South Eastern Health Board

PSYCHIATRIC SERVICES

REPORT

OF

SUB-COMMITTEE

October 1982

INDEX

FOREWORD

It gives me great pleasure to introduce this report on the Psychiatric Services to the Board.

Mental illness is a major health problem and brings with it serious social disability.

The Sub-Committee was therefore anxious to ensure that its report would identify clearly the direction in which the service should develop, and which would enable it also to respond flexibly and quickly to the needs of the mentally ill.

The main thrust therefore of the report is that the psychiatric service should continue to develop its capacity to deal with mental illness outside hospital in so far as this is possible.

I would like to pay tribute to my fellow members of the Sub-Committee whose interest in and contribution to the discussions were of a high order.

I would also like to acknowledge on behalf of the Sub-Committee, the assistance and advice of the following who presented papers to the Sub-Committee on various aspects of the problem.

Dr. B. Blake, Retired R.M.S., St. Dympna's Hospital, Carlow.

Dr. P. J. Grace, R.M.S., St. Canice's Hospital, Kilkenny.

Dr. S. Lennon, R.M.S., St. Otteran's Hospital, Waterford.

Dr. T. K. McKeogh, R.M.S., St. Senan's Hospital, Enniscorthy, Co. Wexford.

Dr. P. A. Meehan, R.M.S., St. Luke's Hospital, Clonmel, Co. Tipperary.

Dr. J. J. Wilson, R.M.S., St. Dympna's Hospital, Carlow.

Dr. D. Broderick, Director Child Psychiatric Service, Brothers of Charity, Lota, Glanmire, Co. Cork.

Dr. L. Daly, Clinical Director, Central Mental Hospital, Dundrum.

Medical Director and staff, St. Patrick's Hospital, Belmont Park, Waterford.

Dr. H. O'Brien-Moran, G.P., Board Member.

Dr. C. K. O'Doherty, G.P., Board Member.

Dr. D. Walsh, Medico-Social-Research Board.

Special thanks and appreciation are due to the Chairman and Members of the Western Health Board, Mr. E. Hannon, Chief Executive Officer, Mr. S. O'Donoghue, Programme Manager, Special Hospitals and to the many other professional and administrative officers of the Western Health Board on the occasion of the Sub-Committee's visit to that Board in October, 1981.

Signed : .....

JOSEPH CUMMINS,
Chairman of the Sub-Committee.

TERMS OF REFERENCE OF SUB-COMMITTEE

The Health Board passed a resolution on the 14th February, 1980, as follows :-

> "That the South Eastern Health Board set up a Sub-Committee to examine the Board's psychiatric services in hospitals and in the community and to make recommendations to the Board as to how best these services might be developed and improved."

The following members and officers were appointed to the Sub-Committee :-

Chairman :

Alderman J. Cummins.

Members :

Senator D. Bolger, M.C.C.

Cllr. K. Brady-O'Neill

Miss B. Butler, Supt. P.H.N.

Mr. T. Byrne, R.P.N.

Cllr. L. Carthy

Cllr. W. Quinlan

Officers :

Dr. B. Blake, R.M.S., St. Dympna's Hospital, Carlow - until December, '80.

Dr. P. J. Grace, R.M.S., St. Canice's Hospital, Kilkenny.

Dr. S. Lennon, R.M.S., St. Otteran's Hospital, Waterford.

Dr. T. K. McKeogh, R.M.S., St. Senan's Hospital, Enniscorthy, Co. Wexford

Dr. P. A. Meehan, R.M.S., St. Luke's Hospital, Clonmel, Co. Tipperary.

Dr. J. J. Wilson, R.M.S., St. Dympna's Hospital, Carlow. - from Jan., 1981.

Programme Managers :

Mr. J. A. Cooney, - since 1st May, 1981.

Mr. M. V. Millett - until his transfer to Community Care Programme on 1st May, 1981.

Secretary :

Mrs. Margaret Purcell.

INTRODUCTION TO THE REVIEW

Until the 1950's severe mental illness typically required severing the patient's contacts with his home and working environment and placing him for long periods in an institution where his disorder could be controlled and treated. This decision was often made in the interests of society as much as for the patient and was universally accepted practice. Durling that period and since, improved treatments were discovered which removed, reduced or at least controlled those symptoms of illness which hitherto had greatly distressed both the patients and their families and colleagues. While the impact of these discoveries was immediate and dramatic, they have been available a relatively short time by comparison with the institutions where they are now being applied. Their application has moved at different rates from hospital to hospital and have not yet fully worked themselves out in their effects on how services should be organised. Accordingly, this review is occurring in our own region at an appropriate time when these developments have changed and are still changing the face of psychiatry within our mental hospitals and in the community outside. Such a review now gives the Board an opportunity to give practical consideration to what further support these changes should receive in order that the opportunities presented can be fully exploited in the interests of patients.

FORMAT OF REPORT

Chapter 1 — attempts to describe the scale of the problems of mental illness in this region.

Chapter 2 — provides some financial background to the service.

Chapter 3 — analyses the patients' needs in terms of service and outlines the main ideas on which the service should be structured. The core idea is that a modern community psychiatric service consists in a balanced integrated and flexible use of community based and hospital facilities

Chapter 4 — deals with community based facilities in greater depth.

Chapter 5 — discusses the groups of patients who need hospital services in two main respects :

(a) acute short-stay care

(b) long-term care.

Chapter 6 — recognises that the service is provided by people for other people and discusses some aspects of the management problems raised by human relations in the system.

Chapter 7 — discusses the question of alcoholism and drug addiction.

Chapter 8 — outlines a programme of physical development.

Chapter 9 — deals with other special services, i.e. forensic psychiatry and psychology services.

In the conclusion there is a brief review of progress to date and an acknowledgement of the efforts of all personnel involved in achieving this.

SUMMARY OF RECOMMENDATIONS

CHAPTER 3

DEVELOPMENT OF A STRATEGY FOR DELIVERY OF A PSYCHIATRIC SERVICE

The Sub-Committee recommends the following as the main elements of a community psychiatric service :-

1. The Board should develop a policy for the prevention, early detection and treatment of psychiatric illness.

2. The primary service for the mentally ill, as with other illnesses, should be the family doctor, supported as appropriate by the psychiatric services.

3. Admission to a psychiatric hospital or a psychiatric unit in a general hospital, should be regarded as a final treatment resource and to this end treatment facilities outside hospital should be developed so as to maintain as much as possible the patient's links with his community and to minimise his stay in hospital when this is necessary.

4. For patients who need hospitalisation, a high standard of treatment, caring and rehabilitative facilities should be provided both in short-stay and long-stay units, so as to maximise the patients' chance of rehabilitation.

