly, Longford, Westmeath	0	730	No information given
Mater	1	60	No information given

	Urgent	Non-urgent	In-patient
Louth, Meath, Cavan, Monaghan	1	300	No information given
Dublin South West, City, North West and Kildare	No information given	No information given	No information given
*South Lee & West Cork	No information	720	No information

*Only one team provided information

Day Services

Day services were minimal throughout the country. St. Vincent's Hospital in Fairview provided day hospital services through St. Joseph's adolescent unit which offered a comprehensive day programme delivered by a multidisciplinary team. Louth had a regional day programme which was provided twice a week. Most services were not in a position to offer structured educational services. St. Anne's Centre in Galway, St. Joseph's Adolescent and Family Service offered curriculum based education provided by the Department of Education for both in-patients and day patients.

Team Staffing

There were improvements in staffing in many areas with the appointment of seven consultant psychiatrists. The in-patient unit in Galway received five new multidisciplinary posts while a further five posts were due for appointment in Sligo in 2009. In Limerick, Waterford and Donegal the appointment of new teams had been approved. A consultant was recruited for the adolescent team in the Linn Dara service. *A Vision For Change* (2006) stated that two teams should be provided for each sector of 100,000 population. As can be seen from the table below the recommended team resourcing in *A Vision for Change* had not been met. There was a marked shortage in particular of occupational therapists and speech and language therapists.

Table: Staffing of Child and Adolescent Community Mental Health Teams per 100,000 Population

	Population	Consultant Psychiatrist	NCHDs	Nurses	Clinical Psychologist	Social Worker	Social Care	Occupational Therapy	Speech & Language
*Recommended by *Vision For Change*	Per 100,000	2	2	2	4	4	2	2	2
Galway, Mayo, Roscommon	463,383	1.29	2.2	2	0.43	2.15	2.4	1.29	0.86
Donegal	145,000	1.38	2	1.8	0.5	1.38	2	0	0
Sligo, Leitrim	91,053	1.1	1.1	0.7	1.1	1.97	2.6	0	0
Limerick, Clare, N. Tipperary	361,028	1.1	1.1	2.2	0.83	0.96	0.6	0	0
Kerry	139,565	1.1	0.7	0.7	1.1	1.1	0	0	0
S. Tipperary	83,221	1.2	1.2	1.2	2.4	1.2	0	0	0
Carlow, Kilkenny	120,671	1.49	0.8	0.6	0	1.4	0	0	0
Wexford	131,000	0.76	2.3	0	0	0	0	0	0
North Lee	178,692	1.1	2	0	1.67	1.84	0	0.5	0
North Cork	80,795	1.24	1.2	1.2	0.74	1.24	0	0.61	0
Waterford	120,017	0.83	0.8	0.8	1.7	0.5	0	0	0
Laois, Offaly, Longford, Westmeath	250,000	1.36	2	1.7	1.4	1.2	0	0.8	0.2
Mater	380,856	1.28	1.65	0.9	2.73	1.5	0	0.65	1.96
Louth, Meath, Cavan, Monaghan	392,889	1.17	2	1.1	0.68	1.45	0	0	0
Dublin South West, City, North West and Kildare	500,000	2.68	4	2.14	1.82	1.6	1.9	0	1.82
**South Lee & West Cork (Bandon Team)	86,000	1.16	1.16	0	1.16	1.16	0	0	0

* *Vision for Change* recommendation per 100,000 population incorporated within two teams

** Only one team provided information

In-Patient Services

Progress in the opening of new in-patient beds had been slow. Services complained about the amount of time spent searching for a free bed for admissions. One hundred and ninety three children were admitted to adult units in 2009. Although there were 10 beds in St. Anne's Children's Centre in Galway this unit was seldom full, despite the fact that children continued to be admitted to adult mental health units throughout the country. A six-bed unit for adolescents opened in St. Vincent's in Fairview, Dublin. Warrenstown House continued to provide six beds. The building of the new unit in Galway that will provide 10 extra beds had commenced. The interim unit (eight beds) in St. Stephen's Hospital in Cork had opened and the new unit in Cork (20 beds) had progressed to building stage at the time of the report. St. John of God Hospital had 12 beds which can be accessed privately and the HSE have availed of this arrangement where necessary. St. Patrick's Hospital plan to open a private adolescent unit. The Haven, a private facility in Maynooth was now an approved centre and will open in early 2010 with five beds.

Conclusion

There have been increases in staffing in child and adolescent teams in 2009 with the appointment of consultant psychiatrists and other staff. However, staffing of teams still remained well below the staffing for child and adolescent teams recommended in *A Vision for Change*. There was a considerable shortage of occupational therapy and speech and language therapy. Because of shortage of staff, individual and group work offered to children and their families were very limited. However, some services offer a diverse range of programmes and therapies.

Data collection within the services remained very poor and it was impossible to collect data on diagnosis and age from the majority of services for the purpose of this report.

Difficulties with accessing in-patient beds continued in 2009 with most services spending extended periods of time looking for beds for unwell children. The two new units with a total of 40 beds should be open in 2010 bringing the number of beds provided by the HSE up to 52. Meanwhile there were a total of 30 HSE beds nationally.

Waiting lists tended to vary nationally. While the majority of services were able to see children and adolescents urgently some waiting lists for non urgent cases could be up to two and a half years. It appears that where there have been waiting list initiatives the waiting time had decreased.

Recommendations

1. The number and staffing of community mental health teams should be in line with *A Vision for Change*.
2. There should be a national director for child and adolescent mental health services.
3. Services should be standardised nationally so that at least a minimal service was delivered in each area in line with best practice.
4. Computer based data collection systems should be put in place in each catchment area.
5. Evaluations should be carried out on programmes offered by each service.

Appendix 9: Mental Health Services for Persons with an Intellectual Disability

Dr. Fionnuala O'Loughlin, Assistant Inspector of Mental Health Services

In 2009, a self-assessment questionnaire was sent to each of the local health areas responsible for delivering mental health services to persons with an intellectual disability. The information received was used to compile this report. Information was also gathered at the national overview meeting of the services held in Dublin in November 2009.

Description of Services

HSE West

Mayo

There was one Mental Health of Intellectual Disability (MHID) team in Mayo, which provided a service to an estimated population of 960 persons with an intellectual disability. The team comprised one consultant psychiatrist, one NCHD, one nurse specialist (dual diagnosis) and one clerical staff. Admissions, when required, were to the approved centre in Castlebar General Hospital.

The service did not have a day centre, and did not provide a service for those with an autism spectrum disorder.

Regular meetings were held with the voluntary sector to discuss possible service developments.

Galway East

The service in East Galway was established in 1990 and served a population of 111 individuals. The MHID team had a consultant psychiatrist, employed half-time and minimal allocation of time from junior doctors. Two nurses worked in the day centre, and there were 46.6 nurses based in the community group homes, with one ADON.

Individuals requiring admission were admitted to the admission unit at St. Brigid's Hospital, Ballinasloe.

There were no specific services for those with an autism spectrum disorder. Transfer of residents from St. Brigid's hospital to more suitable accommodation was a priority for the service in 2009 but this was dependent on funding being provided. Discussions about forming an alliance with the voluntary sector had commenced.

Roscommon

There was no specialist MHID service in the Roscommon area. Services were provided by the voluntary sector. Roscommon Mental Health Service provided 24-hour care to six residents in the Castlerea sector.

Clare

There was no specialist MHID service in the Clare area. The voluntary sector, through the Brothers of Charity and Daughters of Charity, provided a service to individuals with an intellectual disability. This service had 1.8 WTE Consultant Psychiatrists, with two NCHDs.

Proposals by the HSE to provide a dedicated MHID service were under consideration in 2009. The service was also sourcing suitable alternative accommodation for individuals with an intellectual disability, currently resident in psychiatric hospitals.

Limerick

The Limerick catchment area had no dedicated MHID service. A service was provided by the voluntary sector team in the Clare area.

The mental health service for the Mid-West was developing a framework for delivery of an MHID service.

Sligo/Leitrim/West Cavan

The MHID team for this area served a population of 864 persons with an intellectual disability. The team had one consultant psychiatrist and one NCHD and had access to a day centre. An Autism Steering committee had been established in 2009 in conjunction with the Autism services in St. Angela's College, Sligo.

Individuals requiring admission to acute mental health units were admitted to the acute psychiatric unit in Sligo.

Donegal

The MHID service was established in Donegal in 2001 and served a population of 652 individuals with an intellectual disability. The team consisted of one consultant psychiatrist and one NCHD; generic community psychology services provided support where possible. There was no speech and language therapy or dedicated occupational therapy service available. A generic disability nurse provided care for approximately 20 individuals.

In 2009 formal meetings between mental health services and mental health for intellectual disability services were instigated, and the service was mapping current available services.

When admission to an acute psychiatric unit was required, individuals were admitted to the acute psychiatric unit in Letterkenny.

A mental health service was provided for adults with Autism Spectrum Disorder.

HSE Dublin North East

Cavan/Monaghan

There was no dedicated MHID team in this area. Services were delivered by the Disability Services to 598 persons registered on the National Intellectual Disability Database in the area.

The HSE had approved posts for the commencement of a specialist service to meet the mental health needs of people with an intellectual disability.

Meath

Meath had no dedicated MHID service, and the difficulty for adults accessing a psychiatric service was acknowledged by the HSE.

Services were provided to 637 persons with an intellectual disability by the local Disability Service.

Plans for recruiting a consultant psychiatrist to cover the Meath and Louth areas were at an advanced stage and it was hoped to appoint a consultant in 2009.

Louth

There was no MHID team in Louth, which had 1053 individuals registered on the national database of intellectual disability. A service was provided by the Disability Service.

Plans were underway in 2009 to appoint a consultant psychiatrist to cover both Meath and Louth.

St. Joseph's Intellectual Disability Service

St. Joseph's provided a service to 247 residents in care; 165 of these residents lived on site in St.Ita's Hospital, Portrane, and 82 lived in 24-hour supervised community residences. There were two teams, each with a consultant psychiatrist and NCHD. The teams were multidisciplinary and included an occupational therapist, social worker, art therapist, speech and language therapist and healthcare assistants.

Provision of new accommodation on-site in the grounds of St.Ita's Hospital was planned for 2009.

In addition to its residential service, St. Joseph's provided a day service to service users.

HSE South

North Cork/North Lee/West Cork

The MHID team consisted of one consultant psychiatrist with a special interest in ID, and an NCHD (0.5 WTE post). Nursing and multidisciplinary staff worked in the generic disability service. Proposals to recruit a second consultant psychiatrist have been submitted.

A new 30-bedded unit in St. Raphael's Centre was due to be completed in August 2009, and a Working Group on Mental Health/Intellectual Disability for the HSE South was established during 2009.

The Autism Steering Group for Children was reconvened to review the development of a catchment area-based Autism Spectrum Disorder in the Cork/Kerry region.

South Lee

MHID services in this area were provided by the voluntary sector through the Brothers of Charity. It provided a service to adults and children.

Kerry

There was no MHID team in Kerry. A service for individuals with an intellectual disability was provided by the voluntary sector. Where necessary, the consultant psychiatrist in general adult psychiatry in Kerry referred individuals to the MHID consultant in Cork.

Wexford/Waterford/South Tipperary

There was no MHID team in this area but the HSE worked in partnership with the voluntary sector to provide a service. Services in this area were provided by three consultant psychiatrists who have access to three psychologists.

In 2009, the HSE continued to address the issue of transferring residents with an intellectual disability currently in psychiatric hospitals, to more suitable accommodation. A number of residents were transferred from St. Luke's Hospital, Clonmel to alternative accommodation. Children with Autism Spectrum Disorder were referred to community disability services for assessment and diagnosis.

Carlow/Kilkenny

The Carlow/Kilkenny area did not have an MHID team, but services were provided by the voluntary sector. This service had access to psychologists and a social worker on request.

In 2009, 17 residents in St. Dympna's Hospital, with an intellectual disability were transferred to four purpose–built bungalows in the grounds of the hospital at Kelvin Court.

North Tipperary/East Limerick

There was no MHID team in this area. Services were provided by the voluntary sector which had two consultant psychiatrists and two NCHDs.

The HSE was proposing to progress a plan to provide a dedicated MHID team in 2009.

HSE Dublin Mid-Leinster

Stewarts Hospital

Stewarts Hospital provided a specialist mental health service for children and adults with an intellectual disability and provided a multidisciplinary team approach for its day service and clinics. It also operated an approved centre for individuals requiring in-patient treatment. There were 225 people on the database of service users in 2009. The Mental Health Management team was multidisciplinary and meets monthly.

The service had 1.5 WTE consultant psychiatrist posts and 1.5WTE NCHD posts. In addition, there were three psychologists, and one social worker in the MDT team.

Whilst there was no dedicated autism spectrum disorder service, children with the disorder were provided with assessment, treatment and educational services as part of the overall service in Stewarts Hospital.

Longford/Westmeath/Laois/Offaly

This area operated as one area for the purposes of providing an MHID service. It provided a community based service with one consultant psychiatrist, two NCHDs, with an occupational therapist (0.5 WTE post) in Laois/Offaly. Funding was provided through the Disability Services, and attempts to secure funding from the Mental Health Services had been unsuccessful to date. Recent quality initiatives have included the introduction of standardised and structured assessment instruments to allow more detailed and systematic assessments of individual service users.

The service provided a diagnostic assessment of individuals with autism spectrum disorder and treatment of concurrent mental health problems.

Good Counsel Centre, Ballyboden, Dublin

This service was a stand-alone, non-catchment based MHID service for residents of four intellectual disability services and was funded by the Disability Service. The service was provided by one consultant psychiatrist and a psychologist (0.6 WTE post). A number of quality initiatives were implemented

in 2009, including the development of a centrally located filing system specific to mental health, collaborative working between psychologists in one disability service and the MHID team, data collection and on-going developments of screening packs for dementia, autism and mental health problems.

Current mental health assessments include screening for autism spectrum disorder.

Conclusion

The provision of MHID services continues to be variable around the country. There were ten MHID teams (HSE) with the remainder of services provided by the voluntary sector. The HSE teams operate an almost entirely medical/nursing model and there was a significant lack of multidisciplinary input. Funding for these teams comes from either the mental health or the disability budgets.

Few services were able to report any developments in services in 2009, but there was a particular focus by services on sourcing alternative accommodation for residents still remaining in psychiatric hospitals. The opening of four new, purpose-built bungalows in Carlow for residents of the former Kelvin Grove was welcomed, as was the transfer of a number of residents to more suitable accommodation from St. Luke's Hospital, Clonmel.

It was clear also from the self-assessment questionnaires returned and participation at the national meeting, that there was a good deal of uncertainty amongst practitioners as to who holds responsibility for providing a service for mental health for persons with intellectual disability. The policy document, *A Vision for Change* 2006, points out that *"while there was ring-fenced funding for intellectual disability services, the funding for mental health services within this was not clearly identified"*(p.126). *A Vision for Change* also makes a number of recommendations about providing a mental health service for individuals with an intellectual disability which include *"specialist MHID teams that were catchment area-based and which should be distinct and separate from, but closely linked to, the multidisciplinary teams in intellectual disability services who provided a health and social care service for people with intellectual disability"* (p.129). The document also recommends that two MHID teams should be provided per 300,000 population, which would equate to approximately 26 teams in the country.

Whilst many individuals benefit from the services provided by the voluntary sector, implementation of the recommendations in *Vision for Change* would ensure a more streamlined and cohesive approach to the provision of mental health services to people with intellectual disability.

Appendix 10: Mental Health Services for Homeless People 2009

Dr. Susan Finnerty, Assistant Inspector of Mental Health Services

Many studies have been carried about the rates of mental illness amongst the homeless population. The results of these studies suggest that between 30%-50% of homeless people have some form of mental illness. According to the Dublin Simon Community 25% of Dublin's homeless population suffer from severe mental illness.

A Vision for Change (2006) specifically states that a community mental health team with responsibility for the homeless population in each catchment area be clearly identified and should be equipped to offer an effective outreach service. It also states that two multidisciplinary community based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population. *A Vision for Change* also recommends that there be a crisis house of ten beds for these two teams, specifically for homeless people who are not seriously psychotically ill and do not require admission to acute in-patient units.

The Inspectorate carried out a survey of mental illness in homeless populations in urban areas in Ireland. It also looked at the mental health services specifically provided for homeless people by the HSE. The relationship between the mental health services and the services for homeless people was also explored.

Twenty four separate voluntary homeless services were identified in Dublin, Cork, Limerick, Galway, Sligo, Waterford, Tralee, Nenagh and Athlone. A self-assessment questionnaire was sent to each service. Information sought included:

- Numbers of homeless people experiencing mental illness and numbers of those who had received treatment within the mental health service.
- Access to mental health services.
- Waiting times for assessments in the mental health services.
- Quality of mental health services for homeless people in the area.

Seventeen voluntary services, covering 765 homeless people, completed questionnaires. Forty three per cent of homeless people had mental health problems – of these only 43% were accessing mental health services. Twenty seven per cent had an admission to a psychiatric hospital, and of these 16% had spent more than 6 months in hospital.

Table 2: Homelessness and mental health

	Number of Homeless	History of mental illness	Admission to psychiatric unit	>6 months in hospital	Attending Outpatient visits
Total number	765	329 (43%)	205 (27%)	33 (16%)	142 (43%)

Access to Mental Health Services

North and South Dublin had access to teams for mental health services for homeless people as well as to local mental health teams. In Cork there was limited access to a small specialised team for homeless people. It was reported that women in the Focus Ireland service in Cork do not have access to this service. In Galway and Limerick there was a dedicated community mental health nurse. However in Galway this post had been vacant for six months. There was no dedicated mental health service for homeless people in Tralee or Nenagh.

Dedicated Services for People with Mental Illness

Cork: There was an adult homeless multidisciplinary team in Cork City. This covered a population of 323,000. There were admitting rights to St. Michael's unit in the Mercy Hospital and Cork University Hospital. The team had a caseload of 51 people. There were two weekly outpatient clinics. Waiting time for an appointment was 1-4 weeks. There were close links with a wider homeless team consisting of GP, public health nurse, registered nurse, community welfare officer and addiction services.

Developments in the service included a new computer package, support for methadone services, involvement in physical needs assessment, and enhanced women's services.

There were good links with SHINE advocacy service. There was frequent liaison between the voluntary services and CMHN.

Staffing

POST	WTE
Consultant Psychiatrist	0.6
NCHD	0
ADON	0
CMHN	2
Day Facility Nurses	0
Psychologist	0.3
Social Worker	0
Occupational Therapist	0
Addiction Counsellor	0
Other	0

North Dublin Programme for the Homeless Mentally Ill

This team covered a population of 534,233 and had a caseload of 101 clients. It was based in Usher's Island where there was a day centre. The day centre was open 365 days a year. The team had admitting rights to St. Brendan's Hospital. There was outpatient service once a week and no waiting times for appointments once the client had been accepted to the service. It was originally set up in 1979 for patients of St. Brendan's Hospital. The service had gradually increased the Assertive Outreach component and occupational therapists worked within hostels.

Developments within the service included the appointment of a social worker and the availability of a psychologist for consultations. Multidisciplinary care plans and risk assessments were in operation. A series of meetings had been held with the ACCES team in South Dublin to enhance co-operation and plan for the future. A position paper for the College of Psychiatry in Ireland on mental health services for homeless was being prepared.

Interactive lectures were held with clients in the day centre. There was a formal review of Activity Profiles in the day centre with clients. Budgetary help was available and there was facilitation of will making, with lawyers attending the day centre. The Wellness Recovery Action Plan (WRAP) was in operation. There were monthly community meetings and clients had the use of an allotment.

Staffing

POST	WTE
Consultant Psychiatrist	1
NCHD	3 (shared)
ADON	0.5
CMHN	1
Day Facility Nurses	2
Psychologist	0
Social Worker	0.6
Occupational Therapist	1
Addiction Counsellor	0
Outreach Worker	1

ACCES Team (Dublin South City)

This team covered a population of 674,661and had an active case load of 78 homeless people. It saw 81 new assessments in 2008. Its headquarters was in Parkgate Hall. Most work was done through outreach clinics and visits to hostels. Referrals were accepted from frontline staff as well as GPs and hospitals. Staffing remained a problem; at present there were two community mental health nurses, a social worker, an NCHD and a psychiatrist. A social worker and community mental health nurse post had not been filled. There was no psychologist or occupational therapist. The Service used FACE as an assessment and treatment tool. Discussions were continuing with the Programme for the Homeless in an effort to have one homeless team for Dublin City. Emphasis was put on multi-agency working and there was involvement in a Care and Case Management Programme run by the Homeless Agency. There were weekly team meetings and care plan reviews. There were plans to develop a 10-bed facility in Weir House to treat mentally unwell homeless people in crisis.

Staffing

POST	WTE
Consultant Psychiatrist	0.7
NCHD	0.7
ADON	0
CMHN	1.8 (1 vacant post)
Day Facility Nurses	0
Psychologist	0
Social Worker	1 (1 vacant post)
Occupational Therapist	0
Addiction Counsellor	0
Outreach Worker	0

Waiting Times for Mental Health Assessments

Throughout the country waiting times for mental health assessments varied considerably from five days for urgent appointments to three months for non urgent appointment.

Table 3: Waiting times for assessment

	Waiting times for mental health assessments
DUBLIN	
Simon	7 weeks
Novas Women's Services Mount Brown	2 weeks
CORK	
Good Shepherd Services	1 week - 6 months
Focus Ireland	No information
Simon	3 weeks
LIMERICK	
Novas Br. Russell Hse	3-10 days
Novas DIAL	3-10 days
Focus Ireland	3 weeks
GALWAY	
Simon	3-6 months
COPE	2-3 months
NENAGH	
Novas Initiatives	6 weeks
KERRY	
Simon	3 weeks
Novas Tralee	1 week

Relationship between Homeless Services and Mental Health Services

The majority of homeless services described their relationship with the mental health services as good, satisfactory or excellent. Mental health services in Limerick were described as being ad hoc and piecemeal with lack of uniformity between different mental health teams. Homeless services in Galway described their relationship with the mental health services as being poor and unsupportive. They cited lack of communication as a difficulty. In Dublin 8 the relationship was described as poor and lacking in strong links. Lack of flexibility was highlighted as a difficulty within the mental health services and practical problems included lack of discharge information and lack of mental health representation at case conferences.

Most services could access mental health services through community mental health nurses who also provided follow-up services.

Conclusion

There were three dedicated teams for the mentally ill homeless persons, two in Dublin and a part-time team in Cork. This was in line with *A Vision for Change* on the number of teams, although no team had adequate staffing and there was no crisis house or day hospital. However, the voluntary services in the areas served by these teams rated the services as good. Other areas such as Limerick and Galway had a dedicated post of CMHN for homeless people. The post in Galway had been vacant for some time. Other voluntary services were dependent on the local mental health services and in general found this arrangement difficult in terms of access, flexibility, working relationships and lack of communication. Waiting times for appointments varied and could take up to six months which was far from satisfactory.

The recommendations for *Vision for Change* with regard to a community mental health team with responsibility for the homeless population in each catchment area being clearly identified and equipped to offer an effective outreach service, had not been met. This had lead to an ad hoc provision of service in many areas. The recommendation in *Vision for Change* that there should be two multidisciplinary community based teams, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population had been met, but the teams were inadequately resourced.

Recommendations

1. A community mental health team with responsibility for the homeless population in each catchment area should be clearly identified and equipped to offer an effective outreach service.

2. In the meantime a dedicated community mental health nurse should be appointed to provide services for mentally ill homeless people.

3. Each homeless person in receipt of mental health services should have regular case conferences at which both voluntary and mental health personnel attend.

4. The existing mental health teams for homeless mentally ill people should be adequately staffed.

Appendix 11: Mental Health Services Staffing

Patricia Doherty, Assistant Inspector of Mental Health Services

Table 1: Bed Numbers standardised per 100,000 population

Catchment Area	Total approved centre beds per 100,000	24-hour staffed residence places per 100,000	Total number of catchment beds per 100,000 pop
HSE SOUTH			
North Cork	129	52	181
West Cork	45	99	144
North Lee	54	45	99
South Lee	45	10	55
Kerry	73	52	125
Waterford	107	22	*128
Carlow Kilkenny	111	128	239
South Tipperary	159	45	*203
Wexford[1]	77	21	98
HSE WEST			
Clare	76	81	157
North Tipperary[2]	0	0.00	0.00
Limerick	83	60	*142
Roscommon	38	143	181
East Galway	85	75	*161
West Galway	60	14	74
Mayo	72	36	108
Sligo/Leitrim/Sth Donegal	52	70	122
Donegal	36	52	*87
HSE DUBLIN NORTH EAST			
Dublin North Central	71	15	*87
St. Joseph's ID	74	26	100
St. Ita's Hospital/Nth Dublin	54	35	89
Dublin North West	86	87	173
Louth/Meath	30	25	*54
Cavan/Monaghan	46	39	85
HSE DUBLIN MID LEINSTER			
Kildare/West Wicklow	14	14	28
Newcastle	50	24	74
Dublin South West	29	20	49
Dublin South City	38	15	53
Dublin South East[3]	35	93	128
South County Dublin (Chluain Mhuire)[4]	15	12	27
Laois Offaly	54	22	76
Longford Westmeath	97	34	131

* *Numbers correct to two decimal places*

[1] *Wexford – includes staffing for pre-discharge unit.*

[2] *North Tipperary avails of beds in South Tipperary Mental Health Service.*

[3] *Dublin South East – some services provided to a number of catchment areas.*

[4] *South County Dublin – avails of in-patient beds in St. John of Gods Hospital.*

In Figure 1 below, we show total figures for bed numbers per catchment area. These are standardised to populations of 100,000.

Figure 1: Total Beds in Catchment per 100,000 Population

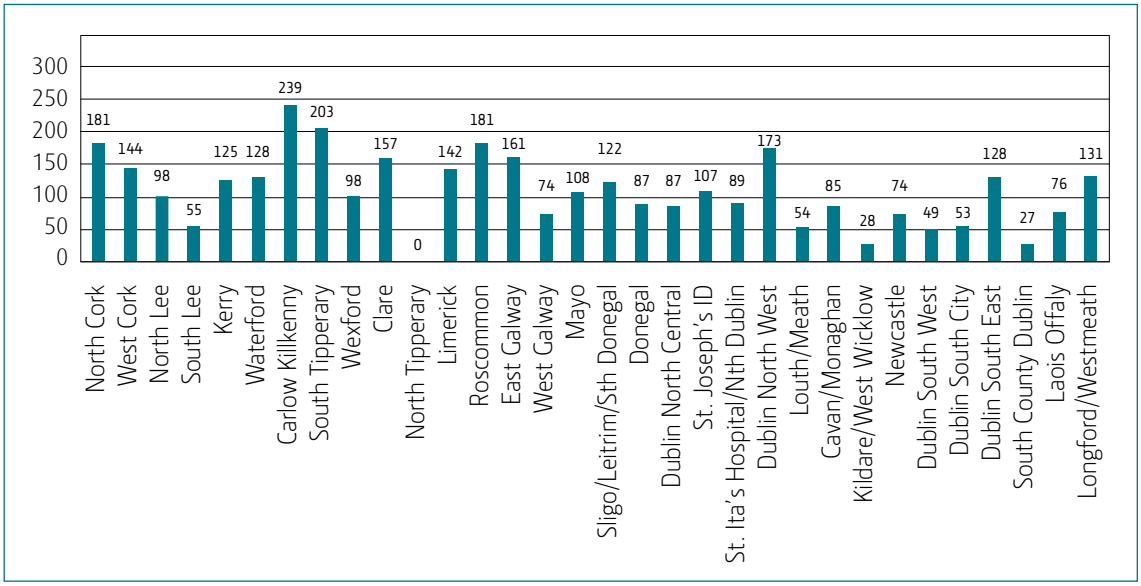


Table 2: IN-PT and Community Staffing Numbers per 100,000 – Specialist Teams at Regional or National Level Excluded

SERVICE	Nurses based in approved centres per 100,000	Nursing Staff for 24-hour residences per 100,000	Community mental health nurses per 100,000	Care Assistants per 100,000	Medical Staff		Occupational Therapy	Psychology	Social Work
					Cons	NCHDs			
HSE SOUTH									
North Cork	126	27	14	0	5	10	4	4	1
West Cork	37	56	7	0	6	9	4	2	4
North Lee	87	18	9	0	4	7	4	3	4
South Lee	31	4	7	0	5	8	1	3	2
Kerry	96	40	9	0	4	7	2	2	2
Waterford	88	17	6	0	6	7	1	4	4
Carlow Kilkenny	65	88	12	13	6	10	3	2	3
South Tipperary	142	25	7	0	7	8	1	1	5
Wexford[1]	61	19	11	0	5	6	2	3	3
HSE WEST									
Clare	40	117	3	0	5	8	4	5	4
North Tipperary[2]	0	0	3	0	3	5	0	5	3
Limerick	68	32	3	0	6	8	2	3	2
Roscommon	43	67	7	0	5	9	6	2	3
East Galway	68	94	10	0	7	10	5	4	5
West Galway	44	9	9	0	4	11	5	3	5
Mayo	94	41	9	0	6	9	4	3	5

SERVICE	Nurses based in approved centres per 100,000	Nursing Staff for 24-hour residences per 100,000	Community mental health nurses per 100,000	Care Assistants per 100,000	Medical Staff		Occupational Therapy	Psychology	Social Work
					Cons	NCHDs			
Sligo/ Leitrim/Sth Donegal	84	61	12	0	7	9	7	1	5
Donegal	54	36	10	0	7	10	4	3	3
HSE DUBLIN NORTH EAST									
Dublin North Central	72	10	13	0	7	14	3	3	2
St. Joseph's ID	66	35	3	89	1	1	0	0	0
St. Ita's Hospital/Nth Dublin	51	11	9	28	5	11	1	1	3
Dublin North West	87	47	12	20	8	19	9	3	4
Louth/Meath	35	13	4	1	4	8	0	2	2
Cavan/ Monaghan	51	23	55	0	5	11	3	2	4
HSE DUBLIN MID LEINSTER									
Kildare/West Wicklow	18	8	9	0	4	7	2	1	3
Newcastle	33	12	5	0	4	8	0	2	1
Dublin South West	26	12	16	9	5	8	5	2	4
Dublin South City	24	7	5	0	5	9	5	4	4
Dublin South East[3]	34	63	6	0	8	5	4	3	3
South County Dublin (Chluain Mhuire)[4]	N/A	4	6	0	4	9	2	3	4
Laois Offaly	58	15	12	0	6	7	3	3	3
Longford Westmeath	101	32	4	0	6	9	3	3	3

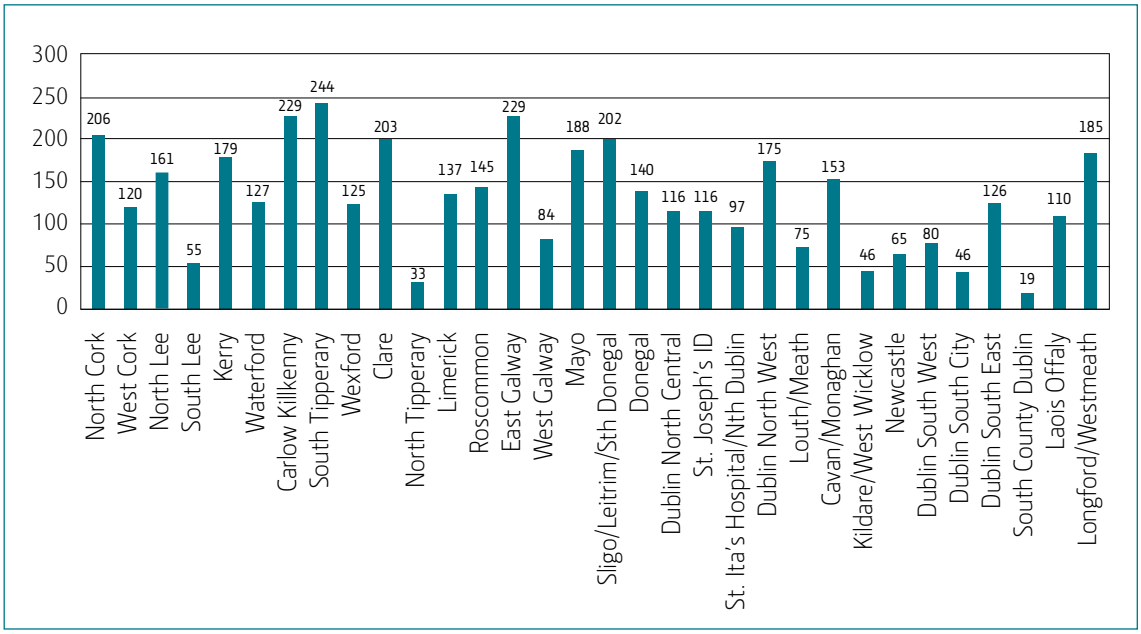
[1] Wexford – includes staffing for pre-discharge unit.

[2] North Tipperary avails of beds in South Tipperary Mental Health Service.

[3] Dublin South East – some services provided to a number of catchment areas.

[4] South County Dublin – avails of in-patient beds in St. John of Gods Hospital.

Figure 2: Total Nursing per 100,00 Population



The information presented in the above tables and charts was obtained via Local Health Offices during the course of the 2009 inspection process.

CHAPTER 5

Overview of Catchment Mental Health Services within HSE Area

Catchment Reports by HSE Area

These reports were prepared on the basis of information and documentation obtained during catchment area meetings and received from local health offices during the 2009 inspection process.

Chapter 5 Contents

HSE Dublin North East

Mental Health Services 2009
Catchment Area Report
Cavan/Monaghan

HSE Area	HSE Dublin North East
Catchment	Cavan/Monaghan
Mental Health Service	Cavan/Monaghan Mental Health Services
Population	118,791
Number of Sectors	2
Number of Approved Centres	2
Specialist Teams	Psychiatry of later life Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	7 May 2009

Service 2009

Description of Service (Including Distinct Features)

The Cavan/Monaghan service was primarily a home-based community-delivered service. This model of service delivery had been developed over the last 15 years. The last five years had seen a shift in the profile of the population within the catchment. There had been a population expansion, especially in Cavan, and this had resulted in a 60 per cent increase in the number of referrals to the team. Many people moved from Dublin to Cavan during the property boom. Historically the catchment had had a higher than the national average number of elderly people, many of them living alone. There was also a centre for asylum seekers in the area.

At the time of reporting the service was undergoing a significant change process that was due to impact directly on the future delivery of services. A decision on the location of the acute in-patient service was due by the end of 2009. A more immediate problem was the expected rate of retirements from the nursing profession over the following year. Travel restrictions were posing problems for the teams in visiting service users.

There was a lack of health and social care professionals on the teams; no new staff had been appointed in 2009 to date.

Progress on Recommendations from the 2008 Report

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

Outcome: There had been no progress.

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 multidisciplinary care approach, introduced within the last year should continue.*

Outcome: The premises in St. Davnet's Hospital remained unchanged since last year. They are reported on in detail in the approved centre report.

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

Outcome: No new appointments had been made since the last inspection.

Outline of Local Health Service Plan 2008–2009

There was a local service plan for 2009.

Developments 2008–2009

- A consumer panel was being developed. A pilot project was due to commence in June. Service users' opinions were been sought through the Solas Centre in Monaghan.

Hospital Closure Plans

St. Davnet's Hospital had been reconfigured over the years and was now a complex with many health services on site. Mental health care and treatment was still provided in three wards, an acute ward and two elderly continuing care wards. The future provision of acute services was being decided and a decision was expected later in 2009.

The Inspectorate team have been very critical of the environment in the elderly care wards for the last number of years and reports received from the management team that works would be completed were given to the Inspectorate year after year, but again in 2009 there was no progress to report (detailed individual reports are available on the MHC website).

At this meeting, confirmation that funds were being ring-fenced for the upgrading work was given but no start date was available. The Inspectorate was monitoring the progress on this objective in late 2009.

Service User Involvement

Peer Support/Advocacy

Peer advocacy support was provided by the Irish Advocacy Network (IAN). The IAN representative attended two approved centres and a number of community facilities. It was reported that the staff in the service had welcomed the advocacy service and that the advocate was invited to join a number of local and regional committees. Discussions on attendance at the management team were at an early stage.

The advocate highlighted a number of resident restrictions that operated within two approved centres: locked entrance doors, locked bathrooms, lack of outdoor space, and restricted use of mobile phones.

The work of the advocate had highlighted an unmet need for a carers group in the catchment. There were many calls from family members concerning the Mental Health Act 2001 and the need for ongoing support for themselves. The service was planning to establish a consumer panel.

Service User Participation

Service users were involved in the delivery of mental health services through representation on local and regional *Vision for Change* groups. The IAN representative had been invited to join the local group looking at the provision of acute services in the area.

The service had commenced plans to establish a carer's council. Service user opinions were being sought.

Governance

Quality Improvements (Audits And Reviews)

Since the 2008 inspection, the service management team had been widened to include health and social care professionals. All had appropriate line management structures within mental health. It was too early to report on the impact of this change on the service. Terms of reference had been agreed and there was a full agenda to be implemented.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	9
Specialist registrar	4

Nursing Staff

Post	WTE in post
DON	1
ADON	3
Nurses based in in-patient services	60.12
Nurses based in community residences	27.37
Community mental health nurse	64.75 (all grades)
Nurses based in day hospitals	4
Nurses based in day centre	12.07
Other – temporary staff panel	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	2
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	7.82
Advanced nurse practitioner	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	2
Social work	4.94
Occupational therapist	3.84
Art therapist	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Community Rehabilitation Team Report

Team Description	Community Rehabilitation Team
Population	118,791

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	1	1
ADON	0	0
CMHN	65	62.95
Clinical psychologist	0	0
Social worker	0.8	0.8
Occupational therapist	0	0.4
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008	2009
Day hospital	Not applicable	Not applicable
Day centre	1	1

Psychiatry of Later Life Team Report

Team Description	Psychiatry of Later Life
Population	118,791

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	1	1
ADON	0	0
CMHN	13	13
Clinical psychologist	0	0
Social worker	0.91	0.91
Occupational therapist	0.69	0.69
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008	2009
Day hospital	1	1
Day centre	0	0

In-Patient Facilities

There were two approved centres one in each county. Monaghan had 11 acute beds and 27 elderly care beds on the site of St. Davnet's Hospital. In Cavan acute in-patient services were located in Cavan General Hospital. Individual approved centre reports are available on the MHC website. A decision on the location of the acute service in the future was pending. The refurbishment of the elderly care units in Monaghan was seen as a short-to-medium term plan. The service's preferred option was a purpose-built regional unit.

The service had been asked to admit children for in-patient care. Both units were unsuitable and clinical staff were aware of this. The staff were frustrated by the lack of a regional protocol for the admission of young people aged 16 to 17 years for in-patient care.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

Cavan: The service was in breach of a number of Regulations. This related in part to the reviewing of policies. Access to an occupational therapist on the unit had improved since 2008 but activities were not linked to assessed need identified in a care plan.

Monaghan: A number of policies were in need of review.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

Cavan: Seclusion, ECT and Mechanical Restraint were not in use in the unit.

Monaghan: The service was compliant with Part 5 of the Rules on Mechanical Restraint. Seclusion and ECT were not used.

Codes of Practice

Cavan: The service was compliant with the Code of Practice on physical restraint. As the unit was unsuitable for the care and treatment of children the service was unable to achieve compliance with the code of practice on the admission of children.

Monaghan: The centre was compliant.

Multidisciplinary Care Planning

Each team had a core multidisciplinary team (MDT) in place, with the health and social care professional inputs spilt between teams. There was a single individual file that followed the service user through the service from in-patient care to outpatients care. The file was divided into sections for the disciplines to record their assessments and interventions.

24-Hour Supervised Community Residences

Description

There were three community residences providing 24-hour care in the service, with a total of 46 places.

The residences were under the care of the community rehabilitation team (CRT). It was reported during the meeting with the Inspectorate that all residents had recently been assessed and that there was active rehabilitation ongoing. It was reported that the environment in all the residences was of a good standard.

Residence	Number of places	Number of residents	Team responsible	Care plan type
St. Jude's	15	15	CRT	MDT
Lisdarn Lodge Hostel	15	15	CRT	MDT
Woodvale	16	16	CRT	MDT

Conclusion

- The Cavan/Monaghan Mental Health Service appears to be at a crossroads. Decisions are pending which will shape the future of the service; some of which are outside the control of staff. The location of the new acute unit will be identified by the end of 2009 and it still is not clear whether the unit will be in Monaghan or Cavan. A local group has been set up to research the best available option. A more immediate concern is the replacement of nursing staff in the current economic and recruitment freeze. All these factors are impacting on the staff morale.

- A wider concern on the admission of children to adult in-patient units needs to be addressed at a regional and national level.

- For the service users there is limited access to health and social care professions. Systems to influence the direction of services have commenced but further work is required. There is a reported need for carer and family support and a service user council. The latter is currently being developed.

- The service and staff are committed to the provision of home based care and treatment within the community. It was evident that all staff are working extremely hard to resolve issues in difficult economic times.

Recommendations and Areas for Development

1. *A decision regarding the future location of acute services must be made and human resources needs planned to implement the service.*

2. *The approved centres must be in compliance with all statutory requirements under the Mental Health Act 2001 and associated Regulations and Rules.*

3. *A carers support group and consumer council should be progressed.*

4. *A plan to address the deficits in human resources must be developed.*

5. *Community mental health teams must be resourced in line with national policy.*

6. *The structural deficits in the living environment in St. Davnet's Hospital must be addressed and an action plan with a time line submitted to the Inspectorate.*

Mental Health Services 2009
Catchment Area Report
Dublin North Central

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 Adolescent
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	16 September 2009

Service 2009

Description of Service (Including Distinct Features)

Dublin North Central provided a service to an area that had a number of challenging factors: high levels of deprivation, a culturally diverse population, and a very busy accident and emergency service at the Mater Hospital. Acute services were provided at two sites, the Mater Hospital and St. Vincent's Hospital.

There were six sector teams, all of them poorly resourced. Work was continuing to align the sectors along district electoral division (DED) boundaries and move to larger sector teams. There was one day hospital and a small nurse-led home care service. These factors put considerable pressure on the use of in-patient beds.

The service had access to 40 acute in-patient beds across two sites: Mater Hospital with 10 acute beds and 5 liaison beds, and St. Vincent's Hospital with 30 acute beds, 9 continuing care beds, 6 psychiatry of later life beds, 21 continuing care of the elderly beds, 18 rehabilitation beds and 6 adolescent beds. In addition, there were 22 high support community residential places and 71 medium or low support community residential places. There were plans in place to reduce the number of acute beds by ten in 2009.

The service had a number of speciality services, rehabilitation, liaison, psychiatry of later life, and a newly established in-patient service for young people aged 16–17 years.

The development of a single cohesive service continued.

Progress on Recommendations from the 2008 Report

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

Outcome: Four consultant psychiatrists, including the child and adolescent consultant psychiatrist, were permanently appointed to posts in the last year. There were no additional posts assigned to any of the sector teams. The sector teams were acutely short of health and social care professionals, especially in social work.

Outline of Local Health Service Plan 2008–2009

A copy of the Level II Business plan for Dublin North Central PCCC Local Health Office was received by the Inspectorate team in advance of the meeting. The area action plan for mental health was linked to the National Implementation Plan for *A Vision for Change* 2009–2013.

The key goals for this area in 2009 were identified as the closure of 10 acute beds in St. Vincent's Hospital, relocation of identified residents from St. Vincent's Hospital to more appropriate settings, and the development of community services.

Developments 2008–2009

- The opening of a 6-bed unit for adolescents aged 16–17 years in March 2009.
- A clinical psychologist post was assigned to the liaison team by the Mater Hospital.
- Plans for the development of acute in-patient services at the Mater Hospital were advanced. Work was continuing with estates management on the capital budget, time frames and priority listing within the overall Mater project.
- A cultural advisory panel was established as part of the cultural clinic based in the Mater sector. It included service users and its aim was to assist the development of services with appropriate awareness of cultural issues.
- ECT services have been discontinued at St. Vincent's Hospital and transferred to the Mater Hospital. The new service commenced in July. The service was aiming to develop this as a regional centre.
- A review group was established to look at the functioning and purpose of the day hospital in the service. Implementation of the review's findings were due to be completed in the following months.
- Following reconfiguration, a new sector was created serving the Marino/Tolka area. It was put into operation this year with considerable input from all staff.
- Risk management policies and procedures were advanced both in St. Vincent's Hospital and the community. The catchment is a pilot site for the HSE Quality Integrated Safety and Quality Committee (ISQC) project.
- Care planning process was further advanced at the Mater Hospital.
- A new evening social club was established in the Mater sector for service users.
- Service users' information continued to be developed on the St. Vincent Hospital web site.
- The Grace Park House 24-hour community residence was upgraded and the number of beds reduced from 16 to 6 in the last year. There were plans to reduce the level of staffing support provided.

Hospital Closure Plans (Where Applicable)

There were no plans to close St. Vincent's Hospital, rather to develop certain specialist services on site.

A 6-bed adolescent unit opened in March for elective admissions. It was a regional unit for Dublin North East. It has also accepted referral from other regions. Data was being collected. There were plans to look at extending the number of adolescent beds in the future.

The 100-bed community nursing unit building project had commenced since the last meeting with the Inspectorate. It was expected to open in April 2010. A number of residents from St. Clare's Ward who had been assessed as requiring nursing home accommodation were due to be discharged to this unit. It was reported that the assessments had been completed and that families had been involved in the process.

Service User Involvement

Peer Support/Advocacy

A peer advocacy service was provided by the Irish Advocacy Network (IAN) in the approved centres, the day hospital and day centre. The advocate reported that the advocacy service was widely supported across the service.

In the approved centres, service users were positive in their support of staff, development of information sites on medication, access to psychiatrists and the range of recreational activities provided. On St. Aloysius ward service users commented positively on the support provided by the social worker regarding accommodation and the occupational therapy programme.

Of concern to service users at the Mater was the lack of outdoor space and limited access to occupational therapy (one session a week). In St. Vincent's Hospital, service users continued to highlight year after year the lack of access to social workers during acute admissions and the lack of occupational therapy.

It was reported that long-stay residents of the hospital felt that they were "lost causes" or "hopeless cases". They were uncertain as to where services would be provided for them in the future.

Service User Participation

Service users were represented by the IAN on various internal working groups. They also attended the monthly heads of discipline group meeting.

Governance

Quality Improvements (Audits And Reviews)

Management structure: There was a two-tier management structure in place. An executive management team was established a number of years ago to develop a more cohesive working relationship between the three service providers. There was no representative from the health and social care professionals on this group. There was a monthly heads of discipline meeting, attended by all disciplines and by the advocate.

Research/Audit: Ongoing research and audits were completed within disciplines. There were active links with the medical school in UCD.

Incidents: A new system for reviewing and managing risk had been developed. A multidisciplinary group had been established to review incidents and recommend changes in policy and practice.

Staffing Dedicated to Specialist Mental Health Services

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
Community mental health nurse	18.5
Nurses based in day hospitals	14.63
Nurses based in day centre	3.5

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	0
Advanced nurse practitioner	0
Substance abuse	2
Family therapy	2
Behaviour therapy	1
Care of the elderly	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4.5
Social work	2.82
Occupational therapist	4
Art therapist	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation
Population	143,333

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	1.2	1.2
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	None	None
Day centre	Shared	Shared

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life (POLL)
Population	32,500 (over 65 years)

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	3.5	4
NCHD (including specialist registrar)	4	4
Dedicated team coordinator	0	0
DON	1	1
CMHN	4	4
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	6	6 (including Eccles St day Hospital)
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Two	Two
Day centre	Not applicable	Not applicable

Liaison Team Report

Team Description	Liaison
Population	Not provided

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Clinical psychologist	0	1
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	Not applicable	Not applicable
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not applicable	Not applicable
Day centre	Not applicable	Not applicable

Adolescent In-Patient Team Report

Team Description	Adolescent
Population	Regional

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0	1
NCHD (including specialist registrar)	0	Not provided
Dedicated team coordinator	0	Not provided
ADON	0	Not provided
CMHN	0	Not provided
Clinical psychologist	0	Not provided
Social worker	0	Not provided
Occupational therapist	0	Not provided
Dedicated addiction counsellor	0	Not provided
Day facility nurse staffing	0	Not provided
Health care assistant	0	Not provided

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not applicable	Not applicable
Day centre	Not applicable	Not applicable

In-Patient Facilities

There were three approved centres in the catchment area, located at two sites: the Mater Hospital and St. Vincent's Hospital, Fairview. Both adult centres had unannounced inspections in April and June of 2009. The Adolescent Unit opened in March in St. Vincent's Hospital. It was inspected in July 2009.

The bed numbers were configured as follows, 51 acute beds (including elderly care), 21 continuing care, 21 rehabilitation, and 9 privately funded beds. The acute beds were based across two sites, Mater Hospital and St. Vincent's Hospital Fairview.

Statutory Requirements for Approved Centres

The three registered approved centres were St. Aloysius Ward, Acute Psychiatric Unit, Mater Hospital, St. Vincent's Hospital, Fairview, and St. Joseph's Adolescent In-patient Unit, St. Vincent's Hospital, Fairview.

Regulations (S.I. 551 of 2006)

St. Aloysius Ward, Acute Psychiatric Unit, Mater Hospital: The service was compliant with 25 of the 30 Regulations. Some improvement was noted in the physical environment and the provision of information. The implementation of individual care plans for all residents had not been achieved. Services users had limited access to a therapeutic programme during in-patient admissions due to poor skill mix.

St. Vincent's Hospital, Fairview: This service was also compliant with 25 of the 30 Regulations. The implementation of care planning and therapeutic programmes had improved since the last inspection. There was still considerable skill mix shortage on the community mental health teams.

St. Joseph's Adolescent In-patient Unit, St. Vincent's Hospital, Fairview: This centre achieved compliance with 25 of the Regulations. It was reported that the service had worked hard in a short period to achieve this level of compliance. There was no occupational therapist available to service users.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

St. Aloysius Ward, Acute Psychiatric Unit, Mater Hospital: The service was not compliant with the Rules on seclusion, ECT and Mechanical Restraint (Part 5).

St. Vincent's Hospital, Fairview: The service was not compliant with the Rules on seclusion. ECT was no longer provided on site.

St. Joseph's Adolescent In-patient Unit, St. Vincent's Hospital, Fairview: The service had seclusion facilities. No resident had been secluded at the time of the inspection. Mechanical restraint had not been used.

Codes of Practice

St. Aloysius Ward, Acute Psychiatric Unit, Mater Hospital: The service was compliant with the Code of Practice on notification of deaths and incidents. It was unable to meet all the requirements for ECT, physical restraint and the admission of children.

St. Vincent's Hospital, Fairview: The service was fully compliant with the Codes of Practice on notification of deaths and incidents and on physical restraint. It did not provide ECT. It was unsuitable for the admission of children.

St. Joseph's Adolescent In-patient Unit, St. Vincent's Hospital, Fairview: Two Codes of Practice were applicable, the admission of children and notification of deaths and incidents. The service was unable to meet the requirements of the latter code. Attempts had been made to initiate compliance.

Multidisciplinary Care Planning

Approved centres: Care planning had commenced in the in-patient units. It was at various stages of implementation. There was evidence of plans to address deficits found during the inspections.

Community: It was reported that the rehabilitation team had multidisciplinary care plans in the community. There were no plans currently to extend this to the sector teams.

24-Hour Supervised Community Residences

Description

There were two residences with 24-hour nursing support provided. Since the last meeting with the Inspectorate, Grace Park House had been upgraded and the number of beds reduced by ten. The residents were mainly transferred to nursing home accommodation. It was planned to reduce the level of nursing support provided in the coming months.

There was a waiting list for 24-hour community placement in the area. It was managed by the rehabilitation team. It was reported that there is an unmet need for ten high support places.

The service has 71 medium/low support places.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Grace Park House	6	6	General adult	Nursing
Gallen House	16	16	Rehabilitation	MDT

Conclusion

The service continues to make progress on redirecting the services to provide a single cohesive service for all service users. A number of the changes required now are structural and will require additional capital monies; others will require the realignment of sector boundaries and the provision of acceptable community facilities for service users and staff. There is a commitment by all staff and advocates to achieving this. This has been reflected in the achievements to date.

In tandem with the reduction in acute beds, there is a real and immediate need to build up the skill mix and capacity on the community mental health teams. Service users must have equal access to all disciplines and the full range of interventions. Any resources released following the closure of beds must be used for this. Alternatives to in-patient care must be further developed.

The service has developed a regional in-patient facility for adolescents, recently established a rehabilitation service and has a well-established psychiatry of later life service.

Recommendations and Areas for Development

1. *The staffing levels and skill mix on each team must be in line with national policy recommendations.*

2. *Plans to progress the development of the Mater site for the provision of an acute service must continue.*

3. *Alternatives to in-patient care must be developed.*

Mental Health Services 2009 Catchment Area Report Louth/Meath

HSE Area	HSE Dublin North East
Catchment	Louth/Meath
Mental Health Service	Louth/Meath Mental Health Service
Population	271,845
Number of Sectors	12 including 2 MHSOP
Number of Approved Centres	2
Specialist Teams	2 MHSOP
Per Capita Expenditure 2008 [>18 Years]	96.02 euro
Date of Meeting	13 May 2009

Service 2009

Description

The Louth/Meath catchment area had 12 sector teams, including one Mental Health Service for Older Persons (MHSOP) team in each county. It was primarily a home-based community mental health service. There was a home-based treatment team in each county. The service had no day hospital but there were six day centres: three in Louth and three in Meath. The catchment area had two approved centres: the Department of Psychiatry in Our Lady's Hospital, Navan and St. Brigid's Hospital, Ardee. There were five 24-hour supervised residences, two medium and one low support residences. There was one nurse-led assertive outreach team.

Progress on Recommendations from the 2008 Report

1. *Increased resourcing of multidisciplinary teams should be made available, particularly in the area of occupational therapy.*

Outcome: An audit of each community mental health team composition had been completed and matched to *A Vision for Change* requirements with a view to reconfiguration of existing resources to meet requirements.

2. *The service needs a rehabilitation team particularly in light of ongoing continuing care.*

Outcome: A nurse-led assertive outreach team had been established in Louth, following the amalgamation of St. Ita's Unit and Our Lady's Unit in St. Brigid's Hospital in Ardee. Along with the Meath assertive outreach team, links were maintained with community mental health teams, community residences, local authorities and community agencies.

3. *Improvement should take place in the provision of therapeutic activities for residents in both approved centres.*

Outcome: There was no occupational therapy service in Meath. The occupational therapy service for St. Brigid's Hospital was insufficient to meet the needs of residents.

Outline of Local Health Service Plan 2008–2009

The number of beds at St. Brigid's Hospital had been reduced to 50. There were 25 in-patient beds at the Department of Psychiatry in Navan General Hospital.

To reconfigure existing community mental health teams in line with *A Vision for Change* recommendations.

To recruit current vacant posts to achieve full compliance with approved centre recommendations.

Developments 2008–2009

- The amalgamation of two continuing care units into one with the total reduction of four beds.
- Acquisition of a sector headquarters for the Trim sector.
- Development of a nurse-led assertive outreach team for Co. Louth.
- Development of a carer's support group in Co. Louth.
- Reorganisation of outpatient services in Drogheda sectors to a centralised location in Haymarket community premises.
- Establishment of infection control and hygiene committees in both Louth and Meath.
- Introduction of integrated individual care planning.
- Completion of quality and risk self-assessment for both Louth and Meath mental health services.
- Development of a Louth mental health service risk register.
- Commencement of the building of a replacement day centre for the Navan area.

Hospital Closure Plans

There were no concrete plans to close St. Brigid's Hospital, Ardee. The amalgamation of St. Ita's Ward and Our Lady's Ward was a positive development. The issue of the future of the acute unit at St. Brigid's Hospital remained uncertain. A feasibility paper had been initiated – drawing on *A Vision for Change* – that an acute unit should be part of a larger Louth County Hospital at the Dundalk site. It was stated in the HSE's Business Plan 2009 for North Louth that a "local *Vision for Change* group was in the process of developing a plan to facilitate the relocation of the acute inpatient unit in St. Brigid's Hospital, Ardee, and to develop a strategy for the future function of the complex".

Peer Support/Advocacy

The regional advocate had been invited to join many panels and groups within Louth/Meath and had been consulted on numerous policies and initiatives, e.g. hostel referral committee, hostel strategy committee, consumer panel. It was reported that staff had readily facilitated the advocate in accessing patients detained under the Mental Health Act 2001, thus enabling the advocate to fulfil their remit of providing information and support to anyone who was involuntarily detained. This helped to build the client-advocate relationship that in many cases extended from in-patient hospital care to the community following discharge.

While the Department of Psychiatry in Navan General Hospital had an open door policy that appeared to be working well, the implementation of the open door policy in the acute unit in St. Brigid's had been delayed by a year.

Participation in the Delivery of Mental Health Services

It was reported by the regional advocate that the Louth/Meath mental health services had embraced the concept of service user involvement with the mental health services.

The regional peer advocate from the Irish Advocacy Network (IAN) attended the Louth and Meath services every Wednesday and Thursday. The regional advocate was also available by phone from 0900h to 1700h on a weekly basis.

A recent advocacy course, attended by some long-term residents was also attended by a member of nursing staff and an occupational therapist from St. Brigid's Hospital, Ardee.

A peer advocacy training programme was held in July 2008 by IAN and funded by the HSE.

Service user involvement in the quality and best practice group and consumer involvement group present feedback from service users which was then fed back to management team meetings.

The regional advocate was involved in meetings relating to planning and development of future services, e.g. design and development of a new acute unit for Louth, a day centre replacement facility for Meath, and an amalgamation of units in St. Brigid's Hospital, Ardee.

The regional advocate team had been involved in presentations to undergraduate nursing students in Dundalk Institute of Technology and involved student nurses on placement in the work of the advocate.

Governance

Quality Improvements (Audits and Reviews)

The senior management team comprised of members of the multidisciplinary team. Plans to include the IAN representative were at an advanced stage.

The service had conducted a number of audits during the previous year, including an audit on seclusion, physical restraint, record keeping, medication management and hygiene.

A quality and risk assessment survey was carried out.

Occupational therapists had conducted a research project assessing the impact of the introduction of an occupational therapy service to a unit and examined the service user's and staff perspectives.

Some staff members had been trained as instructors in courses such as Prevention and Management of Violence (PAMV), manual handling, and basic life support.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	11
NCHD	17
Specialist registrar	5

Nursing Staff

Post	WTE in post
DON	1
ADON	5.8
CNM 3	2
Nurses based in in-patient services	91.94
Nurses based in community residences	36.32
Community mental health nurse	9.9
Nurses based in day hospitals	0
Nurses based in day centre	15.5

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1.86
Clinical placement coordinators	1.5
Nurse practice development coordinator	0.5
Counsellors	4
Advanced nurse practitioner	0
Affective disorder	2
Community support team	2
Family therapy	2
Cognitive therapy	1.42
Clozaril nurse	1.51
Home-based	12.5
Assertive outreach	7
MHSOP	3.8

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	6.61
Social worker	6.23
Occupational therapist	0
Art therapist	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

MHSOP Team Report

Team Description	Louth Mental Health Service for Older Persons
Population	Not provided

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN (1 CNM2, 1 Staff)	2	2
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

MHSOP Team Report

Team Description	Meath Mental Health Service for Older Persons
Population	Not provided

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0	0
CMHN (1 CNM2, 1 Staff)	2	2
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

In-Patient Facilities

There were two in-patient facilities attached to the service.

The Department of Psychiatry at Our Lady's Hospital, Navan, was a bright spacious and well-maintained unit with an enclosed garden to provide relaxation for residents. A room previously used for ECT had been converted to an activities area and there were plans to further develop this.

St Brigid's Hospital, Ardee, was a large two-storey red-bricked building which provided care and treatment for acute admissions and elderly continuing care from the Louth area. Our Lady's Ward and St. Ita's Ward were preparing to amalgamate and move to a purpose-built unit, which was ready for occupation, and which was situated in the main building.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

Both approved centres were either fully or substantially compliant with all the Regulations. The lack of an occupational therapist in the Department of Psychiatry in Navan affected compliance with the Regulations relating to therapeutic services and staffing levels. A similar situation applied in St. Brigid's Hospital, although an occupational therapist was employed there.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

ECT was not used in either approved centre.

Mechanical restraint was only used for enduring self-harming behaviour in St. Brigid's Hospital, which was substantially compliant with the Rules governing its use. Mechanical restraint was not used in other situations in either approved centre.

The Department of Psychiatry in Navan was fully compliant with the Rules in relation to the use of seclusion but the facilities in St. Brigid's were not compliant.

Codes of Practice

Both centres were either fully or substantially compliant with the Code of Practice relating to the use of physical restraint.

Both were fully compliant with the Code of Practice on the notification of deaths or incidents.

Children were not admitted to St. Brigid's Hospital and there was a policy to this effect. In Navan, although children were admitted, it was an adult unit and not suitable for the admission of children.

Multidisciplinary Care Planning

Integrated individual care plans were in operation at the Department of Psychiatry in Navan. Therapeutic activities were linked to these care plans. The care plans were reviewed regularly, with input from the service user.

Integrated individual care plans had been introduced to all units within St. Brigid's Hospital Ardee. On Our Lady's Ward, the Inspectorate found that there was a lack of multidisciplinary team care planning.

Nursing care plans were in operation and regular review of residents by medical staff tended to be of a physical nature with a lack of mental health reviews documented in the clinical files examined.

The psychiatry of later life team had no access to clinical psychology services.

The Dunshaughlin sector had no access to clinical psychology services, which was a core basic service to a population of over 46,000 people.

There was a lack of occupational therapy services in the catchment area.

The Ardee and Louth Drogheda sectors had no social work services.

24-Hour Supervised Community Residences

Description

The age profile of the residents in each of the 24-hour supervised community residences was described by the service as a challenge. In order to adapt to the rising age profile of residents, appropriate and adequate fixtures and fittings would need to be put in place in these residences. Each resident will require appropriate monitoring and assessment on an ongoing basis.

The development of the referral process had opened up vacancies across the service. There was a central referral group. Individuals with mental health difficulties underwent the Camberwell Assessment of Need (CAN) and an appropriate placement was offered to the individual.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Rath na Riogh, Navan	12 2 respite	10	Referring team	Nursing
De La Salle, Ardee	14 1 respite	14	Referring team	Nursing
An Solasan, Dundalk	14 2 respite	14	Referring team	Nursing
Moorings, Dundalk	13 2 respite	12	Referring team	Nursing
St. Mary's, Drogheda	14 1 respite	14	Referring team	Nursing

Conclusion

The service had limited access to adequate health and social care professions such as clinical psychology, social work and particularly occupational therapy.

It was very apparent that all members of the multidisciplinary team were striving, in some cases with great difficulty, to provide a quality service in these difficult economic times.

The outstanding vacancies in clinical psychology, social work and occupational therapy need to be filled.

Recommendations and Areas for Development

1. *The psychiatry of later life service should have access to clinical psychology services in line with national policy.*

2. *The Dunshaughlin sector should have access to clinical psychology services in line with national policy.*

3. *The lack of an occupational therapy service needs to be immediately addressed in line with national policy.*

4. *The elderly residents in continuing care in St. Brigid's Hospital, Ardee, should come under the clinical direction of the psychiatry of later life team.*

5. *The newly refurbished unit for continuing care residents should be opened without delay.*

Mental Health Services 2009
Catchment Area Report
North Dublin

HSE Area	HSE Dublin North East
Catchment	North Dublin
Mental Health Service	North Dublin Mental Health Service
Population	225,145
Number of Sectors	6
Number of Approved Centres	1
Specialist Teams	Rehabilitation MHSOP
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	26 August 2009

Service 2009

Description of Service (Including Distinct Features)

The service covered a large population, and had six sector teams and long-established speciality teams in rehabilitation and mental health services for older persons (MHSOP). There was one approved centre attached to the catchment area, St. Ita's Hospital in Portrane. This was a large, sprawling red-bricked Victorian building situated in extensive grounds. There was a particular shortfall in psychology and occupational therapy posts throughout the sector teams. It was reported that since the MHSOP admissions unit, Unit 8, closed in October 2008 due to budgetary constraints and nursing staff shortages, admissions of older people were now made to units unsuitable for the needs of that patient group.

Progress on Recommendations from the 2008 Report

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.*

Outcome: Conditions in the hospital remained extremely poor. This had been highlighted in previous Inspectorate reports.

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

Outcome: For the previous twenty years there had been numerous plans to relocate the admission service to Beaumont Hospital but this had never been achieved. The need for new admission accommodation in Beaumont Hospital remained, but little had been done to achieve this to date.

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

Outcome: This had not yet occurred.

Outline of Local Health Service Plan 2008–2009

It was reported by the senior management team that this plan had yet to be finalised.

Developments 2008–2009

- The service had been awarded a place on a training course in palliative care in dementia by the Irish Hospice Foundation. A staff development programme in dementia care was scheduled to begin in October 2009.
- A duty social worker was now available to residents on the Admission Unit two mornings a week.
- A support group for women using the mental health services in Raheny and Artane had commenced.
- A carers' support group had been introduced in Raheny.
- A bereavement group had begun in Artane.
- A dialectical behaviour therapy group for individuals at risk of self harm had begun in the Swords sector.
- A psychology group had commenced for people with severe obsessional thoughts across a number of sectors.
- A psychology group was developed in the Swords sector for people presenting with depression and/or anxiety.
- Completion of the initial stages of the development of occupational therapy service facilities in Kilrock House.
- The establishment and development of an evidence-based therapeutic programme commencing with occupational therapy groups in Willowbrook and Woodview.

Hospital Closure Plans (Where Applicable)

St Ita's Hospital was a large Victorian-era psychiatric hospital, situated in north County Dublin in extensive grounds. There were seven wards in the hospital complex, with 125 residents, 77 of whom were long-stay. Any hospital closure plans were unclear. The future of the long stay residents was unclear. The catchment area had a population of 225,145 in six sectors.

Conditions in the hospital were extremely poor. For the past twenty years there had been a number of plans to relocate the admission service to Beaumont Hospital. None had been achieved. The service was in dire need of a new admission unit as the present admission units were unfit for purpose. But any such plans were not concrete and were unclear.

Any plans regarding the sale or future use of the hospital and the development of community facilities for the remaining in-patient population had not come to fruition.

In the meantime, 125 people were living in substandard accommodation that was not fit for purpose.

Service User Involvement

Peer Support/Advocacy

The peer advocate from the Irish Advocacy Network (IAN) visited the approved centre once a week, to the admission units either on Tuesdays or Thursdays with prior notice given, and to all remaining units upon request. Contact details were also posted prominently throughout the approved centre. An ad hoc service was also provided to Artane day centre and to St. Francis day hospital.

It was reported that the peer advocacy service had been widely accepted and accommodated in all facilities.

It was reported that staff were helpful and approachable regarding issues of concern to service users.

Residents had noticed a positive change in staff-patient relations. They had praised the introduction of protected time and stated that in general, staff on the wards made themselves available when they needed someone to listen to them.

The activity unit was enjoyable.

A common theme with residents was that they still felt that they had little or no voice regarding issues pertaining to medication. Boredom during weekends was an issue.

Residents said that they would like to have more time with their consultant psychiatrist.

Residents reported the conditions at St. Ita's Hospital to be inadequate.

Service User Participation

IAN had been invited to join many panels and groups and had been consulted on some policies and initiatives. Examples included a therapies development group meetings, integrated care plan meetings, management team meetings, and a *Vision for Change* local implementation group.

An audit of residents' views and opinions of the services/programmes provided in the Admission Unit was completed in June 2009.

Governance

Quality Improvements (Audits And Reviews)

- Audit tools and processes were in place to support compliance with the Regulations.
- A hygiene audit and an environmental audit had been undertaken recently and it was reported that the resulting recommendations were in the process of being implemented.
- An infection control committee had been established whose chief remit was to audit and ensure that good infection control practices were in place.
- A drugs and therapeutic committee was established to support prescribing practices, including the nurse prescribing project.

- A clinical risk management committee had been established to facilitate clinical discussion groups on the units.
- An audit of residents' views and opinions of the services/programmes provided in the Admission Unit was completed in June 2009.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	10
NCHD	22
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1 (Acting)
ADON	8 (including 1 Acting
Nurses based in in-patient services	108
Nurses based in community residences	30
Community mental health nurse	16
Nurses based in day hospitals	10
Nurses based in day centre	5.5
Home care	11

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1 (vacant post)
CNS (MHSOP and Dementia)	2
Family psychotherapy	1
Clinical placement coordinators	6.5 (3 assigned to St. Brendan's Hospital)
Nurse practice development coordinator	2 (1 assigned to St. Brendan's Hospital)
Counsellors	0
Advanced nurse practitioner	0
Other (lecturers)	5

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3.85
Social work	8
Occupational therapist	3
Art therapist	1
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

MHSOP Team Report

Team Description	Mental Health Services for Older Persons
Population	221,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	1	1
CMHN	2	2
CNS (dementia care)	0	1.5
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	No	No

Rehabilitation Team Report

Team Description	Rehabilitation
Population	221,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
ADON	1	1
CMHN	0	5*
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	3	3
Health care assistant	0	0

** There were five RPNs assigned to the community outreach rehabilitation team (one CNM3, one CNM2 and three staff nurses).*

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	Artane day care centre	Artane day care centre

Liaison Team Report

Team Description	Liaison psychiatry
Population	Not provided

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0	0
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
ADON	0	0
CNS	1	1 (vacant)
CMHN	0	0
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	–	–
Day centre	–	–

In-Patient Facilities

It is difficult to convey the extent of dilapidation of the St. Ita's Hospital building. Long corridors in poor conditions, toilets with no privacy, paint peeling, mould in showers, broken furniture, ill-fitting doors, cramped dormitories, the smell of urine, poor ventilation and a bare drab environment were clearly evident. It appeared that there was no funding to rectify the poor sanitary conditions in some wards. It should be acknowledged that people live in these appalling conditions and that there were little or no plans evident to rectify the situation.

It was also reported by the service that a facility for homeless youths had opened in early spring inside the entrance to the approved centre. It was reported that a small number of incidents had been documented and reported, involving a number of these youths. These incidents included intimidation of residents of the approved centre; in one instance, one resident of the approved centre had been accosted by two youths who had demanded money. Residents had reported to staff that they were now afraid to walk down to the local shops and beach. It was reported that meetings to resolve this issue had been instigated.

Statutory Requirements for Approved Centres

St. Ita's Hospital, Portrane, was in receipt of an announced inspection on 25 August 2009.

Regulations (S.I. 551 of 2006)

Individual care plans were implemented in all areas of the approved centre, except for the Kilbarrack East sector. Individual care plans were required under the Regulations for Approved Centres. The service was not compliant with Article 21 (Privacy) and Article 22 (Premises). See section on in-patient facilities above.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

There was no record as to whether the resident's next of kin was informed of the episode of seclusion nor had the reason for not informing them been documented in the resident's individual care plan. There was no evidence in the clinical file that the resident had been afforded an opportunity to discuss the seclusion episode with a member of the multidisciplinary team.

Codes of Practice

The approved centre was not suitable for the admission of children.

Multidisciplinary Care Planning

Individual care plans were implemented in all but the Kilbarrack East sector. Care plans were required under Article 15 of the Regulations for Approved Centres. The care plans that were in operation in all other areas were excellent and linked well with the statutory requirement under Article 16.

24-Hour Supervised Community Residences

Residence	Number of places	Number of residents	Team responsible	Care plan type
Kilrock House, Howth	12	12	Rehabilitation	Nursing care plan
Carlton House, Lispopple	10	10	Rehabilitation	Nursing care plan
Inch House, Balrothery	9	9	Rehabilitation	Nursing care plan

Conclusion

There had been a number of significant areas of good practice throughout the service as highlighted above.

There had been significant progress with the introduction of individual care plans for residents of St. Ita's Portrane, from all sectors bar Kilbarrack East. The staff are to be commended for the obvious amount of preparation and work that went into this project. Despite the extremely poor quality physical environment for residents, staff and visitors, there was evidence throughout the approved centre that clinical staff maintained a high level of clinical care and treatment of residents.

However, it has to be stated that the physical conditions in St. Ita's Hospital are extremely poor in what is a dilapidated, desolate and depressing environment for all who live there, for all who work there and for all who visit there.

In the meantime there are 165 people residing in this appalling environment with no plans to remove them to environments that are more suitably fit for purpose.

Recommendations and Areas for Development

1. *St. Ita's Hospital is not fit for purpose and should close.*

2. *The in-patient admission of older persons under the care and treatment of the MHSOP team should be into a suitable and appropriate area.*

3. *The shortfall in psychology, social work and occupational therapy posts in the sector teams should be filled.*

4. *The accommodation in the rehabilitation unit at Willowbrook is unsuitable and should be replaced to enable a more comprehensive rehabilitation programme to be provided for a different case mix of residents.*

Mental Health Services 2009
Catchment Area Report
North West Dublin

HSE Area	HSE 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 Liaison Psychiatry of later life Programme for homeless mentally ill Low secure team
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	8 September 2009

Service 2009

Description Of Service (Including Distinct Features)

North West Dublin served a population of 165,755 with three approved centres: St. Brendan's Hospital, the Department of Psychiatry in Connolly Hospital and Sycamore Unit in Connolly Hospital. There were four sectors, with two of them, Blanchardstown East and Blanchardstown West, admitting to Connolly Hospital with the others, Finglas and Cabra, admitting mainly to St. Brendan's Hospital, but with the use of five beds in the Department of Psychiatry in Connolly Hospital. Admissions to St. Brendan's Hospital will cease when a new wing in the Department of Psychiatry is opened. Conditions in St. Brendan's Hospital were extremely poor and there were plans for a new hospital structure on site in the near future. Sycamore Unit was a dedicated unit for psychiatry of later life. There were two rehabilitation teams, which were currently being merged, and a liaison team for Connolly Hospital. There was also a psychiatry of later life team and a team for homeless people with mental illness.

Progress on Recommendations from the 2008 Report

1. *The mix of patients on Unit 3A and Unit 3B was untenable and all admissions to these units should cease immediately.*

Outcome: As Pine Unit in the Department of Psychiatry in Connolly Hospital had not yet opened admissions to Unit 3A and Unit 3B continued. Advertising for staff had commenced.

2. *The mix of patients on Unit O was untenable and gaps in current secure services for women should be addressed nationally by the HSE.*

Outcome: There had been ongoing developments which had improved the conditions in Unit O. There had been progress regarding the client mix.

3. *To facilitate the cessation of admissions to St. Brendan's Hospital 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 Health Service early in 2009 should proceed promptly and without delay. Funding should be made available for the recruitment of all additional staff required to run the unit.*

Outcome: Pine Unit has been returned to the Mental Health Service. Decoration of the unit had commenced. Advertising for staffing had commenced. However as Pine Unit had not yet opened, admissions to St. Brendan's Hospital continued.

4. *St. Brendan's Hospital should identify clearly and agree with the 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.*

Outcome: This had been achieved.

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.*

Outcome: This had not been achieved.

6. *Remaining areas of non-compliance on Rules, Regulations and Codes of Practice should be addressed without delay.*

Outcome: The service remained non-compliant on a number of Regulations, Rules and Codes of Practice.

7. *While refurbishment had taken place on some units at St. Brendan's Hospital, 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 Agency.*

Outcome: Full planning permission had been received for the replacement mental health facilities on the Grangegorman site.

Outline of Local Health Service Plan 2008–2009

The business plan included closure of St. Brendan's Hospital and its replacement with new buildings, the opening of Pine unit, refurbishment of the facilities in the Finglas sector, the merging of both rehabilitation teams and the reconfiguring of supervised residences.

Developments 2008–2009

- A basic grade psychologist had been appointed to St. Brendan's Hospital.
- Cognitive behavioural psychotherapy and mindfulness group therapy was available in the Department of Psychiatry.
- An increase in the number of psychologists in training was facilitating greater access for service users in the Finglas sector to psychological interventions.
- Extra evening programmes in alcohol service offers aftercare to those in full time employment.

Psychiatry of Later Life

- The service had been involved with the National Implementation Group in developing the assessment forms for nursing homes so that mental health needs were included.
- A temporary consultant psychiatrist post had been filled.
- The service care group had nominated a member to become an advocate for service users.

Hospital Closure Plans

The conditions in St. Brendan's Hospital were extremely poor and unsuited to providing a mental health service. The Grangegorman development plan had incorporated a plan to provide replacement mental health accommodation on the site of the hospital. This was due to consist of a 30-bed intensive care unit, a 20-bed continuing care unit and a 16-bed rehabilitation unit. The plan was now at planning permission stage. The service was awaiting confirmation that funding would be made available to allow implementation of the plan.

In the meantime, admissions continued to St. Brendan's Hospital because Pine unit in the Department of Psychiatry, Connolly Hospital had not yet opened. The service had advertised for nursing staff to staff the unit (as well as fill vacancies elsewhere in the service). The unit was currently vacant and minor refurbishment was taking place.

Residents in St. Brendan's Hospital had been assessed with regard to their need for accommodation.