5. Hospital units, community based units and services in each catchment area should function as a co-ordinated, balanced, flexible service under the professional direction of the Chief Psychiatrist.

6. Any further change in the role of long-stay hospitals can only take place after alternatives have been developed. The discharge of a patient into a community which is not equipped to care for the patient can result in a deterioration in the patient.

COMMUNITY PSYCHIATRIC SERVICES

CHAPTER 4

4 (I) *PREVENTION OF MENTAL ILLNESS*

7. A policy of preventing mental illness should be developed by encouraging the undertaking of research into factors which contribute to the illness.

8. A national policy of education of the general population should be developed on the need for community acceptance of patients and on aspects of mental health which would help people to recognise symptoms and encourage them to seek earlier advice and treatment.

9. Similar local education measures should be developed by encouraging social organisations to inform themselves about mental illness, by increasing their contacts with service personnel and by promoting community acceptance of these policies.

10. Consultant psychiatrists or other appropriate persons or agencies who are interested in research projects should receive positive assistance.

11. There should be a promotion of improved awareness among, and co-operation with, other branches of the health service and their personnel, including :-

    (a) formal and regular contact between the Director of Community Care and the Chief Psychiatrists of each area concerning matters of common concern;

    (b) improved liaison between community psychiatric nurses and district public health nurses;

    (c) consultations between Chief Psychiatrists and the Directors of Community Care and general practitioners about seeking their assistance in preventive measures.

4 (II) *THE PROVISION OF COMMUNITY BASED TREATMENT FOR MENTALLY ILL PERSONS*

12. The Sub-Committee recommends that consultation should take place between consultant psychiatrists, Directors of Community Care and general practitioners and that policies be developed which will help to optimise the role of the general practitioner in the provision of a first line psychiatric service. These policies should include :

    (a) assistance from consultants in general or particular cases;

    (b) procedures for reporting on general practitioner's patients who are being referred to or from the consultant psychiatrist;

    (c) care of patients who have been referred back to the family doctor;

(d) liaison concerning family and other circumstances of patients;

(e) domiciliary visits by consultant psychiatrists in cases where the patient could not or would not otherwise receive necessary treatment;

(f) the making available of the services of the community psychiatric nurse to the general practitioner.

13. The present developed system of out-patient clinics should be maintained and improved where necessary.

14. The out-patient clinics should ideally be situated as near as possible to population centres and should be located in the local health centres where these are available.

15. Out-patient clinics should be serviced by a proper appointment system.

16. Where lack of transport facilities is a factor in preventing patients from keeping clinic appointments, consideration should be given to the provision of a transport service by the Board.

17. Patients should be referred back to their family doctors after completion of treatment.

18. Patients should be served by their nearest psychiatric hospital service and to this end, the necessary adjustments should be made in the catchment areas to match the re-arranged community care areas.

19. A programme for the provision of day centres should be developed for each catchment area, providing the following range of facilities :-

(a) treatment facilities for use by medical staff;

(b) care facilities for use in meals, chiropody, physiotherapy, bathing, etc.

(c) limited activation facilities and programmes for social training.

20. The Sub-Committee recommends that a day care centre be provided initially in Dungarvan and that the centres be designed as flexibly as possible to include the widest number of uses.

21. It is recommended that a programme for the provision of hostel residential accommodation be extended in each county in accordance with local needs.

22. A special residential centre with associated activation facilities should be provided in the region similar to the unit at Toghermore, Tuam, Co. Galway.

23. The Sub-Committee endorses and emphatically reiterates many key principles of the Care of the Aged Report and especially the following which impinge also on the provision of a community psychiatric service :

1. The appointment of geriatricians is essential to a *basic* service for the elderly and the elderly mentally infirm;

2. The community assessment teams should continue and be expanded to include a consultant psychiatrist who would be called in appropriate cases;

3. No elderly mentally ill patient should be admitted to a psychiatric hospital without having been assessed by a consultant psychiatrist;

4. Assessment units should be provided in all general hospitals and should include facilities for assessment of psycho-geriatric cases;

5 Adequate housing is an important factor in preventing psychiatric illness in old persons who live alone or are isolated. Sheltered housing and hostels provided by local authorities are the appropriate remedies in this case;

6. Family support services including information and advice to allay their anxieties, community nursing services, home helps, meals on wheels, chiropody and physiotherapy are all important factors in containing psychiatric illness in the elderly at home and in helping families to cope adequately with it;

7. Day centres to which the old can be brought during the day are also valuable in preventing illness and helping families to cope. The concept of short-term relief by admission to hospital can also be important in deserving cases.

IN-PATIENT PSYCHIATRIC SERVICES

CHAPTER 5

(A) SHORT-TERM CARE

24. The policy of providing acute psychiatric units in general hospitals is endorsed by the Sub-Committee and it therefore recommends the provision of these units in Kilkenny and Wexford general hospitals.

25. An upgraded, integrated admission unit should be provided in St. Dympna's Hospital, Carlow.

26. Parent hospitals will continue to require admission facilities which should be of a high standard and if possible should be fully integrated.

27. Research should be undertaken into the causes of re-admissions to hospital which account for a high proportion of total admissions.

(B) LONG-TERM CARE

28. It is recommended that up-to-date regional guidelines be developed in relation to the numbers of beds and related facilities for the main categories of long stay patients.

29. There should be no increase in the numbers of psychiatric beds and the existing numbers should be reduced as the hospitals long stay population declines. Remaining beds should be upgraded.

30. Resources should be directed towards ensuring that the following objectives are achieved :-

(a) replacement of grossly sub-standard accommodation where it exists;

(b) elimination of overcrowding if and where it exists;

(c) introduction where appropriate, of separate facilities for different classes of patients whose needs vary, e.g. psycho-geriatrics, mentally handicapped, admission units, rehabilitation patients, etc.

(d) adequate provision of day space and dining facilities;

(e) provision of more privacy in wards;

(f) adequate provision of sanitary facilities;

(g) provision of ground floor accommodation for frail elderly patients;

(h) improvements in general internal standards of decoration;

(i) provision of suitable training and activation facilities for patients who can be rehabilitated in some degree, including pre-hostel training units;

(j) improving fire standards;

(k) reduction of ward size.

31. Each hospital should prepare a five year plan for the upgrading of any defective areas in the hospital based on the above principals. (see recommendation No. 30).

REHABILITATION PROGRAMMES

32. The Sub-Committee recommends that as far as possible each patient should have a personal programme of suitable activation measures prescribed for him which nursing staff could organise, encourage and assist the patient to do.

33. The Sub-Committee recommends that the range and frequency of recreational activities be increased where necessary including the introduction or re-introduction of art therapy, music, physical training, etc.

34. It is recommended that a policy to encourage visiting be developed with the assistance of community nurses and/or psychiatric social workers.

35. The Board itself must set a major value on this rehabilitation programme and provide the necessary will and resources.

36. There must be identification at the highest management levels with the programme. Accordingly, it should become a recurring item on the agenda of the Special Hospitals Committee.

37. Rehabilitation must become a major organisational aim of each area's service to which the inter-disciplinary senior management of the service should direct its attention.

38. Each major caring profession must ensure that the highest professional standards are sought from its members on behalf of these patients.

39. Successful rehabilitation programmes involve major personnel management policy changes which, unless made, may vitiate the effort.

40. The special role of the nursing profession in this area of rehabilitation is emphasised.

41. It is essential that adequate training be provided for nurses in rehabilitation skills and the Sub-Committee recommends that the matter be taken up with An Bord Altranais in the first instance and that local measures be also pursued in relation to training of staff.

42. The Sub-Committee considers that this commitment to rehabilitation will be successful only if it is :-

    (a) maintained over the requisite (and possibly long) period of time;

    (b) based on thorough individual assessment, setting of objectives and regular review;

    (c) led by a consultant psychiatrist supported by a selected team drawn from all relevant disciplines and including a senior administrative nursing officer;

(d) provided with appropriate accommodation facilities, equipment and trained non-professional staff to allow patients access to a wide range of occupational retraining;

(e) based on a rehabilitation programme designed to bring the patient from small successes to more ambitious tasks as self confidence and self esteem develop. Undue emphasis on production targets should be avoided in the earlier phases of growth of the patient's capability, but facilities must include access to more disciplined industrial environments.

43. Each hospital should prepare an annual statement of its programme plan indicating specific objectives and the officers responsible for their implementation.

44. There should be an annual report produced by the hospital management on the execution of the annual plan and this report should be submitted to the Board.

45. Patients should receive financial reward, proportionate to their achievements.

46. As part of the incentive for effort by patients, consideration should be given to providing higher standards of private accommodation within hospitals, together with access to personal choice of clothing and a wider range of recreational opportunities.

(D) CARE OF THE ELDERLY

47. It is recommended that no elderly patient be processed for admission to a psychiatric hospital until the patient has been examined by a consultant psychiatrist.

48. Existing community assessment teams for the elderly should be broadened to include a consultant psychiatrist.

49. Each catchment area with a general hospital should have the services of a geriatrician and a geriatric assessment unit which would assist in coping with certain categories of the elderly with mental illness.

50. Pending the provision of proper geriatric services, interim assessment units for psychiatric hospitals should be provided separate from other admission facilities.

51. The following requirements of elderly patients should be provided :-

(a) accommodation should be provided at ground floor level particularly for non-ambulant patients. Ambulant patients accommodated above ground floor level should be provided with lifts for access to and egress from wards in normal circumstances. They must also have adequate egress routes in the event of fire.

(b) special bathing and toilet facilities suitable for elderly patients;

(c) physiotherapy, chiropody, occupational and recreational therapy service and also sight and hearing testing services;

(d) special aids such as wheelchairs, walking aids, hearing aids, spectacles, etc.

(E) CARE OF MENTALLY HANDICAPPED PATIENTS

52. Separate, upgraded accommodation should be provided for existing mentally handicapped patients.

53. Existing mentally handicapped patients in hospital should be reassessed by a specialist team to define the degree of handicap and design a suitable activation programme for each individual.

54. Nurses trained in mental handicap should be used as much as possible in these units.

55. The policy of not admitting further mentally handicapped patients to psychiatric hospitals is endorsed. The provision of the special centre in Enniscorthy as recommended by the Report on Mentally Handicapped in the region is also endorsed.

56. Professional co-operation and liaison between consultants in centres for mentally handicapped and psychiatric hospitals should be encouraged.

PERSONNEL MANAGEMENT IN THE PSYCHIATRIC SERVICE

CHAPTER 6

57. The SubCommittee recommends that a common task orientated management framework be established involving the formulation of planned objectives within the hospital with arrangements for a regular review of their implementation.

58, The Sub-Committee recommends that the Board would therefore ensure that its industrial relations department is adequately equipped in numbers and training to do this important task well.

59. A review is needed of basic organisational arrangements for training student nurses along the lines suggested by An Bord Altranais, i.e. centralised teaching facilities.

60. The content of the syllabus for nurse training requires to be reviewed to ensure the right emphasis on a full range of nursing skills.

61. Training of post graduate nurses, especially supervisory grades, needs improvement.

62. The special training needs of existing and future community nurses requires consideration.

63. Mentally handicapped patients should be nursed by staff trained in mental handicap nursing skills.

64. Nurse training generally and the standards of nursing practice would be enhanced if senior nursing grades introduced a degree of specialisation into their role, e.g. in training, rehabilitation, the handicapped, the elderly, recreation, etc., while retaining existing general nursing responsibilities.

65. Nursing training and practice would benefit if there was a more balanced mix of nursing and domestic staff on the wards. To achieve this, additional domestic posts are required.

66. Catering staff require a programme of training in food preparation and hygiene. They should also be given reasonable periods on these duties so as to allow the development of their skills and to improve the standards of food preparation in the hospitals.

67. All hospitals should establish themselves as training hospitals for medical staff by collaborating together to mount the necessary facilities.

68. Consideration should be given to enabling consultant psychiatrists to have areas of special interest, e.g. rehabilitation or psycho-geriatrics, while retaining their full range of professional activity.

69. The Sub-Committee also recommends that attention be given to the following matters which are of national scope but which significantly affect the quality of care given :-

(a) guidelines on acceptable staff/patient ratios for various categories of patient;

(b) the need to reduce the dichotomy between male and female staff and patients in hospital;

(c) the methods of selecting people for promotion;

(d) the methods of rostering staff.

ALCOHOLISM AND DRUG ADDICTION

CHAPTER 7

70. Each psychiatric catchment area should have an initial complement of two trained staff specialising in counselling alcoholics and their families.

71. These staff would liaise with other primary care staff in the health system including general practitioners, public health staff, community nursing staff, etc., and also with interested voluntary agencies, especially A.A., Al Anon, Al Ateen.

72. The local psychiatric hospital facilities should be retained and improved to provide facilities for more intensive treatment of alcoholics including emergency treatment.

73. A special regional 25 bed alcoholic unit should be provided in Ardkeen incorporating day care and treatment facilities for 10 day patients, designed to provide the optimum conditions for care and rehabilitation of patients referred by consultant psychiatrists from the local psychiatric hospitals. Pending its provision, St. Patrick's Hospital, Belmont Park, Waterford which is discharging many of these functions should be supported and developed until the Ardkeen unit is available and the role of St. Patrick's can again be reviewed with the Board.