Service User Involvement

Peer Support/Advocacy

Advocacy was provided weekly in the Department of Psychiatry and in Unit 3A, Unit 3B, Unit O in St. Brendan's Hospital and on request in Unit 8A and Unit 8B. It is hoped that advocacy services will be extended to Unit 8A and Unit 8B.

Service users were very positive about the service and the care and treatment they received. They praised the refurbished garden area and the occupational therapy department in Connolly Hospital, and also the quality of the information leaflets available. The staff in St. Brendan's Hospital were reported to be helpful and approachable. The occupational therapy department and social workers were described as being helpful, and the renovations in Unit 3A, Unit 3B, and Unit O were praised. The quality of the information available in St. Brendan's Hospital was also praised.

Some residents complained about the quantity and side-effects of medication they were receiving. There were also difficulties in obtaining suitable accommodation following discharge. In St. Brendan's Hospital the lack of a visiting room in Unit O was highlighted and service users in Unit 3B complained that nursing staff were not always available to them. Service users in the Department of Psychiatry wanted a communal room without a TV set.

Service User Participation

The advocate participated in a number panels and working groups. Examples included involvement in patient information leaflets, service user questionnaires, special care therapy meetings and the patient resource pack. There were regular meetings between managers, staff and advocates. The Irish Advocacy Network had represented service user interest in the Grangegorman development project and attended monthly management meetings in St. Brendan's Hospital.

Governance

Quality Improvements (Audits and Reviews)

The management team was multidisciplinary. In St. Brendan's Hospital there were ongoing audits on hygiene and seclusion, a bimonthly audit on the Regulations, and an audit of multidisciplinary care planning. In North West Dublin, there was a medication review group, a safety and quality committee and a quality and risk management committee. There was a clinical data base that facilitated review of the psychology service. A medication management standard had been introduced with corresponding audit tool and audit team in North West Dublin. Education relating to this standard had also been done with ward staff.

A core care plan for seclusion had been introduced in St. Brendan's Hospital with education sessions on seclusion and physical restraint.

In the Department of Psychiatry, audits included care planning, documentation, policies and procedures and patient satisfaction. A medication management audit tool had been developed. There was a nursing documentation standard and an audit of the clinical learning environment for student nurses.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	14
NCHD	19
Specialist registrar	3

Nursing Staff

Post	WTE in post
DON	2
ADON	12
Nurses based in in-patient services	139
Nurses based in community residences	78
Community mental health nurse	20
Nurses based in day hospitals	6
Nurses based in day centre	8
Other – temporary staff panel	7.5

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1
Clinical placement coordinators	3
Nurse practice development coordinator	0.75
Counsellors	1 behaviour therapist 2 bereavement therapists 3 family therapists 6 nurse therapists
Advanced nurse practitioner	0
Other	1 CNM3 Alcohol service

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5
Social work	7
Occupational therapist	15 + 3 assistants
Art teacher	1
Other	8 alcohol counsellors 1 outreach worker

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Until recently there were two separate rehabilitation teams in the catchment area. These two teams were being merged and were developing common policies and assessment tools. Care planning was being reviewed.

Team Description	Rehabilitation
Population	166,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	3	2.75
Dedicated team coordinator	0	0
ADON	1	1.5
CMHN	3	1.75
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	3	2
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	12	12

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

Liaison Team Report

Team Description	Liaison Psychiatry
Population	300,000 (catchment area of Connolly Hospital)

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
Liaison nurse	1	1
Clinical psychologist	0	0
Social worker	0.5	0
Occupational therapist	0	0
Dedicated addiction counsellor	0.5	0.5
Day facility nurse staffing	Not applicable	Not applicable
Health care assistant	Not applicable	Not applicable

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not applicable	Not applicable
Day centre	Not applicable	Not applicable

Programme for the Homeless Mentally Ill Report

This service was based at Usher's Island where there was a day centre. It served the mentally ill homeless people in Dublin City Centre.

Team Description	Programme for the homeless mentally ill
Population	Caseload of 110

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
ADON	1	0.5
CMHN	1	1
Clinical psychologist	0	0
Social worker	0	0.75
Occupational therapist	2 +1 assistant	1 + 1 assistant
Dedicated addiction counsellor	0	0
Day facility nurse staffing	4 +1 outreach worker	4 + 1 outreach worker
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	1	1

Low Secure Team Report

This service was located in St. Brendan's Hospital and covered Unit 8A, Unit 8B and Unit O. It was divided into male and female. It was a regional tertiary service and accepted admissions from the Greater Dublin area and discharges from the Central Mental Hospital.

Team Description	Low secure team (male and female)
Population	36 beds (regional in-patient service)

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	2	2
CMHN	Not applicable	1
Clinical psychologist	0	0.5
Social worker	0	1
Occupational therapist	3	2
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not applicable	Not applicable
Day centre	Not applicable	Not applicable

Community Services and Nursing Homes Report

Team Description	Community Services and Nursing Homes
Population	The service consisted of Weir Home, three nursing homes in Bray, Co. Wicklow, and one nursing home in The Ward, Co. Dublin.

Staffing	2008 WTE in post*	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	0.25
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0.5	0.25
Clinical psychologist	0	0
Social worker	0	0.25
Occupational therapist	1	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

Psychiatry of Later Life Report

This service covered North Dublin and included a service base in the Mater Hospital, a day hospital in Eccles Street, a day hospital in Connolly Hospital, six acute beds in St. Vincent's Hospital Fairview, and 40 long-stay beds in Sycamore Unit in Connolly Hospital. There were also 67 nursing home beds in the service. A liaison service to the Mater Hospital and Connolly Hospital, St. Mary's Park, a nursing home in Castleknock and a 50-bed unit in Glasnevin were also provided.

Team Description	Psychiatry of later life
Population	32,500 over 65

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	3.5	4
NCHD (including specialist registrar)	4	No information
Dedicated team coordinator	0	0
ADON	1	1
CMHN	4	4
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	6	6 (including Eccles St. Day Hospital)
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	1	2 (including Mater)
Day centre	0	0

In-Patient Facilities

There were three in-patient facilities in the catchment area, all approved centres.

St. Brendan's Hospital was a large Victorian psychiatric hospital, in extensive grounds, which was not suitable for providing inpatient psychiatric care. It has 82 beds. There are three low secure units (Unit 8A, Unit 8B, Unit 0) and two acute and continuing care wards (Unit 3A and Unit 3B). There was a separate occupational therapy department and a special care therapy unit. Conditions in the hospital had been the subject of criticism over the past number of years. In the past 18 months, a number of renovations have taken place in Unit 3A, Unit 3B and Unit 0 but the facilities remained inadequate. Planning permission had been received for new replacement units. Admissions continued to St. Brendan's Hospital but were due to transfer to the Department of Psychiatry in Connolly Hospital on the opening of Pine Unit.

The Department of Psychiatry was located in Connolly Hospital. It was on a lower ground floor and had 27 beds. There was a high dependency unit with five beds. The unit was modern and there was a central enclosed courtyard.

Sycamore Unit was in Connolly Hospital and was under the care of the psychiatry of later life team. It had 34 beds for continuing care residents. Admissions were from Dublin North West and Dublin North Central.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

St Brendan's Hospital: St. Brendan's Hospital was non-compliant with 14 Regulations. It was non-compliant in food safety, visits, communication, searches, individual care plan, therapeutic activities, general health, provision of information, privacy, premises, use of CCTV, staffing, maintenance of records and operating policies and procedures.

Department of Psychiatry: The Department of Psychiatry was non-compliant with individual care plan, therapeutic activities and general health.

Sycamore Unit: Sycamore Unit was non-compliant with therapeutic activities, premises and staffing.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

St. Brendan's Hospital: St. Brendan's Hospital was non-compliant with the Rules governing the use of seclusion.

Department of Psychiatry: Seclusion, ECT and mechanical restraint were not used in the unit.

Sycamore Unit: Seclusion, ECT and mechanical restraint were not used in the unit.

Codes of Practice

St. Brendan's Hospital: St. Brendan's Hospital was non-compliant with the Code of Practice on physical restraint.

Department of Psychiatry: The Department of Psychiatry was non-compliant with the Code of Practice for physical restraint.

Sycamore Unit: Sycamore unit was non-compliant with the Codes of Practice relating to notification of deaths and incident reporting.

Multidisciplinary Care Planning

Considerable effort had been made by St. Brendan's Hospital to have individual care planning. All residents had an individual care plan. There were ongoing audits of care planning. There were regular team meetings on each unit.

The Department of Psychiatry had introduced care planning in one sector on a pilot basis.

In Sycamore Unit, care planning was in operation.

24-Hour Supervised Community Residences

Description

There are ten 24-hour supervised community residences in the catchment area, with 144 beds. They were all under the care of the rehabilitation team. Many residents were elderly and had been settled in the residences for many years. Community integration was good. At present, there was an ongoing review of all community residences and an assessment of the residents' needs.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Adelphi House	15	14	Rehabilitation/ General Adult	Nursing
Ard na Gréine	10	10	Rehabilitation/ General Adult	Nursing
Daneswood House	14	14	Rehabilitation/ General Adult	Nursing
St. Elizabeth Court	26	26	Rehabilitation/ General Adult	Nursing
175 Navan Rd.	9	9	Rehabilitation	ISP/Face
San Remo	10	10	Rehabilitation	ISP
266 North Circular Rd.	15	15	Rehabilitation	ISP
Avondale	10	9	Rehabilitation	MDT care plan
Weir Home	23	22	Rehabilitation	MDT care plan
Maysyl Lodge	12	12	Rehabilitation	ISP

Conclusion

It appears that a number of developments will take place in the service in 2009 and 2010. It is likely, after a long period of waiting, that Pine Unit will open in the Department of Psychiatry as soon as staff are recruited. This will allow acute admissions to St. Brendan's Hospital to cease. The plan for replacement units for the remaining residents in the hospital had received planning permission. It is vitally important that this plan go ahead as conditions in St. Brendan's Hospital are not suitable for providing an in-patient service. The frustration of staff at the continued delays in the progress of the closure of the hospital is understandable as it becomes increasingly difficult to provide an adequate service. However the lack of compliance in St. Brendan's Hospital with many of the Regulations for approved centres cannot be excused by lack of resources or conditions in the hospital.

There has been little development of the community services and the specialist teams. In particular the Finglas sector is deficient in both staffing and facilities, and it appears that funding for improvement of facilities may not be forthcoming. There is a lack of psychology and social work input, which currently has no management structure. The merging of the two rehabilitation teams and the review of the accommodation and the needs of residents in the supervised accommodation sector will result in a more streamlined service.

There is evidence that service users are pleased with the quality of care provided by the service. It is also evident that considerable effort has been made to increase service user participation in the service.

As a whole the service offers an extensive and varied mental health service: a community service, acute inpatient care, rehabilitation, regional low secure care, psychiatry of later life, a programme for the

homeless mentally ill, a liaison service, rehabilitation, and continuing care. All effort should be put into continuing to develop these services with the provision of adequate staffing and appropriate facilities.

Recommendations and Areas for Development

1. *The plan to provide the replacement units for St. Brendan's Hospital must proceed.*
2. *Funding should be provided to fill vacant posts on community and specialist teams.*
3. *Progress on the provision of facilities for the Finglas sector should continue.*

Mental Health Services 2009
Catchment Area Report
St. Joseph's Intellectual Disability Service

HSE Area	HSE Dublin North East
Catchment	St. Joseph's Intellectual Disability Service
Mental Health Service	St. Joseph's Intellectual Disability Service
Population	222,049
Number of Sectors	1 Team
Number of Approved Centres	1
Per Capita Expenditure 2008 [>18 Years]	23.948 euro
Date of Meeting	13 May 2009

Service 2009

Description of Service

St. Joseph's Intellectual Disability Service was based in St. Ita's Hospital in Portrane. There were 247 residents receiving care from its services: 165 residents residing on the campus at St. Ita's in Portrane and 82 residents residing in a variety of supported living environments in the community. There was also a day service on the campus. A new development was due to open in 2009 for 60 residents on the campus. A multidisciplinary team had recently been appointed.

Progress on Recommendations from the 2008 Report

1. *There should be a dedicated admission unit as part of the new streetscape development.*

Outcome: While an admission unit had not been identified there were plans in the medium term to re-configure one unit to become an admission unit.

2. *The health and social care professionals should become part of the management team following appointment.*

Outcome: As the team members had only recently been appointed this had not yet happened. There were plans to include all disciplines in the senior management team. The service had recruited a dietician, occupational therapist, speech and language therapist and physiotherapist, all at senior grade. The service had been unable to recruit a psychologist.

3. *The appointment of an additional community team should be considered.*

Outcome: A new community team had not been appointed.

Outline of Local Health Service Plan 2008–2009

The local health service plan was submitted. It included the provision of suitable accommodation, enhancing quality and safety, enhancing the estate and facilities, participation in collaborative relationships, development of leadership, management and governance capacity and development of the work force. Current status and completion dates were outlined.

Developments 2008–2009

- The new development of accommodation for 60 residents in a streetscape layout was nearing completion and was expected to be ready in September 2009.
- A new community-based residence for 9 residents, Barden Lodge, was scheduled for commissioning in January 2010.
- A new multidisciplinary team consisting of a senior social worker, a senior occupational therapist, a senior dietician, a senior speech and language therapist and a senior physiotherapist had been appointed.
- A new permanent appointment of a consultant psychiatrist had been made.
- Two nurses had commenced training in a nurse prescribing programme.
- A comprehensive review of day services had been completed.
- A service newsletter, issued every six weeks, had commenced.

Hospital Closure Plans

The plan for closure of the hospital was continuing with the new development of the 10 bungalows and the new community residence. This would enable 69 beds in the older part of the hospital to close.

Service User Involvement

Advocacy

Since 2006 Inclusion Ireland had provided an advocacy service through the HSE. It was available two days a week. The advocate was based in the hospital and in the community. There were plans to develop self advocacy and training was to commence in June 2009. It was also planned to have a dedicated phone line where service users or staff on their behalf could access advocacy services.

There was an advocacy steering group which met monthly.

Service User Participation

There was a service user forum which was chaired by service users and attended by representatives of the services. Service users had had input into the development of the information booklet. This was an excellent booklet written in appropriate language specifically for service users.

There was a family and friends of service users group that met regularly and had input into the development of the service.

A shared learning experience in mental health was scheduled for September 2009 in Dublin City University for a service user, a carer and a key worker.

Governance

The management team was tripartite but there were plans to have a multidisciplinary senior management team in the near future.

There was a risk, quality and safety committee and dedicated resources to analyse incidents.

There were a number of ongoing audits such as diagnostic systems, case notes, infection control and hygiene. An audit on seclusion had clearly shown that the rate of seclusion was decreasing.

A pilot of CORE information technology system was currently taking place for human resources data.

Staffing Dedicated to Specialist Mental Health Services

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	146
Nurses based in community residences	78
Community mental health nurse	6
Nurses based in day hospitals	0
Nurses based in day centre	16
Other – temporary staff panel	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	3
Nurse practice development coordinator	1
Counsellors	0
Advanced nurse practitioner	0
Other	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	0
Social work	1
Occupational therapist	1
Art therapist	1
Speech and language therapist	1
Dietician	1
Physiotherapist	1
Day services manager	1
Montessori teachers	3.5
Health care assistants	197
Instructors (gym, woodwork, physical education)	3.5

In-Patient Facilities

Currently all in-patient facilities were in the grounds of St. Ita's Hospital in Portrane. Many of the units were old, in poor condition and were unsuitable for the residents. A new streetscape development of 10 bungalows for 60 residents was to provide vastly improved conditions for accommodation and also for day services.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The majority of Regulations had been met by the service. There continued to be a requirement for care planning throughout the approved centre. The current premises and the lack of privacy in some units were in breach of Regulations.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service was compliant with all Rules.

Codes of Practice

The service was either substantially compliant or fully compliant with all Codes of Practice.

Multidisciplinary Care Planning

Up until now there was no multidisciplinary staff apart from medical and nursing staff. Despite this the service was well on the way to providing a multidisciplinary care plan for residents. The care plan was currently being piloted in a small number of areas with a view to rolling it out to all units in the near future. Clinical files were being integrated. There were weekly clinical meetings and monthly team meetings in the unit.

24-Hour Supervised Community Residences

Description

There were five 24-hour supervised residences with 58 places. The process of rolling out a new system of care planning was under way and it was reported it would be completed by 31 August 2009.

Residence	Number of places	Number of residents	Team responsible	Care plan type*
Clonmethan Lodge (5 houses)	30	30	Adult IDS	Nursing care plan with phased introduction of MDT care plans
Glebe House	6	6	Adult IDS	Nursing care plan with phased introduction of MDT care plans
Hilltop House	7	7	Adult IDS	Nursing care plan with phased introduction of MDT care plans
Woodlawn	8 (3 respite)	8	Ault IDS	Nursing care plan with phased introduction of MDT care plans
Avoca	7	7	Adult IDS	Nursing care plan with phased introduction of MDT care plans

Conclusion

St Joseph's Intellectual Disability Service continues to improve the quality of the care given to residents. There is obvious enthusiasm in all staff despite the changes that are currently going on within the service. The fact that the new development of 60 places and the new community residence is near completion is particularly welcome and it is obvious that an enormous amount of work has been done by staff in the assessment and preparation for this move. The continuous development of the advocacy service is also welcome and the information booklets for residents are excellent. In all, the service demonstrates that it is service user orientated and committed to service improvement.

Recommendations and Areas for Development

1. *Efforts should continue to recruit a senior clinical psychologist.*

2. *Care plans should be rolled out for all service users as soon as the pilot care planning is completed.*

HSE DUBLIN MID LEINSTER

Mental Health Services 2009
Catchment Area Report
Dublin South City

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
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	23 June 2009

Service 2009

Description of Service

Dublin South City Mental Health Services had a population of 133,095, divided into three sectors: Camac, Drimnagh and Owendoher. There were two day hospitals, one in St. Martha's House in Kilmainham and the other located in Jonathan Swift Clinic. Both provided outpatient services. There was multidisciplinary access on each sector team although staffing levels were still low. The transfer of community services from St. Patrick's Hospital was ongoing.

The approved centre was the Jonathan Swift Clinic in St. James's Hospital, which had 51 beds, with 26 acute beds, 16 continuing care beds and 9 beds for psychiatry of later life. There was no rehabilitation team but there was a psychiatry of later life team.

The service was provided under a dual management arrangement involving the HSE and St. James's Hospital.

Progress on Recommendations from the 2008 Report

1. *There should be a written plan to direct and guide the provision of service.*

Outcome: A service plan was now available.

2. *There is an urgent need for a fully staffed multidisciplinary rehabilitation team for this service.*

Outcome: There had been no progress on the recommendation.

3. *All teams should be fully staffed and have community services.*

Outcome: There had been no progress on the recommendation.

Outline of Local Health Service Plan 2008–2009

A service plan was provided. It included the following which were all funding dependent:

- The development of a rehabilitation team.
- Catchment area team enhancements.
- Minor capital developments.
- Sector headquarters, day hospital and outpatient departments for all three sectors.
- Development of day hospital and headquarters for the psychiatry of later life team.
- Transfer of community services from St. Patrick's Hospital.
- Realignment of catchment area and sector boundaries.

Developments 2008–2009

- The dual management system was now in place with the HSE and St. James's Hospital.
- A foundation course in psychotherapy for multidisciplinary team members was in progress.
- The therapeutic garden in St. Martha's Day Hospital had been completed.

Service User Involvement

Peer Support/Advocacy

A service user survey which had been completed looked at access to the service.

There had been regular meetings between the Irish Advocacy Network (IAN) representatives and clinical nurse managers. These meetings had been expanded to include other interested disciplines and had been formally named the St. James's Advocacy Steering Group. The group hoped to develop a patient resource welcome pack and a suggestion box system.

Through IAN, residents in Jonathan Swift Clinic said they found the staff friendly, approachable and accommodating. They complained that the smoking room was too cramped and poorly ventilated, the information stand was not always adequately filled with information pamphlets and the menu was not varied enough. They also said that they were not getting enough quality time with staff members and that they felt uncomfortable and anxious during team meetings when meeting the entire team.

Service User Participation

There was a service user representative and a service carer representative included in the heads of discipline group. The DCU Cooperative Learning Leadership course supported this initiative.

An annual research project was carried out in collaboration with the service provider, service user and carer representative through DCU. This project was designed to assist in implementing change.

Governance

Quality Improvements (Audits And Reviews)

The governance structure consisted of a corporate governance group, an executive management group, a heads of department group, the multidisciplinary teams, and the department meetings.

A number of audits, both clinical and non-clinical had been carried out. These included care planning and admission audits (both carried out monthly), a benzodiazepine audit, an audit of medical review of outpatients, audits of waiting times, and referrals to psychology and hygiene. Due to time and resource constraints the service had found it difficult to prioritise research.

Staffing Dedicated To Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7
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
Community mental health nurse	7
Nurses based in day hospitals	5
Nurses based in day centre	1
Other – temporary staff panel	3

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	0
Advanced nurse practitioner	0
Other	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5
Social work	5.5
Occupational therapist	7
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community mental health team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	18,012

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	0	0
ADON	2	2
CMHN	1	1
Clinical psychologist	1.5	1
Social worker	1	1
Occupational therapist	2	2
Dedicated addiction counsellor	0.2	0.2
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	own	own
Day centre	0	0

In-Patient Facilities

There was one approved centre, Jonathan Swift Clinic, in the catchment area. It had 51 beds and provided acute care, psychiatry of later life and continuing care. It was located in St. James's Hospital and was on two levels.There was also a day hospital in the unit. There were a number of residents in the unit who had been in hospital for more than six months and the lack of a rehabilitation team had meant that progress in moving them to more appropriate accommodation had been slow.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The service had some difficulties in meeting Regulations at the time of inspection as some policies were not up to date, the insurance certificate and food and fire safety reports were not made available, care plans were not fully completed and not all residents received appropriate information about their clinical team. This appeared to demonstrate a lack of attention to detail as all Regulations could be met without resource implications. (The insurance certificate and food and safety reports were later submitted to the Inspectorate on further request).

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

Documentation on ECT was inadequate but the service was compliant in all other aspects on the Rules for ECT. Seclusion and mechanical restraint were not used in the approved centre.

Codes of Practice

The approved centre was compliant with all Codes of Practice.

Multidisciplinary Care Planning

The service had put considerable work into developing and implementing a care plan. However, care plans were not fully completed. Care planning was audited monthly.

There were weekly team meetings and the resident attended the team meetings where the care plan was decided. Residents did not always receive a copy of their care plan.

24-Hour Supervised Community Residences

Description

There were two 24-hour community residences, each with 10 beds. A new care plan had been developed for the residents. There was no rehabilitation team available.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Quilca	10	9	CMHT	MDT
Ashdale House	10	10	CMHT	MDT

Conclusion

Dublin South City Mental Health Services demonstrated a growing service user and carer involvement. The inclusion of a service user and carer on the heads of discipline group was welcome.

The absence of a rehabilitation team was a serious deficiency, especially in view of the presence of long stay residents in the continuing care ward and the supported accommodation in the community. A community rehabilitation team would be in a position to progress movement of residents into more independent accommodation and ultimately close long stay beds.

The lack of funding had resulted in lack of development of the community mental health teams, both in staffing and in facilities, despite plans to improve both.

The successful transfer of undertakings from St. Patrick's Hospital with retention of staffing numbers was commendable. The services were now under dual management between the HSE and St. James's Hospital.

Recommendations and Areas for Development

1. *A rehabilitation team is essential to facilitate the transfer of residents in residential settings to more independent living.*

2. *All multidisciplinary teams should be fully staffed.*

3. *The service should ensure that it is compliant with all Regulations for approved centres.*

Mental Health Services 2009
Catchment Area Report
Dublin South East

HSE Area	HSE Dublin Mid Leinster
Catchment	Dublin South East (General adult) Dublin South East and Cluain Mhuire Catchment (Psychiatry of later life) Dublin Mid-Leinster (Eating disorders)
Mental Health Service	Dublin South East Mental Health Services
Population	110,000 (General Adult) 285,000 (Psychiatry of later life) 1.5 million (Eating disorder)
Number of Sectors	3.5
Number of Approved Centres	1
Specialist Teams	Psychiatry of later life Eating disorder
Per Capita Expenditure 2008 [>18 Years]	Service funding comes from the HSE and St. Vincent's Hospital
Date of Meeting	29 September 2009

Service 2009

Description of Service

Geographically, the catchment area was small, 8km by 3km, and spanned the Dublin 2, 4, 8 and 14 postal codes. It had the largest elderly population in the country.

The service had one approved centre based in Elm Mount, St. Vincent's University Hospital, Dublin. Outpatient services for three sectors were provided in Baggot Street Hospital. The conditions there were inadequate and required refurbishment. One sector, D4, operated its outpatient services in the primary care unit in Irishtown. There was one day hospital, which was for psychiatry of later life.

Progress on Recommendations from the 2008 Report

1. *There should be a fully staffed rehabilitation team.*

Outcome: There had been no progress on this recommendation.

2. *All multidisciplinary teams should be fully staffed.*

Outcome: No new additional posts were appointed.

3. *Further development of community mental health facilities was required.*

Outcome: One sector had access to office space in the new primary care building in Irishtown. The service had no sector headquarters and the Baggot Street clinic was in need of capital improvement.

Outline of Local Health Service Plan 2008–2009

The business plan presented was an updated version of the 2008 plan. This plan described proposals to amalgamate sectors, develop a full liaison service and additional psychiatry of later life services, restructure the eating disorder service and continue community developments. There had been little progress with these proposals during the year, and it was reported that the main priority at present was to maintain service delivery. Previous service plans proposed the reorganisation of sectors and the service continued to look at developing this plan.

Developments 2008–2009

- A new home care team called Remishe, commenced operation in March 2009. This service enabled the teams to provide care for service users in their own homes, and has reduced the rate of admission to the acute unit. Staff in the Outreach team had undertaken a week's training course in the provision of this service.
- Medication booklets were introduced to the community residences.
- Integrated care planning was introduced into the community residence for the elderly in Carew House.
- A new integrated file for use within the entire hospital was introduced after consultation with staff in the medical and surgical areas of the hospital.
- The service ran a course in ECT and included participants from other hospitals.
- 16 household staff members had completed a Clean Pass course which is required to meet the standards of HIQA.
- An out-of -hours course in cognitive behavioural therapy for anxiety management commenced in the Glenmalure Day Centre.

Service User Involvement

Peer Support/Advocacy

The advocate visited the acute unit weekly. In reporting to the meeting with the Inspectorate, the advocate described having a good relationship with staff. Areas where the advocate was involved included attendance as support for patients at tribunals, involvement in the ECT and general training programmes for nurses, and participation in the group involved in implementing the integrated care planning for residents. In conjunction with management, the advocate had been involved in the development of an audio cassette of the patient information leaflet.

At the request of the Irish Advocacy Network (IAN) , staff were currently implementing the Service User Rating of Effectiveness (SURE) survey forms, as part of a nationwide survey.

Areas in need of attention, as described by some residents, included over-reliance on medication, insufficient time with consultants, poor ventilation, and inaccessibility of call bells for residents in wheelchairs. Boredom and lack of activity at the week-ends were also cited as difficulties.

Service User Participation

The advocate attended the meetings on integrated care planning.

Governance

Quality Improvements (Audits and Reviews)

Management: The executive management team continued to be tripartite, but other disciplines were involved in the broader management team. However, this team had not met in the previous four months.

Research/Audits: An audit of the first six months' work of the new outreach home care team had been completed in August 2009.

Reviews of the pilot programmes in medication management and Integrated care planning were carried out in 2009.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	9
NCHD	4
Specialist registrar	2

Nursing Staff

Post	WTE in post
DON	1
ADON	6
Nurses based in in-patient services	37
Nurses based in community residences	69.5
Community mental health nurse	7
Nurses based in day hospitals	2
Nurses based in day centre	6

Nursing Specialist Posts

Speciality	WTE in post
Liaison	2
Family therapy	2
Biofeedback	1
Counsellors	1
Advanced nurse practitioner	1
Elderly theraputic intervention	1
ECT nurse	0.5
CBT nurse	1
Nurse practice development coordinator	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4.8
Social work	3
Occupational therapist	4
Art therapist	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	28,000-32,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	3	3
ADON		
CMHN	6	6
Clinical psychologist	1.8	1.8
Social worker	2	2
Occupational therapist	2	2

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Owned	Owned
Day centre	Access generic day centres	Access generic day centres

In-Patient Facilities

There was one in-patient facility, Elm Mount, at St. Vincent's University Hospital. An unannounced inspection was conducted on 15 April 2009. Bed numbers had been reduced and resources deployed to a pilot home care assertive community treatment.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The service was largely compliant with the Regulations. There was a system in place for care planning and therapeutic activities. On the day of inspection, they had not been completed for all residents.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service did not use seclusion or mechanical restraint. ECT was in order apart from the provision of information to one detained patient on the day of the inspection.

Codes of Practice

The service was compliant with the relevant codes for adults. It was an unsuitable environment for children and was non-compliant with the code for children.

Multidisciplinary Care Planning

Approved centres: There was a system in place for care planning. However, care plans had not been completed for all residents.

Community: There were plans in place to extend the hospital-based system to the community. It had begun in one area.

24-Hour Supervised Community Residences

Description

The service had access to three 24-hour community residences and three continuing care units for the elderly. Apart from residences attached to the psychiatry of later life team, there was no rehabilitation team. The other residences were under the clinical responsibility of the sector teams. Multidisciplinary care plans were planned for 2010.

The house on Grosvenor Road required the kitchen to be upgraded. This will require capital money. Initial plans have been drawn up.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Morehampton Road	10	10	Sector	Nursing
Grosvenor Road	14	14	Sector	Nursing
Cois Céim	26	26	Psychiatry of later life	Nursing
Unit D	26	26	Psychiatry of later life	Nursing
Unit E	26	26	Psychiatry of later life	Nursing

Conclusion

The Dublin South East catchment area was an active one that was continuing to develop its community programmes. In March 2009, the service commenced its outreach service to deliver care to service users in their homes, with good results. One of the effects of this new service was to reduce the rate of admissions to the approved centre. The service engaged in training programmes for its staff, and had established a good relationship with the IAN representative.

The approved centre was largely compliant with the Regulations and Rules pertaining to the implementation on the Mental Health Act 2001.

Despite its proposals to amalgamate and restructure its sectors, there seemed to be little progress in this regard. Similarily, there was little progress in establishing a full liaison service for the busy general hospital where the approved centre is located. Although recognising the size of its elderly population, the service continues to operate only two psychiatry of later life teams for an elderly population of 33,000. Recent staff shortages in the day hospital for older persons have raised concerns amongst staff for the effective delivery of services to its users.

The lack of a rehabilitation team continues to be disappointing in a service with a number of high and medium support hostels.

Recommendations and Areas for Development

1. *There should be a fully staffed rehabilitation team.*
2. *Plans to amalgamate sectors should continue.*
3. *There should be a full liaison team within the general hospital.*
4. *The service for older persons should be expanded to provide for a third psychiatry of later life team.*
5. *Alternative community facilities should be sought to allow a more community-focused service to develop.*

Mental Health Services 2009
Catchment Area Report
Dublin West/South West Mental Health Service

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	Psychiatry of later life Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Total expenditure 31,984,000 euro
Date of Meeting	22 April 2009

Description

Description of Service (Including Distinct Features)

The Dublin West/South West mental health service was largely community based, with two approved centres located at AMNCH Tallaght and at St. Loman's, Palmerstown. The unit at Tallaght was an acute admission unit and St. Loman's provided for rehabilitation and continuing care of long-stay residents. There were four sectors in the catchment area with two additional specialist teams: psychiatry of later life and rehabilitation. The service operated five day hospitals, one in each area and an additional one for psychiatry of later life. A liaison psychiatry service was also provided in conjunction with AMNCH.

Progress on Recommendations from the 2008 Report

1. *The approved centres must ensure compliance with the relevant Regulations, Rules, Codes of Practice and with Section 60, Mental Health Act 2001.*

Outcome: The approved centres continued to be non-compliant with a number of Regulations, Rules and Codes of Practice.

2. *The Service should develop the management team to include heads of clinical psychology, social work and occupational therapy.*

Outcome: The management team continued to operate under the tripartite system of governance and there were no plans to alter the management system. It was suggested there were barriers to the expansion of the management system, despite the fact that the heads of the other disciplines were keen to be involved.

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 mental health policy.*

Outcome: Not all teams were resourced to provide full multidisciplinary teams.

Outline of Local Health Service Plan 2008–2009

The service could not offer a local health service plan, apart from indicating that it was attempting to maintain existing service provision, as it was awaiting information on funding before developing a service plan.

Developments 2008–2009

- An occupational therapy day rehabilitation programme had been introduced in the rehabilitation unit at St. Loman's.
- Eight nurses had completed the nurse prescribing course, and three nurses were registered to prescribe.
- A second consultant psychiatrist in psychiatry of later life had been appointed, but was as yet without team members.
- The service had engaged in collaborative discussions with staff in psychiatry of later life in St. James's Hospital and Bloomfield regarding the possibility of establishing a community aspect to service delivery.
- The service was in the process of standardising a programme for anxiety management groups throughout the service.
- The service supported two service users, two carers and two staff members to undertake the Cooperative Learning Leadership programme in DCU and had commenced work establishing a service users and carers council.

Hospital Closure Plans

There was a building programme plan to develop new accommodation for the residents of St. Loman's and the service expressed a wish to replace the current ward setting with more suitable accommodation. In addition, planning permission had been sought to provide two more community residences. It was reported that the ultimate aim was to close the unit at St. Loman's Hospital and to build community facilities inclusive of a health centre and community residences in various parts of the catchment area.

Service User Involvement

Advocacy

There was a strong peer support and advocacy group in the service, particularly in the unit in AMNCH. Advocates visited the wards regularly and as required. They facilitated a peer support group and were involved in the integrated care planning group and the development of integrated care plans. They also participated in the clinical governance group.

The advocate stated the desire to expand the service to the 24-hour supervised residences in the near future, but stated that accessing funding for peer advocacy training was a difficulty.

The Irish Advocacy Network also visited the approved centre at St. Loman's Hospital.

Governance

Quality Improvements (Audits and Reviews)

Quality audits were conducted regularly.

A new multidisciplinary care plan had been developed and was due to be introduced across all sections of the service in May 2009.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	14
NCHD	18
Specialist registrar	2

Nursing Staff

Post	WTE in post
DON	1
ADON	8
Nurses based in in-patient services	66
Nurses based in community residences	32
Community mental health nurse	12.87
Nurses based in day hospitals	16
Nurses based in day centre	6
Nurses based in home care	24.74
Assertive outreach	3
Other – temporary staff panel	2

Nursing Specialist Posts

Speciality	WTE in post
Clinical placement coordinators	4
Nurse practice development coordinator	1, shared
Counsellors	0
Advanced nurse practitioner	0
CNS	5.5

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	6
Social work	10
Occupational therapist	13
Art therapist	0
Other	3

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	256,566

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	1	1
CMHN	2	2
Clinical psychologist	0	0
Social worker	2	2
Occupational therapist	2	2
Dedicated addiction counsellor	0	0
Day facility nurse staffing	2	2
Home care team	4	4
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not provided	Owned
Day centre	Not provided	None

Rehabilitation Team Report

Team Description	Rehabilitation team
Population	256,566

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	1	1
CMHN	1	1
Clinical psychologist	0	0
Social worker	0.3	0.3
Occupational therapist	2	2
Day facility nurse staffing	0	0
Assertive Outreach Team	3	3
Nurses based in community residences	30	30
Health care assistants	22.25	22.25

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital		Owned
Day centre		Owned

In-Patient Facilities

The service operated two approved centres, one at AMNCH, Tallaght and one at St. Loman's, Palmerstown. St. Loman's provided continuing care to the residents. On the day of inspection, there were 13 residents, although 22 beds remained in commission. Residents had care plans and had therapeutic programmes based on the care plans. There was no access to a psychologist and the grounds in front of the unit were in a derelict state as a result of building works.

The acute unit at the AMNCH in Tallaght had 52 beds. Policies needed to be updated and there was evidence that physical reviews were not done on residents who had been resident for longer than six months.

In-patient policies at AMNCH had been reviewed and amended for a further three-year period in 2009.

Compliance with Statutory Requirements for Approved Centres

In the acute unit in AMNCH, individual multidisciplinary care plans had not been introduced, although a new system of care planning was due to be introduced in May 2009.

A large number of policies needed to be updated.

Care plans were in operation in St. Loman's.

Regulations (S.I. 551 of 2006)

Care plans for residents were not in operation in the acute unit in AMNCH.

There was evidence that physical health reviews had not been carried out on residents who had been in the acute unit for longer than six months.

The acute unit was unsuitable for the admission of children. Compliance with the Code of Practice relating to ECT was compromised by the layout of the ECT suite.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service was not compliant with the rules in relation to ECT, mainly in layout of the ECT suite. However, the practice of the approved centre was to take the patient straight from the ward and into the ECT suite therefore eliminating the need to wait outside the ECT suite. There was substantial compliance with regard to the Rules regarding the use of seclusion.

Codes of Practice

There was substantial compliance with regard to the use of physical restraint. Compliance with the Code of Practice relating to ECT was compromised by the layout of the ECT suite.

Multidisciplinary Care Planning

Multidisciplinary care plans were in operation in St. Loman's. There were poor care plans in the acute unit in AMNCH, however the Inspectorate was informed that new care plans would be introduced in May 2009.

24-Hour Supervised Community Residences

Description

The service operated four supervised residences, all under the care of the rehabilitation team.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Teach Bán	10	8 (and 2 respite beds)	Rehabilitation	MDT
Grove House	14	14	Rehabilitation	Nursing
Beaufort House	10	10	Rehabilitation/ Sector	Nursing
St. Columba's	18	18	Rehabilitation/ Sector	Nursing

Conclusion

The service provided acute and continuing care for residents in its two approved centres. The introduction of an occupational therapy rehabilitation programme in St. Loman's unit was welcomed, as was the development of a second consultant psychiatrist post in psychiatry of later life. Compliance with the Regulations and Rules was substantial for the most part, but the absence of physical health reviews on residents admitted for longer than six months needs to be addressed quickly. It was disappointing to note the absence of individual multidisciplinary care plans in the acute unit. It was apparent at the catchment area meeting that the current system of tripartite management, with the exclusion of heads of other disciplines, needs to be addressed again.