74. The special regional unit should engage in a comprehensive range of treatments and provide a full range of specialised professional staff, including consultant psychiatrists, psychologists and social workers, etc. This unit would serve as a training unit for local services and also as a research unit for the region.

75. The Board should encourage the development of national policies of education and prevention.

76. The Board should prepare a policy for internal use in dealing with health board personnel who may have problems in this area and should encourage the Regional Council for Alcoholism in its efforts to promote similar schemes in industry generally.

77. The Board should encourage the emergence of social organisations whose aims are to provide recreational facilities in the community which exclude the use of alcoholic drink.

78. The Sub-Committee recommends that as a means of monitoring the growth of the drug problem and engaging the support of parents and community leaders in protecting the young from this social evil, committees should be appointed in each Community Care Area representing the health, teaching and police professions, clergy, parents and organisations interested in young people.

79. Health Education Officers should be appointed whose remit would include education against drug abuse.

DEVELOPMENT PROGRAMME FOR PSYCHIATRIC SERVICES

CHAPTER 8

The Sub-Committee considers that the following priority measures are necessary in order to give effect to the principles of a community psychiatric service discussed in this report.

WATERFORD CATCHMENT AREA

80. A programme for the provision of additional hostel places, supervised and unsupervised, should be drawn up.

81. A day hospital should be provided in Dungarvan with appropriate facilities for treatment, care and activation of patients. A programme of day centres should be prepared for other larger towns in the area in due course.

82. A programme of internal improvements in St. Otteran's Hospital should be prepared including the provision of an integrated admission unit for the severely ill.

83. A separate unit should be provided for the mentally handicapped patients in St. Otteran's Hospital.

84. As part of the new hospital at Ardkeen, the existing St. Declan's Unit should be replaced by an adult unit of 45 beds and day care and treatment facilities for 15 day patients.

TIPPERARY (North and South Ridings) CATCHMENT AREA

85. A programme for additional hostel places, supervised and unsupervised, should be developed.

86. A programme of day centres should be developed in the larger towns to cater for patients in the community.

87. A replacement unit of 100 beds to be provided for mentally handicapped and other patients at St. Luke's Hospital.

KILKENNY CATCHMENT AREA

88. An acute psychiatric unit should be provided at St. Luke's Hospital consisting of 30 beds and 30 day places.

89. A programme of additional hostels, supervised and unsupervised, should be developed.

90. A separate unit for the mentally handicapped should be provided.

91. A programme of day centres should be developed in the larger population centres.

92. A programme of internal improvements in St. Canice's Hospital should be drawn up.

CARLOW/KILDARE CATCHMENT AREA

93. A programme for the provision of hostels, supervised and unsupervised, should be developed.

94. A programme of day centres should be developed in larger population centres.

95. An integrated admission unit should be provided in St. Dympna's Hospital together with a programme of general upgrading of the hospital.

96. A separate unit for the mentally handicapped should be provided.

97. An activation centre for the rehabilitation of patients should be provided at St. Dympna's Hospital.

WEXFORD CATCHMENT AREA

98. An acute psychiatric unit of 40 beds and 20 day places should be provided at the County Hospital Wexford. Pending its provision, an interim day hospital and activation centre should be provided in Wexford town.

99. A programme of day centres should be developed in larger population centres in the county.

100. A programme for the provision of additional hostels should also be developed.

REGION

A development centre with adjacent residential facilities should be provided for selecited patients based on principles in use in the Toghermore Centre, Tuam, Co. Galway.

FINANCING OF PROGRAMME

101. These proposals, in so far as they are for the rehabilitation of patients into the community, may be financed from the European Social Fund if funds are available. These include hostels, activation centres, day centres and units for the mentally handicapped.

102. A special major capital allocation should be sought from the Department of Health to finance those elements of the plan which are not funded by the European Social Fund.

103. A special minor capital allocation should be sought each year to fund the programme of upgrading in the mental hospitals.

104. Where new units such as day hospitals ar day centres require staffing which cannot be met from re-deployment, they should be given high priority in submission of new unit proposals to the Department of Health.

105. Where new units are being developed in Tipperary (N.R.) and County Kildare, a financial contribution should be sought from the respective Health Boards.

106. A special maintenance allocation should be provided for mental hospitals to assist in ensuring a satisfactory environment for patients and a special effort should be made to maintain internal painting programmes in wards to ensure a cheerful atmosphere.

SPECIAL SERVICES

CHAPTER 9

107. The Sub-Committe recommends that no change be made in the present arrangements for forensic psychiatry.

108. The Sub-Committee recommends that a clinical psychologist be appointed to each psychiatric catchment area with appropriate opportunities for liaison between the clinical psychologists in the region.

109. It is recommended that each psychologist should cater for the needs of the other programmes in his area on an arranged basis.

CHAPTER 1

THE PREVALENCE OF PSYCHIATRIC ILLNESS

The Sub-Committee feels that it is appropriate to begin its review by establishing, if possible, the scale of the problem, but notes the serious difficulties which exist in attempting to quantify the prevalence of mental illness in the community. Various estimates have been made of the numbers who actually consult their doctor about some variety of mental illness. In this regard, up to 10% of the population is thought to do so, i.e. some 38,000 people. However, this does not take into account those who seek treatment for illness which is not exclusively psychiatric or which is not identified as psychiatric illness. To these must be added people who require but do not seek any treatment at all. It is clear that taking all these groups into account, the problem is a major one which requires the development of a comprehensive range of measures to deal with it.

The Sub-Committee notes that there has been a considerable growth in one major index of mental illness, i.e. admissions to psychiatric hospitals. This is illustrated in Table 1. However, this does not necessarily mean a growth in the prevalence of mental illness but may reflect a greater willingness to seek treatment.