Recommendations and Areas for Development

1. *Physical health reviews must be carried out on residents admitted for longer than six months.*
2. *Individual multidisciplinary care plans as outlined in the Regulations must be introduced in the acute unit.*
3. *All teams should be resourced to provide full multidisciplinary care for residents.*
4. *The future of the unit at St. Loman's Hospital should be examined in light of the sustained reduction in resident numbers.*
5. *The service should continue to develop the management teams to include heads of clinical psychology, social work and occupational therapy.*

Mental Health Services 2009
Catchment Area Report
Wicklow

HSE Area	HSE Dublin Mid Leinster
Catchment	Wicklow
Mental Health Service	Wicklow Mental Health Services
Population	109,472
Number of Sectors	2
Number of Approved Centres	1
Specialist Teams	Intellectual Disability
Per Capita Expenditure 2008 [>18 Years]	12.254 euro [sic]
Date of Meeting	11 June 2009

Service 2009

Description of Service (Including Distinct Features)

The Wicklow catchment area was divided into two large sectors. Each sector had a distinct population with varying levels of deprivation and concentration of nursing homes. The catchment had a number of high-density urban centres and large rural areas. The rural parts of the catchment were poorly served by public transport. This impacted on service users' ability to access structured day services.

The team was highly motivated and committed to developing and delivering a quality-based service. This had been achieved with minimal resources and with funding from the voluntary support group Friends of Newcastle Hospital.

The service skill mix was poor when measured against national policy standards. Service users had no access to specialist mental health teams.

Progress on Recommendations from the 2008 Report

1. *Specialist teams should be set up to provide rehabilitation and psychiatry of later life.*

Outcome: There was no increase in staffing since the last meeting.

2. *Provision of occupational therapy services and augmentation of psychology and social work staffing should be a priority within the service.*

Outcome: There had been no appointment of an occupational therapist to the service. One social worker retired and the post was not filled. Psychology staffing levels had remained constant.

3. *The implementation of multidisciplinary care plans should be extended to all residents in the approved centre.*

Outcome: Care plans had been extended to both wards. There remained an unmet need for various disciplines in the community mental health teams.

Outline of Local Health Service Plan 2008–2009

There was a written clinical development plan for the service across all aspects of service provision. The service as a team was committed to achieving real measurable targets.

Developments 2008–2009

- The appointment of a consultant psychiatrist and CMHN to the intellectual disability service. This team was part of the catchment area.
- Two full-time permanent consultant psychiatrists had been appointed. They were due to commence work in the North sector in the coming months.
- Systems had been developed to improve patient safety and quality in the approved centre. They included audits and reviews of incidents. All staff were involved.
- The management team had been expanded to include a representative from Wicklow Mental Health Association.
- Key posts remain unfilled due to the HSE employment freeze that was announced on 27 March 2009.
- Psychology services had been rationalised and reorganised to maximise staff resources effectively. It was reported that the project had been successful. An evaluation was currently under way.
- The service budget had been cut from 12.254 million euro in 2008 to 11 million euro in June 2009.
- Provision had been made to accommodate a community mental health team in the new primary care centre in Greystones. A similar was planned for Wicklow Town.

Hospital Closure Plans

There were no closure plans at the time of the meeting. Discussion on integrating the service into a larger catchment area had commenced. An executive clinical director was appointed on 1 June 2009. The area of the new catchment was to include St. Vincent's Hospital, Elm Park, and the Cluain Mhuire services. The project was due to be rolled out using the clinical directorate framework agreed nationally. Baseline data will be collected in year one.

Service User Involvement

Peer Support/Advocacy

A peer advocacy service was provided weekly to the acute in-patient unit by the Irish Advocacy Network (IAN). The advocate had also begun to visit the community residences on the grounds of the hospital.

The advocate reported a number of positive aspects to the organisation and delivery of services. They included awareness of rights, friendliness of staff, and the quality of the food. A number of service users had expressed an interest in completing training in the area of advocacy.

A number of service users commented on the lack of activities on the ward, limited access to social work services and the need for additional supports in the community.

The advocate was planning to facilitate a number of training sessions on the role of peer advocacy to all new staff. It was agreed that a formal link with an ADON should be established to improve resolution of issues in a timely manner for all involved.

Service User Participation

In addition to a peer advocate service, the Wicklow Mental Health Association had a representative on the management team. This was a very new development.

Governance

The management team consisted of a Mental Health Association representative, clinical director, senior clinical psychologist, director of nursing and area manager. The other disciplines were not currently employed in the service.

There had been a significant drive to improve clinical audit systems to ensure compliance with the Mental Health Act 2001. The team met regularly and reviewed progress. The team had worked very hard to ensure that quality systems become embedded in the system and improve services for service users.

In addition the service had a very strong link with the Friends of Newcastle Hospital group. To date this group had funded many initiatives and projects to improve patient care.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	4.3
NCHD	9
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	3
Nurses based in in-patient services	36.5
Nurses based in community residences	13
Community mental health nurse	5
Nurses based in day hospitals	2
Nurses based in day centre	6
Temporary staff panel	5

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	0
Advanced nurse practitioner	0
Other	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	2.4
Social work	1
Occupational therapist	0
Art therapist	0
Physiotherapist	0.5

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Intellectual Disability Team Report

Team Description	Intellectual Disability
Population	109,472

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0	0.6
NCHD (including specialist registrar)	0	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	1
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

In-Patient Facilities

There was one approved centre. It had two wards providing acute care and elderly continuing care.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The Newcastle Hospital centre was compliant with the majority of Regulations. The one area of non-compliance was in relation to skill mix. Since the approved centre inspection in April 2009, the service had put in a new wet floor shower room and added a choice on the food menu.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The centre had ECT facilities and was fully compliant on the day of the inspection. Seclusion facilities were recorded as substantially compliant. All documentation and systems to ensure compliance were of a very high standard.

Mechanical restraint (Part 5) was recorded in full.

Codes of Practice

The centre was fully compliant with all the codes except with the provision of appropriate facilities for children.

Multidisciplinary Care Planning

Care planning was a core objective of the service. It had been successfully introduced in the approved centre. There were now plans to extend it out to service users attending day centres in the area. There was very limited availability to social work and clinical psychology. There was no access to occupational therapy. These factors limited the intervention options for service users.

24-Hour Supervised Community Residences

Description

There were two 24-hour supervised residences in the area. One was inspected in detail and it is reported separately. There was no rehabilitation team in place. Service users remained attached to the general adult community teams. The service had access to 41 beds in low support.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Fitzwilliam House	12	11	General adult	MDT
Ellerslie	14	10	General adult	MDT

Conclusion

The service had used the collective commitment of all staff successfully to achieve almost full compliance in its approved centre. Remaining issues are dependent on additional resources and improved staffing skill mix. These deficits were reflected in the service users comments on lack of talking therapies and the lack of meaningful activities. The budget cuts and recruitment embargo is affecting the development of service beyond minimal requirements.

However the service is ahead in a number of areas. It has commenced discussions on the future configuration of a larger catchment area. Care planning and quality improvement initiatives are becoming the norm in the service.

Recommendations and Areas for Development

1. *All services users must have access to rehabilitation and other specialty teams.*

2. *All service users must have access to a range of disciplines and interventions, especially occupational therapy and social work.*

3. *All service users must have a care plan based on a needs assessment.*

4. *The advocate and a member of the clinical staff should meet on a quarterly basis to review services and share information.*

Mental Health Services 2009
Catchment Area Report
Kildare West Wicklow

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 (E.G. POLL, REHAB)	Rehabilitation Home care
Per Capita Expenditure 2008 [>18 Years]	Not supplied
Date of Meeting	2 September 2009

Service 2009

Description of Service (Including Distinct Features)

Each of the five Kildare/West Wicklow sectors had a sector headquarters either owned or shared but these services had not received the necessary funding to develop and had to rely on an already stretched in-patient service barely able to cope with the demand for care and treatment. In addition to the five sector teams, there was a rehabilitation team and a home care team. There was no psychiatry of later life team and no liaison team in this catchment. In-patient services were provided at Lakeview Unit in Naas General Hospital, where there were 29 acute admission beds.

Progress on Recommendations from the 2008 Report

1. *The new community residence, Clonree House, should be opened.*

Outcome: Due to lack of staff this had not occurred.

2. *The rehabilitation team should be resourced in order to provide an adequate service.*

Outcome: This had not occurred.

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 services.*

Outcome: This had not occurred.

Outline of Local Health Service Plan 2008–2009

The catchment service forwarded a copy of the National Service Plan 2009 for the HSE to the Inspectorate. No local mental health service plan was submitted.

Developments 2008–2009

- Two staff members had been involved with the development of the Wellness Recovery Action Plan (WRAP) programme.

- A dialectical behaviour therapy (DBT) group had been started in North Kildare. Four staff members were to receive specialist training in the UK.
- The rehabilitation service had been relocated to new headquarters at St. Mary's Hospital.
- It was reported that the opening of a community day facility to cater for eight to ten service users was imminent.
- The roof garden at the approved centre was developed and opened to residents until 2000h each evening.
- The core management team had been expanded to become multidisciplinary.

Hospital Closure Plans (Where Applicable)

Not applicable.

Service User Involvement

Peer Support/Advocacy

A weekly service was provided by the Irish Advocacy Network (IAN) to Lakeview Unit in Naas General Hospital. Service users were also seen by an advocate on an individual basis at Celbridge, Kilcock and Athy day services. IAN facilitated presentations regarding the role of the advocate in day hospitals, day centres and within the community at large.

It was reported that service users found staff at Lakeview Unit friendly and approachable.

It was reported that the IAN's attendance as patient's support at mental health tribunals had been welcomed and accommodated by the nursing and medical staff and the clerical officer assigned to the unit.

It was reported that a number of residents of Lakeview Unit indicated to the IAN representative that they had not been supplied with sufficient information regarding medication. They also stated that they were not sufficiently well informed about their care plan and were unclear as to the treatment options available to them.

Service User Participation

There was no service user representation on the multidisciplinary senior management team. It was reported by the management team and the IAN representative that such a move had been sought by the senior management team but no service user interest had been expressed.

It was reported by IAN that as a result of the involvement of Lakeview Unit staff and management and the IAN in the Refocusing Project, the partnership between IAN and the staff and management had become increasingly open and progressive.

Staff and management were currently implementing the Service User Rating of Effectiveness (SURE) survey forms in collaboration with the IAN.

Governance

Quality Improvements (Audits and Reviews)

A clinical risk assessment tool adapted from the Functional Analysis of Care Environment (FACE) had been piloted. This was due to be audited soon.

Staffing Dedicated to Specialist Mental Health Services

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	36
Nurses based in community residences	16
Community mental health nurse	18
Nurses based in day hospitals	6
Nurses based in day centre	4
Other	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	Not supplied by service
Nurse practice development coordinator	Not supplied by service
Counsellors	0
Advanced nurse practitioner	0
CNS	8

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	2
Social work	6
Occupational therapist	5
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation
Population	205,175

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0.36	0.36
NCHD (including specialist registrar)	2	1
Dedicated team coordinator	0	0
ADON	1 session	1 session
CMHN	1	1
Clinical psychologist	0	0
Social worker	1 principal post – sessional	1 principal post – sessional
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

Home Care Team Report

Team Description	Home care
Population	64,149

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0	0
NCHD (including specialist registrar)	0	0
Dedicated team coordinator	0	0
ADON	0	0
CMHN	5	5
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

In-Patient Facilities

Lakeview Unit in Naas General Hospital was situated on two floors. The entrance was on the upper floor which was bright and welcoming. The activities and the dining area, ECT suite and some offices were on this floor.

The in-patient ward was on the lower level. Residents there had access to an enclosed garden space which was used for smoking and relaxation.

The space within the ward was limited. On the day of inspection, the unit was fully occupied. It appeared busy and crowded to the extent that it was not therapeutic for people with severe psychotic or depressive conditions. The activities area of the unit was in use up to 2000h and this freed space from the lower tier of the unit. The space available had been extended with the development of a roof garden on the upper floor. Much work had been put into this garden and staff and residents must be commended for developing it.

Statutory Requirements for Approved Centres

Lakeview Unit received an unannounced inspection on 30 April 2009.

Regulations (S.I. 551 of 2006)

The unit was in breach of five Regulations: Article 7 (Clothing), Article 15 (Individual Care Plan), Article 16 (Therapeutic Services and Activities), Article 17 (Children's Education), Article 20 (Provision of Information to Residents) and Article 22 (Premises).

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

There was no record of the resident's next of kin being informed of the resident's seclusion [Sections 2.4 and 2.10 (a) (b)]. There was no record in the clinical files that the resident was reviewed every four hours by a medical practitioner. The resident's individual care plan did not address the assessed needs of the resident in seclusion [Sections 4.4 and 4.6].

There was no record in the clinical file that the resident was afforded the opportunity to discuss the seclusion episode [Section 6.3]. The seclusion register was only partially completed for the seclusion episode [Section 8.2]. The approved centre did not provide information to residents regarding seclusion [Section 9.1 (a)].

There was no written record indicating that all staff involved in seclusion had read and understood the policy [Section 9.1 (b)], nor that the approved centre reviewed its policy on seclusion on an annual basis [Section 9.1 (d)].

There was no evidence that the multidisciplinary team involved in the resident's care reviewed the episode of seclusion [Section 9.2]. There was no evidence that the approved centre compiled an annual report on the use of seclusion [Section 9.3].

The information on staff training on the day of inspection was limited and did not comply fully with the Regulations.

Codes of Practice

In the clinical files reviewed for physical restraint, it was not evident that the registered medical practitioner was notified of the episode of physical restraint [Section 2.6]. The clinical practice form for physical restraint was only partially completed [Section 2.8].

There was no record in the clinical notes that the resident's next of kin was informed of the physical restraint episode [Section 2.10 (a) (b)]. The use of physical restraint was not clearly recorded in the clinical notes reviewed [Section 5.1]. The clinical practice form for physical restraint was incomplete on the day of inspection [Section 5.2].

There was limited evidence that staff involved in physical restraint had read and understood the policy [Section 6.1 (b)]. The approved centre did not review its policy on an annual basis [Section 6.1 (d)]. There was no record of discussion with the multidisciplinary team [Section 6.2]. There was no record of the approved centre compiling an annual report [Section 6.3]. The record of attendance at training was limited and was not representative of the staffing numbers [Section 7.2].

The approved centre was unsuitable for the care and treatment of children. The risk management policy was in draft form.

Multidisciplinary Care Planning

Multidisciplinary care plans had not yet been developed. It was reported that preliminary work had taken place in adapting a care plan from FACE. This had yet to be implemented.

24-Hour Supervised Community Residences

Residence	Number of places	Number of residents	Team responsible	Care plan type
Bramble Lodge	14	14	Rehabilitation Team	MDT
Larine House	14	14	Rehabilitation Team	MDT

Conclusion

Despite an expanding population in recent years, the catchment of Kildare/West Wicklow reported that it remained one of the lowest funded catchment areas in the country on a per capita basis. Each of the five sectors had a sector headquarters either owned or shared and despite staff commitment to the development of community services, these services have not received the necessary funding to sufficiently develop; the service relied on an already stretched in-patient service barely able to cope with the demand for care and treatment.

Staff expressed frustration at the lack of resources to enable them to provide adequate services, yet demonstrated commitment and dedication – despite these limited resources – to strive where possible to bring about real change that mattered to service users. The development of the roof-top garden was only one example of this commitment, the garden being funded by voluntary sources.

Recommendations and Areas for Development

1. *The new community residence, Clonree House, should be opened.*

2. *The rehabilitation team should be fully resourced so that it can provide a comprehensive service to all users.*

3. *A psychiatry of later life team and a liaison team should be appointed.*

4. *The community day facility which is to cater for between 8 and 10 service users a day and which had been scheduled to open in mid-June should be opened immediately.*

Mental Health Services 2009 Catchment Area Report Laois/Offaly

HSE Area	HSE Dublin Mid Leinster
Catchment	Laois/Offaly
Mental Health Service	Laois/Offaly Mental Health Services
Population	137,927
Number of Sectors	3
Number of Approved Centres	St. Fintan's Hospital, Portlaoise Department of Psychiatry, Midland Regional Hospital, Portlaoise
Specialist Teams	Rehabilitation Psychiatry of later life
Per Capita Expenditure 2008 [>18 Years]	Total expenditure 23,948,000 euro
Date of Meeting	8 April 2009

Service 2009

Description of Service

Laois Offaly Mental Health Services provided acute care in the Department of Psychiatry, Portlaoise, community mental health services through three sector teams, and continuing care and rehabilitation in St. Fintan's Hospital in Portlaoise, which had two wards remaining. There was a rehabilitation team and a psychiatry of later life team in place.

Progress on Recommendations from the 2008 Report

1. *Any refurbishment work should be completed.*

Outcome: There were a number of refurbishments outstanding for which funding was awaited.

2. *The approved centre at the Department of Psychiatry, Portlaoise, should develop multidisciplinary care plans as described in the Regulations.*

Outcome: This had not been achieved.

3. *The occupational therapy input to the Department of Psychiatry should be restored.*

Outcome: There was now an occupational therapist in the Department of Psychiatry.

4. *Documentation regarding ECT for voluntary patients should be reviewed.*

Outcome: The standard of ECT, including documentation, was excellent.

Outline of Local Health Service Plan 2008–2009

The local health service plan stated that the existing level of service should be maintained.

Developments 2008–2009

- An upgrade of Birr Community Mental Health Centre was in progress.
- A day centre in Rathdowney was due to open in September 2009.
- A rehabilitation/recovery unit called Link Centre was opened in March 2009.

Hospital Closure Plans

In the absence of any funding for the closure of St. Fintan's Hospital, there had been no further progress.

Service User Involvement

Peer Support/Advocacy

The amount of information provided to service users with respect to Article 20 of the Regulations for approved centres was good. A member of the Irish Advocacy Network (IAN) attended both approved centres weekly and notices about advocacy services were displayed on notice boards. Voluntary groups such as Grow and SHINE held meetings in the approved centres regularly. Access to advocacy training for service users was not available. The provision of advocacy services was not underpinned by policy. The advocacy team provided an annual report. An advocacy service for psychiatry of later life was being developed.

Services users, through IAN, reported that staff were friendly and helpful although it was felt by residents that they did not have enough time with their consultants. Staff were reported to be positive towards the advocacy service. Female service users said that they were kept in their night clothes for too long following admission. Service users reported insufficient activities and limited access to talking therapies.

Service User Participation

As there was no care plan in operation, residents were not formally involved in the planning, implementation, evaluation and review of their own care and treatment. Service users were not involved in the development and planning of the local mental health service, research, training or education. There was no policy on service user involvement in the service. There were no ongoing arrangements to monitor performance with regard to service user involvement within the mental health service.

The psychiatry of later life team had established a multidisciplinary carers support group. The Lighthouse Club was an out-of-hours social networking unit run by service users in conjunction with IAN. There was also the Finding Your Way to Recovery group, which was a joint initiative between mental health social work, primary care social work, and SHINE. This was delivered in a community setting and was led by a service user.

Governance

The management team remained tripartite and was not multidisciplinary. There was a multidisciplinary catchment team that had met once in the last 12 months.

Mental health assessment tools had been introduced to support clinical practice and to provide standardised assessments. There was an ongoing patient satisfaction survey. Seclusion and ECT audits were planned.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	8
NCHD	8
Specialist registrar	1

Nursing Staff

Post	WTE in post
DON	1
ADON	4.75
Nurses based in in-patient services	79.62
Nurses based in community residences	20.58
Community mental health nurse	16.21
Nurses based in day hospitals	8.43
Nurses based in day centre	10.46

Nursing Specialist Posts

Speciality	WTE in post
Liaison	3.9
Clinical placement coordinators	1
Nurse practice development coordinator	0.5
Counsellors	4.5
Advanced nurse practitioner	1
Other	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3.66
Social work	3.5
Occupational therapist	4
Art therapist	1
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation and continuing care
Population	137,927

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	0.5
Dedicated team coordinator	1	1
ADON	1	1
CMHN	2	2
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	3	3
Community residence staff	20.58	20.58

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	Yes	Yes

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	137,927

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1.5	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.75	0.75
CMHN	4.57	4.57
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	1	1
Day facility nurse staffing	1.82	1.82

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Yes	Yes
Day centre	No	No

In-Patient Facilities

Acute services were provided in the Midland Regional Hospital in a new unit. This unit was in good condition.

The continuing care and rehabilitation services were provided in St. Fintan's Hospital. Some structural and decorative work was required in the units in this hospital.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The service continued to be in breach of the Articles governing care planning and therapeutic activities and considerable effort was required to achieve compliance.

St. Fintan's Hospital required decoration and structural work. There were no health and social care professionals in the units (in particular occupational therapists) to provide therapeutic activities.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service was in compliance with all Rules.

Codes of Practice

The service was compliant with all Codes of Practice.

Multidisciplinary Care Planning

It was disappointing to note that there had been little progress in introducing care planning to the service although there were excellent nursing care plans. The health and social care professionals had not been involved in developing a template for care planning. There appeared to be no coherent reason for the delay and the service was still some considerable distance from achieving even basic care planning. While continuing care and rehabilitation residents had care plans, some were not completed. Team meetings were held regularly in each unit.

24-Hour Supervised Community Residences

Description

There are two 24-hour supervised community residences, both of which had a large number of beds.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Erkina House, Rathdowney	17	16	Rehabilitation Continuing care	MDT care plan
Birchwood House, Tullamore	14	13	Rehabilitation Continuing care	MDT care plan

Conclusion

Laois/Offaly Mental Health Services had a number of positive aspects. There was strong commitment to providing a community service as well as a rehabilitation service. A number of community facilities were being upgraded. It was therefore disappointing that there had been little progress in care planning in the Department of Psychiatry.

Recommendations and Areas for Development

1. *The Department of Psychiatry must introduce care planning as a matter of urgency.*

2 . *Refurbishments in St. Fintan's Hospital should be completed.*

Mental Health Services 2009
Catchment Area Report
Longford Westmeath

HSE Area	HSE Dublin Mid Leinster
Catchment	Longford/Westmeath
Mental Health Service	Longford/Westmeath Mental Health Services
Population	116,000
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	Psychiatry of later life Community alcohol and drug service Psychiatric liaison
Per Capita Expenditure 2008 [>18 Years]	116.00 euro
Date of Meeting	28 May 2009

Service 2009

Description of Service (Including Distinct Features)

The Longford/Westmeath catchment area had one approved centre in St. Loman's Hospital, Mullingar, consisting of six wards spread over three buildings. It had 25 beds for enduring mental illness, 46 beds for elderly care, and 44 beds for acute psychiatry. The service covered three catchment areas: Longford, Athlone, Mullingar and parts of the Meath area with a total population of 116,000. There were three specialist teams: psychiatry of later life, community alcohol and drugs service, and psychiatric liaison.

Progress on Recommendations from the 2008 Report

1. *Each resident must have a care plan as defined in the Regulations.*

Outcome: The service was at an advanced stage of finalisation of the individual care plan.

2. *Therapeutic services and programmes must be linked to the individual care plan.*

Outcome: This had not been achieved.

3. *The unsuitable conditions on the wards in St. Brigid's block, St. Anne's Ward and St. Edna's Ward must be addressed. Funding should be made available to refurbish or replace these wards.*

Outcome: St. Claire's Ward had closed. Residents remained living in unsuitable conditions on St. Edna's Ward, St. Anne's Ward, St. Brigid's Ward and St. Marie Goretti Ward.

4. *Each resident must have equal access to health and social care professionals based on assessed needs and funding should be made available to facilitate this. There must be an appropriate skill mix in place to meet these needs. Residents under the care of the psychiatry of later life team should have access to the team's occupational therapist on the units.*

Outcome: This had not been achieved.

5. *Increased coordination of the household functions in the approved centre would be of benefit in addressing the challenge presented by the age and layout of the premises.*

Outcome: The challenge presented by the age and layout of the premises was sizeable.

Outline of Local Health Service Plan 2008–2009

The service had a capital development plan, which was examined by the Inspectorate. It was to be financed by the sale of hospital lands. However, the service reported that funds raised by the sale of 6.75 hectares (16.75 acres) of hospital land were not put back into the local mental health service, undermining any hope the service had of commencing its capital development plan.

It continued to be of concern to the Inspectorate that residents remained accommodated, cared for and treated in such unsuitable premises and that this situation was likely to continue as no funding had been made available by the HSE to rectify the situation.

Developments 2008–2009

- The psychiatry of later life team had introduced a later life database. The addition of a 0.5 whole-time-equivalent consultant in psychiatry of later life had reduced the waiting list to an average of two weeks.
- Longford sector was piloting a personality disorder therapeutic service which involved assessment of potential service users with borderline personality disorders. The overall aim of the programme was to provide a theoretical outline of personality disorders and treatment issues, and where appropriate, to teach specific skills and encourage the improvement of clinical practice.
- The closure of St. Claire's Ward.
- Reduction in bed numbers from 120 to 115.
- In the absence of a rehabilitation team, a temporary half-time consultant psychiatrist and a half-time CNM3 post had been assigned to oversee the placement of residents. Funding for this post, which had not been approved, had been withdrawn.
- Care planning had been introduced to all sectors.

Hospital Closure Plans (Where Applicable)

The service had developed a capital development plan, which was examined by the Inspectorate and was to be financed by the sale of hospital lands. As indicated above, the proceeds of selling hospital lands had been diverted from the mental health service, undermining any hope the service had of commencing its capital development plan.

Service User Involvement

Peer Support/Advocacy

The peer advocate representative reported that peer advocacy was welcomed and encouraged by staff.

There was a positive attitude from staff in St. Loman's Hospital, Mullingar, in promoting *A Vision for Change*.

Residents who attended the activation unit found it a great help with their recovery.

Residents in the acute units thought an open air outside garden would be a welcome addition.

Service User Participation

The local advocacy representative joined the catchment management team four times a year. It was planned to offer the advocacy representative a permanent place on the team.

Governance

Quality Improvements (Audits and Reviews)

- The liaison psychiatry team had completed collaborative research with the Mater Hospital liaison group.
- An audit on incomplete admission orders was presented at the Royal College of Psychiatrists meeting.
- The community alcohol and drug service had updated its under-18 protocol.
- The community alcohol and drug service presented a poster to the Royal College of Psychiatrists, Amsterdam, on the follow up of substance misuses referred from liaison psychiatry.
- Nursing and medical participation at GP awareness evenings, which involved the sharing of information between primary and secondary care in the Mullingar sector.
- Turas Programme, a tripartite initiative in the Mullingar sector, was set up involving Mullingar community health team, the National Learning Network, and the training organisation Aontacht Phobail Teoranta (APT) in Tullamore.
- A quarterly client review of day centre programme occurred in the Longford sector.
- There had been concordance skills training for staff, outlining a pragmatic way for mental health professionals to talk to service users about their medication, promoting their involvement in decision-making and seeking to develop their skills in dealing with their own illness.
- The multidisciplinary management team were meeting on a monthly basis.
- A drugs and therapeutic committee had been established.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7.5
NCHD	10
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	116.79
Nurses based in community residences	37
Community mental health nurse	5
Nurses based in day hospitals	8
Nurses based in day centre	7.93
Rostered student nurses	15

Nursing Specialist Posts

Speciality	WTE in post
Liaison	2
Clinical placement coordinators	1
Nurse practice development coordinator	0.5
Counsellors	5.82
Advanced nurse practitioner	0
Other	9.95

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4
Social work	3.6
Occupational therapist	3
Art therapist	0
Psychotherapist	0.57

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	113,737

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1.5	1.5
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.2	0.2
CMHN	4.8	4.95
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Day facility nurse staffing	2	2
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Owned	Owned
Day centre	Owned	Owned

Liaison Team Report

Team Description	Psychiatric consultation liaison service
Population	113,737

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0.3	0.3
NCHD (including specialist registrar)	0.3	0.3
Dedicated team coordinator	0	0
CMHN	2	2
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not applicable	Not applicable
Day centre	Not applicable	Not applicable

Community Alcohol and Drug Team Report

Team Description	Community alcohol and drug service
Population	113,737

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	1	1
ADON	0.2	0.2
CMHN	4.82	4.82
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Not applicable	Not applicable
Day centre	Not applicable	Not applicable

In-Patient Facilities

St Loman's Hospital, Mullingar, consisted of six wards spread over three buildings. The male and female admission wards, located within a stand-alone structure built in the 1940s on the hospital campus, had been refurbished a few years before and were in good decorative condition. St. Brigid's Ward and St. Marie Goretti Ward were located in an older building opened in 1938 and were in need of immediate refurbishment. The main building, a granite-grey sprawling edifice opened in 1847, retained two wards: St. Edna's Ward and St. Anne's Ward, which continued to accommodate residents. The Inspectorate remained concerned at the continued use of these wards, which were dilapidated, desolate and depressing, and unsuitable for accommodation and the provision of care and treatment of residents. The cost of refurbishment of the buildings was complicated by the presence of asbestos on some of the wards which incurred a significant financial cost to remove it safely. The physical layout and condition of the latter two buildings provided an ongoing challenge for household and maintenance personnel and required a well coordinated response.

Despite the poor physical environment for residents, visitors and staff, the Inspectorate noted the considerable progress made since the last inspection in relation to clinical practice through increased compliance with the Regulations, Rules and Codes of Practice. It was evident from meetings with management, staff and residents that the service was striving to improve the care and treatment provided to residents, in the context of having no additional funding to rectify deficits or plan for the future, and staff losses arising from HSE recruitment embargo. The Inspectorate was informed that nursing staff shortages in particular have led to a significant overtime budget and associated impact on continuity of care despite a core group of staff being allocated to specific wards, and significant difficulties releasing staff for training, some of which is mandatory training under the Mental Health Act 2001.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

St. Loman's Hospital, Mullingar was fully compliant with 24 of the Regulations for approved centres and substantially compliant with four, while compliance had been initiated with one. However, the approved centre was not compliant with two Articles: Premises and Staffing.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

In the Rules governing the use of seclusion, the approved centre was not compliant with sections 2.10, 6.3, 10.1, and 10.2.

In the clinical file of one resident there was no documentary evidence that the resident's next of kin had been informed of the resident's seclusion and the reason for not informing them was not documented.

There was no documentary evidence in the clinical file, following the ending of seclusion, that the resident had been afforded the opportunity to discuss the episode of seclusion.

The approved centre had no policy and procedures for staff training in relation to seclusion.

The mandatory training for the Rules and Codes of Practice for medical staff was being fulfilled and a register of attendance was maintained.

Codes of Practice

In the Code of Practice regarding the use of physical restraint, the approved centre was not compliant with sections 7.1 and 7.2.

The approved centre had no policy and procedures for staff training in relation to physical restraint.

A record of attendance at training was not maintained as no staff had received training in physical restraint.

The service was also not compliant with the Code of Practice relating to the admission of children in sections 2.5 (b), 2.5 (e), and 2.5 (g).

Multidisciplinary Care Planning

There were three sector teams and three specialist teams: a Psychiatry of Later Life team, a Community Alcohol and Drug Service team and a Psychiatric Liaison team. There was a need for a fully-resourced Rehabilitation team. A multidisciplinary care planning approach had been introduced to the three sectors and specialist teams, however a system for designation of key workers was proving difficult to implement.

24-Hour Supervised Community Residences

Description

There were three 24-hour staffed community residences, one in each sector. All three were under the direction of their respective General Adult teams.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ashford House, Longford	14 (including 1 respite bed)	15	General adult	MDT
Edgewater, Mullingar	13 (including 1 respite bed)	13	General adult	MDT
Glenavon, Athlone	12 (including 2 respite beds)	12	General adult	MDT

Conclusion

The Longford/Westmeath mental health services were provided through three sector teams and three specialist teams. A care planning approach had been introduced but needed to be followed through by using multidisciplinary key workers.

The majority of mental health services at St. Loman's Hospital, Mullingar, were provided in areas that remain of concern to the Inspectorate. These wards, which were dilapidated, desolate and depressing, were unsuitable for the accommodation and the provision of care and treatment of residents.

The service had developed a capital development plan that was to be financed by the sale of hospital lands. However, the service reported that funds raised by the sale of hospital land were not ring-fenced for return to the local mental health service, thus scuppering any hope the service had of commencing its capital development plan.

Despite the poor physical environment for residents, visitors and staff, the Inspectorate noted the considerable progress made since the last inspection in relation to clinical practice through increased compliance with the Regulations, Rules and Codes of Practice. It was evident from meetings with management, staff and residents that the service was striving to improve the care and treatment provided to residents, in the context of no additional funding to rectify deficits or plan for the future, and staff losses arising from the HSE recruitment embargo.

Recommendations and Areas for Development

1. *St Brigid's, St. Edna's, St. Marie Goretti and St. Anne's wards were in poor condition and should be decommissioned as a matter of urgency.*

2. *The psychiatry of later life team should have access to clinical psychology services.*

3. *The multidisciplinary care planning approach introduced to the sector teams and specialist teams needs to be fronted by a designated multidisciplinary key worker.*

4. *There is an urgent need for an occupational therapy service for St. Loman's Hospital, to provide assessments and facilitate therapeutic activities for residents.*

Mental Health Services 2009
Catchment Area Report
South County Dublin

HSE Area	HSE Dublin Mid Leinster
Catchment	South County Dublin
Mental Health Service	Cluain Mhuire Service
Population	175,000
Number of Sectors	3 multidisciplinary teams (not sectorised)
Number of Approved Centres	Contract for beds in St. John of God Hospital
Specialist Teams	Liaison Early intervention for psychosis (DETECT)
Per Capita Expenditure 2008 [>18 Years]	14.7m euro [sic]
Date of Meeting	29 October 2009

Service 2009

Description of Service (Including Distinct Features)

The Cluain Mhuire service had a population of 175,000 and was in South County Dublin. It had no approved centre but had a contract for service with St. John of God Hospital for all admissions that were managed by the Cluain Mhuire sector teams. There was a liaison team serving a wider population and an early intervention for psychosis team both of which serve the wider population of Wicklow and Elm Mount mental health services in addition to the Cluain Mhuire services. There was no rehabilitation team. The psychiatry of later life service was delivered from St. Vincent's University Hospital. There was one 24-hour supervised residence. The catchment area was not sectorised due to the small geographical size but there were three multidisciplinary community teams. There were two consultants on each team.

Progress on Recommendations from the 2008 Report

1. *There should be an occupational therapist on each team.*

Outcome: The recruitment of two occupational therapist had gone some way to progressing this but there was still no occupational therapist on each team.

2. *There should be a specialty team appointed for rehabilitation.*

Outcome: There had been no progress on this recommendation.

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

Outcome: There had been no progress on this recommendation.

Outline of Local Health Service Plan 2008–2009

The local health service plan included:

- Increased occupational therapy staffing and having an occupational therapist on each team.
- Developing a rehabilitation and assertive outreach team.

- Acquiring adequate funding to secure the long-term viability of the regional early intervention service in psychosis.
- Development of an acute day hospital team for 2010.

Developments 2008–2009

- A new day hospital had opened in the Centre for Living in Blackrock. It included an acute psychosis stream. Twenty-eight people attended each day for targeted interventions.
- The community nurses now operate from 0900h to 2000h seven days a week. This service was due to be reduced due to resource problems.
- The Suicide Crisis Assessment Nurse (SCAN) pilot project had been extended to the three multidisciplinary teams.
- There was a reduction in beds contracted from St. John of God Hospital.
- Elvira Gate on the Burton Hall campus was a new development that offered improved recovery programmes. This included a REFRESH rehabilitation programme and a local team base for community mental health nurses. It also included a thrift shop and an information and resource centre, both of which were run by service users.
- The social work department run the following programmes: a Wellness Recovery Action Plan (WRAP) group; a wellness support group for mothers at risk of post-natal depression emotionally unstable personality disorder; a family information and skills group; a support group for children of parents with mental illness; a parenting skills group, a family and carers psycho-education and skills group; a recovery workshop; and a Managing Your Relationships workshop as part of the Centre for Living and REACH programmes.
- The psychology department offered the following programmes: Dealing with Depression (coping with depression), first episode psychosis, cognitive behavioural programme for obsessive compulsive disorder, dialectical behaviour therapy skills group, emotions group and mindfulness-based stress management group.
- REACH was a 21-week psychosocial programme funded by FÁS with a FETAC Level 3 qualification. Fifty per cent of attendees moved to mainstream employment and fifty per cent continued to Level 4. Forty per cent of those attending this service were from outside the catchment area.

Service User Involvement

Peer Support/Advocacy

The Irish Advocacy Network (IAN) visited St. John of God Hospital weekly. It was hoped to extend this service to the community services in the near future. The service users indicated that they found the staff in the hospital easy to talk to, the quality of the food was good and the renovations in the hospital were welcomed. Service users spoke highly of occupational therapy. Some service users complained of boredom in the evenings and at weekends. They also felt that they did not have enough information about medication. They also complained about lack of time spent with their consultant psychiatrists.

Participation in the Delivery of Mental Health Services

The Service User Research Committee (SOURCE) scrutinised research projects from a service user's point of view. A new service user resource and information centre had been opened at Burton Hall and was staffed by service users and volunteers. SOURCE had reviewed the DETECT programme and written material available for service users.

The service had been undertaking regular satisfaction surveys and these were now undertaken by SOURCE.

There was service user participation in all planning committees. They were encouraged and supported in their participation in education programmes.

Governance

Quality Improvements (Audits and Reviews)

The senior management team was not multidisciplinary. There were regular quarterly meetings with heads of discipline. It was proposed to set up a formal clinical governance committee by the end of 2009. The multidisciplinary clinical audit committee met bi-monthly and audits were presented from the multidisciplinary teams. Audits had included psychotropic medication and monitoring side-effects, access to service, physical tests and monitoring, and GP satisfaction.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7.5
NCHD	11 including 3 DETECT and 1 research
Specialist registrar	5

Nursing Staff

Post	WTE in post
DON	1
ADON	0
Nurses based in in-patient services	0
Nurses based in community residences	7
Community mental health nurse	10.53
Nurses based in day hospitals	5.25
Nurses based in day centre	5
Temporary staff panel	2

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	0
Advanced nurse practitioner	0
Other	1.5

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5.9
Social work	7.3
Occupational therapist	4
Art therapist	Sessional
Drama therapist	Sessional

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

DETECT Team Report

Team Description	Early intervention for psychosis
Population	350,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	3	3
Dedicated team coordinator	1	1
ADON	0	0
CMHN	1.5	1.5
Clinical psychologist	0.5	0.5
Social worker	0.5	0.5
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Headquarters	Avila House	Avila House
Day centre	0	0

Liaison Team Report

Team Description	Liaison team covering St. Michael's Hospital, Dun Laoghaire, and St. Colmcille's Hospital, Loughlinstown
Population	

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0	0
CMHN	1	1
Clinical psychologist	1	1
Social worker	1	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0

In-Patient Facilities

Cluain Mhuire services did not have an approved centre. All in-patient care was accessed as required from St. John of God Hospital where Cluain Mhuire teams continued to provide in-patient treatment.