TABLE 1

ADMISSIONS TO MENTAL HOSPITALS AND PSYCHIATRIC UNITS IN GENERAL HOSPITALS

Hospital	Total Admissions 1971	Total Admissions 1981	% Increase
St. Dympna's	213	631	+196.0%
St. Canice's	426	388	−8.9%
St. Luke's	360	682	+89.0%
St. Otteran's	389	403	+3.5%
St. Senan's	353	532	+50.7%
St. Declan's Unit	458	471	+2.8%
St. Michael's Unit	683	853	+24.8%
Regional Total	2,882	3,960	+37.4%

In view of the rise in admissions, the Sub-Committee considers it relevant to compare admission statistics with the country generally. In this context, the annual report of the Medico-Social Research Board were consulted. These indicate the following comparative information :-

TABLE 2

RATES PER 100,000 OF POPULATION 1977/1979

	S.E.H.B.		Average of whole country	
	1979	1977	1979	1977
All admissions	734.5	770.3	812.2	885.9
First admissions	228.6	242.2	256.2	295.0
All admissions 65 - 74 years	1433.3	1358.1	1346.5	1338.0
All admissions 75 years and over	1233.3	1123.5	960.5	918.6
All admissions of :				
Organic psychosis	39.1	49.5	36.9	41.7
Schizophrenia	150.0	167.1	184.3	200.6
Manic depressive psychosis	111.7	174.0	170.8	192.2
Neurosis	152.6	104.3	102.6	101.8
Alcoholism) Alcoholic psychosis)	192.1	176.7	212.5	227.1

The conclusions from this table are that this region has an overall lower level of admissions but has higher admission rates for the elderly. The change in relative incidence of neurosis and manic depressive psychosis in the South Eastern Health Board region between 1977 and 1979 requires further evaluation before any firm conclusion can be drawn.

The following table taken from the 1979 Report of the Medico-Social Research Board indicates that discharge policies in the South Eastern Health Board region are similar to the rest of the country.

Ireland 1979. Health Board Areas. Leaving, discharges (including deaths) and length of stay. Numbers of percentages

	Under 1 month	1-3 months	3 months-1 year	1-2 years	2-5 years	5-10 years	10-15 years	15-20 years	20-25 years	25 years and over	All lengths of stay
					DISCHARGES						
Eastern	5,018	2,595	788	95	98	48	16	5	6	31	8,700
South-Eastern	2,325	847	268	36	39	18	16	4	2	24	3,579
Southern	2,225	781	185	27	31	16	5	7	2	15	3,294
Mid-Western	1,820	618	165	27	26	3	6	3	3	15	2,686
Western	1,856	600	176	32	39	15	28	13	13	42	2,814
Midland	853	427	109	20	18	11	8	7	3	14	1,470
North-Western	1,645	325	87	12	11	12	4	2	3	25	2,126
North-Eastern	1,503	436	176	21	24	17	15	7	2	36	2,237
Non-National	104	33	10	2	2	4	1	0	0	0	156
Total	17,349	6,662	1,964	272	288	144	99	48	34	202	27,062
					PERCENTAGES						
Eastern	57.7	29.8	9.1	1.1	1.1	0.5	0.2	0.1	0.1	0.4	100.0
South-Eastern	65.0	23.7	7.5	1.0	1.1	0.5	0.4	0.1	0.1	0.7	100.0
Southern	67.5	23.7	5.6	0.8	0.9	0.5	0.2	0.2	0.1	0.5	100.0
Mid-Western	67.8	23.0	6.1	1.0	1.0	0.1	0.2	0.1	0.1	0.6	100.0
Western	66.0	21.3	6.2	1.1	1.4	0.5	1.0	0.5	0.5	1.5	100.0
Midland	58.0	29.0	7.4	1.4	1.2	0.7	0.5	0.5	0.2	1.0	100.0
North-Western	77.4	15.3	4.1	0.6	0.5	0.6	0.2	0.1	0.1	1.2	100.0
North-Eastern	67.1	19.5	7.9	0.9	1.1	0.8	0.7	0.3	0.1	1.6	100.0
Non-National	66.7	21.1	6.4	1.3	1.3	2.6	0.6	0.0	0.0	0.0	100.0
Total	64.1	24.6	7.3	1.0	1.1	0.5	0.4	0.2	0.1	0.7	100.0

It will be seen from these tables that the overall pattern of admission and discharge in this region is satisfactory in relation to the country as a whole, in terms of numbers, length of stay and diagnosis. A further interesting statistic is the number of patients currently in our psychiatric hospitals. Table 3 shows the change in numbers of in-patients since 1971.

TABLE 3

COMPARATIVE NUMBERS OF IN-PATIENTS IN PARENT MENTAL HOSPITALS 1971-1981

Hospital	No. of patients in 1971	No. of patients in 1981	% change
St. Dympna's, Carlow	316	366	+16%
St. Canice's, Kilkenny	374	346	−7%
St. Luke's, Clonmel	575	497	−14%
St. Otteran's, Waterford	442	420	−5%
St. Senan's, Enniscorthy	426	392	−8%
All hospitals	2133	2021	−5%

The Sub-Committee was also interested to note the age distribution of existing patients in the parent mental hospitals together with the duration of their stay. Table 4 illustrates that 38% of patients are over 65 years and that 59% of patients are in hospital for over 5 years.

TABLE 4

IN-PATIENT POPULATION OF MENTAL HOSPITALS BY AGE AND LENGTH OF STAY - 1981

	Under 20 yrs.	20-44 yrs.	45-64 yrs.	65 yrs. & over	All ages	% total
Under 3 months	6	78	67	47	198	10%
3-12 months	20	65	62	52	199	10%
1-5 years	8	115	124	174	421	21%
Over 5 years	2	216	485	500	1203	59%
All lengths of stay	36	474	738	773	2021	100%
% of total	1.8%	23.5%	36.5%	38.2%	100%	

CHAPTER 2

FINANCIAL ASPECTS OF THE PSYCHIATRIC SERVICES

The Sub-Committee noted that in 1981 a total of £15.58m. was spent by the Board in the provision of psychiatric services in the region. This represents 23.5% of our total expenditure but it must be noted that the catchment area includes Tipperary (N.R.) and most of Co. Kildare.

Table 5 below shows each hospital's share in this expenditure.

TABLE 5

	Population of catchment area 1981	% of total pop.	Total expend. in 1981 £m.	% of total exp	Expenditure per head of population of psychiatric services £
St. Dympna's Carlow	109,553	22%	2.871	18%	26.84
St. Canice's, Kilkenny	69,156	14%	2.617	17%	37.84
St. Luke's Clonmel	133,741	27%	3.732	24%	27.90
St. Otteran's Waterford	87,278	18%	3.154	20%	36.14
St. Senan's Enniscorthy	96,421	19%	3.206	21%	33.25
Region	496,149	100%	15.580	100%	31.40

Apart from expenditure on community nursing and out-patient clinics covering salaries, travelling and medicines, the above expenditure is the cost of running the five institutions. At the end of 1981 there were 2021 patients in these institutions. Therefore, the average cost at the end of 1981 after allowing for out-patient activities, was running at the rate of £7,422 per in-patient per annum approximately.

The analysis of expenditure in Table 6 below indicates how staff resources are used at present.