Multidisciplinary Care Planning

There was a template for care planning currently in use on the Mental Health Information System (MHIS). There were dedicated care planning meetings. Care planning was done with the service user. There was a detailed formal residential care plan in the 24-hour supervised residence.

24-Hour Supervised Community Residences

Description

There was one 24-hour supervised residence in Stillorgan. It had 21 beds. Each resident had a care plan. There was some movement through the unit in that about five places were available each year. There were no medium support residences and discharges were to low support and independent living.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Oropesa	21	21	Community mental health teams	MDT

Conclusion

The Cluain Mhuire services are a strongly community-based service and have recently opened a new day hospital. They are also orientated to service user involvement and service user participation is evident in many programmes and in care planning. The DETECT programme remains an important service for early intervention in psychosis. Their information system is excellent and the service has moved from a paper base to a computerised service. There are continuous audits and the social work and psychology departments offer a wide range of services.

Recommendations and Areas for Development

1. *There should be an occupational therapist on each community team.*

2. *The senior management team should be multidisciplinary.*

HSE South

Mental Health Services 2009 Catchment Area Report Carlow/Kilkenny

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	Psychiatry of later life Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	12 November 2009

Service 2009

Description of Service (Including Distinct Features)

The Carlow/Kilkenny catchment area had access to a total of 151 hospital beds comprising 44 acute, 24 in psychiatry of later life, 66 rehabilitation and 17 learning disability beds. The services were situated in three approved centres across the two counties. A new purpose-built unit housed people with learning disability. In addition, the service had 155 places in 24-hour staffed community residences.

Progress on Recommendations from the 2008 Report

1. *The rehabilitation team should be fully resourced with an appropriate skill mix of staff to ensure that it can provide more than assessment.*

Outcome: This had not been done.

2. *The community mental health teams must be resourced in line within national mental health policy.*

Outcome: This had not been done. A project group had been set up to formulate a manpower group with a 2–3 year time frame.

Outline of Local Health Service Plan 2008–2009

Seventeen residents in St. Anne's Ward in St. Dympna's Hospital were transferred to Kelvin Court, a new purpose-built development for people with learning disability. This had facilitated the closure of St. Anne's Ward.

Plans to relocate 17 residents from St. Marys Ward in St. Dympna's Hospital were delayed due to staff on leave not being replaced. Families had been contacted and the proposed move had been discussed with them.

Staff planned to carry out assessments of the residents of St. Patrick's Ward in St. Dympna's Hospital, with the intention of moving people who would benefit to the rehabilitation unit. Similarly assessments were to be carried out for the 16 residents of St. Luke's Ward in St. Canice's Hospital.

A new 8-place 24-hour staffed residence was opened on 10 November 2008 in Carlow to facilitate residents discharged from rehabilitative care.

Developments 2008–2009

- Staff were contributing to a multi-agency domestic abuse programme.
- Multidisciplinary care plans incorporating the Sainsbury Centre for Mental Health risk assessment tool had been piloted and were due for further evaluation. Training had been conducted in their use and they were being implemented, albeit unevenly, throughout the service. The acute unit and St. Dympna's Hospital were more successful in this regard than St. Canice's Hospital was.
- The excellent ORCHID information project had been further developed to include St. Canice's Hospital. A new information officer had been appointed. A service user had been involved in the project.
- Therapeutic groups had been developed in the day hospital to include mindfulness, assertiveness training, and anxiety management.
- Post-discharge groups, including a women's support group, had been initiated in a community setting.
- A multidisciplinary eating disorder programme had been initiated. Staff reported that service users were adversely effected by the withdrawal of the dietetic service.
- The Greenbanks crisis house had reduced admissions from the Carlow area.

Hospital Closure Plans (Where Applicable)

Staff reported that St. Canice's Hospital was due to close at the end of 2010, with the exception of psychiatry of later life services, which would remain for Carlow and Kilkenny. Multidisciplinary assessments with the help of social care professionals from other teams were in progress to facilitate this. Assessments of residents in the last remaining ward, St.Luke's, are underway. It was expected that St. Mary's Ward would close early in 2010.

Plans were in place to close St. Dympna's Hospital. St. Anne's Ward closed in February 2009. It was expected that St. Mary's Ward would close towards the end of 2009 and residents would be accommodated in nursing homes. One ward, St. Patrick's, would remain.

Service User Involvement

Peer Support/Advocacy

A representative from the Irish Advocacy Network (IAN) provided support on a regular basis, or by request, to the approved centres, day hospitals and hostels within the catchment area. The advocate reported that a monthly service user meeting with staff had been well received.

However, clients had reported to the advocate that they do not know who their primary nurse or key worker is. They reported that they were frightened on admission and would like more time to be introduced to staff and residents.

Representatives from SHINE were interested in developing an induction pack for residents.

A focus group had been conducted with service users who had attended the service for a number of years. Most discussion concerned the in-patient unit and traumatic events that had occurred on the ward, e.g. dealing with outbursts by other residents. Staff identified a need to develop protocols for handling such events.

A service user and carer were involved on the steering group of the ORCHID Information programme.

A social work team leader who was a member of the multidisciplinary management team had been designated to act as a support to the advocate whose concerns were then fed back to the team meeting.

Service User Participation

Service users were encouraged to participate in the formulation of multidisciplinary care plans and the review of such plans.

A representative of the IAN attended the clinical governance group but not the multidisciplinary management meeting. Contact had been made with the IAN to address this.

Governance

Quality Improvements (Audits and Reviews)

A clinical governance committee is in existence and reports to a multidisciplinary management group that meets fortnightly. A number of groups had been established to support this structure including a clinical incident review group, risk management group, policies development group, multidisciplinary care planning group and a steering group for the development of plans for long-stay wards.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7
NCHD (including specialist registrar)	11.5

Nursing Staff

Post	WTE in post
DON	2
ADON	4
Nurses based in in-patient services	78
Nurses based in community residences	104
Community mental health nurse	15
Nurses based in day hospitals	6
Nurses based in day centre	9
Other – Temporary Staff Panel	40

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1
Clinical placement coordinators	2
Nurse practice development coordinator	1
Counsellors	4
Advanced nurse practitioner	0
Systemic Family Therapy	4
Other	5

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3
Social work	3.8
Occupational therapist	4
Art instructor	Not provided
Other	–

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Specialist Team Report

Team Description	Rehabiliation Service
Population	120,726

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	1	2
CMHN	1	1
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	5.75	6
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	St. Canice's Hospital	Owned
Day centre	Clann Nua	Shared

In-Patient Facilities

The acute unit in St. Luke's Hospital, Kilkenny, was a modern bright unit, with well maintained gardens and facilities. The staff were enthusiastic and had worked hard over recent years to bring about changes to improve services, e.g. service information resources and multidisciplinary care plans. Five sector teams, along with the rehabilitation team and the psychiatry of later life team, admit to the 44 beds.

There were plans in place to close St. Dympna's Hospital, Carlow, and move the remaining residents to more appropriate accommodation. Seventeen residents with learning disability had been moved to a purpose- built facility at Kelvin Court, reducing the in-patient beds to 36.

St. Canice's Hospital provided continuing care. Multidisciplinary plans were not operating evenly and staff reported that the absence of the rehabilitation consultant was affecting the operation of the plans. The nursing staff worked hard to provide good quality care to a mainly elderly population. It was planned to close one ward in this hospital and retain one ward under the care of psychiatry of later life team.

Statutory Requirements for Approved Centres

There was generally a high level of compliance with the Regulations, Rules and Codes of Practice. The exceptions to full compliance are outlined below.

Regulations (S.I. 551 of 2006)

St. Canice's Hospital

Compliance initiated: Article 15 (Care Planning) – Multidisciplinary care plans had not been introduced to St. Luke's Ward.

Compliance initiated: Article 26 (Staffing) – There were insufficient health and social care staff in the service.

Substantial compliance: Article 16 (Therapeutic Activities).

Substantial compliance: Article 22 (Premises).

Department of Psychiatry, Kilkenny

Substantial compliance: Article 26 (Staffing).

St. Dympna's Hospital

Substantial Compliance: Article 6 (Food Safety) – A food safety report from 2009 indicated some areas that needed attention.

Substantial Compliance: Article 22 (Premises) – Although generally well maintained there were some areas of dampness and condensation.

Substantial Compliance: Article 27 (Maintenance of Records) – one file examined was not in keeping with the regulations.

Substantial Compliance: Article 32 (Risk Management) – The policy was undated.

Compliance initiated: Article 26 (Staffing) – There were insufficient health and social care professionals.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

St. Canice's Hospital

Mechanical Restraint: The service was non compliant with Section 21 as the duration of restraint was not recorded in the notes.

Codes of Practice

Department of Psychiatry, Kilkenny

Admission of Children: The service was not compliant with the Code of Practice in relation to the admission of children.

Multidisciplinary Care Planning

A multidisciplinary care planning group facilitated the development of pilot plans and their evaluation in the approved centres. Staff were trained in their use and an audit showed they were being implemented. The exception was St. Lukes Ward in St.Canice's Hospital, which suffered because the consultant was on leave and was not replaced. In spite of this, however, the service user advocate pointed out that residents complained of confusion as to the identity of their treating team.

24-Hour Supervised Community Residences

Description

The service operated 14 supervised residences, four of which were for people with an intellectual disability. One of the houses functioned as a crisis house. In all, there were 155 places in these residences. The service had established a group to examine the residences with a view to implementing the recommendations of *A Vision for Change*.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Altamont Hostel	13	13	Rehabilitation Kilkenny North Kilkenny West Kilkenny East	Nursing care plan
Lismore	10	9	Rehabilitation	Nursing care plan
Kincora Hostel	14	13	Rehabilitation	Nursing care plan
Mount Lacken Hostel	10	10	Rehabilitation	Nursing care plan
Millenium Court Hostel	7	7	Rehabilitation	Nursing care plan
Caomhnú	21	18	Rehabilitation	Nursing care plan
Alcantra	9	9		Nursing care plan
Park Lodge	9	9	Rehabilitation	Nursing care plan
Court View Hostel	8	7	Rehabilitation	Nursing care plan
65 Beechwood Drive	9	9	Rehabilitation	Nursing care plan
Sacred Heart	8	8	Carlow North	Nursing care plan
75 Elm Park Drive	8	6	Rehabilitation	Nursing care plan
Greenbanks	12	6	North/South and Rehabilitation	Nursing care plan
Kelvin Court	17	17	General Adult	Nursing care plan

Conclusion

The service in the Carlow/Kilkenny catchment area continues to improve facilities and care for its service users. Closure plans for St. Dympna's Hospital are progressing and a further ward was closed in 2009. There were a number of developments in service provision with the introduction of theraputic groups and the ORCHID Project in the community. The Local Health Service Plan had focused on assessing residents and identifying more suitable residences for each individual.

All three approved centres performed well on inspection during 2009. The Inspectorate also inspected the day hospital at St. Dympna's Hospital and made a number of recommendations to improve its use. An inspection of the new accommodation unit of Kelvin Court was also carried out. Although the residence provides an excellent facility for the residents, the lack of an intellectual disability specialist team limits the effectiveness of the good accommodation.

Closure plans for St. Dympna's are advanced, and plans for St. Canice's provide for the retention of one ward there.

Recommendations and Areas for Development

1. *All teams should be fully staffed in terms of multidisciplinary members.*

2. *Closure plans for St. Dympna's Hospital should continue to be implemented.*

3. *In view of the reported unavailability of services from the local voluntary service for intellectual disability, consideration should be given to providing an intellectual disability specialist team for the catchment area.*

Mental Health Services 2009
Catchment Area Report
Kerry

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
Per Capita Expenditure 2008 [>18 Years]	240,984 euro [sic]
Date of Meeting	17 June 2009

Service 2009

Description of Service (Including Distinct Features)

The mental health services in Kerry served a population of 139,835 and for the purposes of service delivery the county was divided into five sectors. The service was delivered in a combination of community-based facilities located in each sector, including outpatients clinics and community day services, with shared in-patient facilities in the form of 44 acute admission beds at Kerry General Hospital and 58 continuing care beds at St. Finan's Hospital in Killarney.

Progress on Recommendations from the 2008 Report

1. *Community mental health services should be implemented.*

Outcome: A steering group and three sub-groups had been developed for the implementation of Vision into Action, the Kerry Local Health Office strategic plan for the implementation of *A Vision for Change*.

2. *St. Finan's Hospital should close.*

Outcome: Design briefs for the facilities identified for the closure of St. Finan's Hospital had been submitted and were awaiting approval for funding.

3. *A psychiatry of later life team should be developed.*

Outcome: This had not been achieved.

Outline of Local Health Service Plan 2008–2009

That future service delivery in Kerry will be orientated through a planned process from institutional care to alternative community mental health services that are delivered safely and effectively, as outlined in the Vision into Action strategy.

The service had submitted plans for the closure of St. Finan's Hospital, the building of 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. The plan was dependant on capital funding.

Developments 2008–2009

- The local mental health strategy Vision into Action had been signed off.
- The strategy subgroups were in the process of addressing human resources, training and organisational change.
- Mental health sector boundaries were aligned with primary care.
- The number of personnel in the rehabilitation team had been expanded.
- Two permanent consultant psychiatrists had been appointed to sector teams.
- A purpose-built 24-hour community residence was about to be handed over to the service to replace Cherryfield.

Hospital Closure Plans (Where Applicable)

St. Finan's Hospital was a mid-nineteenth century Victorian hospital which still accommodated three wards within it, with two others remaining on campus. The service had submitted plans for the closure of St. Finan's Hospital, the building of 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. The plan was dependent on capital funding.

St. Paul's Ward, St. Peter's Ward and St. Martin's Ward were in need of complete refurbishment and were not suitable for habitation by residents, nor for the provision of care and treatment to those residents.

The number of beds in the Department of Psychiatry, Kerry General Hospital, had been reduced from 50 to 44. The plans to reassign appropriate staff to the community following the reduction in beds had been caught up in industrial relations issues.

Service User Involvement

Peer Support/Advocacy

Department of Psychiatry, Kerry General Hospital: The service user advocate described as a positive development the refurbishment and decorating of the Department of Psychiatry in Kerry General Hospital. The development of the computer room was also a positive sign. The sensory garden had been opened and had been a welcome addition to the unit. Increased one-to-one nursing interventions had proved another positive development. The continuing transfer of residents from Kerry General Hospital to St. Finan's Hospital was of concern to service users.

St. Finan's Hospital, Killarney: This approved centre was viewed as unsuitable for residents. An occupational therapy post had been lost and not replaced. It was reported that dormitories were locked during certain hours to encourage residents to attend therapies. It was reported that some residents who were experiencing the effects of medication were prevented from lying on their beds for this reason.

Service User Participation

There was no service user representation on the multidisciplinary team catchment area meeting. There was service user participation on Vision into Action sub-groups. A service user representative on the local clinical governance committee had been proposed and accepted.

Governance

Quality Improvements (Audits and Reviews)

Revised arrangements for clinical governance had been proposed as an integral part of the Vision into Action mental health strategy. The terms of reference for this were consistent with the HSE Quality and Risk agenda and the Mental Health Commission's Quality Framework. This group will take the lead in developing audit and internal quality improvement and establish links to collate results across the region.

Local audits had been carried out by individual disciplines. Examples included: specialing, assisted admissions, educational and clinical placement audits and clinical risk in the acute unit.

It was envisaged that the clinical governance group would offer an opportunity to undertake these audits more systematically and on a multidisciplinary team basis.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	7
Specialist registrar	3

Nursing Staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	134
Nurses based in community residences	56.5
Community mental health nurse	12
Nurses based in day hospitals	6
Nurses based in day centre	10.5
Temporary staff panel	20

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	2
Nurse practice development coordinator	1
Counsellors	0
Advanced nurse practitioner	0
Enduring mental illness and therapeutic rogrammes	2

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3
Social work	3
Occupational therapist	3
Art therapist	0
Other	0

Specialist Mental Health Teams

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation
Population	139,835

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	Shared	Shared
CMHN	0	2
Clinical psychologist	0.4	0.5
Social worker	0.6	0.6
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	2	2
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	No	No

In-Patient Facilities

The acute adult mental health unit located in Kerry General Hospital comprised two wards, Reask Ward and Valentia Ward. Generally Reask Ward admitted service users from two of the community mental health teams (CMHTs) and Valentia admitted from the other three CMHTs. On the day of inspection, the door into and out of the unit was locked. The total number of beds had been reduced from 50 to 44.

St. Finan's Hospital, Killarney, was built in Victorian times in 1849 and was situated on an elevated prominence overlooking the town. Five wards continued to provide care and treatment to residents. Of these, St. Paul's Ward, St. Peter's Ward and St. Martin's Ward were in need of complete refurbishment and were not suitable for habitation by residents, nor for the provision of care and treatment to those residents. The other two wards, East Wing and West Wing, were separate from the main building, but on campus, and were undergoing complete refurbishment, the West Wing having been completed prior to the inspection. Although acute in-patient services were provided by the Department of Psychiatry in Kerry General Hospital in Tralee, St. Finan's Hospital continued to receive transfers of residents in acute distress who required more intensive care and treatment in a more secure and safe setting.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

Department of Psychiatry, Kerry General Hospital: The policy in relation to transfer of residents as required by Article 18(2) referred only to transfers to and from the secure units in St. Finan's Hospital. A policy on transfers to and from the acute unit was required. The Inspectorate was informed that residents were transferred from the acute unit only to one of the two secure wards in St. Finan's. However on the day of inspection, the Inspectorate team noted that at least two transfers had taken place to O'Connor East and West within the previous month.

St. Finan's Hospital, Killarney: The approved centre was in breach of Article 20 (Provision of Information to Residents), Article 21 (Privacy) and Article 22 (Premises).

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

Department of Psychiatry, Kerry General Hospital: Policies in relation to Rules must be reviewed annually.

St. Finan's Hospital, Killarney: On the day of the inspection, it was reported that the seclusion room in St. Peter's Ward was being used as a bedroom.

Policies in relation to Rules must be reviewed annually.

A number of residents required the use of lap belts and bed rails under Part 5: use of mechanical means of bodily restraint for enduring self-harming behaviour. In the prescription orders examined, the duration of usage was not documented. In the approved centre's own documentation for this use, the section for the date of review had not been completed.

Codes of Practice

Policies in relation to physical restraint in both centres must be reviewed annually.

The approved centres risk management policy must be amended to be compliant with the Code of Practice on notification of deaths and incident reporting.

Multidisciplinary Care Planning

Multidisciplinary care planning was operational in the rehabilitation team network. This involved service user input in pre-care planning with the key worker and in the planning meeting. A care plan was reviewed every six months by as many multidisciplinary team members as possible.

Multidisciplinary care planning at the Department of Psychiatry was operational.

The CMHT training and development programme – which was developed by the World Health Organisation and included provision to address areas such as case management – was designed to allow systems of care that would facilitate a CMHT care coordinator to develop and be responsible for review of care plans. This would also facilitate shared care with primary care in managing individuals with severe and enduring mental illness.

Multidisciplinary care planning in areas responsible for care of older persons was in need of development.

24-Hour Supervised Community Residences

Description

There were five community residences providing 24-hour care in the Kerry catchment area, with a total of 73 places. Four residences were under the care of the rehabilitation team while one, Writer's Grove in Listowel, was under the care of the North Kerry CMHT. Cherryfield was due to transfer to a new purpose-built residence.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Writer's Grove, Listowel	14	14	North Kerry CMHT	Nursing
Island View, Caherciveen	13	23	South Kerry CMHT	MDT
Teach an Chúraim, Rathmore	12	12	Rehabilitation	MDT
Killarden House	18	18	Rehabilitation	MDT
Cherryfield	16	16	Rehabilitation	MDT

Conclusion

St. Finan's Hospital was a mid-nineteenth century Victorian hospital which still accommodated three wards within, with two others remaining on campus. The service had submitted plans for the closure of St. Finan's Hospital, the building of 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. The plan was dependent on capital funding.

St. Paul's Ward, St. Peter's Ward and St. Martin's Ward were in need of complete refurbishment and were not suitable for habitation by residents, nor for the provision of care and treatment to those residents.

Recommendations and Areas for Development

1. *St. Finan's Hospital should close.*
2. *Funding should be made available for the development of the 4-bed high observation unit at the Department of Psychiatry, Kerry General Hospital.*
3. *The service is in need of a psychiatry of later life team.*
4. *Remaining multidisciplinary team vacancies on sector teams need to be filled.*

Mental Health Services 2009
Catchment Area Report
North Cork

HSE Area	HSE South
Catchment	North Cork
Mental Health Service	North Cork Mental Health Service
Population	80,795
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams	Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	15 April 2009

Description

Service Description

St. Stephen's Hospital was currently the headquarters for the North Cork mental health services, which served a population of 80,795 and was divided into three sectors. There were two acute units (male and female) on site, with four long stay units. There was also an incomplete rehabilitation team and a number of community facilities. There was no team for psychiatry of later life. A significant number of long stay residents were from outside the North Cork catchment area.

It had been the plan for some time that the North Lee and North Cork catchment areas would amalgamate. However any progress on this had been slow.

Progress on Recommendations from the 2008 Report

1. *Each team should be fully staffed as a multidisciplinary team as recommended in A Vision for Change.*

Outcome: A social worker had recently been appointed. Apart from this no further additions had been made to the multidisciplinary teams, which remain under-resourced. There was no psychiatry of later life team in North Cork.

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.*

Outcome: A steering group had been formed in the HSE South to progress the amalgamation of North Lee and North Cork.

3. *Training needs for health and social care professionals should be addressed.*

Outcome: The training needs of staff were now being addressed on an ongoing basis and training was recorded.

4. *Efforts should continue to facilitate the provision of alternative accommodation based on assessed need, either in specialised rehabilitative care or in nursing homes.*

Outcome: This was ongoing. For example, the Carrigabrick housing project in Fermoy had opened with discharged residents from St. Stephen's Hospital, and other residents had been moved to nursing homes.

5. Each unit should be self-staffing.

Outcome: This had been referred to the HR department and might be reviewed in the context of the introduction of a 35-hour week for nursing staff.

Outline of Local Health Service Plan 2008–2009

The service plan included the following: progress the implementation of *A Vision for Change*, to shift mental health services to community-based settings in line with the PCCC transformation and reconfiguration programme, and to basically improve services for service users.

Developments 2008-2009

- The Carrigabrick housing project opened in July 2009. This had 14 beds and allowed closure of beds in St. Stephen's Hospital.
- A sector HQ opened in Fermoy, consisting of offices, clinical space and a kitchen.
- A new day care centre in Charleville (Turas Nua) opened in October 2008.
- A CNS in behaviour therapy began working in Mallow sector in January 2009.
- A CNS in behaviour therapy began working in Kanturk sector in December 2008.
- A CNM2 was appointed to Charleville day care centre in January 2009.
- A seven-day community mental health service commenced in 2009 with two community mental health nurses on duty each weekend.
- The establishment of two advanced nurse practitioner posts was at discussion stage.

Service User Involvement

The advocate was involved in the policy and procedure group of the mental health service and was invited to management meetings.

Peer Support/Advocacy

The advocate attended both acute units and long stay units as well as the recreation centre. The advocate also occasionally attended the community residences and day-centres. However there were no formal meetings between management and the advocate to feed back service user concerns. This had resulted in some issues not being passed on to management. The service undertook to rectify this.

Most service users reported that they were pleased with their treatment in St. Stephen's Hospital. They praised the food, the occupational therapy department and the information available to them. There was some concern expressed that service users were not consulted about the reconfiguration of the therapeutic activity service. They feel the premises was too small compared to what had been available previously and they had less time there. There was special praise of the music sessions which take place in different units.

Participation in the Delivery of Mental Health Services

The advocate had attended management meetings on occasion. The advocate had also been part of the policy and procedure committee.

The rehabilitation consultant, the advocate, and service users had introduced a service user feedback form for use at multidisciplinary team meetings.

Governance

There was a multidisciplinary management team that met monthly. All policies were developed with multidisciplinary input.

There were a number of audits taking place. These included an audit of community key working, an audit of drug prescribing, and an audit of the liaison service.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	4
NCHD	8
Specialist registrar	Not applicable

Nursing Staff

Post	WTE in post
DON	1
ADON	3.79
Night superintendant	2
Nurses based in in-patient services	101.78
Nurses based in community residences	21.44
Community mental health nurse	11
Nurses based in day centre	17.96
Other	Clozapine nurse (1) CNM3 training (0.85) Behaviour therapy nurse in community (2.5) – 1 vacant

CNS Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	2.79
Advanced nurse practitioner	0
Other	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3.4
Social work	1
Occupational therapist	3.36
Art therapist	0.56
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation
Population	80,795

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
CMHN	3	3
Psychologist	0	0
Social Worker	0	0
Occupational therapist	1	1
Day facility nurse staffing	Shared with sector teams	Shared with sector teams
ADON	1	1

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Day hospital on grounds of St. Stephen's Hospital – shared between 3 sectors and rehab Owned by HSE	Day hospital ceased operating in 2009 – see Day Centre below Owned by HSE
Day centre	4 Kanturk – HSE owned Mallow – HSE owned Fermoy – Leased Mitchelstown – owned by Senior Citizens assoc and rooms rented	6 Kanturk – HSE owned Mallow – HSE owned Fermoy – leased Mitchelstown – owned by senior citizens association and rooms rented Charleville – leased Day Centre –HSE owned

In-Patient Facilities

North Cork in-patient facilities were provided in St. Stephen's Hospital in Glanmire. The hospital was located about 8km from Cork City in a rural setting. It had extensive grounds and the complex mainly consists of individual units. There was a unit for individuals with challenging behaviour, two admission units (male and female) and continuing care units. There was also an Alzheimer's unit that was not part of the approved centre.

The condition of the buildings was relatively good and there was a regular programme of maintenance. All areas were very clean and privacy was maintained as far as was possible.

While there appeared to be a commitment to reduce beds, a closure plan for the hospital was difficult to ascertain. Closure had been complicated by the fact that a large proportion of the long stay population originated from other catchments and there was an expectation that these other catchments would take responsibility for re-housing their residents. This appeared to be highly unlikely as North Lee in particular had few available resources to do this. A steering group had been set up with North Lee to look at future provision of accommodation.

The admission units were on the grounds of the hospital. Due to the uncertain future of the Mercy Hospital in Cork no plans for the relocation of the acute units to a general hospital site were available.

Compliance with Approved Centre Statutory Requirements

Regulations (S.I No.551 of 2006)

The approved centre of St. Stephen's Hospital was fully compliant with all Regulations.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The approved centre of St. Stephen's Hospital was fully compliant with all Rules.

Codes of Practice

The approved centre of St. Stephen's Hospital was fully compliant with all Codes of Practice.

Multidisciplinary Care Planning

Multidisciplinary care planning was in place throughout the hospital. There was an excellent care pathway in operation for rehabilitation residents. Multidisciplinary care plans were also in place in the supervised residences.

24-Hour Supervised Community Residences

Residence	Number of places	Number of residents	Team responsible	Care plan type
Solas Nua Housing Project, Spa Glen, Mallow	14	14	Rehabilitation	MDT
Cois Alla Housing Project, Kanturk	14	14	Rehabilitation	MDT
Carrigabrick Housing Project, Fermoy	14	12	Rehabilitation	MDT

Conclusion

North Cork Mental Health Services are to be commended for being in compliance of all Regulations, Rules and Codes of Practice for approved centres. It was evident that staff had worked hard to improve services. There was a good system of care planning in operation. Therapeutic activities had been reconfigured and now extended to different units. While there were no direct complaints to the inspectorate by service users there were some issues raised by service users through the Irish Advocacy Network that required addressing and a forum for raising service user issues was not in place.

Although the condition of the hospital was adequate it was still an institution that housed 76 long stay residents with differing needs, who require alternative community accommodation. From the information received it seemed unlikely that this requirement would be met in the near future. There had been some reduction in the number of long stay residents in 2009 with the opening of a supervised residence.

The amalgamation of North Cork and North Lee does not appear to have progressed in any meaningful way and there was uncertainty around the future of St. Stephen's Hospital and the service as a whole.

Recommendations and Areas for Development

1. *Management and the Irish Advocacy Network representative should meet regularly on a formal basis.*

2. *A clear plan for the amalgamation of North Lee and North Cork catchment areas should be completed. This should include plans for the future accommodation of long stay residents in St. Stephen's Hospital and the future location of the acute unit.*

Mental Health Services 2009
Catchment Area Report
North Lee

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 (e.g. POLL, REHAB)	1
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	6 November 2009

Service 2009

Description of Service (Including Distinct Features)

The North Lee catchment area provided a mental health service to an area of Cork with a high level of social deprivation, particularly in the north of the city. Geographically, it spread from inner city to the suburbs of Cork. It had two approved centres: St. Michael's Unit, Mercy Hospital, and Carraig Mór in Shanakiel. St. Michael's Unit was the acute admission unit, and Carraig Mór provided continuing care to the 22 residents on the first floor and functioned as a PICU on the ground floor with 18 beds.

The catchment was served by four sector teams, which included a home-based treatment team. There were no specialist teams for rehabilitation or psychiatry of later life. The service had developed an outreach service which was working well and which provided an after-hours service.

Up to 10 patients remained in St. Michael's Unit because of lack of appropriate accommodation to move on to. One person had been in acute care for 4 to 5 years for this reason. Community nursing units in the city could not address this difficulty. The Inspectorate was informed that traditionally there had not been good access to long-term community beds in the catchment area.

Progress on Recommendations from the 2008 Report

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.*

Outcome: No specialist teams had been appointed.

2. *Breaches in the statutory Rules and Regulations for approved centres should be immediately addressed as should breaches of Codes of Practice.*

Outcome: The two approved centres failed to meet full compliance with the Regulations and Codes of Practice.

3. *Multidisciplinary teams should be fully resourced.*

Outcome: Teams were not fully staffed with multidisciplinary members. There was no psychologists in the psychiatric intensive care unit (PICU) in Carraig Mór and there was an inadequate number of occupational therapists and social workers.

4. The development of a full regional forensic service should be advanced as quickly as possible.

Outcome: This had not been achieved.

Outline of Local Health Service Plan 2008–2009

The Inspectorate was not provided with a service plan for 2009. Management indicated in a self-assessment form that its focus would be on community-delivered services.

Developments 2008–2009

- A multidisciplinary day therapy programme had been implemented in May 2009. It provided for up to 12 service users to attend groups and workshops.
- An acute day hospital opened in April 2009 to provide day services for residents in the City North sector.
- An outreach programme had begun operating in City North from a newly refurbished facility at Erinville/Inniscarrig Centre.
- The home-based treatment team had relocated to a more central location providing easier access to assessments for its service users.
- A multidisciplinary psychological therapies programme had been introduced to enable quicker access for service users referred directly by GPs. Two sessions a week were allocated for assessment by the members of the psychological therapies team.
- Psycho-educational focus groups took place in the day programme, on topics such as hearing voices, bipolar disorder and anxiety. Some of these were conducted out of hours.

Hospital Closure Plans (Where Applicable)

There was no hospital closure plan. The future of the admission unit at St. Michael's Unit was discussed in previous years, with a view to possible amalgamation with Cork University Hospital.

No plans had been put forward regarding residents in the continuing care section of Carraig Mór.

Service User Involvement

Peer Support/Advocacy

The advocate who visited all the facilities in the North Lee catchment area presented a report on the work of the advocate. The advocate reported that a number of issues in St. Michael's Unit had been resolved. The director of nursing undertook to follow up issues brought to the attention of the advocate in Carraig Mór, including the failure of senior staff to meet quarterly with the advocate, lack of privacy when making phone calls, and the perceived failure to hold community meetings for residents.

Residents in the service's hostels had expressed surprise at the increase of 66 per cent in their rent contribution. This followed from the recent new charge introduced by the HSE.

Administrative problems had resulted in some patients not getting adequate notice of mental health tribunal dates, independent review appointments and solicitors' visits. Staff agreed this would be addressed.

Service User Participation

The advocate met monthly with the multidisciplinary members of the community mental health teams. One of the advocates presents to the nurses in training in UCC on the role of the advocate in the mental health service. Individual service users met with their multidisciplinary team weekly and had an input in the development of their care plan. They are also involved in the design of a course on boat-building which leads to a FETAC qualification up to Level 5.

Governance

Quality Improvements (Audits and Reviews)

The multidisciplinary management team in St. Michael's Unit met weekly, and met the Local Health Manager quarterly. Due to some confusion about the role of the executivec clinical director, this meeting did not take place for some months during the year. The matter had now been resolved and meetings were taking place again.

In Carraig Mór, there were management meetings every six weeks, but they did not include occupational therapy or social work managers. The service user advocate was not currently involved in the management team, but management agreed to review this situation.

Two audits on the individual care plans in St. Michael's Unit were conducted, and the heads of discipline carried out a safety audit of the service, including outside units, during the past year. The home-based treatment team administered a satisfaction scale to each client at the end of their intervention. Positive feedback had been reported.

A risk management group coordinated the response to high-risk issues while minor incidents were triaged and reported every six months to the Mental Health Commission.

Staffing Dedicated to Specialist Mental Health Services

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

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	145
Nurses based in community residences	30
Community mental health nurse	15
Nurses based in day hospitals and day centres	18
Other – Temporary staff panel	52

Nursing Specialist Posts

Speciality	WTE in post
Liaison/Part-time GP	0.5
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors (including 2 substance misuse)	3
Advanced nurse practitioner	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4.5
Social work	7
Occupational therapist	5.6
Art therapist	1

In-Patient Facilities

In-patient facilities were provided at St. Michael's Unit and at Carraig Mór. An unannounced inspection was carried out in Carraig Mór in 2009. Between them, the approved centres provided an acute admission unit, a continuing care unit and a regional PICU. Clinical responsibility for the residents in the continuing care section of Carraig Mór was shared between consultant psychiatrists and many of the residents did not come from the North Lee catchment area.

Statutory Requirements for Approved Centres

The Inspectorate carried out inspections in each approved centre during 2009.

Regulations (S.I. 551 of 2006)

St Michael's Unit was compliant with the majority of the regulations. The service had initiated compliance only in regard to Article 15, provision of individual care plans for residents. It was substantially compliant with Article 16 (therapeutic services) and Article 26 (staffing).

The approved centre at Carraig Mór failed to meet full compliance in a considerable number of Regulations. It was substantially compliant with Article 5, Article 19, Article 25, and Article 31, but had only initiated compliance in Article 15, Article 16, Article 26, and Article 27.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

Seclusion was not used in St. Michael's Unit and no resident had been mechanically restrained in the unit within the previous year. The service was substantially compliant with the Rules in relation to provision of information on ECT, and was fully compliant with the remainder of the rules on ECT.

Mechanical restraint and ECT were not used in Carraig Mór. In relation to the use of seclusion, the service was substantially compliant with the section on facilities and had only initiated compliance on staff training.

Codes of Practice

The centre at Carraig Mór did not admit children, hence the Code of Practice on admission of children was not applicable. It was fully compliant with the Code of Practice on notification of deaths and incidents. Both St. Michael's Unit and Carraig Mór were fully compliant with all sections of the Code of Practice governing the use of physical restraint except in relation to staff training on physical restraint.

St. Michael's Unit was fully compliant with the Code of Practice on notification of deaths and incidents. It was only substantially compliant with the Code of Practice on admission of children as the unit was not suitable for the admission of children.

Multidisciplinary Care Planning

There were no individual care plans as described in the Regulations on the first floor of Carraig Mór. The PICU in Carraig Mór had good care plans. In St. Michael's Unit, comprehensive care plans had been introduced, but in a limited way owing to lack of multidisciplinary team members. The IAN representative reported that patients did not have copies of their care plans and that in some instances staff were completing them.

24-Hour Supervised Community Residences

Description

The North Lee catchment area had four 24-hour supervised residences, three in Cork city and one in Midleton.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Gougane Barra House	15	15	General adult	Nursing
Millfield House	16	16	General adult	Nursing
St. Colman's House	12	12	General adult	Nursing
Owenacurra	32	32	General adult	Nursing

Conclusion

The North Lee catchment area service provided a mental health service to a population of almost 168,000 with four community mental health teams. It had no specialist service to provide rehabilitation or psychiatry of later life care to its service users, but had developed a home-based service in one of its sectors. None of the sector teams were fully resourced in terms of multidisciplinary membership, for example psychologists, occupational therapists and social workers. The inability of the service to access accommodation for some residents has resulted in inefficient use of in-patient facilities.

Residents in the continuing care section of the approved centre at Carraig Mór did not have individual care plans and although care plans had been introduced in St. Michael's Unit, these had not been completed for all residents.

The service continued to develop the community care aspect of its work during the previous year, with provision of multidisciplinary day therapy, the opening of a day hospital in the City North sector, and an after- hours service.

Recommendations and Areas for Development

1. *Individual care plans should be introduced for all residents in both approved centres.*

2. *Specialist services in rehabilitation and psychiatry of later life should be put in place.*

3. *Plans should be drawn up to provide care in more suitable accommodation for the long-term residents in the continuing care ward of Carraig Mór.*

4. *Multidisciplinary teams should be adequately resourced to provide full multidisciplinary care.*

Mental Health Services 2009
Catchment Area Report
South Lee

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 psychiatry
Per Capita Expenditure 2008 [>18 Years]	13,436,089 euro [sic]
Date of Meeting	21 October 2009

Service 2009

Description of Service

South Lee Mental Health Service had both urban and rural components. Its per capita funding was relatively low (75 euro). Its community teams were poorly staffed and there were minimal community facilities. The acute unit was in Cork University Hospital and was not designed to provide an acute service. The service had two long stay wards in St. Finbarr's Hospital: St. Monica's and St. Catherine's, which had a rehabilitation focus. There was no rehabilitation team. The service had admitting rights to Carraig Mór which was a psychiatric intensive care unit.

Progress on Recommendations from The 2008 Report

1. *A rehabilitation team should be appointed in the service as a priority.*

Outcome: There had been no progress on this recommendation.

2. *Staffing of the teams should be multidisciplinary and should include an appropriate skill mix.*

Outcome: There had been no progress on this recommendation.

3. *Work should progress on making the unit in Cork University Hospital more suitable for all residents.*

Outcome: The new reception area had been completed. Further work was required to meet this recommendation.

Outline of Local Health Service Plan 2008–2009

The service provided a Level 1 Business Plan for the HSE South. The plan to establish a rehabilitation team and provide further community mental health team staffing was not due to be achieved in 2009 due to funding restrictions.

Developments 2008–2009

- There had been some reconfiguration of service in Heatherside, where staff had been released by amalgamating wards.

- The new reception area in the acute unit in Cork University Hospital had been completed.
- The community facility in St. Patrick's Street had been extended. There were now two outpatient clinics a week.
- An early intervention programme for young people with schizophrenia was in progress.
- The music therapy programme was continuing and had been successful.