TABLE 6

ANALYSIS OF EXPENDITURE 1981

Category of pay costs	% of total pay costs	% of total pay and non-pay
Medical pay costs	5%	4%
Nursing pay costs	68%	51%
Housekeeping staff pay costs	10%	7%
All other staff costs	17%	13%
Total pay costs	100%	75%

It is clear from these figures that staff costs represent the largest cost factor and that the utilisation of manpower is the major issue of cost effectiveness in the provision of the service.

The Sub-Committee feels that on economic grounds there is clearly a very strong case for consideration if alternative methods of care exist which, though less institutionalised than at present, would provide as effective a service. An example of this would be patients whose illness does not require continuous medical supervision and therefore may not require to be in hospital at night or at weekends. Due to the unsocial hours involved for staff, these periods are the most expensive service periods to provide In addition to directing patients towards an appropriate and cost effective level of professional care, the Sub-Committee feels that it is clearly desirable that the institutional services which are expected to be more intensively staffed should have regional guidelines for medical and nurse/patient ratios and for the utilisation of catering and housekeeping staff and other staff so that a standard resources framework can be used for all hospitals and regions. Such norms should be derived as scientifically as possible.

In addition, it would facilitate planning and evaluation of the service if the level of provision of beds, day care places, etc. and other guidelines were also developed at national level.

The Sub-Committee also considers that a review should be undertaken of the carrying on of farming activities in mental hospitals in relation to their cost, value of output and their role in assisting in creating a therapeutic environment for patients.

The Sub-Committee notes that the cost of energy in the mental hospitals is running at £690,000 p.a. in the region. Technical services should be strengthened by the recruitment of technical officers skilled in the design and monitoring of large energy complexes such as hospitals. The Sub-Committee is convinced that large sums could be saved on a recurring basis if this is done.

CHAPTER 3

DEVELOPMENT OF A STRATEGY FOR DELIVERY OF A PSYCHIATRIC SERVICE

It is now very evident that mental illness need no longer be the grim event that past generations had come to accept. Treatment rather than custodial care can be offered and is now typically more successful. It also occurs over a shorter period of time and can take place at home, in the family doctor's surgery, in out-patients clinics or in short or long stay hospital units as circumstances require. Only a small minority of patients now require to be detained for their own safety. Even severe illness can in many cases be brought sufficiently under control to allow the patient to maintain his presence in the community given appropriate support. For those who need long-term care in hospital, the general standards of care are sufficiently high to ensure the patient's basic well-being consistent with his mental condition. These improved options create a major opportunity to re-examine the right balance of services as between hospital services and community based services and establish whether sufficient resources of the right quality have been provided to the psychiatric service in its totality to enable professional staff to fully exploit the opportunities for the prevention of illness and its early detection and treatment so as to minimise the ravages of the disease on the patient's personality, family and social life.

It also creates an opportunity to avail of the growing public perception of the mentally ill person as a person whom the community can help and support rather than as someone to be isolated in an institution and forgotten.

While recognising these welcome developments, severe mental illness is still a formidable challenge which can impair a person's quality of life for long periods of time. The Sub-Committee considers it useful therefore to consider how this impairment affects the patient and also what is the range of individual psychiatric patient needs before adopting any over-all policy framework or model for the delivery of a psychiatric service over the next ten years.

It is evident that the range of needs varies with the severity and duration of the patient's illness and the availability and quality of suitable family and other support. In cases of severe illness, the patient's personality may be so impaired that he may not be able by himself to resume an effective place in his family, employment or in the community generally. This may be compounded by the absence of a family or by family or personal circumstances which inhibit the patient's recovery. In such situations the service is faced with the virtual total reconstruction of the patient's life. It would be unusual if this were to happen very quickly and the normal situation would be acute treatment of the illness followed by personal supports in the form of residential, social and occupational re-orientation and training. Such support can vary in its intensity, duration and location. It requires to be provided after a comprehensive assessment of the patient's situation and may need to be introduced gradually and with sensitivity. Progress may vary among patients and will be accompanied by regression and recurring admissions and in a minority of cases, the patient may appear to be unresponsive in spite of intensive support. Patients who cannot survive as a viable personality outside hospital, must be provided with long-term residential care which then becomes their home.

It will be appreciated that where a weakened personality has had to spend considerable periods as an in-patient, the process of functional recovery can be slowed or damaged by the inevitably organised life style possible in an institution. The role of all professional staff especially the nursing profession, in this regard is of major importance and requires considerable skill and dedication from staff as well as high grade facilities in order to avoid the growth of such undue dependence on the hospital.

It is clearly an advantage to the patient and the service if hospitalization can be avoided or minimised and this supports the case for alternative non-institutional places of treatment which would complement rather than replace the hospital and which would form part of a co-ordinated range of options for treating any patient. Such facilities include day hospitals, day centres, out-patient departments, district clinics, hostels, activation centres, etc.

Having considered the developments of recent decades referred to above, and the needs of the psychiatric patient, the Sub-Committee is convinced that the elements set out below form the basis of a sound psychiatric service.

Accordingly, it RECOMMENDS them to the Board as a model for the delivery of the service over the next ten years. As a number of these elements have already commenced in some places in the region, the Sub-Committee's proposal is to some extent a re-affirmation and expansion of current attitudes and policies. Furthermore, detailed consideration will be given to these elements in future chapters of this report.

The following therefore are recommended as the main elements of a community psychiatric service :-

1. The Board should develop a policy for the prevention and early detection and treatment of psychiatric illness.

2. The primary service for the mentally ill as with other illnesses should be the family doctor, supported as appropriate by the psychiatric services.

3. Admission to a psychiatric hospital or a psychiatric unit in a general hospital should be regarded as a final treatment resource and to this end treatment facilities outside hospital should be developed so as to maintain as much as possible the patient's links with his community and to minimise his stay in hospital when this is necessary.

4. For patients who need hospitalisation, a high standard of treatment, caring and rehabilitative facilities should be provided both in short-stay and long-stay units, so as to maximise the patient's chance of rehabilitation.

5. Hospital units, community based units and services in each catchment area should function as a co-ordinated balanced flexible service under the clinical direction of the Chief Psychiatrist.

6. Any further change in the role of the long-stay hospital can only take place after alternatives have been developed. The discharge of a patient into a community which is not equipped to care for the patient can result in a deterioration in the patient's well-being.

CHAPTER 4

COMMUNITY PSYCHIATRIC SERVICES

As was discussed above, the Sub-Committee accepts the broad validity of a community psychiatric service as the appropriate service model for the provision of services to the mentally ill. This concept regards the patient as part of his own community and seeks if at all possible to avoid disrupting this link. Rather, where the patient has been hospitalized, it seeks to re-establish and strengthen his former links as soon as possible. While it has been demonstrated elsewhere that a well organised, adequately staffed and efficient community service can maintain a majority of psychiatric patients in their community without adverse affect on their clinical progress, the difficulties experienced in achieving this may be considerable and will require the determined support of the whole service.