Hospital Closure Plans (Where Applicable)

There were currently no plans to close the two wards (St. Monica's and St. Catherine's) in St. Finbarr's Hospital. The lack of a rehabilitation team and community residential facilities had meant that there were difficulties moving residents to more appropriate accommodation.

Service User Involvement

Peer Support/Advocacy

There was regular peer advocacy throughout the service. The service users praised some of the staff and welcomed the activities available in the acute unit and St. Catherine's Ward. The residents in Glenmalure residence produced a regular magazine. There had been some concerns raised about the rubbish collecting in the garden in the acute unit. The regular meetings between nursing staff and the advocate helped to resolve many issues that arose but the report of the advocate suggested that this forum didn't facilitate resolution of all issues. This was an issue the service needed to address.

Service User Participation

The advocate had been invited to attend some management team meetings. Service users had been involved in planning, implementation and evaluation of care planning in most parts of the service. Two service patient satisfaction surveys had been carried out. There was service user involvement in the induction programme for NCHDs and student nurses.

Governance

Quality Improvements (Audits And Reviews)

The senior management team was multidisciplinary and met every six weeks. There was a policy review board and a risk management group as well as a clinical audit group.

There was regular review of incident reports.

Psychology statistical returns were due to be completed at year end and would link to developments in psychology service provision early in 2010.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	8.23
NCHD	15
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	56
Nurses based in community residences	8
Community mental health nurse	12.42
Nurses based in day hospitals	4
Nurses based in day centre	9.19
Temporary staff panel	20.17

Nursing Specialist Posts

Speciality	WTE in post
Liaison	2
Clinical placement coordinators	4
Nurse practice development coordinator	1
Counsellors	2
Advanced nurse practitioner	0
Other	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5.5
Social work	3
Occupational therapist	1
Art therapist	1.31
Other	1

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Liaison Team Report

Team Description	The liaison team was located in Cork University Hospital. Planned developments of general acute services to be located in the hospital were expected to increase demand for liaison services.
Population	Not provided

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Clinical psychologist	1	0.8
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	2	2
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	-	-
Day centre	-	-

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	179,133

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0	0
CMHN	1.82	2.82
Clinical psychologist	0.8	0.8
Social worker	0	0
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0.8	0.8
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	Togher Community Centre -rented and shared 2 days a week Awbeg suite, CUH shared	Togher Community Centre -rented and shared 2 days a week Awbeg suite, CUH shared

In-Patient Facilities

There were two approved centres. The acute unit in Cork University Hospital was unsuitable in design as an admission unit. The two long-stay units were based in St. Finbarr's Hospital. The structure of these units was not suitable and many residents should be accommodated in community residences. In the absence of a rehabilitation team any movement towards closure of these units was unlikely.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

Acute Unit, Cork University Hospital: The unit was non-compliant in individual care planning, therapeutic activities, premises, ordering prescribing storing and administration of medication and staffing.

St Finbarr's Hospital: The units were non-compliant in care planning, therapeutic activities, general health, premises, ordering prescribing storage and administration of medication, staffing and operating policies.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

Acute Unit, Cork University Hospital: The unit was non-compliant in ECT and mechanical restraint.

St. Finbarr's Hospital: ECT, seclusion and mechanical restraint were not used in these units.

Codes of Practice

Acute Unit, Cork University Hospital: The unit was non-compliant in ECT, physical restraint, admission of children, and notification of deaths and incident reporting.

St. Finbarr's Hospital: ECT and physical restraint were not used in these units.

Multidisciplinary Care Planning

Integrated care planning was not fully in operation throughout the in-patient service though it was reported that it was in use in the community sector teams. However the low numbers of multidisciplinary staffing had meant that the multidisciplinary component was lacking.

24-Hour Supervised Community Residences

Description

There was only one 24-hour supervised residence in the South Lee Mental Health Service. Despite the lack of a rehabilitation team, there was social work involvement in moving residents to more appropriate accommodation.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Glenmalure	18	18	City South East general adult team	Nursing care plan

Conclusion

The lack of resources in the South Lee Mental Health Service had seriously hindered the development of the service and had resulted in poor infrastructure and lack of multidisciplinary team input. The service had implemented integrated care plans in the in-patient services but the multidisciplinary input was limited. The lack of a rehabilitation team had resulted in lack of any meaningful rehabilitation service although the service had attempted to cover this deficit as best it can with little resources. It is difficult to see any development happening within this service in the current funding restrictions.

Recommendations and Areas for Development

1. *Every effort should be made to expand the sector mental health teams in terms of staffing and resources.*

2. *The absence of a rehabilitation team should be addressed.*

3. *Occupational therapists should be recruited, especially in the acute unit and long-stay units.*

4. *The service should review its current arrangements for feedback from the peer advocate to ensure that issues raised are addressed appropriately.*

Mental Health Services 2009
Catchment Area Report
South Tipperary

HSE Area	HSE South
Catchment	South Tipperary
Mental Health Service	South Tipperary Mental Health Service
Population	83,052
Number of Sectors	3
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of later life
Per Capita Expenditure 2008 [>18 Years]	291.69 euro
Date of Meeting	11 November 2009

Service 2009

Description of Service (Including Distinct Features)

Three sector teams were in operation within the catchment: Clonmel East, Clonmel West and Tipperary. In addition there were two specialist teams: rehabilitation and psychiatry of later life.

There were two approved centres attached to South Tipperary Mental Health Services: St. Luke's Hospital, Clonmel, opened in 1835, and St. Michael's Unit, an acute admissions unit situated in the grounds of South Tipperary General Hospital.

South Tipperary catchment also provided beds to North Tipperary catchment, which had no in-patient beds of its own. A number of long-stay residents from North Tipperary were continuing to reside in St. Luke's Hospital.

Since last year the number of beds in St. Luke's Hospital had been reduced from 106 to 83. St. Michael's Unit had 49 beds. Both approved centres had been subject to a Section 55 Mental Health Act 2001 inquiry the report of which was published in March 2009. Conditions were imposed on the registration of both approved centres on 14 May 2009. Full compliance must be obtained by St. Luke's Hospital and St. Michael's Unit under the Regulations for approved centres in relation to individual care plans, therapeutic services and programmes, transfer of residents, provision of information to residents, premises, staffing and risk management procedures. In addition the inquiry recommended that both approved centres should be inspected on three occasions during 2009.

Progress on Recommendations from the 2008 Report

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.*

Outcome: St. John's Ward had closed. The above recommendation had been achieved in regard to St. Bridget's Ward.

2. *St. Luke's Hospital should be closed. In the interim, the conditions in the hospital must be brought to an acceptable standard.*

Outcome: Conditions throughout the hospital had improved. St. John's Ward had closed during the year. It was reported that closure plans for St. Luke's Hospital were on track. It was reported by the service that St. Bridget's Ward was scheduled for closure in January 2010.

3. *Admissions must cease to St. Luke's Hospital, apart from appropriate admissions to the psychiatry of later life and rehabilitation services, which are located within the hospital.*

Outcome: This had been achieved.

4. *The issue of provision of in-patient services for North Tipperary must be resolved at both management and clinical level.*

Outcome: This issue was ongoing.

Outline of Local Health Service Plan 2008–2009

The local service plan was submitted to the Inspectorate and was examined.

Developments 2008–2009

- A seven-day out-of-hours service extending to 2030h had been established.
- St. John's Ward had been closed.
- All wards in both approved centres were now using individual care plans as defined in the Regulations.
- A programme of bed closures and resettlement of clients into alternative appropriate accommodation was continuing.
- Consumer panels had been established and met on the fourth Wednesday of every month.
- It was reported that the newly-appointed executive clinical director was, with other executive clinical director colleagues, looking towards formulating national standards for a clinical governance structure for consistency throughout the country.
- It was reported that there was now broad agreement among most staff from all disciplines that the Section 55 inquiry had been beneficial to the service.

Hospital Closure Plans (Where Applicable)

St. John's Ward had closed during the year. It was reported that St. Bridget's Ward was scheduled for closure in January 2010. The number of beds in St. Luke's Hospital had reduced over the last year from 106 to 83. It was reported that the scheduled date for full closure of St. Luke's Hospital was 2013.

Service User Involvement

Peer Support/Advocacy

The peer advocacy service, it was reported, had been welcomed by both residents and staff. The advocacy representative outlined the positive aspects of the service provided to residents including that recreational activities and therapeutic programmes had been well-received by residents. A room was available to the advocacy representative should the need arise. The relocation of residents to more appropriate facilities was welcomed by residents. The food was reported to be of good quality. Staff were

generally reported to be friendly and approachable. The advocate reported that the clinical director and the director of nursing's door were always open to him.

Areas that residents identified could be improved: It was reported that St. Michael's Unit was at times cramped and overcrowded and that it lacked a garden where residents could avail of fresh air. Residents had informed the peer advocate that different staff on different shifts had different sets of rules and boundaries, for example: time to go to bed and time for switching the TV set off, which, it was reported, often angered and confused residents.

Service User Participation

The peer advocate reported that the voice of the service user was now represented at all levels within the service. The peer advocate attended project team meetings, policy development meetings and management meetings. The peer advocate was not a member of the senior management team.

Governance

Quality Improvements (Audits and Reviews)

It was reported by a number of staff that the Section 55 Mental Health Act 2001 inquiry had been a catalyst in improving standards across the service. All residents of both approved centres now had individual care plans as defined in the Regulations.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	7
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	117.8
Nurses based in community residences	21
Community mental health nurse	6
Nurses based in day hospitals	10
Nurses based in day centre	5
Temporary staff panel	21.8

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1
Clinical placement coordinators	1
Nurse practice development coordinator	0
Counsellors	5
Advanced nurse practitioner	0
Other (CNS)	9

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4
Social work	3.8
Occupational therapist	0.8
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Specialist Team Report

Team Description	Rehabilitation
Population	83,052

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.2	0.2
CMHN	3	3
Clinical psychologist	0.5	1
Social worker	0	0
Occupational therapist	1	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	2	2
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	No	No

Specialist Team Report

Team Description	Psychiatry of Later Life
Population	83,052

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.2	0.2
CMHN	3	3
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	0.8	0.8
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	No	No

In-Patient Facilities

There were two approved centres within the South Tipperary Catchment Area: St. Luke's Hospital, Clonmel and St. Michael's Unit, located in South Tipperary General Hospital. A number of areas within St. Luke's Hospital were in need of refurbishment and this was reported in the individual approved centre reports. It was reported that conditions in St. Michael's Unit were cramped and the approved centre was continuing to operate above 100 per cent bed occupancy rates.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 Of 2006)

Both approved centres had compliance issues with Article 26 of the Regulations (staffing): there was a shortfall of health and social care professionals across all teams and there was also a need for ward-based occupational therapists in both approved centres. Article 22 (premises) compliance issues related to St. Luke's Hospital, which was an old pre-Victorian building opened in 1835 and a programme of closure of this approved centre was progressing. However, the rate of this progression was dependent on capital funding. Both approved centres were compliant with remaining Articles.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

St. Michael's Unit was continuing to use seclusion rooms as bedrooms imposing on them a breach of Rule 7.5.

Codes of Practice

St. Michael's Unit was not suitable for the admission of children and there were breaches in regard to Section 2.5 (b), Section 2.5 (e), and Section 2.5 (g).

Multidisciplinary Care Planning

Multidisciplinary care planning was now in use throughout all wards in both approved centres.

24-Hour Supervised Community Residences

Description

There were three community residences providing 24-hour care in the South Tipperary catchment area with a total of 37 places. Two residences were under the care of the rehabilitation team while one, Mount Sion in Tipperary Town, was under the care of a general adult team.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Mount Sion, Tipperary Town	17	15	Adult	MDT
Lorica, Cashel	10	9	Rehabilitation	MDT
Edel Quin, Clonmel	10	10	Rehabilitation	MDT

Conclusion

St. John's Ward in St. Luke's Hospital had closed. The bed reduction this year had been from 106 to 83. The time frame for St. Bridget's Ward to close was reported to be January 2010. St. Michael's Unit was frequently operating at above 100 per cent occupancy rate and it was reported that the practice of using seclusion rooms as bedrooms was continuing in emergency situations. There was also no enclosed garden area where residents could avail of fresh air. Both approved centres were inspected three times in 2009. Each subsequent report showed the degree of increasing compliance by both approved centres with the Regulations, Rules and Codes of Practice. The commitment and energy of staff to improving the quality of care of residents was obvious. In order for the closure of St. Luke's Hospital to be expedited, additional resources should be put in place to enhance the staffing of the three sector teams, the rehabilitation team and the psychiatry of later life team.

Recommendations and areas for development

1. *Written agreement regarding house rules and boundaries, localised to individual wards, should be established across all shifts, day and night, in both approved centres, so that these house rules and boundaries are clearly visible in written form to both residents and staff.*

2. *The closure plan for St. Luke's Hospital should be expedited.*

3. *Former residents of St. Luke's Hospital should be placed in appropriate settings based on need.*

4. *The skill mix of staff on the three sector teams, the rehabilitation team and the psychiatry of later life team should be in accordance with A Vision for Change recommendations.*

5. *The issue in relation to the provision of in-patient beds for North Tipperary should be resolved.*

Mental Health Services 2009 Catchment Area Report Waterford

HSE Area	HSE South
Catchment	Waterford
Mental Health Service	Waterford Mental Health Services
Population	123,000
Number of Sectors	4
Number of Approved Centres	2
Specialist Teams	Rehabilitation Psychiatry of later life Child and adolescent
Per Capita Expenditure 2008 [>18 Years]	Not returned
Date of Meeting	20 May 2009

Service 2009

Description of Service (Including Distinct Features)

Waterford Mental Health Services operated two approved centres: the Department of Psychiatry at Waterford Regional Hospital, with 44 acute beds, and St. Otteran's Hospital, with 78 beds for rehabilitation and psychiatry of later life.

The catchment included South Kilkenny and had a total population of 123,844 for adult services and 120,017 for child and adolescent mental health services. There were four sector teams: East Waterford, Mid Waterford, West Waterford and South Kilkenny, and three specialist teams: psychiatry of later life, rehabilitation and child and adolescent.

Progress on Recommendations from the 2008 Report

1. *Each resident of the two approved centres must have an integrated individual care plan as defined in the Regulations.*

Outcome: Individual care plans were being introduced in the Department of Psychiatry and in St. Otteran's, individual care plans were being rolled out one resident at a time.

2. *Consideration should be given to amalgamating sectors in line with national health policy.*

Outcome: Waterford and Wexford were amalgamating catchment areas in line with *A Vision for Change* recommendations and the appointment of an executive clinical director was imminent.

3. *Community mental health teams should be adequately staffed in order to provide a comprehensive community service.*

Outcome: A reconfiguration of staff was in process. The recruitment of two occupational therapists was about to take place as the service had only just received clarification from the HSE that these posts were exempt from the present moratorium on recruitment.

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.*

Outcome: A group had been set up to look at the broader recommendations in *A Vision for Change*. Over the previous year the number of beds in St. Otteran's Hospital had fallen from 115 to 78.

Outline of Local Health Service Plan 2008–2009

In line with *A Vision for Change*, and with requirements from previous Inspectorate reports, a plan was being developed to provide for the closure of St. Otteran's Hospital.

Developments 2008–2009

St Otteran's Hospital

- A sub-committee with a consultant psychiatrist as leader had been established to develop an integrated file incorporating a collaborative care plan for residents of St. Otteran's.
- Screening of clients on psychotropic medication was being conducted with general practitioners.
- Pilot outreach – one patient in independent living was being managed by a CNS on the rehabilitation team.

Department of Psychiatry, Waterford Regional Hospital

- Audits of admission procedures were being carried out.
- An interactional psychotherapy group was established.

Hospital Closure Plans

In line with *A Vision for Change*, and with requirements from previous Inspectorate reports, a plan was being developed to provide for the closure of St. Otteran's Hospital.

Twelve long-stay residents had been transferred to nursing homes.

The transfer of 16 residents from St. Claire's Ward to a purpose-built unit on campus, Grangemore, was imminent.

The closure of St. Joseph's Ward for refurbishment was about to take place; following this refurbishment and the building of an enclosed garden, the residents of St. Aidan's Ward were to be transferred there.

A new 4-place low support residence was being purchased and a second residence for two residents was to be rented. Residents and their families had already been contacted regarding assessments for these places.

Remaining residents would be living in St. Monica's Ward and St. Joseph's Ward.

The above developments will enable the old hospital to be vacated.

Service User Involvement

Peer Support/Advocacy

Residents reported that the food was of good quality. The relaxation sessions facilitated by nursing staff were enjoyed by residents. Music therapy had been facilitated some months ago which was enjoyed by residents and it was hoped that this therapy might be a regular part of the therapeutic programme. Residents stated that they found the talks given by support organisations such as GROW, AWARE, Shine, and Befriending very beneficial.

Residents felt that different staff had different sets of rules that were quite confusing for them. They also felt a need for an open space or garden at the Department of Psychiatry.

It was reported by the advocacy representative that clients on the 10-bed acute unit in the Department of Psychiatry had no access to advocacy services.

Participation in the Delivery of Mental Health Services

Waterford Mental Health Services had a policy of including service users on their decision-making bodies.

It was reported at the catchment meeting that a service user nominee had been requested by the executive management team for formal inclusion onto the executive management team in line with *A Vision for Change* recommendations. The advocacy representative confirmed the name of the nominee.

Governance

Quality Improvements (Audits and Reviews)

- In admission procedures, a new admission proforma was introduced.
- A liaison psychiatry audit was being carried out.
- A psychotropic usage audit was being carried out by the rehabilitation service in conjunction with GPs.
- The nursing care plan was audited by the nurse practice development co-ordinator and clinical placement coordinator.
- A nursing training audit was conducted by An Bord Altranais in 2009.
- In medication management, patients were being encouraged to self-medicate.
- The multidisciplinary team policy development group was making an ongoing contribution to developing service policies.
- A clinical review group was reporting into the multidisciplinary team policy development group.
- An interagency group on suicide prevention, with participation from the mental health service, submitted a report to a city development board for implementation.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	9
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	108.9
Nurses based in community residences	21
Community mental health nurse	7
Nurses based in day hospitals	8.5 (4 Brook House, 4 Newport, 0.5 Lismore)
Nurses based in day centre	0
Other – Temporary staff panel	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	1
Nurse practice development coordinator	0
Counsellors	0.5
Advanced nurse practitioner	0
Other	6

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5.5
Social work	4.6
Occupational therapist	1
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of Later Life
Population	14,977

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.3	0.3
CMHN	2	2
Clinical psychologist	0.3	0.2
Social worker	0.25	0.25
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

Rehabilitation team report

Team Description	Rehabilitation
Population	93,595

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.5	0.5
CMHN	1	2
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	Shared	Shared

CAMHS Team Report

Team Description	Child and Adolescent
Population	30, 249

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	1	1
Clinical psychologist	2	1
Social worker	0.6	0.6
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

In-Patient Facilities

Waterford Mental Health Services operated two approved centres: the Department of Psychiatry, which had 44 acute beds at Waterford Regional Hospital, and St. Otteran's Hospital with 78 beds for rehabilitation and psychiatry of later life.

The resident's from St. Claire's Ward were about to be transferred to the purpose-built Grangemore unit, a stand-alone unit on campus.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The majority of Regulations had been met by the service, though in the case of a number of Regulations, compliance had only been initiated, and in a few instances the service was not compliant. There continued to be a need for care planning throughout both approved centres. The current premises and the lack of privacy in some units were in breach of Regulations.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service was compliant with all Rules.

Codes of Practice

The service ranged from compliance initiated to fully compliant with all Codes of Practice.

Multidisciplinary Care Planning

The Department of Psychiatry at Waterford Regional Hospital was introducing an integrated care plan on a rolling basis in 2009. The implementation of this new integrated care plan was September 2009.

In St. Otteran's Hospital, the new integrated care plan had so far been applied only to a limited number of residents.

24-Hour Supervised Community Residences

Description

The service had two 24-hour supervised community residences, one of which was inspected by a member of the Inspectorate team. Both were under the clinical direction of the rehabilitation team.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ard na Déise	13	13	Rehabilitation	Nursing
Springmount House	14	11	Rehabilitation	Nursing

Conclusion

There have been some improvements in the service since 2008 with a number of quality improvements. There had been some progress in commencing the closure of St. Otteran's Hospital. It was disappointing that despite a reduction in resident numbers in St. Otteran's there has been no increase in staffing numbers in the community mental health team. The service had commenced work on the integrated care planning and it was hoped to commence this in September 2009.

Recommendations and Areas for Development

1. *The composition of the teams should be enhanced with the necessary multidisciplinary professionals.*
2. *A risk assessment should be undertaken regarding access to the garden facilities for residents at the Department of Psychiatry, Waterford Regional Hospital.*
3. *Individual care plans should be introduced in line with the requirements of the Regulations.*
4. *Training in multidisciplinary care planning should be provided for all staff.*
5. *The information booklet for residents should be completed and introduced for all residents and families.*
6. *Advocacy services should be available in the acute unit at the Department of Psychiatry, Waterford.*
7. *There should be a written plan for the closure of St. Otteran's Hospital, with time frames, reduction of bed capacity, and enhancement of specialty and sector teams to ensure residents have an adequate follow-up on discharge to the community.*

Mental Health Services 2009
Catchment Area Report
West Cork

HSE Area	HSE South
Catchment	West Cork
Mental Health Service	West Cork Mental Health Services
Population	53,445
Number of Sectors	1
Number of Approved Centres	1
Specialist Teams	None
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	25 June 2009

Service 2009

Description of Service

West Cork was a mainly rural catchment area and had one large sector with three sub-sectors. There was one team coordinator who processed all referrals to the community service. The approved centre was in Bantry General Hospital and had 18 beds. There were no long-stay beds in the service. There were three 24-hour supervised community residences. The service had a long history of service user involvement and was active in mental health promotion and networking with voluntary organisations. Staffing of multidisciplinary teams remained low.

Progress on Recommendations from the 2008 Report

1. *The approved centre must be compliant with all Regulations, Rules and Codes of Practice.*

Outcome: There had been significant improvement in this area and the approved centre was now compliant with the majority of Regulations, Rules and Codes of Practice.

2. *The sector teams should be adequately staffed with core members of the multidisciplinary team.*

Outcome: This had not been achieved. There were still significant gaps in team staffing.

3. *The service should continue to develop service initiatives in the current environment of financial and staffing restraints that can be sustained over time.*

Outcome: The service had continued to develop service initiatives which were service user orientated.

Outline of Local Health Service Plan 2008–2009

The 2009 service business plan included the following:

- Extension and refurbishment to Perrott House, a 24-hour supervised community residence.
- Preparation as a host exchange site for the International Initiative for Mental Health Leadership 2010.
- Progression of Bantry social housing in conjunction with Cork Mental Health Foundation.

- Development of the third sub-sector in Clonakilty.
- Progress with Phase 2 of the co-operative Learning Leadership Programme 2009/2010.
- Developing and recruiting a full-time service user post.
- Development of a service user focus group.
- Development of a befriending group in conjunction with voluntary organisations.
- Development of a supervision policy for all staff, including team building and training.

Developments 2008–2009

- A new medical records department had been developed. An audit of multidisciplinary integrated clinical files had been completed.
- The second phase of the residential review had been completed.
- There were an increased number of activities such as music and art sessions in the acute unit.
- A community garden project had commenced, using community allotments.
- The art project The Road to Recovery was being completed by service users, staff and volunteers.
- A Moving Towards Recovery group had been developed by the occupational and psychology department. This was a skill-based group for young adults and provided community based activities, peer support and coping skills. Examples included relaxation, cooking, kayaking, sailing and mindfulness.
- A garden had opened in the acute unit and a gardening group had commenced.
- A drop-in centre called "Ais Eirí" had opened and was managed by a mental health support worker.
- A carers pack had been developed.
- The assertive outreach programme Home Focus had been extended.
- An advanced nurse practitioner post for mental health in a primary care setting was being developed.
- The Wellness Recovery Action Plan (WRAP) programme had been implemented in Saol Nua.
- There was a community mental health forum which consisted of an alliance of community activists, service users, carers, Primary Community and Continuing Care (PCCC) and service providers.
- The West Cork Mental Health Week had been planned in October 2009.

Service User Involvement

Peer Support/Advocacy

Through the Irish Advocacy Network, service users stated that they were pleased with the service offered. They felt that the service was service user orientated. There were some concerns expressed about the fact that junior doctors changed every six months and this had a detrimental effect on the continuity of care.

A patient information pack had been developed and was given to residents and carers.

Service User Participation

The West Cork Cooperative Learning Leadership had implemented a questionnaire for all people involved with the service with a view to making changes in the service.

The drop in centre Ais Eirí had opened.

A service user and carer representative participated on the West Cork policy development group, the medical records committee, the residential review committee and the risk management group. All changes and developments in service were discussed with the service users and a carer representative.

The West Cork Mental Health Forum had informal monthly meetings to provide a channel for service users to voice opinions, identify supports and engage the community with mental health issues and challenge the stigma of mental health.

Governance

Quality Improvements (Audits and Reviews)

An audit of the multidisciplinary integrated notes had been completed.

The review of residential places was in its second phase.

There was no formal audit or review system in place. Information was available on a number of topics, including assisted admissions, Garda escorts, transfers, outpatient attendances and admissions. There had been an increase in referrals to the service in 2008.

There were a number of committees to review current practices and make recommendations. These include a risk management committee, hygiene committees, policy development group and external review committee.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	3
NCHD	5
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	4
Nurses based in in-patient services	20
Nurses based in community residences	30
Community mental health nurse	4
Nurses based in day hospitals	0
Nurses based in day centre	0
Nurses based in resource centre	1

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	3.2
Advanced nurse practitioner	0
Primary care nurse	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	1
Social work	2.2
Occupational therapist	1.85
Art therapist	0
Team coordinator	1

Specialist Teams (Excluding Primary Care Teams)

There were no specialist teams in the service.

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

In-Patient Facilities

There was one approved centre: the acute unit in the grounds of Bantry General Hospital. It had 18 beds. It was unsuitable as an admission unit as it was laid out on three levels, had narrow corridors and was small and cramped. It operated at approximately 50 per cent occupancy.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The acute unit in Bantry General Hospital was compliant with all Regulations apart from Article 22 (Premises). The premises was unsuitable for an admission unit: it was on three levels and was too small.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

No ECT, seclusion or mechanical restraint was carried out on the unit.

Codes of Practice

The approved centre was in breach of Article 2.5 of the Code of Practice relating to the admission of children in that the unit was unsuitable for the admission of children.

It was compliant in the Code of Practice on the notification of deaths and incident reporting.

The approved centre was non-compliant in the Code of Practice on physical restraint as staff training was not adequate.

Multidisciplinary Care Planning

The service was currently piloting a second revised multidisciplinary care plan. This appeared to be working well and met the requirements of a multidisciplinary care plan. Residents were able to sign their care plan and could receive a copy. Team meetings were held weekly in the unit.

24-Hour Supervised Community Residences

Description

There were four 24-hour supervised residences in West Cork. Perrott House was a large supervised residence in need of some renovation.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Perrott House	24	24	General adult	MDT
Ard Réalt	10	9	General adult	Nursing
Elmwood House	11	11	General adult	MDT
Saol Nua	8	7	General adult	MDT

Conclusion

West Cork mental health service continues to provide a service user orientated service with a multidisciplinary focus. There are now multidisciplinary care plans for all residents. There are a large number of initiatives that directly involve service users and also use voluntary and community agencies. The operation of the catchment as one large sector appears to be working well, and the provision of a third consultant is welcome. There is still a deficiency in multidisciplinary staffing. The home focus team

has received funding to continue until December 2009. However it is difficult to develop this service with piecemeal funding. There are no speciality services.

The problem with the structure of the acute unit remains and it is difficult to see how this can be rectified under the constraints of the building. There is no high observation area in the unit. The opening of the new garden provides a welcome outdoor space and gardening activities.

Recommendations and areas for development

1. *There should be an increase in multidisciplinary staffing in line with national policy.*
2. *An alternative to the current acute unit should be considered.*
3. *The Home Focus team should be provided with ongoing funding.*

Mental Health Services 2009
Catchment Area Report
Wexford

HSE Area	HSE South
Catchment	Wexford
Mental Health Service	Wexford Mental Health Services
Population	131,615
Number of Sectors	2
Number of Approved Centres	1
Specialist Teams	Rehabilitation Psychiatry of later life
Per Capita Expenditure 2008 [>18 Years]	195 euro
Date of Meeting	20 May 2009

Service 2009

Description of Service (Including Distinct Features)

Wexford Mental Health Services provided a service to the population of County Wexford. Services were primarily delivered via two large sector teams and two speciality teams. The service had embraced and set targets to achieve a change process that is intended to see its development plan implemented in full. The population of Wexford was a mixture of rural and urban centres. The service had access to one approved centre and had developed a number of community services.

Progress on Recommendations from the 2008 Report

1. *Sleeping out of patients in other wards must cease.*

Outcome: This continued at a lower level. Information on numbers was provided. A new formal agreement was being progressed with the Department of Psychiatry in Waterford Regional Hospital which would allow acute admission if necessary.

2. *All teams must be staffed to the required level outlined in the national policy document.*

Outcome: No additional posts had been allocated to the service since December 2008. A number of nursing posts had been redeployed following the closure of wards.

3. *All residents with an intellectual disability living in the hospital must be relocated to more suitable accommodation.*

Outcome: Since the last inspection, St. Bridget's Ward had closed and the residents had moved to a new purpose-built home in a nearby village. There were still 17 residents with an intellectual disability living in institutional care at the time of writing. It was reported that in order to relocate people to the community additional funding was required but no such funding was currently available.

4. *The hospital closure plan must be funded and resourced.*

Outcome: The staff of the service had worked extremely hard to progress the closure plan. They had been creative in working within budgetary constraints. They were now at the point where additional funding was required and a decision taken on the future location of acute in-patient services.

5. *Nursing home care must be funded for those residents for whom it is appropriate.*

Outcome: To date the funding for nursing home care had been taken from the mental health services budget. A number of residents had been placed in nursing home care and followed up using the code of practice issued by the MHC. The nursing home resettlement programme was being funded from the mental health revenue budget.

6. *Any money raised from the sale of the lands must be ring-fenced for the provision of services in Wexford.*

Outcome: No land had been sold since the last Inspectorate report.

Outline of Local Health Service Plan 2008–2009

The service continues to work from its 5 year plan 2007 - 2011. A number of capital projects had been submitted to the HSE development plan for consideration.

Developments 2008–2009

- The closure of three wards, relocation of service users to appropriate care facilities, and the redeployment of nursing staff to community teams.
- The continued development of the liaison and suicide crisis assessment nurse (SCAN) service at Wexford General Hospital. It was to be expanded to a seven-day service in 2009. Research and publication of findings was in progress.
- Four nurses had been assigned to an assertive outreach component of the rehabilitation team, two to each sector. Initial findings were positive.
- A new Mental Health Centre for Gorey Town was at commissioning stage. Funding was pending.
- The day services were to be reconfigured to optimise the use of human resources and provide a Further Education and Training Awards Council (FETAC) accreditated course for service users.
- The occupational therapy service had been reconfigured to maximise the use of 3.0 whole-time-equivalent posts across the sectors and in-patient services.
- The psychology service had established the Wexford Information and Self Help (WISH) scheme to increase access within the public and primary care services to good quality self-help materials in the area of mental health and emotional and psychological well-being.
- Formal links had been established between the service and child care services.
- Two additional staff were been trained as health care assistants.

Hospital Closure Plans (Where Applicable)

The hospital had a five-year plan for its closure and for the relocation of service users and services to appropriate environments. It was currently on target but there was no additional funding available to progress to the final stages. There was no decision on the location of acute services in the future.

Service User Involvement

Peer Support/Advocacy

A peer advocacy support service was provided by the Irish Advocacy Network (IAN). Currently there was a weekly service to the acute wards in St. Senan's Hospital and a quarterly service to two day hospitals in the county. No service was provided to the long-stay wards due to lack of human resources. It was planned to commence a training programme for volunteers who can work with the advocate.

The advocate in a written report to the Inspectorate was keen to highlight the support and welcome that was provided by staff to the IAN. Service users reported satisfaction with nursing staff, the quality of food and the availability of open space. Service users reported to the IAN concerns about the lack of social worker cover for maternity leave, lack of stimulation on the acute wards, and different rules in operation on different nursing shifts.

There was a system in place for the advocate to report any concerns to the director of nursing. It was planned that this would be formalised.

Service User Participation

At a clinical level, a number of service users were involved in signing their own care plans. All were invited to attend reviews.

At a planning level, the IAN representative was involved in *Vision for Change* implementation meetings and in the SCAN service. There were plans for the IAN advocate to be involved in multidisciplinary team clinical governance meetings and in policy development meetings.

Governance

There was a multidisciplinary team management structure in place. The occupational therapist manager was based outside the mental health service but directly supervised clinical staff. Since last year's inspection a social worker team leader had been appointed to the multidisciplinary management team.

A new clinical governance committee had been established. Its remit included reviews of all incidents, seclusion and restraint.

The service was part of a multi-centre study on suicide crisis assessment. Research was continuing. In addition, the service had acted on recommendations made in the independent report commissioned following in-patient suicides. This had resulted in the development of a checklist for residents returning from leave. It was the policy of the service to commission an independent report following an in-patient suicide.

At the time of inspection, there were four teams with a nominated team leader and part-time team co-ordinator in post.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	6
NCHD	8
Specialist registrar	0

Nursing Staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	80
Nurses based in community residences	25.5
Community mental health nurse	15
Nurses based in day hospitals	12
Nurses based in day centre	Included in figure above
Temporary staff panel	20

Nursing Specialist Posts

Speciality	WTE in post
Liaison	2
Clinical placement coordinators	1
Nurse practice development coordinator	1 Shared
Counsellors	2
Advanced nurse practitioner	0
Other	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4
Social work	3.5
Occupational therapist	3
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation
Population	131,615

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.5	0.5
CMHN	3	5
Clinical psychologist	0.4	0.4
Social worker	0.8	0.8
Occupational therapist	0.8	0.8
Dedicated addiction counsellor	0	0
Day facility nurse staffing	3	3
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	2 Shared	2 Shared

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	131,615

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.5	0.5
CMHN	4	4
Clinical psychologist	0.2	0.2
Social worker	0.2	0.2
Occupational therapist	0.2	0.2
Dedicated addiction counsellor	0	0
Day facility nurse staffing	1	1
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	None	None
Day centre	1	1

In-Patient Facilities

In-patient facilities were provided in St. Senan's Hospital. It had three primary functions, the provision of acute care, continuing care and care for persons with an intellectual disability.

The facilities had been the subject of much criticism over the years. The building was a large old institution, unsuitable for the provision of care and treatment. It was unacceptable that persons with an intellectual disability continued to live in institutional care.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

St. Senan's Hospital had worked very hard at addressing any deficits from previous reports. Multidisciplinary care planning had been rolled out to all the wards. A number of barriers were outside the control of the local management team including the continued use of a large institution to provide care and treatment.

The detailed individual approved centre report is available on the Mental Health Commission web site.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service had ECT, seclusion and mechanical restraint (Part 5) in use in the hospital. The service was largely compliant. Details are given in the approved centre report.

Codes of Practice

The service used physical restraint, reported incidents, provided ECT and admitted children. The hospital was unsuitable for the admission of children. Regional beds planned for the area were not yet operational. Details are given in the approved centre report.

Multidisciplinary Care Planning

Multidisciplinary care planning had commenced in the rehabilitation team. It was been extended to the general adult teams. A common assessment tool was been developed and piloted in the South sector.

24-Hour Supervised Community Residences

Description

There were three community residences in total. All were under the clinical direction of the rehabilitation team. Two were dedicated to people with an intellectual disability.

The team had access to three medium support residences and six low support residences. All service users were registered as having a housing need with the county council as appropriate.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Ardmine	11	11	Rehabilitation	MDT
Westlands	8	8	Rehabilitation	MDT
Ballynaslaney House	8	8	Rehabilitation	MDT

Conclusion

The staff and management of Wexford Mental Health Services have again reported positive developments within the service. These have spanned the closure of wards, provision of suitable accommodation in the community for residents, and the development of links with other providers and partners in the county. The five-year development plan was on target. Staff have been redeployed as appropriate.

There has been significant progress made in the area of service user involvement in the service and there were plans for this to be progressed further.

The remaining targets that will bring about completion of the *Vision for Change* implementation plan are dependent on additional resources and funding.

The HSE must address immediately the continued use of institutional care in unacceptable standards for those with an intellectual disability and those who remain on long-stay wards simply because community accommodation has not been provided. The provision of acute services in appropriate environments must be fast-tracked. The current wards are unacceptable and lack privacy.

Recommendations and Areas for Development

1. *The hospital must close and alternative and appropriate accommodation must be provided based on assessed needs of the residents.*

2. *Acute in-patient services must be provided in a general hospital and an action plan put in place to achieve this.*

3. *Sleeping out of residents from the acute wards poses risk management issues is an unacceptable practice and must be discontinued.*

4. *The teams must be staffed in line with national policy agreements.*

5. *Multidisciplinary care plans must be extended to all areas.*

HSE WEST

Mental Health Services 2009
Catchment Area Report
Clare

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	Psychiatry of later life Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Total expenditure 24,993,450 euro
Date of Meeting	4 June 2009

Service 2009

Description of Service (Including Distinct Features)

Clare Mental Health Services cover a population of 110,950 which is spread across a large geographical area with a poor infrastructure. There are four general adult community mental health teams and two established speciality teams in psychiatry of later life and rehabilitation. Service delivery is community based.

The catchment had three approved centres. One of them, Cappahard Lodge, had shown little evidence of progress in relation to compliance since it was registered in October 2008, and approximately eight months after receiving recommendations from the Inspectorate in relation to compliance. In the view of the Inspectorate, there was a lack of agreement about the nature of the service and an absence of strong leadership to bring about compliance with the Regulations, Rules and Codes of Practice. These statutory minimum standards were not being applied to the care and treatment of residents, thereby increasing clinical risks and breaching the rights of residents.

Progress on Recommendations from the 2008 Report

1. *The management team should be representative of all disciplines that have knowledge of the provisions of mental health services.*

Outcome: Operational management continued to be conducted along traditional tripartite lines. A management steering group comprising multidisciplinary staff from mental health and Primary Community and Continuing Care (PCCC) and the Irish Advocacy Network (IAN) representative had been established.

2. *All teams should be fully resourced.*

Outcome: Completion of community mental health teams in line with *A Vision for Change* are being progressed insofar as current financial constraints and acceptance of changing practice within the service allows.