The basic objectives of this service model invoke the following : -

(i) Prevention of mental illness

(ii) Treatment and caring services outside hospitals if possible and advisable.

(i) *Prevention of mental illness*

Prevention involves taking measures to prevent illness by enabling people to avoid it or by early detection and referral for treatment before a disturbance develops and consolidates into full psychosis. Prevention would also include measures to prevent recurring episodes of illness. The case for preventive psychiatry is of course the same as for all branches of medicine. Avoidance of mental ill health by an individual greatly enhances his quality of life and that of his family, and releases the resources of the service to concentrate on the needs of the less fortunate.

A prevention policy is also of particular importance where the service is moving away from its former identification of psychiatry with institutions. Such a move towards the community requires that it (the community) be prepared for its role by education and information on the nature and extent of the problem, the positive prognosis now possible for many mental illness syndromes, the needs of discharged patients and the actual contribution possible by society including the realisation that rejection of patients would force an inevitable return to an institutional system once more.

It is the Sub-Committee's view that this attitude is an important element in ensuring the success of a community psychiatric approach and in the process provides additional opportunities for the dissemination of values, attitudes and information which will help to prevent psychiatric illness or lead to its earlier detection and containment at a less serious level. It must also be recognised that such a programme of education of families, employers, etc., must avoid making undue demands or creating unrealistic expectations which could undermine the individual patient's position and the confidence of the public in the service. This is important since many patients who have had severe illness may always have some residual symptoms.

The Sub-Committee considers that education of the public can make an important contribution to any programme for the prevention of mental illness. The objective of any such education programme should be to inform selected target groups about the recognition of symptoms of mental illness and the need to seek advice earlier and from whom such advice can be obtained. Such an approach is considered feasible, e.g. in relation to symptoms of depression or confusion in elderly persons. Education programmes should be pursued both at local level and at national level.

At local level the objectives to be aimed at should include :

(a) general education measures aimed at social organisations and agencies which would help to disseminate useful information. To this end contacts should be developed between service personnel and local voluntary bodies, social organisations, women's organisations, marriage counselling agencies, schools, etc.

(b) encouraging local bodies to take an interest in the psychiatric service and in the problems of patients, including their social needs and generally helping to create a helpful attitude among the local population.

At national level education programmes should be developed by the Health Education Bureau after consultation with Health Boards. These should be aimed at helping people to detect symptoms more quickly, encouraging them to seek help immediately and promoting generally the society's acceptance of a community based psychiatric service. Accordingly, the Sub-Committee RECOMMENDS :-

(a) that the Board should encourage the development of a national programme of education directed towards the prevention and earlier detection of mental illness by professional staff;

(b) the psychiatric service should develop local education measures by encouraging local social organisations to inform themselves about mental illness and to increase their contacts with the service and to promote local acceptance of a community service.

In this context the Sub-Committee considers that a special appreciation is due to the Mental Health Association of Ireland and all other voluntary agencies, local and national, in respect of the very valuable work which they undertake in interpreting the service to the community and in helping the prevention of mental illness and fostering an awareness of mental health and in the social support which they provide for individual patients.

It follows from the above that this is a sensitive and time consuming matter which requires thought and which will have manpower implications. The major difficulty encountered in attempting to frame specific preventive measures is that the multiple causes of mental illness are not fully understood as to their relative importance or interaction and this limits direct primary medical measures as such. In this regard, the Sub-Committee considers it right that this Board should adopt a constructive attitude towards research into factors which contribute to illness. Accordingly, the Sub-Committee RECOMMENDS that consultant psychiatrists or other appropriate persons or agencies who are interested in research projects, should receive positive assistance. Such projects might also be undertaken with the assistance of the Medico-Social Research Board and appropriate financial assistance given.

The Sub-Committee attaches importance also to promoting an improved awareness and co-operation among the other health professions and services. The Sub-Committee is convinced that such co-operation should be developed both formally and informally and it RECOMMENDS that this should include the following : -

(a) formal and regular contact between the Director of Community Care and the Chief Psychiatrist of the corresponding area. These meetings should include consultation on areas of common interest including general practitioner services, psycho-geriatric services, mental handicap, welfare homes, sheltered workshops and promotion of co-operation between services at nursing level.

(b) community psychiatric nurses should meet with public health nurses in their areas at least twice per year to discuss problems of mutual concern. All future appointments to office of community psychiatric nurse should be to a base in the area served where this is remote from the hospital.

(c) the Chief Psychiatrist in each area should consult with the Director of Community Care and with general practitioners with a view to enlisting their aid in early detection and discuss with them the best methods of achieving this.

(ii) *The provision of community based treatment to mentally ill persons.*

Once illness is detected, it frequently presents in the first instance to the general practitioner. This can occur either as a direct consultation by the patient or by a member of the patient's family. In any event, the general practitioner deals with the vast majority of minor psychiatric illnesses and thereby enables the specialist psychiatric services to concentrate on the more difficult cases. In a region in which two thirds of the population are dispersed in rural areas, remote from psychiatric facilities, the general practitioner must assume a very important role as a first line of defence.

The Sub-Committee therefore RECOMMENDS that consultation should take place between the general practitioners and the Directors of Community Care and the consultant psychiatrists and that policies be developed locally which ensure that the role of the general practitioner is optimised especially in relation to the following : -

(a) assistance from consultants in general or in particular cases.

(b) reporting procedures about general practitioner's patients who are being referred to or from the consultant psychiatrist.

(c) care by the general practitioner of patients discharged from hospital, out-patients departments, psychiatric clinics, etc.

(d) liaison concerning family and other circumstances of patients.

(e) possibility of domiciliary visit by consultant psychiatrist where it is agreed patient cannot otherwise seek aid or in other appropriate circumstances.

(f) the making available of the services of the community psychiatric nurse to the general practitioner.

There will be a number of patients whose illness has developed to a more serious degree of neurosis or to a psychosis. The general practitioner will rightly want to refer these cases to the appropriate consultant. Where the referral is not of critical urgency, the appropriate services available are the district psychiatric clinics. The Sub-Committee notes that a developed system of clinics already exists and RECOMMENDS that this facility be continued and improved. It is RECOMMENDED that these clinics should ideally be situated as near as possible to population centres and should be located in the local health centres where these are available.

The Sub-Committee notes that as in common with clinics in other services, patients do not always keep their appointments for clinics. For some psychotic patients this can be a particular problem compounded by the distances to be travelled. Is is RECOMMENDED therefore that an appointments system be developed which would provide written notice to the patient and would also highlight absences for appropriate follow up. This system, however, should not be so rigid that patients could not attend a clinic on a spontaneous basis.