3. Each approved centre should be compliant with the Regulations.

Outcome: None of the three approved centres in the Clare catchment were fully compliant with the Regulations, Rules and Codes of Practice. Cappahard Lodge had an unacceptably low level of compliance.

Outline of Local Health Service Plan 2008–2009

A copy of the local mental health service plan was requested by the Inspectorate but was not forwarded.

Developments 2008–2009

2008 Developments

- Implementation of *Vision for Change*: Recommendations from *A Vision for Change* were progressed through sub-committees, e.g. care planning, sector review. A local multidisciplinary mental health steering group was established.
- General adult psychiatry: The sector review sub-committee progressed work concerning reconfiguration of sectors in line with *A Vision for Change* recommendations, aligned with primary care teams.
- Child and adolescent mental health services: Training in Children First was undertaken by identified staff and linkages with the child and adolescent mental health service (CAMHS) team continued to be advanced in line with best practice.
- Authorised officers: Staff were identified in 2008 to undertake training.
- Cappahard Lodge: A review of policies and procedures at Cappahard Lodge was undertaken which informed future service delivery at Cappahard Lodge.
- Reconfiguration: A number of nursing posts were transferred to community settings to meet increasing needs.

2009 Developments

- Nursing home transfers: During February and March 2009, 24 patients from the long-stay unit transferred to nursing home accommodation on foot of multidisciplinary team assessment.
- Nursing resources: There were ongoing discussions concerning the reconfiguration of nursing resources in line with the strategic policy objectives of *A Vision for Change*.
- Cappahard Lodge: Changes to staffing practices in line with Quality Framework for Mental Health Services (Mental Health Commission 2008) and the Residential Standards for Older Person Services (HIQA 2008).
- Quality Framework roll-out: Roll out and implementation of aspects of the Quality Framework was advanced through piloting of individual multidisciplinary care plans at sector level. Individual care plans based on the recovery model already in place in rehabilitation.
- Quality risk standards and governance: The Clare mental health services were integrated into the new governance structure in Clare PCCC. The new structure was intended to facilitate progress of the Mental Health Service quality agenda. For example, since January 2009 the service had had access to the PCCC infection control nurse and this was helping to progress and embed a culture of quality awareness within the mental health services.

- Mental health and primary care: There was a consolidation of linkages with primary care. The area manager and director of nursing were recently joined by a consultant psychiatrist on the local primary care implementation group.

- Authorised officers: Three staff members underwent training and were available to Clare Mental Health Services to fulfil the authorised officer role in line with Mental Health Act 2001.

Hospital Closure Plans (Where Applicable)

This was not applicable.

Service User Involvement

Peer Support/Advocacy

The Irish Advocacy Network (IAN) has been providing a peer advocacy service in the Clare mental health services since 2006. The IAN service was being extended throughout Clare mental health service. The IAN visited the Acute Psychiatric Unit and Orchard Grove weekly, however, peer advocacy was not yet available in Cappahard Lodge.

Regular information sessions were provided by the IAN to service users.

Patient information sheets continue to be updated and made available.

Service User Participation

In the community rehabilitation service and Orchard Grove, all service users were involved in their own individual recovery care plans. Residents in the acute psychiatric unit and one of the sectors were involved in their individual care plans.

Feedback from service users was being facilitated through the care planning process and the HSE "Your service your say" procedures. The IAN representative was on the Clare mental health management steering group, the policy group, and the multidisciplinary care plan development committee.

Governance

The existing management structure had been reviewed and it was being reconfigured in line with *A Vision for Change*. The move to establish the regional area in line with the envisaged Mid-West catchment area along with the appointment of a regional director should be followed by the establishment of the multidisciplinary area management team.

At local level the existing traditional tripartite line management structures remain. A local multidisciplinary steering group comprising mental health and PCCC had been established to assist in providing strategic direction to local plans.

Quality Improvements (Audits and Reviews)

The services of an infection control nurse have being made available to Clare Mental Health Services since January 2009.

Approval has been given for the piloting of intensive community-based treatment (ICBT) in the West Clare community mental health team and consideration will be given to the extension to other sectors depending on the feedback from the pilot.

A number of clients have been transferred following multidisciplinary team assessment to more appropriate care settings with a consequent reduction in inpatient numbers in Orchard Grove.

Staffing Dedicated to Specialist Mental Health Services

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
Community mental health nurse	3
Nurses based in day hospitals	12.16
Nurses based in day centre	13.09
Other – Temporary staff panel	1.37

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	0
Advanced nurse practitioner	0
CNS (ECT)	1
CNS (CMHN)	6
CNS (Rehabilitation)	4

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5
Social work	4.6
Occupational therapist	4.2
Art therapist	Sessional commitment
Addiction counsellors	2.5

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of Later Life
Population	12,921

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	1	1
CMHN	2	2
Clinical psychologist	0	0
Social worker	0	0.6
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Nurses based in approved centre	29.74	28.74
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

Rehabilitation Team Report

Team Description	Rehabilitation
Population	110,950

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	1	1
CMHN	0	0
Clinical psychologist	1	1
Social worker	1	1
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Nurses in community residences		59.32
Day facility nurse staffing	0	8.37
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital		
Day centre	Orchard Day Centre, Kilrush Ennis Day Centre (Rented)	Orchard Day Centre, Kilrush Ennis Day Centre (Rented)

In-Patient Facilities

There were three approved facilities in the Clare mental health services. Cappahard Lodge stood out because of its poor level of compliance with the Regulations, Rules and Codes of Practice on the day of inspection. Due to the level of concern in relation to lack of compliance, the matter was reported directly to the MHC and will continue to be monitored.

Details of approved centre inspections are available in the respective approved centre reports.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

Capphard Lodge was compliant with 6 articles of the Regulations. Orchard Grove was compliant with 23 articles of the Regulations. The acute psychiatric unit was compliant with 21 articles of the Regulations.

Details of approved centre inspections are available in the respective approved centre reports.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

Cappahard Lodge: Neither seclusion nor ECT were used. The service was not compliant with some aspects of Part 5 of the mechanical restraint Rules.

Orchard Grove: Neither seclusion, ECT nor mechanical restraint were used.

The Acute Psychiatric Unit was substantially compliant with regard to the use of seclusion. The designated ECT nurse had not been trained in ECT. Mechanical restraint was not used.

Details of approved centre inspections are available in the respective approved centre reports.

Codes of Practice

Physical Restraint

Cappahard Lodge: There was no policy in place.

Orchard Grove: The unit was substantially compliant.

APU: The unit was not fully compliant.

Admission of Children

Cappahard Lodge: Children were not admitted.

Orchard Grove: Children were not admitted.

APU: Although children had been admitted to the unit it was not fully compliant.

Notification of Deaths and Incident Reporting

Cappahard Lodge: The service was not compliant.

Orchard Grove: The service was compliant.

APU: The unit was fully compliant.

ECT for Voluntary Patients

Cappahard Lodge: ECT was not used.

Orchard Grove: ECT was not used.

APU: The designated ECT nurse had not been trained in ECT.

Details of approved centre inspections are available in the respective approved centre reports.

Multidisciplinary Care Planning

In Cappahard Lodge, none of the residents had an individual multidisciplinary team care plan. In Orchard Grove, a multidisciplinary team recovery care plan was in place for each resident. In the acute unit all residents had individual multidisciplinary care plans that clearly documented the team's involvement and resident participation in the care planning process.

24-Hour Supervised Community Residences

Description

The service had six 24-hour supervised hostels. Two of the hostels had no mental health team responsible for the residents, a number of whom had intellectual disability.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Orchard Lodge	21	18	Rehabilitation	MDT
Cois Mara	16	16	None	None
Avonree house	11	9	None	None
Deilgnis	14	14	Rehabilitation	MDT
Gort Glas	20	19	Rehabilitation	MDT
Teach na Beithe	8	7	Rehabilitation	MDT

Conclusion

The Acute Psychiatric Unit and Orchard Grove continued to progress towards full compliance with the Regulations, Rules and Codes of Practice. However, Cappahard Lodge had a poor level of compliance on the day of inspection. This was despite the fact that the three approved centres are part of the same service and knowledge and practices could easily be shared across the approved centres, particularly in the area of policies. During the inspection, senior managers reported that they were aware that Cappahard Lodge had significant deficits in relation to compliance, yet no action was taken. The poor level of compliance was reported to the Mental Health Commission and will continue to be monitored.

Recommendations and Areas for Development

1. *Each of the three approved centres must be compliant with the Regulations, Rules and Codes of Practice and compliance with regard to Cappahard Lodge must be a priority.*

2. *The management team should be representative of all disciplines.*

3. *All of the clinical teams should be fully resourced.*

Mental Health Services 2009
Catchment Area Report
Donegal

HSE Area	HSE West
Catchment	Donegal
Mental Health Service	Donegal Mental Health Services
Population	139,432
Number of Sectors	4
Number of Approved Centres	2
Specialist Teams	Child and family Intellectual disability MHSOP Rehabilitation and recovery
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	15 October 2009

Service 2009

Description of Service (Including Distinct Features)

Donegal Mental Health Services had four sector teams and four specialist mental health teams that covered a largely rural area and two urban areas: Letterkenny and Donegal Town. St. Conal's Hospital, which on the day of inspection had 19 residents, 13 male and 6 female, and the acute psychiatric unit at Carnamuggah, which had 30 residents, were both approved centres. The building in which the acute psychiatric unit was temporarily accommodated was purpose-built for use as a nursing home. Because of this, the staff-to-resident ratio was high and the lease of the building by Donegal Mental Health Services amounted to €300,000 per annum. The new unit had been scheduled to begin construction in the first quarter of 2009 but this had not happened. It was reported that the tender for the construction of the new building had been accepted and that the project was awaiting approval from the Department of Finance. There were specialist rehabilitation, older people, child and family, and intellectual disability teams. There was one day hospital used by the Central Sector. All remaining sectors had use of a day centre. The older people and child and family teams had access to no day centre.

Progress on Recommendations from the 2008 Report

1. *All teams should be adequately resourced with the full complement of multidisciplinary team members.*

Outcome: This had not occurred.

2. *The closure of St. Conal's Hospital should proceed and remaining residents should be placed in suitable alternative accommodation.*

Outcome: It was reported that a business plan for the closure of St. Conal's Hospital was at an advanced stage.

3. *All residents should have an individual care plan as described in the Regulations, and a single composite set of notes should be kept.*

Outcome: All residents of both approved centres had a single composite set of notes. Each resident of St. Conal's Hospital had an individual care plan as defined in the Regulations. Residents of the acute psychiatric unit had nursing care plans.

Outline of Local Health Service Plan 2008–2009

The local health service plan was examined by the Inspectorate. It highlighted the service's progress in implementing *A Vision for Change*, modernisation of the mental health service and developments within the catchment area.

Developments 2008–2009

- Ongoing assessment of service users over 65 years in supervised residential accommodation by the elderly service regarding their suitability to be placed in a community care setting. All service users who are moved to community facilities are followed up by the community mental health nurse or consultant psychiatrist.
- STEER Advocacy Services had scheduled visits to approved centres.
- The "proof of concept" phase of an information system for mental health services called WISDOM being piloted in Donegal Mental Health Services began.
- Referral, transfer and discharge policies were developed for the community mental health teams.
- Meetings between Letterkenny General Hospital and local mental health services to proactively manage referral and liaison issues had been established.
- An audit of the occupational therapy service had been completed.
- A draft position paper on governance of occupational therapy in Donegal Mental Health Services had been produced.
- A service user questionnaire for service users of Donegal Mental Health Services had been developed and was being used.
- A service user satisfaction survey had been developed by the service in partnership with STEER.
- The Hearing Voices group, run in conjunction with the department of occupational therapy, began in the summer 2009, and met fortnightly.
- A dance, voice and music group met weekly in St. Conal's Hospital.
- A multidisciplinary policy development group had been established, chaired by the STEER representative.

Hospital Closure Plans (Where Applicable)

The closure of St. Conal's Hospital has been planned for some time. It was anticipated that the remaining male residents would be accommodated in a 24-hour supervised residence within the following six months. The service was at an advanced stage of negotiation with a voluntary body regarding provision of alternative accommodation in a small housing unit for the female residents.

Service User Involvement

Peer Support/Advocacy

The advocate visited St. Conal's Hospital and the acute unit at Carnamuggagh and reported an excellent working relationship with the staff in both units.

In addition to providing advocacy to service users, the peer support group STEER was actively involved in education and training programmes. The group had participated in the leadership programme run by DCU and had conducted an audit of service users, the report of which was due to be presented to the service on completion.

STEER established a primary action group which functioned as a consumer panel for service users. In response to concerns of service users, the advocacy group also established a housing association for its clients.

Service User Participation

The service users advocacy group was involved in a number of activities within the service. The advocate who co-chaired the policy group was a member of the management team and sat on various other committees.

Governance

Quality Improvements (Audits and Reviews)

The management team was reconfigured in 2008 and now includes all heads of discipline. It met on a monthly basis. A representative from this team participated in the mental health management team of the service. A medication management audit, including items such as prescription signatures and legibility, had been carried out and was currently posted on the wards for validation. A mental health quality and risk management forum was established and a quality and risk management framework self-assessment process had been completed.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	10
NCHD	12
Specialist registrar	2

Nursing Staff

Post	WTE in post
DON	1
ADON	4
CNM3	2
Nurses based in in-patient services	75
Nurses based in community residences	50
Community mental health nurse	14
Nurses based in day hospitals	7.75
Nurses based in day centre	5
Other – Temporary staff panel	19

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1
Clinical placement coordinators	1
Nurse practice development coordinator	0.5
Cognitive behavioural therapists	5 CNM2
Advanced nurse practitioner	0
Student allocation officer	1
Nurse addiction counsellor	7 (3 CNS, 4 CNM2)
Generic counsellor	1 CNS
Other – Youth addiction counsellor	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4
Social work	3.5
Occupational therapist	4.5
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Rehabilitation Team Report

Team Description	Rehabilitation
Population	139,432

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator (ADON)	1	1
CMHN	6	6
Clinical psychologist	1	1
Social worker	1	0
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	2	2
Health care assistant	4	4

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	Owned	Owned

MHSOP Team Report

Team Description	Mental Health Service for Older People (MHSOP)
Population	18,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	1	1
CMHN	5	5
Clinical psychologist	1	1
Social worker	1	1
Occupational therapist	0.5	0.5
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	No	No

Intellectual Disability Team Report

Team Description	Intellectual Disability
Population	150,000

Staffing	2008 WTE in post*	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Community intellectual disability nurse	1	1
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	2 owned	2 owned

Child and Family Team Report

Team Description	Child and Family Mental Health
Population	40,288

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	2	2
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0	0
CMHN	2.6	2.6
Clinical psychologist	0	0.8
Social worker	1	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No	No
Day centre	No	No

In-Patient Facilities

The service had two in-patient units. St. Conal's Hospital provided continuing care under the rehabilitation team for 11 male and 6 female residents. Closure plans were well advanced and it was expected that all residents would be transferred to more suitable accommodation within the next twelve months.

The acute admission unit was located in a temporary building at Carnamuggagh, pending the construction of a new acute unit in Letterkenny General Hospital. It had been at its present location for the previous three years and construction of the new unit had not yet commenced. The acute unit accommodated 38 residents and had a full complement of residents on the day of inspection.

Statutory Requirements for Approved Centres

An inspection of both approved centres was carried out on 14 October 2009.

Regulations (S.I. 551 of 2006)

Neither approved centre was fully compliant with Article 6 (Food Safety), Article 24 (Health and Safety), Article 26 (Staffing) and Article 29 (Operational Policies). The acute unit at Carnamuggagh was not compliant with the Regulation governing individual care plans, and was only substantially compliant with the Regulations on provision of therapeutic services, children's education, food and nutrition and premises.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The Rules on seclusion, mechanical restraint and ECT for detained patients were not applicable as these were not in use in St. Conal's Hospital.

The acute unit did not use seclusion or mechanical restraint. No patient was receiving ECT at the time of inspection.

Codes of Practice

Physical restraint was not used in St. Conal's and children were not admitted to that centre. The unit at Carnamuggagh was substantially compliant with the Codes of Practice relating to use of physical restraint and admission of children.

Both units were fully compliant with the Codes of Practice on reporting of deaths and incidents, and use of ECT in voluntary residents.

Multidisciplinary Care Planning

The rehabilitation team had introduced an excellent care plan for the residents in St. Conal's Hospital. Individual care plans as defined in the Regulations had not been introduced in the acute unit, but the service was in the process of piloting care plans for residents in the admission unit.

24-Hour Supervised Community Residences

Description

The Donegal service operated four 24-hour supervised residences. One of these was under the care of the rehabilitation team and residents there had individual care plans. The other residences were under the care of the CMHTs and nursing care plans were in operation.

Residence	Number of places	Number of residents	Team responsible	Care plan type*
Cleary House, Letterkenny	20	12	Rehabilitation and Recovery	MDT and nursing
Park House, Dungloe	18	11	North West CMHT	Nursing
Rowanfield House	16	14	South West CMHT	Nursing
Radhairc na Sléibhe	18	17	North East CMHT	Nursing

Conclusion

The catchment area of Donegal served a population of almost 140,000 people. It had four CMHTs and provided a specialist service in rehabilitation, psychiatry of later life, intellectual disability and child and family psychiatry. The service was proceeding well with its plans to effect closure of St. Conal's Hospital within the year. The process of fixing a tender for the construction of a new acute unit in Letterkenny General Hospital was taking considerably longer than anticipated, and residents continued to be accommodated in a unit, which although providing accommodation of a very good standard, was nonetheless unsuitable as an acute psychiatric admission unit.

CMHTs were not fully resourced in terms of multidisciplinary input and it was disappointing to see that some teams, including the rehabilitation team, functioned without a social worker.

The Inspectorate was impressed with the quality of the care plans for residents in St. Conal's, and would encourage the adaptation of these plans for use in the acute unit.

Recommendations and Areas for Development

1. *Individual care plans, as defined in the Regulations, should be introduced in the acute unit.*

2. *The closure of St. Conal's Hospital should proceed and residents transferred to more suitable accommodation.*

3. *All CMHTs should be fully resourced in terms of multidisciplinary input.*

Mental Health Services 2009
Catchment Area Report
East Galway

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	Psychiatry of later life Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	16 July 2009

Service 2009

Description of Service (Including Distinct Features)

The service had a catchment area covering the geographic area of East Galway, serving the main towns of Ballinasloe, Mountbellew, Glenamaddy, Loughrea, Athenry, Portumna, Gort, Tuam and Headford. Acute and continuing care in-patient services were provided in the two remaining units of St. Brigid's Hospital in Ballinasloe. The service had four adult community mental health teams and specialist teams in the areas of rehabilitation and psychiatry of later life. All of the services provided a continuum of care ranging from brief intervention, to more specialised day hospital or day care interventions, as well as in-patient care. Home care was encouraged and all services encouraged family involvement and were using a recovery model approach.

Addiction services were community based across all four sectors and in Tuam and Loughrea worked on a shared basis with the community addiction workers. Historically the service had provided services to a large cohort of adults with an intellectual disability. All were on the National Intellectual Disablity Database (NIDD) and all but ten clients had been discharged from the hospital to supported community accommodation provided by the Mental Health Service. Three training centres also formed a part of the service. The service had undergone major change in recent years in shifting from the mainly hospital setting to a community based one.

Progress on Recommendations from the 2008 Report

1. *All Rules, Regulations and Codes of Practice should be adhered to.*

Outcome: The service continued its efforts to reach full compliance.

2. *The training of staff in management of aggression should be addressed as a matter of urgency.*

Outcome: A programme of mandatory training was underway over the past year with 83 staff having completed training in violence and aggression management.

3. *Community teams and specialist teams should be fully staffed.*

Outcome: Teams were not fully staffed. Candidates for two occupational therapy posts had been selected and offered posts. The psychiatry of later life team was recruiting to fill two CMHN posts.

Outline of Local Health Service Plan 2008–2009

- Reduce in-patient bed numbers to 80.
- Establish a psychiatry of later life service.
- Introduce STARS Web tracking system as part of risk management.
- Implement HSE attendance management policy.
- Appoint *A Vision for Change* implementation group for Galway.
- Reorganise switchboard operations at St. Brigid's Hospital.
- Cease in-house laundry service at St. Brigid's Hospital.
- Redeploy CNM2 positions due to closure of wards by looking at areas for development of CMHN posts.
- Review heat, light and power usage. The service had installed wood burning stoves in St. Brigid's Hospital, which resulted in substantial savings.
- Reduction in travel.

Developments 2008–2009

- A consultant psychiatrist in psychiatry of later life had been appointed.
- Two additional occupational therapy community posts had been approved.
- Closure of Ward 21A and Ward 16.
- Continuation of policy to discharge older people to more appropriate settings.
- Production of closure plan for the "New Building".
- Establishment of enhanced nurse management structure in the acute area.
- Refurbishment of areas of the hospital.
- Refurbishment and re-opening of Portumna Day Centre.
- Establishment of a clinical audit group representative of all staff.
- Establishment of a risk management group.
- Establishment of a clinical practice group in the acute area, developing generic assessment tool, enhanced documentation, case files, and care plan documentation.
- Work continued in alignment of services with the new primary care teams.
- Discussions continued with voluntary service provider in respect of intellectual disability services hand over.
- Work continued on redeployment of staff and services from the main hospital building.

- Planning application submitted to the local authority in respect of refurbishment of the former nurses home as catchment headquarters.
- Introduction of an on-call senior nurse service for out of hours.
- Involvement of staff in design team for the new 50-bed CNU on the St. Brigid's campus which will facilitate the discharge of about 20 older people to this facility.
- Home-based care team commenced in Portumna area.
- A number of education events were organised during the year in the areas of governance, clinical practice and service user involvement.
- Establishment of group representative of all Galway services to review provision of Addiction services.
- The service sponsored three participants on the DCU cooperative learning leadership programme. Their project work was on the area of empowerment of the service user.
- Unit staffing had been successfully introduced in the in-patient units. This had impacted positively on service delivery.
- Six service users from Ballinasloe accompanied by two staff joined six from Chalon in France on a therapeutic exchange at a location on the French Mediterranean coast.
- The Wellness Recovery Action Plan (WRAP) programme had been introduced across the services.
- The service was becoming increasingly recovery-orientated in terms of its philosophy.

Hospital Closure Plans (Where Applicable)

The number of residents continued to decline. There were 52 residents in long-stay care in St. Brigid's Hospital on the day of inspection. Two wards, Ward 16 and Ward 21A, had been closed since the previous inspection. Residents were no longer accommodated in the original Victorian building. The next phase of closure is expected to see the closure of Ward 17, with suitable residents being accommodated in nursing homes, given their age profile.

Service User Involvement

Peer Support/Advocacy

An advocate visited St. Brigid's Hospital regularly. In some wards there were routine visits; the advocate visited other wards as required. There were good relations between the staff and the advocate, and there were no difficulties in reporting service user concerns.

The advocate described some common issues raised by service users, namely perceived overuse of medication, being unaware of their care plans, lack of support in the community, and insufficient information about their illness. There was concern among some residents in one of the long-stay wards about the proposed move to alternative accommodation.

Service User Participation

There was a service user on the audit group. A consumer panel was established in the Galway region. However, due to the inability of the Local Health Manager's office to provide funding to facilitate travel or expenses for participants, the members of the panel withdrew. At the catchment meeting, it was reported that an arrangement could now be set up to facilitate travel payments. It was expected that the consumer panel would resume in the Autumn.

Governance

Quality Improvements (Audits and Reviews)

The service continued to operate a tripartite system of management. While the management team met with the catchment managers, it was reported that no catchment meeting had been held since December 2008. Apart from this meeting, there was no forum for links with the management team. The occupational therapy and psychology managers expressed a desire for an opportunity for greater involvement in management. Similarly, there had been no involvement in the management team by the advocate.

An audit committee had been in place since January 2009.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7.45
NCHD	11
Specialist registrar	None

Nursing Staff

Post	WTE in post
DON	1 (acting)
ADON	7 (including 3 acting)
Nurses based in in-patient services	74.65 (acute unit and two long stay wards)
Nurses based in community residences	104 (including 46 intellectual disability and 11 rehabilitation)
Community mental health nurse	11
Nurses based in day hospitals	20
Nurses based in day centre	18
Other – temporary staff panel	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1 (nursing home liaison)
Clinical placement coordinators	1
Nurse practice development coordinator	1
Counsellors	9 (addictions)
Advanced nurse practitioner	0
Cognitive behavioural therapy	3
Acute care	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4
Social work	6
Occupational therapist	6
Art therapist	0
Physiotherapist	1

Specialist Teams (Excluding Primary Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	110,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1 Locum	1 since June 2nd 2009
NCHD (including specialist registrar)	0.5	2
Dedicated team coordinator	1	1
ADON	0	0
CMHN	0	0
Clinical psychologist	0	0
Social worker	0	1 since February 2009
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

Rehabilitation Team Report

Team Description	Rehabilitation
Population	110,000

Staffing	2008 WTE in post*	2009 WTE in post
Consultant psychiatrist	1	0
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0.5	0.5
CMHN	0	0
Clinical psychologist	0	0
Social worker	1	1
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	0	0
Day centre	0	0

In-Patient Facilities

St. Brigid's Hospital, Ballinasloe, was an approved centre under the Mental Health Act 2001 and was part of a wider community mental health service. The hospital consisted of three main buildings: the main building at the front of the campus was a grey-bricked pre-Victorian edifice built in 1833 which for the past few years had been used for administration purposes only. At the rear of the campus was the "New Building" opened in 1903, which provided three wards consisting of 53 beds for continuing care residents. Off campus, across the road, was a 1930s structure that also contained three wards, consisting of 41 beds, which were part of the Admission Unit. Four sector teams admitted to the acute admissions unit. The service also had two specialist teams: a psychiatry of later life team and a rehabilitation team.

Statutory Requirements for Approved Centres

All wards in the approved centre were visited during the inspection and all the Regulations were inspected in two wards. The seclusion and ECT facilities were also inspected, as were the registers for physical restraint and seclusion.

Regulations (S.I. 551 of 2006)

The approved centre was fully compliant with the majority of the Regulations. The centre was not compliant with the Regulation relating to privacy, and had initiated compliance with the Regulations on individual care plans, therapeutic services, staffing and complaints procedures. The Inspectorate was informed that the individual care plans as described in the Regulations would be introduced in September 2009.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service had initiated compliance with the Rule sections on facilities for seclusion S69(7), and the use of CCTV S69,11.2(b). There was full compliance with the remainder of the Rule on seclusion.

Codes of Practice

The service was not fully compliant with the Code of Practice relating to the admission of children. The approved centre was unable to provide age-appropriate facilities for the admission of children. Children should not be admitted to adult units. The approved centre was compliant with the Codes of Practice on ECT, physical restraint and notification of deaths and incidents.

Multidisciplinary Care Planning

The psychiatry of later life team was in the process of introducing recovery care plans for all residents in its care. The Inspectorate was informed that multidisciplinary care plans would be introduced in the acute admission wards in September 2009.

24-Hour Supervised Community Residences

Residence	Number of places	Number of residents	Team responsible	Care plan type
Callow View, Portumna	6	4 + 2 respite	Portumna/Gort	Nursing
2 Bridge Road, Portumna	4	4	Portumna/Gort	Nursing
Ennis Road, Gort	5	5	Portumna/Gort	Nursing
Tulla Hill, Loughrea	6	6	Loughrea/ Athenry	Nursing
Brook House, Mountbellew	8	7 + 1 respite	Ballinasloe/ Mountbellew	Nursing
Grove House, Moher, Ballinasloe	5	4 + 1 respite	Ballinasloe/ Mountbellew	Nursing
Toghermore House, Tuam	25	22	Tuam/Headford	Nursing
Aishling, Milltown Road, Tuam	9	7	Tuam/Headford	Nursing
Riverview House, Ballinasloe	9	9	Rehabilitation	Nursing
13 Garbally Oaks, Ballinasloe	6	6	Rehabilitation	Nursing

Conclusion

The East Galway catchment team was a progressive team as is evidenced by the range of initiatives and developments reported to the Inspectorate. Lack of funds inhibited further developments. The closure plan for the older section of St. Brigid's Hospital was proceeding and residents were no longer accommodated in the old building. The number of residents accommodated in the "New Building" section continued to decline. It was encouraging to see the appointment of a psychiatry of later life

team to the service but the rehabilitation team needs to be fully staffed in view of the long-stay nature of some of the residents. The service continued to retain its tripartite system of management which is contrary to *A Vision for Change* and which, by its nature, fails to fully utilise the skills of its multidisciplinary managers. The report that the Local Health Manager's office can now facilitate travel expenses for participants of the consumer panel enabling members to re-establish it was encouraging.

Recommendations and Areas for Development

1. *Multidisciplinary care plans should be introduced to all residents in the approved centre.*

2. *Renovations should be carried out to improve bathroom standards in the approved centre.*

3. *The service should consider extending its core management system to include managers of other disciplines.*

Mental Health Services 2009
Catchment Area Report
Limerick

HSE Area	HSE West
Catchment	Limerick
Mental Health Service	Limerick Mental Health Services
Population	184,055
Number of Sectors	5
Number of Approved Centres	3
Specialist Teams	Forensic Liaison Rehabilitation
Per Capita Expenditure 2008 [>18 Years]	Not provided
Date of Meeting	9 July 2009

Service 2009

Description of Service (Including Distinct Features)

Limerick Mental Health Services provides a service to Limerick city and county. It had three approved centres at Limerick Regional Hospital, St.Joseph's Hospital and in Tearman and Curragour wards at St. Camillus's Hospital. The community was served by five community mental health teams and there were four specialist teams. The specialist teams provided care in liaison, forensic, rehabilitation and a recently created post in psychotherapy.

Progress on Recommendations from the 2008 Report

1. *The urgent closure of St. Joseph's Hospital should be advanced from plan to action.*

Outcome: The service had drawn up a comprehensive plan for the closure of St. Joseph's and provision of more suitable accommodation for residents. From the Inspectorate report, it was apparent that the plan had not been implemented as yet and that in fact there continued to be admissions. In November 2009, Unit 10 was closed following the discharge of residents to appropriate community care settings.

2. *More suitable normalised accommodation should be sought for those in large 24-hour supervised residences.*

Outcome: Although this had not happened, suitable places in nursing homes had been identified for some of the residents, and consultation had begun with families. In addition, the plan called for the discharge of residents of long standing from O'Connell House to nursing home care. The rights of these residents must be respected in any such move.

3. *The rehabilitation team should be enhanced to provide assessment and active rehabilitation for the above group of service users.*

Outcome: The rehabilitation team does not have a clinical psychologist or social worker.

Outline of Local Health Service Plan 2008–2009

The service had produced a service plan. The service plan reiterated its priority objective of relocating residents from St. Joseph's Hospital to more suitable accommodation. The development of the high observation area in Unit 5B was being progressed through the remaining stages of its development and planning permission had been approved. The plan proposed to continue the process of integration of psychiatry of later life into the mental health services within the Limerick area.

Developments 2008–2009

- A new multidisciplinary individual care plan based on a recovery approach had been piloted and was expected to be fully introduced to the approved centre at Unit 5B by the autumn.
- A consultant psychiatrist with special interest in psychotherapy had been appointed and was in post, and a second consultant in child and adolescent mental health was appointed in July.
- Interviews had been held for the post of professor of psychiatry, associated with the University of Limerick, and funding had been approved for a lecturer's post.
- The rehabilitation and recovery centre at Iniscara in Limerick city had won a national award for its work in developing a daily programme for service users.
- The CMHN on the CAMHS team participated in drawing up the care plan of any child admitted to Unit 5B.
- An external hygiene audit was carried out in St. Joseph's Hospital late in 2008. The report was awaited.

Hospital Closure Plans

The service had a closure plan for St. Joseph's Hospital.

Service User Involvement

Peer Support/Advocacy

The regional advocate presented a report to the catchment meeting. It was reported that the advocate had no difficulty accessing residents and patients in any of the facilities, and staff were generally helpful to the advocate. Keys to the acute unit and to a ward in St. Joseph's Hospital had been provided for ease of access.

One of the main complaints highlighted by the advocate was the almost permanent locking of the entrance door. Some residents were unaware of their care plans, others complained of an over emphasis on medication. Some residents requested more information on their medication; some people didn't know what they were taking.

The advocate was unaware that Tearman and Curragour Wards in St. Camillus Hospital were functioning as an approved centre. Following the catchment meeting, it was reported to the Inspectorate that an advocate now visited Tearman and Curragour Ward every three to four weeks.

Service User Participation

The consumer panel in Limerick had been disbanded, following a failure to resolve the issue of expenses for participants. It was subsequently reported that it had been reactivitated.

The advocate was involved in the development of the care plans in Unit 5B.

Governance

Quality Improvements (Audits and Reviews)

The service continued to retain the tripartite system of governance. The head of psychology services in mental health had requested inclusion in the process and stated that the consultative process was not yet active. It was subsequently reported to the Inspectorate that a multidisciplinary management team was in place.

The issue of the governance of psychiatry of later life teams posed difficulties for the consultant psychiatrists. The local health manager's office was of the view that psychiatry of later life came under the governance of "elderly care", while the practitioners were clearly of the view that the specialty lay within mental health. As there was no reference to St. Camillus Hospital in the catchment area self-assessment forwarded to the Mental Health Commission, it would appear that there was a lack of clarity regarding this approved centre and its staff.

Staff identified a difficulty in the operation of the authorised officer system under Section 9 of the Mental Health Act 2001. These officers were not functioning in Limerick and had to be recruited from outside the area when required. This matter needed to be resolved as soon as possible. It was subsequently reported that one of these officers was operating in the area.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	10.39
NCHD	12
Specialist registrar	2

Nursing Staff

Post	WTE in post
DON	1
ADON	8
Nurses based in in-patient services	126
Nurses based in community residences	58
Community mental health nurse	6
Nurses based in day hospitals	27.5
Nurses based in day centre	9
Nurses – Rehabilitation	4
Nurses – Forensic	0.5
Nurses – Administration	3
Nurses – Practice Development Unit	4

Nursing Specialist Posts

Speciality	WTE in post
Liaison	4
Clinical placement coordinators	0
Nurse practice development coordinator	1
Counsellors	0
Advanced nurse practitioner	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	5.5
Social work	4
Occupational therapist	3
Art therapist	0.1
Addiction counsellors	3

Specialist Mental Health Teams

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Forensic Team Report

Team Description	Forensic team
Population	184,055

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	0.5	0.5
NCHD (including specialist registrar)	0.5	0.5
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0.5	0.5
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	Owned	Owned
Day centre	No information	No information

Rehabilitation Team Report

Team Description	Rehabilitation team
Population	184,055

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Clinical psychologist	0	0
Social worker	0	0
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	9	9
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	No information	No information
Day centre	Owned	Owned

Liaison Team Report

Team Description	Liaison team
Population	184,055

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	0	0
CMHN	0	0
Clinical psychologist	0	0.5
Social worker	0	0
Occupational therapist	0	0
Dedicated addiction counsellor	0	0
Day facility nurse staffing	4	4
Health care assistant	0	0

In-Patient Facilities

The Limerick catchment area had three approved centres at the Department of Psychiatry, Limerick General Hospital, St. Joseph's Hospital and Tearman and Curragour wards in St. Camillus's Hospital. Although there was a closure plan in place for St. Joseph's Hospital, residents continue to be admitted.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The approved centre at St. Joseph's Hospital was not compliant with a number of Regulations, including therapeutic services, and had initiated compliance in relation to the introduction of integrated individual care plans.

Unit 5B, Limerick General Hospital, had initiated compliance with the introduction of integrated individual care plans and therapeutic services. Children continued to be admitted to the unit despite its unsuitability.

The approved centre in St. Camillus's Hospital was under the care of two psychiatry of later life teams and this was its first inspection as an approved centre. The admission of elderly patients with a medical illness only to this unit was a cause for concern as there was no clear line of clinical responsibility for these patients.

Following the catchment meeting, a recovery-orientated multidisciplinary approach to therapeutic services had been developed in conjunction with service advocates.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

ECT was provided in Unit 5B. The unit was substantially compliant with the Rules in relation to ECT. Seclusion was not in use in any of the approved centres. The centres were compliant with the Rules in relation to the use of mechanical restraint.

Codes of Practice

Children continued to be admitted to Unit 5B, despite its unsuitability. The unit was not compliant with the Code of Practice on admission of children. A new initiative ensured that a community mental health nurse was with the child on the acute unit at all times. Staff report this had been well received. Although a consultant psychiatrist had been appointed for child and adolescent mental health services since July 1, no other staff had been appointed as yet. Staff for that unit were to be prioritised in terms of replacement posts.

Multidisciplinary Care Planning

Individual care plans as described in the Regulations were not in operation in Unit 5B, St. Joseph's Hospital, or in Tearman and Curragour wards.

24-Hour Supervised Community Residences

Description

The 24-hour supervised residences were large; one of them accommodated up to 34 residents. The service had a plan to transfer residents from some of these residences to more suitable accommodation.

Residence	Number of places	Number of residents	Team responsible	Care plan type
New Strand House	17	16	General adult	Nursing care plans
Ferndale	20	18	General adult	Nursing care plans
Ivernia House	14	14	General adult	Nursing care plans
O'Connell House	25	25	General adult	Nursing care plans
Inisgile	34	34	General adult	Nursing care plans

Conclusion

The Limerick catchment area had a number of projects in hand to facilitate its development into a service which will better serve its catchment area population. These should be progressed as soon as possible. The development of a psychiatry of later life team was a welcome development, but presented challenges to the organisation that needed to be addressed. In progressing plans for the old age population, the rights of people who have lived in long stay accommodation in the service should be protected as much as possible. Likewise the admission of children to the acute unit was a cause for concern, particularly when they were often admitted for short periods. Even when the new admission facilities in Galway are fully developed, the need for alternative care arrangements for this group of children should be examined.

Recommendations and Areas for Development

1. *Admissions to St. Joseph's Hospital should cease.*
2. *Governance issues in St. Camillus' Hospital should be clarified.*
3. *The refurbishment of Unit 5B should begin as soon as possible.*
4. *An analysis should be made of the length of stay of children on the acute unit with a view to assessing whether alternative care is more appropriate.*
5. *All teams should be fully resourced in line with the recommendations of A Vision for Change.*
6. *Multidisciplinary care plans should become fully operational as soon as possible*
7. *Issues with regard to the authorised officer system should be addressed.*

Mental Health Services 2009
Catchment Area Report
Mayo

HSE Area	HSE West
Catchment	Mayo
Mental Health Service	Mayo Mental Health Service
Population	123,839
Number of Sectors	5
Number of Approved Centres	4
Specialist Teams	Psychiatry of later life Rehabilitation and recovery
Per Capita Expenditure 2008 [>18 Years]	30 million [sic]
Date of Meeting	23 July 2009

Service 2009

Description of Service (Including Distinct Features)

Mayo Mental Health Service provided a community based service across five sectors. The sectors were in the process of being aligned with the new primary care networks. In addition to the general adult teams there were three specialist teams: psychiatry of later life, rehabilitation and intellectual disability. There was a limited liaison service to Mayo General Hospital.

The service was a largely rural area with a number of urban centres that was facing a number of significant challenges in the coming years. There had been a significant number of senior nurse retirements and this had impacted on the service. Reconfiguration of the current total bed complement of 101 beds, the required skill mix, and the provision of resources to expand the community service all had to be considered.

Progress on Recommendations from the 2008 Report

1. *All teams should be resourced with the appropriate skill mix to ensure provision of a full multidisciplinary team approach.*

Outcome: There were no additional resources provided in 2009. A number of nursing posts were suppressed.

2. *The current management system of tripartite management would be improved by the introduction of multidisciplinary involvement.*

Outcome: There was no progress on this recommendation. It was unclear to the Inspectorate what the barriers to change were.

Outline of Local Health Service Plan 2008–2009

There was a written business plan for 2009/2010. Plans are contingent on the current financial situation and the recruitment strategy of the HSE.

Developments 2008–2009

- The bed numbers in An Coilín had been reduced and integrated. This was in compliance with the long-term objective of providing 10 rehabilitation beds and 15 continuing care beds.
- The closure of a day centre in Kiltimagh. This had resulted in service users accessing more appropriate generic services in the community.
- The care planning process had been under active review and discussion by the service. Amended documentation was now complete.
- St. Anne's Unit in the Sacred Heart Home, Castlebar, had been registered as an approved centre under the Mental Health Act 2001.
- A consumer panel had been established.
- Electroconvulsive Therapy Accreditation Service (ECTAS) accreditation for ECT was almost complete.

Hospital Closure Plans (Where Applicable)

Not applicable.

Service User Involvement

Peer Support/Advocacy

A peer advocacy service was facilitated by the Irish Advocacy Network (IAN). An advocate visited all the approved centres and also a number of the community facilities. The advocates, in a written report to the Inspectorate team, highlighted a number of positive aspects within the service as reported to them by service users. These positive aspects included the following: that staff are friendly, that activities in the acute unit are valued, especially the music sessions, and that there are good working relationships. The areas for concern were mainly focused on the acute in-patient unit. They included the locked door policy, the lack of meaningful activities, the lack of time with nursing and medical staff, and having to repeat their stories to various doctors.

Service User Participation

The consumer panel met on a regular basis and had good working relationships with the management team. A piece of research was currently under way by the IAN. The questionnaire based on the recovery principles was currently being administered to 25 service users of the rehabilitation team.

There was structural and regular input from families and service users into a number of working groups.

All service users were encouraged to be actively involved in the care planning process.

Governance

There was a traditional management structure in place to oversee the provision and development of Mayo Mental Health Services (director of nursing, hospital manager and clinical director). The hospital manager had formal links with the Local Health Manager and the Primary Community and Continuing

Care (PCCC) management structure. It was a recommendation last year that the structure be extended to include heads of discipline in accordance with *A Vision for Change*. This had not happened and it was difficult to pinpoint the exact reason. It was reported that all staff were widely consulted on issues and that there were good working relationships in place. Formal meetings with heads of discipline had not occurred in recent months.

At a clinical level, a quality framework group had been established to ensure all approved centres are in compliance with the Regulations (S.I. 551, 2006 of the Mental Health Act 2001).

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	10
Specialist registrar	1

Nursing Staff

Post	WTE in post
DON	1
ADON	6
CNM 3	7
Nurses based in in-patient services	110
Nurses based in community residences	51
Community mental health nurse	11
Nurses based in day hospitals	4
Nurses based in day centre	17.7
Dedicated team coordinator	1
Temporary staff panel	11

Nursing Specialist Posts

Speciality	WTE in post
Liaison	2
Clinical placement coordinators	2
Nurse practice development coordinator	1
Counsellors	5
Advanced nurse practitioner	0
Cognitive behavioural therapy	2
Other	2

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	4
Social work	6
Occupational therapist	5
Art therapist	2.3
Music therapist	1
Pharmacist	1

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	18,500

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.5	0.5
CNM 3	0.5	0.5
CMHN	3	3
Clinical psychologist	1	1
Social worker	1	1
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	0
Health care assistant	0	0

Facilities	2008 Shared or own	2009 Shared or own
Day hospital	None	None
Day centre	Shared with generic services	Shared with generic services

Rehabilitation Team Report

Team Description	Rehabilitation and recovery
Population	123,839

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	0	0
ADON	1	1
CNM 3	1	1
CMHN	0	0
Clinical psychologist	0	0
Social worker	0.6	0.6
Occupational therapist	1	0.5
Dedicated addiction counsellor	0	0
Day facility nurse staffing	0	3
Health care assistant	0	0

Facilities	2008 Shared or own	2009 Shared or own
Day hospital	None	None
Day centre	None	1

In-Patient Facilities

There were four approved centres in Mayo providing a total of 101 beds. There were 32 acute beds, 34 continuing care beds and 10 specialised rehabilitation beds. In addition there were 15 elderly care beds. All were centralised in Castlebar.

Statutory Requirements for Approved Centres

There were four approved centres.

Regulations (S.I. 551 of 2006)

Overall there was a high level of compliance with the Regulations across the four centres. The service had demonstrated that there were systems in place to review policies and procedures on a regular basis. Incidents were reviewed and detailed reports were available.

The main areas of non-compliance were in relation to care planning and therapeutic services and programmes. Since the last inspection, the service had established a working group to review and improve the care planning documentation. At the time of inspection this was ready to go live.

The lack of access to and input from health and social care professionals was most notable in Teach Aisling. Additional resources will be needed.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The application of the Rules applied mainly in the acute unit at Mayo General Hospital. The service was in substantial compliance. The main areas that required attention were the documentation process and affording service users the right of review.

Mechanical restraint was being used in Teach Aisling.

Codes of Practice

The service was in compliance across most areas. Detailed individual reports can be found in the approved centre sections.

Multidisciplinary Care Planning

There was a working group in place. Care plans had been adapted since the last inspection. They had been introduced in the rehabilitation service and were to be introduced to the approved centres. There were no plans currently to extend them to the outpatient services.

24-Hour Supervised Community Residences

Description

The service had access to 45 beds. Clinical responsibility for the residences was divided between teams. This was because of the wide geographical location of some of the residences. It was reported that all residents had multidisciplinary care plans in place.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Fairways	23	23	Rehabilitation	MDT
Swinford	5	5	General adult	MDT
Ballina	12	12	General adult	MDT
Ashbrook House	5	5	Rehabilitation	MDT

Conclusion

There is a strong commitment from staff and policy/plans within the service to a mental health service based and delivered in the community. Since the last meeting with the Inspectorate in December 2008, the service has actively reviewed the care planning process, embedded service user participation in service development, and reconfigured a number of day centres.

In the future the service will have to decide on the location and number of beds and services that it is providing. The needs of the service users discharged to alternative placements following the closure of St. Mary's in 2006 have now changed. Staffing numbers, skill mix and working hours are all real challenges for the service. There is a need to move towards a seven-day alternative to in-patient acute care.

Recommendations and Areas for Development

1. *There should be a single multidisciplinary team management structure in place in accordance with national policy.*

2. *All teams should be staffed in accordance with agreed numbers as per national policy.*

3. *The number of beds for future rehabilitation and continuing care needs to be planned.*

4. *Service users should have the option of a seven-day alternative service to in-patient care.*

Mental Health Services 2009
Catchment Area Report
North Tipperary

HSE Area	HSE West
Catchment	North Tipperary
Mental Health Service	North Tipperary Mental Health Service
Population	66,023
Number of Sectors	2
Number of Approved Centres	None
Specialist Teams	Community mental health sector teams
Per Capita Expenditure 2008 [>18 Years]	Requested but not forwarded
Date of Meeting	23 July 2009

Service 2009

Description of Service (Including Distinct Features)

North Tipperary Mental Health Services was in the unique position among catchments of providing a community mental health service only. The service was fully staffed by two sector teams but had no occupational therapist. Services to people needing in-patient care and treatment were provided by South Tipperary Mental Health Services based in Clonmel in HSE South. Input from North Tipperary into this service was severely limited in terms of general planning in the running of the in-patient service and in terms of its input into individual care plans. Social workers and psychologists did not generally visit in-patients because of the distance involved. In-patients had access to social work services by referral. Liaison between the two services was provided by a consultant psychiatrist who had responsibility for in-patients from the area and attended team meetings in North Tipperary fortnightly. A community mental health nurse also attended alternate meetings in both services. The Inspectorate was informed that all patients discharged from South Tipperary to its catchment were seen within a week.

Progress on Recommendations from the 2008 Report

1. *A decision for the future plans for service organisation and delivery must be made as matter of urgency.*

Outcome: The establishment of a project team to modernise the South Tipperary Mental Health Service was due to be announced by the HSE early in 2009. Staff in North Tipperary were not involved in decisions that were being taken, even though they would effect the services they provided. It was reported that plans were being discussed which would result in the transfer of in-patient services to Limerick. A decision had been taken by the project team that no in-patients from North Tipperary would be admitted to South Tipperary from 31 December 2010. The implications for the provision of community services to those residents discharged to their area had not been discussed with them.

Outline of Local Health Service Plan 2008–2009

A copy of a document titled 2008 North Tipperary – South Tipperary Plans for the Separation of Mental Health Services was given to the Inspectorate along with a copy of the *Vision for Change* implementation plan. The former plan did not include plans for the closure of Clonmel and had been superseded by the project management team for South Tipperary. No copy of this plan was available to the Inspectorate.

Developments 2008–2009

- The situation with regard to the future of the service was more uncertain since the 2008 report had been superseded by the South Tipperary project team.
- Contacts with the developing primary care teams were ongoing. Sector areas were almost completely aligned with the primary care networks.
- All heads of department were on the senior management team. Service user involvement was being considered.
- Three focus groups had been established, focusing on organisational developments.
- Clinic hours had been extended to 1900h one evening a week in the Thurles sector.
- Multidisciplinary assessment and care planning forms had been developed and were piloted in February.
- A system of clinical supervision for all nurses had been developed.
- A mindfulness-based cognitive behavioural therapy group for people with depression was held twice yearly.

Hospital Closure Plans (Where Applicable)

A decision had been taken to stop admissions to St. Michael's Unit in Clonmel, for residents of North Tipperary from 31 December 2010. Alternative in-patient facilities were being explored by the project team in South Tipperary.

Service User Involvement

Peer Support/Advocacy

The peer advocate reported that as a representative from Irish Advocacy Network he was made welcome by staff in North Tipperary. The advocate visited the day centres and Áras Folláin on a regular basis and had been given a key to the peer support facility, which was found to be helpful. Discussions had begun between the regional advocate and the principal social worker to restart a local advocacy group that had been discontinued the previous year.

However, the advocate identified some issues that needed to be addressed. There was no representative service user committee. Some clients had little awareness of their care plans. Some would like an exercise programme. Some worried about the effects of multiple medication and some felt there was too much emphasis on medication, rather than on talk therapies.

Service User Participation

The community peer support facility Áras Folláin was intended to provide an environment where people had an opportunity to develop their physical, emotional and spiritual wellbeing. It was run by service users with representation from the principal social worker on behalf of the mental health services.

The new care planning forms were expected to facilitate user participation in their care plans.

The regional advocate had made a presentation to the multidisciplinary team highlighting issues that had arisen in relation to service user participation on the management team. Work was continuing on the development of protocols.

Governance

Quality Improvements (Audits and Reviews)

An evaluation of the mindfulness-based cognitive therapy programme had been undertaken by the senior psychologist.

An audit of patient files was completed in Nenagh, focusing on Mental Health Commission and An Bord Altranais standards.

A clinical governance group focusing on activities, risk management and training had been initiated.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	2
NCHD (including specialist registrar)	3

Nursing Staff

Post	WTE in post
DON	0
ADON	0
Nurses based in in-patient services	0
Nurses based in community residences	0
Community mental health nurse	2
Nurses based in day hospitals	0
Nurses based in day centre	11
Temporary staff panel	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0
Nurse practice development coordinator	0
Counsellors	2
Advanced nurse practitioner	2
Liaison	4
Deliberate self harm	1

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3
Social work	2
Occupational therapist	0
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

As there were no specialist teams this was not applicable.

In-Patient Facilities

The service had admitting rights to St. Michael's Unit in South Tipperary General Hospital where 20 residents were identified as belonging to North Tipperary. In addition, 21 long stay residents in St. Luke's Ward were from the catchment area. Twenty-seven residents of community residences were from North Tipperary. The service had little input into the care provided in the in-patient facilities, although the South Tipperary service had been criticised in a report pursuant to Section 55 of the Mental Health Act 2001 published earlier in the year by the Mental Health Commission, for the quality of care provided to its residents in South Tipperary.

Details of the inspection of the in-patient facilities are contained in the reports on South Tipperary Mental Health Services.

Statutory Requirements for Approved Centres

As there were no approved centres these were not applicable.

Multidisciplinary Care Planning

A multidisciplinary care and assessment plan had been developed and piloted during the year. Service users were to be facilitated to contribute to their care plans.

24-Hour Supervised Community Residences

There were no 24-hour supervised community residences in the area.

Conclusion

This service is developing well at the level of the community mental health teams. It is regrettable that it still has no occupational therapy service. At another level however, the service and the population it serves suffer from being divorced from its in-patient service and not having the full range of facilities which are necessary to provide a service to people with enduring mental illness. It continues to exist in a

climate of uncertainty as it does not know where its in-patient service will be based after 31 December 2010 and what preparations it needs to make to facilitate this.

Recommendations and Areas for Development

1. *This service should include plans for development of its in-patient and specialised community services as soon as possible.*

2. *The service should have its own development plan.*

3. *An occupational therapist should be included on the community teams as soon as possible.*

Mental Health Services 2009
Catchment Area Report
Roscommon

HSE Area	HSE West
Catchment	Roscommon PCCC
Mental Health Service	Roscommon Mental Health Services
Population	63,000
Number of Sectors	3
Number of Approved Centres	1
Specialist Teams (e.g. POLL, REHAB)	None
Per Capita Expenditure 2008 [>18 Years]	Not Provided
Date of Meeting	16 July 2009

Service 2009

Description of Service (Including Distinct Features)

Roscommon Mental Health Services had a catchment area population of 63,000. There were three general consultants and no specialist teams. The service had one approved centre at the Department of Psychiatry located on the ground floor within Roscommon County Hospital. There had been a reduction in acute beds from 30 to 22 since 2008. A private bedroom with en-suite facilities for children between the ages of 16 and 18 had been developed and commissioned since 2008. A new 4-bed high observation area had also been developed and commissioned since 2008. There was one 7-day day hospital in operation and three training centres located in Boyle, Castlerea and Roscommon. The service had six day centres in six locations around the catchment area. Seventy-three long-stay beds were provided in hostel accommodation. This included 34 beds provided for elderly and dementia care.

The service had seen a reduction in mental health funding of 6.5 million euro in the two years.

Progress on Recommendations from the 2008 Report

1. *The high observation unit should be completed and commissioned as soon as possible.*

Outcome: The high observation unit had been commissioned and completed.

2. *Each team should be sufficiently staffed in order to provide a full multidisciplinary team approach to the care of service users.*

Outcome: No extra staffing to enhance multidisciplinary care had been provided.

3. *The training centre in Castlerea should be upgraded in light of the very poor condition of the current building.*

Outcome: A full review of the facility had been completed. No money had been provided to refurbish this building. Employee relations issues had delayed a plan to provide alternative day services outside the HSE.

Outline of Local Health Service Plan 2008–2009

The existing training centre had been reported as unacceptable to younger patients. Since the closure of St. Patrick's Unit in 2007, it had become a sheltered workshop. There was now a need for a four-year training programme for younger people.

Castlerea day centre was full and significant investment was required, but there was no alternative at present. Attendees needed to transfer to rehabilitation services, but employee relations issues were impeding this development.

There were no specialist teams and it was suggested that a shared care arrangement with a larger catchment area might help address this service deficit.

Developments 2008–2009

- The facility for young people aged 16-18 years had been opened.
- A review of Castlerea training centre had been completed and a needs assessment of clients had been undertaken.
- A public/private partnership plan to develop a new mental health headquarters and day hospital in association with Primary Community and Continuing Care (PCCC) had been developed and contracts had been signed. Completion is expected in November 2012.

Hospital Closure Plans (Where Applicable)

There are plans to close two community residence and move the residents into six purpose built housing units with nursing staff support.

Service User Involvement

Peer Support/Advocacy

The peer advocate visited the range of services in the catchment area and provided a report to the inspectorate.

The peer advocate reported that staff were accommodating and welcoming.

Service users reported that they found the seven-day training centre at Ros na Suan day hospital very helpful.

The advocate suggested that service users in the approved centre were bored especially at weekends. They reported that there was an overreliance on medication and a lack of talking therapies available in the approved centre.

The peer advocate reported that the training centre at Castlerea was still open and that service users who utilised the service felt demoralised. It was stated that older and younger residents did not mix easily in the day centre due to their different needs.

Consumer Panels were now in place and adequate training had been provided. Some funding for this had been provided by the HSE.

Service User Participation

The advocate from the Irish Advocacy Network (IAN) expressed concern that the consumer panel that had been planned in line with *A Vision for Change* policy was refused funding that would enable service users to attend. As a result it was not functioning. Agreement was reached with the general manager to examine the issues.

Governance

Quality Improvements (Audits and Reviews)

Health of the Nation Outcome Scales (HoNOS) assessments had been undertaken in the community mental health teams.

Multidisciplinary care plans had been introduced. These facilitated service user input.

Regular reviews and planning meetings were taking place with residents.

Staffing Dedicated to Specialist Mental Health Services

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Medical Staff

Post	WTE in post
Consultant psychiatrist	3
NCHD	4
Specialist registrar	1

Nursing Staff

Post	WTE in post
DON	1 (vacant)
ADON	3 (1 vacant)
Nurses based in in-patient services	25 (4 vacancies)
Nurses based in community residences	39 (5.5 vacancies)
Community mental health nurse	4 (1 vacancy)
Nurses based in day hospitals	3.5
Nurses based in day centre	25.75 (3 vacancies)
Other – Temporary staff panel	0

Nursing Specialist Posts

Speciality	WTE in post
Liaison	0
Clinical placement coordinators	0.5 (vacant)
Nurse practice development coordinator	0
Counsellors	3.5
Advanced nurse practitioner	0
Other	0

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	1
Social work	2
Occupational therapist	3.5 (2 vacancies)
Art therapist	0
Other CNS (acute unit)	1

In-Patient Facilities

The Department of Psychiatry was located on the ground floor within Roscommon County Hospital and had three general adult teams. There had been a reduction in acute beds from 30 to 22 in 2009 with 12 residents in the approved centre on the day of inspection. A private bed room with en suite facilities had been developed and commissioned since 2008 for children between the ages of 16 and 18. A new 4-bed high observation area had also been developed and commissioned since 2008. The bathrooms and toilet areas had been renovated to a high standard. The ward was bright, clean and well maintained. It had a high staff to patient ratio, there was no pressure on beds and time was available for direct patient contact.

Statutory Requirements for Approved Centres

The approved centre had a number of non-compliance issues with the Regulations on the day of inspection. Issues surrounding recreational activities, care planning, therapeutic activities and privacy required further action.

Regulations (S.I. 551 of 2006)

The operating policies and procedures needed to be updated and reviewed appropriately.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

There were a number of breaches of the Rules in relation to seclusion and physical restraint that needed to be addressed. It is important to ensure that staff have read and understood the policies, once they have been adopted.

Codes of Practice

There were a number of breaches in the Codes of Practice in relation to physical restraint and these should be addressed. There was no policy available to the Inspectorate in relation to physical restraint.

The service was compliant in relation to the Code of Practice on notification of deaths and incident reporting.

It was unacceptable for children to be admitted to an adult unit. A number of policies in relation to the admission of children were not available.

Multidisciplinary Care Planning

Multidisciplinary care plans were in place. The plans facilitated service user input but this was not being achieved. Therapeutic activities were not linked to care plans. There was no evidence of health and social care contribution to the care plans in the files inspected.

24-Hour Supervised Community Residences

Description

The service had six 24-hour supervised community residences.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Castlerea	73		Castlerea	Nursing
Boyle	9	7	Boyle	Nursing
Strokestown	7	7	Strokestown	Nursing
Knockroe House, Castlerea	15	15	Castlerea	Nursing
Tithe na gCarad, Castlerea	18	18	Castlerea	Nursing
Rosalie Unit, Castlerea	34	32	Castlerea	Nursing

Conclusion

There had been some improvements in the service since 2008 however; it was disappointing that despite a reduction in resident numbers in the approved centre there had been little increase in staffing numbers in the community mental health team. A number of residents in the approved centre on the day of inspection seemed to be without activities and were lying on their beds or sitting around. While it is acknowledged that an occupational therapy assistant worked in the unit, the lack of an on-site occupational therapist contributed to the lack of a needs-based therapeutic environment. It was likely that the lack of completed individual multidisciplinary care plans as outlined in the Regulations also contributed to this. Multidisciplinary care plans were in place in 24-hour supervised residences.

It was of concern to the Inspectorate that adolescents continued to be admitted to this adult unit. It was reported that all requests for admission to St. Anne's Child and Adolescent Unit in Galway were refused due to lack of vacancies in there.

The service had suffered a reduction in staff numbers during the year and this may be related to the reduction in beds. However, staff reported that those who had left tended to be the more experienced staff and the expectation was that this would impact on service delivery in the future.

Recommendations and Areas for Development

1. *The composition of the teams should be enhanced with the necessary multidisciplinary professionals.*

2. *Each resident must have an individual care plan. The system developed must be reviewed and all disciplines must be responsible for meeting the requirements of Article 15.*

3. *The care plans should be linked to the therapeutic activity and educational programme.*

4. *Training in multidisciplinary care planning should be provided for all staff.*

Mental Health Services 2009
Catchment Area Report
Sligo/Leitrim Mental Health Services

HSE Area	HSE West
Catchment	Sligo/Leitrim/South Donegal
Mental Health Service	Sligo/Leitrim/South Donegal Mental Health Services
Population	99,875
Number of Sectors	5
Number of Approved Centres	1
Specialist Teams	Rehabilitation and recovery Psychiatry of later life
Per Capita Expenditure 2008 [>18 Years]	Total expenditure 28,127,272 euro
Date of Meeting	3 December 2009

Service 2009

Description of Service (Including Distinct Features)

Sligo/Leitrim/South Donegal had a population of approximately 100,000 with five small sectors. There were plans to reconfigure the service so as to have two large sectors. There was a rehabilitation and recovery team and a psychiatry of later life team. Multidisciplinary staffing was spread thinly across teams. There was one approved centre with an admission unit and a special care unit. There were tentative plans to open a new admission unit in Sligo General Hospital. There were six community residences, only two of which were under the care of the rehabilitation and recovery team.

Progress on Recommendations from the 2008 Report

1. *Service user advocacy should be introduced.*

Outcome: Peer advocacy through the Irish Advocacy Network (IAN) was now available.

2. *All teams should be resourced with an appropriate multidisciplinary team skill mix.*

Outcome: A senior occupational therapist began a new post in North Leitrim in August 2009. Apart from this no development of teams had taken place.

3. *Provision of a new acute unit should be a priority.*

Outcome: There had been no progress on this recommendation.

4. *Community residences should come under the care of the rehabilitation team as soon as possible.*

Outcome: This had not been fully achieved, but one further community residence was taken under the care of the rehabilitation team in 2009.

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.*

Outcome: This remained at planning stage.

6. *The needs of people with serious mental ill-health should be prioritised by community staff funded by the mental health service.*

Outcome: There had been no progress on this recommendation.

Outline of Local Health Service Plan 2008–2009

The business plan for the service included plans to reconfigure the sectors to have two large sectors with 60,000 and 39,000 population respectively. The Leitrim sector was to have two consultants and the Sligo sector 2.5 consultants. This was expected to be completed in early 2010. There were also plans to reconfigure and upgrade the existing facilities.

The new acute unit was at phase three planning stage and awaited final approval.

Developments 2008–2009

- Bank House community residence had closed and resources had been deployed to cover overtime and to provide day services in Manorhamilton.
- Day services in North Leitrim had been enhanced.
- A senior occupational therapist commenced in August 2009.
- Advocacy services had commenced.
- A three-year eating disorder programme was to commence with three eating disorder practitioners as a community-based service.
- A day hospital review had taken place to assess satisfaction and access to day hospital services.
- The service was involved in a perinatal pathway post-natal depression project.
- Two nurses completed the nurse prescribing course.
- The psychiatry of later life team held public meetings, presented at a user group study day, and were involved in an art project. They achieved low admission rates and had no waiting lists. They provide carer support and carried out audits of case notes, benzodiazepines and health and safety.
- The occupational therapy department had implemented a new referral pathway, a priority system and new electronic assessments. The community mental health occupational therapy service had been extended in Sligo and in the rehabilitation and recovery team.

Service User Involvement

Peer Support/Advocacy

Peer advocacy had recently been started and was currently being extended to the community facilities. In general, the service users described the staff as friendly and approachable and there were no difficulties accessing people detained under the Mental Health Act. The occupational therapy was praised, as was the access to the garden.

Some service users said they were bored on the unit. The service stated that it had addressed the issue of compulsory pregnancy testing and had stated in its policy document that it was not compulsory. Some

female residents complained about the lack of secure lockers and the lack of tea and coffee on Sundays. Many residents wanted more information about their medication, would like more time with their doctors, more awareness of their care plans and more participation in the drawing up of their discharge plans.

Participation in the Delivery of Mental Health Services

There was feedback on the patient satisfaction questionnaire from the advocate and service users. There was a Mental Health Ireland representative at meetings.

Governance

Quality Improvements (Audits and Reviews)

There was a multidisciplinary catchment area management committee, a clinical risk committee and a drugs and therapeutics committee. A policy manual was in place. There was also an implementation group for *A Vision for Change*. Incidents were reviewed weekly and the STARS Web reporting system had been introduced. A risk manager was appointed recently.

There had been monthly audits on clinical charts, an audit on the discharge system, an audit on Mental Health Act 2001 compliance, a benzodiazepine audit, and a health and safety audit.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	7
NCHD	8
Specialist registrar	1

Nursing Staff

Post	WTE in post
DON	1
ADON	5
Nurses based in in-patient services	84.3
Nurses based in community residences	61
Community mental health nurse	12
Nurses based in day hospitals	6
Nurses based in day centre	13.7

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1
Clinical placement coordinators	1
Nurse practice development coordinator	0
Counsellors	6
Advanced nurse practitioner	0
Family therapy and cognitive behavioural therapy	11

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	1
Social work	4.5
Occupational therapist	7
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of later life
Population	99,875

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	1	1
CMHN	4	4
Clinical psychologist	.12	.12
Social worker	1	1
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	2	2
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	–	1
Day centre	1	0

Rehabilitation and Recovery Team Report

Team Description	Rehabilitation and recovery, which included an assertive outreach team
Population	99,875

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	1	1
Dedicated team coordinator	1	1
CMHN 2	0	5
Clinical psychologist	.12	.12
Social worker	1	1
Occupational therapist	1	1
Dedicated addiction counsellor	0	0
Day facility nurse staffing	4.8	0
Health care assistant	0	0

Facilities	2008 Shared or owned	2009 Shared or owned
Day hospital	–	–
Day centre	1	1

In-Patient Facilities

There was one approved centre which was a two storey structure. Male admission unit and the special care unit were located on the ground floor and the female admission unit was on the first floor.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The approved centre was non compliant in the Regulations with regard to choice of food, care planning, therapeutic activities, general health, privacy, premises and CCTV. The service has initiated or completed compliance in these Regulations since the time of inspection.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The service was non-compliant with the Rules regarding the use of seclusion. A checklist system had since been put in place to rectify this.

Codes of Practice

The service was also non-compliant with the Code of Practice regarding physical restraint. A checklist system has since been put in place to rectify this.

Multidisciplinary Care Planning

All service users in the approved centre had multidisciplinary care plans. There was a multidisciplinary care plan working group. An audit of care planning had been carried out.

24-Hour Supervised Community Residences

Description

Two 24-hour supervised residences were under the care of the rehabilitation and recovery team. Both of these use multidisciplinary care plans. Bank House had recently been closed.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Castlecourt House	10	9	Rehabilitation and Recovery	MDT
Ashbrook House	19	12	Rehabilitation and Recovery	MDT
Cypress Lodge	18	16	Adult Mental Health	MDT
Sliabhan House	8	8	Adult Mental Health	MDT
Benbulben Lodge	10	9	Adult Mental Health	Nursing
Linden House	15	15	Adult Mental Health	Nursing

Conclusion

The Sligo/Leitrim Mental Health Service is a busy service. It currently has five small sectors with thinly spread multidisciplinary staffing. This will change early in 2010 to two large sectors with better access to different disciplines. However staffing will still be below that recommended by *A Vision for Change*. The progress of the new admission unit in Sligo General Hospital has, to all intents and purposes, stalled and there seems little prospect of a new unit in the immediate future. The commencement of peer advocacy is particularly welcomed and it appears that the service has already extended into the community. The non-compliance issues with Regulations and Rules for approved centres are being addressed. There are some interesting developments within the service, especially the eating disorder project which is due to commence shortly.

Recommendations and Areas for Development

1. *The new admission unit in Sligo General Hospital should progress as quickly as possible.*

2. *There should be full multidisciplinary staffing of all teams.*

Mental Health Services 2009
Catchment Area Report
West Galway

HSE Area	HSE West
Catchment	West Galway
Mental Health Service	West Galway Mental Health Services
Population	121,567 (95,097 over 18 years)
Number of Sectors	4
Number of Approved Centres	2
Specialist Teams (E.G. POLL, REHAB)	Psychiatry of later life
Per Capita Expenditure 2008 [>18 Years]	14.23 million [15 euro per capita expenditure] [sic]
Date of Meeting	16 July 2009

Service 2009

Description of Service (Including Distinct Features)

West Galway Mental Health Services provided a catchment area service to 121,567 people (95,097 over 18 years). The catchment had a significant population of third level students, a significant transient tourist population in summer and also provided services to an offshore island population.

The catchment area was spread over a large geographical area covering a rural and urban mix with high levels of deprivation in both urban and isolated rural areas.

There were two adult approved centres; the Department of Psychiatry, University Hospital Galway, and Unit 9A, Merlin Park. The service had a high number of beds for the population, 43 acute beds and 26 continuing care beds. There had been poor development of community-based mental health services, with all staff based in and working from the acute unit. There was one day hospital in the city. All service users had to attend a centralised outpatient clinic in the acute unit, many travelling up to 80 km.

A liaison service was provided from the Department of Psychiatry to University Hospital and Merlin Park Hospital which in turn provided a regional service for HSE West in the absence of a fully resourced liaison team.

Progress on Recommendations from the 2008 Report

1. *A full rehabilitation team should be provided.*

Outcome: There was no progress reported on this recommendation.

2. *A liaison team should be provided.*

Outcome: There was no progress reported on this recommendation.

3. *Tully hostel must open as a matter of urgency.*

Outcome: There was no time frame available, although staff hoped that it would be during the current year.

4. *Clarity should be provided as to the exact nature of the provisions to progress the merging of East and West Galway.*

Outcome: There was no further clarity available.

5. *A multidisciplinary team senior management group should be in place by early 2009.*

Outcome: Monthly meetings of senior staff and heads of department were scheduled with the general manager. The focus was strategic and operational. Minutes were circulated to the Local Heath Manager and the Assistant National Director of Mental Health Services.

Outline of Local Health Service Plan 2008–2009

There was a business plan for the Galway Mental Health Services. It outlined targets for 2009.

Developments 2008–2009

- Construction of a high observation area in the acute psychiatric unit was completed. It had not opened due to staff shortages.
- A pilot Wellness Recovery Action Plan (WRAP) programme had been initiated.
- A scoping exercise for the introduction of sectorisation was in progress.
- Dietetic service and pharmacy service were embedded into the services and expanded.

Hospital Closure Plans (Where Applicable)

The business plan reported that Unit 9A bed numbers would be reduced by half this year. A number of residents would move to a 24-hour residence in Tully. This plan had been debated for a number of years now. Progress had been painfully slow, and in the interim service users were inappropriately placed in hospital.

Service User Involvement

Peer Support/Advocacy

The Irish Advocacy Network (IAN) provided a peer advocate service throughout the catchment area. On the day of the Inspectorate catchment meeting, they presented a written report to the Inspection team. The report highlighted a number of positive aspects, in particular the helpfulness and support of domestic staff to service users during admission, input from occupational therapists, availability of a community employment programme, and that there was an open door policy.

Of concern to service users was the perceived overuse of medication, reluctance on the part of staff to discuss or support service users who wanted to discuss traumas they had suffered, lack of staff to access the gym and having to repeat their history to junior doctors. Others reported that there was limited time with nursing staff, lack of meaningful activities, rights not been fully explained and being given special one-to-one nursing in a single bedroom with no bathroom facilities. In the community service, users complained about the lack of a community service and poor access to community nurses.

Service User Participation

It was reported that service users were included and took an active part in quality initiatives in the hospital, including voluntary accreditation processes. The views of residents on the psychiatric unit were sought through an ongoing McLean Perception of Care survey and through weekly meetings with senior staff. Outpatients' views were sought through a satisfaction survey. There was a mechanism in place to receive feedback from service users in the acute unit. A family and carers group was in the planning stages for later in the year.

The psychiatry of later life team had an established carers group in operation. It ran for 6 to 8 weeks and was facilitated by members of the team.

Service users had developed an employment and social support report from a survey of mental health service users in Galway.

Governance

Quality Improvements (Audits And Reviews)

A new governance structure had been developed. It was reported that it would be implemented in September 2009.

There was an ongoing research programme allied to the Department of Psychiatry at National University of Ireland Galway.

A scoping exercise with a view to facilitating sectorisation was in progress.

A growing issue of concern for the service was the inability to release staff for training purposes.

Staffing Dedicated to Specialist Mental Health Services

Medical Staff

Post	WTE in post
Consultant psychiatrist	5
NCHD	9
Specialist registrar	4

Nursing Staff

Post	WTE in post
DON	1
ADON	3
Nurses based in in-patient services	52.95
Nurses based in community residences	10.5
Community mental health nurse	10
Nurses based in day hospitals	3.4
Nurses based in day centre	8
Temporary staff panel	3

Nursing Specialist Posts

Speciality	WTE in post
Liaison	1.2
Clinical placement coordinators	1
Nurse practice development coordinator	1
Addiction	3.5
Advanced nurse practitioner	0
Clozaril	2.4
Cognitive behavioural therapy	0.5

Health and Social Care Professionals

Post	WTE in post
Clinical psychologist	3.41
Social work	5.6
Occupational therapist	5.91
Art therapist	0
Other	0

Specialist Teams (Excluding Primary Care Teams)

Community Mental Health Team (CMHT) staffing numbers by sector are available on the Mental Health Commission website www.mhcirl.ie

Psychiatry of Later Life Team Report

Team Description	Psychiatry of Later Life
Population	15,000

Staffing	2008 WTE in post	2009 WTE in post
Consultant psychiatrist	1	1
NCHD (including specialist registrar)	2	2
Dedicated team coordinator	0	0
ADON	0.2	0.2
CMHN	2	2
Clinical psychologist	1	1
Social worker	1	1
Occupational therapist	1	1

Facilities	2008 Shared or own	2009 Shared or own
Day hospital	None	None
Day centre	Shared	Shared

In-Patient Facilities

There were two adult approved centres, the Psychiatric Unit, University College Hospital, Galway, and Unit 9A, Merlin Park. St. Anne's Children's Centre was reported separately.

Statutory Requirements for Approved Centres

Regulations (S.I. 551 of 2006)

The Psychiatric Unit was not compliant in a number of areas, including care planning, information and having current policies in place. Residents had been transferred to another hospital for the purpose of alleviating bed shortages, although the rate was lower than in 2008.

There were difficulties in Unit 9A with regard to being compliant with the Regulations. This was influenced by the lack of a rehabilitation focus, lack of a dedicated team and that residents were inappropriately placed in hospital when alternative community accommodation was available but not in use. Beds were used inappropriately to accommodate bed shortages in the acute unit.

Rules (Section 59.2 and Section 69.2, Mental Health Act 2001)

The Psychiatric Unit was non-compliant in the provision of information on ECT, renewing policies yearly and completing the documentation on seclusion in accordance with the Rules.

Unit 9A did not use any form of treatment that was governed by Rules.

Codes of Practice

The services had a number of breaches in the use of physical restraint and in relation to policies for children.

Unit 9A was in compliance with the Codes of Practice that were applicable to the centre.

Multidisciplinary Care Planning

Multidisciplinary care planning was in its infancy in the inpatient units. There was no multidisciplinary care planning in operation in the general sector teams.

The psychiatry of later life team had a multidisciplinary approach to care planning.

24-Hour Supervised Community Residences

Description

There were two residences in operation. The service users accessed their sector team. There was no access to a rehabilitation team. Both houses were reported to be in good condition.

Tully House remained unopened at the time of the report.

Residence	Number of places	Number of residents	Team responsible	Care plan type
Breadagh House	7	7	4 general adult	Nursing
Sycamore	10	9	2 sector teams	Nursing
Tully House	Vacant	Vacant	Unopened	

Conclusion

West Galway is a bed-rich service with 43 acute and 26 continuing care beds for an adult population of 120,000. There are no dedicated elderly care beds, the team access generic services and nursing home accommodation. A community mental health service has not been developed, despite a catchment that covers a wide geographical area. While the business plan for Galway Mental Health Services advocates a community-based approach, there is still some distance between the aspiration and the practice on the ground. The service remains significantly behind most other services in the country in this regard. All clinicians are based in and work from the acute in-patient unit.

Recommendations and Areas for Development

1. *Service users should have access to a community-based service in their local area in accordance with national mental health policy.*

2. *Residents in Unit 9A who no longer require in-patient care should be discharged to Tully residence.*

3. *A plan should be developed with specific outcomes stated and with a time line to put in place a community-based service, with real alternatives to in-patient care. Costing should be included.*

4. *The number of beds should be reduced to reflect the population level.*

5. *The teams should be staffed according to national policy norms.*

6. *The transferring of residents from the acute unit to Merlin Park due to overcrowding must cease and the high observation area should open as a matter of urgency.*

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 of 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
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 and Midwives Organisation	www.inmo.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.omc.gov.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
Health Information Resources	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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