The Sub-Committee also RECOMMENDS that the transport service is utilised where necessary to ensure attendance. Because of the long-term nature of their disability, patients attending clinics may continue attending although the patient's general practitioner might take over the case. It is noted that there has been a general reduction in the number of attendances in recent years due to the return of patients to the general practi ioner in this way. The Sub-Committee RECOMMENDS that this practice of returning patients to their general practitioner be continued and accelerated where appropriate.

In addition to the foregoing, it is RECOMMENDED that patients would normally be served by the psychiatric team from the nearest mental hospital. This will involve a re-drawing of the catchment areas for St. Otteran's Hospital, Waterford and St. Luke's Hospital, Clonmel to incorporate south Kilkenny and north Waterford respectively. These areas will then also correspond to the present community care areas.

The Sub-Committee recognises that there is a number of patients who have been referred to consultant psychiatrists by the family doctor but who need very frequent contacts with professional staff but may not need twenty-four hour medical and nursing care. In such cases, admission to hospital may be counter productive and therefore some facility is needed wherein they can receive the treatments required while still living at home.

In addition there are patients who have been discharged from hospital but who need a gradual return to their former life or to their normal occupation and in the interim require a degree of support.

Similarly, there are patients who can return home after their discharge but who are subject to recurring breakdown partly because of their social and family or material situation. Also some patients who have survived in the community because of family support, may be suddenly unable to survive because of the death of a parent.

Such cases are currently dealt with by recalls to clinics or by periodic contact with the community nurse. However, these arrangements are not always satisfactory with the

result that the patient fails to enjoy a basic level of comfort which he requires to avoid re-admission. These problems are often compounded by unemployment and by the patient's inability to cope with a steady job or with the normal social process. The net result is admission to hospital on a long-term basis.

The Sub-Committee considers that some additional support facility is needed to bridge this gap between the out-patient and the in-patient. There is provision now in the mental hospitals for patients to return for assistance in training for employment in the hospital activation units and there is also some small degree of day care activity being carried on in the hospitals. While this is useful, it tends to be available only to those who are not too remote from the hospitals. In view of the dispersion of the population the Sub-Committee feels that there is a case for the provision of special centres in other larger towns where there is no psychiatric hospital. An example of this would be Dungarvan serving the west Waterford area which is thirty miles or more from the hospital. Similarly, Wexford town does not have any local facility for coping with these situations.

Accordingly, the Sub-Committee RECOMMENDS that the provision of day care centres should be considered for each catchment area.

It is RECOMMENDED that these centres would provide the following facilities :-

(a) treatment facilities for use by the consultant psychiatrist, psychologist, etc.

(b) care facilities in which patients can receive bathing, meals, chiropody, physio-therapy, etc.

(c) limited activation facilities including social retraining programmes, occupational therapy, etc.

The Sub-Committee RECOMMENDS that Dungarvan and Wexford be given priority for the provision of these facilities.

The Sub-Committee also RECOMMENDS that such centres be designed to provide the maximum flexibility for other local uses, e.g. elderly patients.

The Sub-Committee considers that these centres will help to reduce the incidence of re-admission to hospital and will also provide needed relief to families who are trying to cope with the presence of a mentally ill member of the family who can now avail of the day centre as often as is considered necessary.

The Sub-Committee gave considerable thought to the residential problems of patients who are ready for discharge and cannot be discharged due to the lack of a suitable residence or of people who will become long-stay patients because of their totally un-satisfactory family situation.

In these cases the availability of a hostel would result in the stabilization of the patient's environment and would help greatly to ensure his survival outside hospital. Already a number of hostel places have been provided successfully.

The Sub-Committee RECOMMENDS that the policy of providing hostel accommodation be extended in each county according to local needs.

In relation to the needs of patients who require assistance with training for employment the Sub-Committee notes that in addition to the existing activation units in the mental hospitals, such patients can have access to sheltered workshops or community workshops for the handicapped. The Sub-Committee however was very impressed by the effectiveness of the sheltered unit at Toghermore, Tuam, Co. Galway which provided residential and sheltered employment for up to fifty ex-psychiatric patients. It is therefore RECOMMENDED that a similar unit be provided in this region in a suitable location based on this unit and incorporating its staffing principles.

The elderly in our community present a special and challenging problem to the psychiatric service. As longer life expectancy is achieved, a greater number of people will survive into their late seventies and eighties and of these, up to 10% will develop psychiatric illness. At present, only a small fraction of these patients are being cared for in hospital - the majority are at home. The pressure on hospiial beds is steadily increasing however. While about 11% of the population is over 65, nearly 40% of the present patient population of psychiatric hospitals (both sexes) is over 65 years. However, in the case of female patients the percentage reaches 60% in some cases. Accordingly, it is essential that a wide range of community orientated measures be used to contain this problem. The need for these measures is reinforced by the fact that many of these elderly persons were admitted to psychiatric hospitals because of the absence of more suitable alternative facilities in their catchment area. In this respect, the Sub -Committee recognises the close interdependence which exists between the geriatric services and the provision of psychiatric services for the elderly.

Accordingly, the Sub-Committee endorses and emphatically re-iterates many key recommendations of the Care of the Aged Report and especially the following which impinge on the provision of a community psychiatric service.

1. The appointment of geriatricians is essential to a *basic* service for the elderly and the elderly mentally infirm.

2. The community assessment teams should continue and be expanded to include a consultant psychiatrist who would be called in appropriate cases.

3. No elderly mentally ill patient should be admitted to a psychiatric hospital without having been assessed by a consultant psychiatrist.

4. Assessment units should be provided in all general hospitals and should include facilities for assessment of psycho-geriatric cases.

5. Adequate housing is an important factor in preventing psychiatric illness in old persons who live alone or are isolated. Sheltered housing and hostels provided by local authorities are the appropriate remedies in this case.

6. Family support services including information and advice to allay their anxieties, community nursing services, home helps, meals on wheels, chiropody and physiothearapy are all important factors in containing psychiatric illness in the elderly at home and in helping families to cope adequately with it.

7. Day centres to which the old can be brought during the day are also valuable in preventing illness and helping families to cope. The concept of short-term relief by admission to hospital can also be important in deserving cases.

CHAPTER 5

IN-PATIENT PSYCHIATRIC SERVICES

Hospital based psychiatric services are part of an integrated consortium of services required by a modern community psychiatric service. They are expected to provide services for those who are acutely ill either temporarily or chronically and who require treatment and care at a level of complexity or intensity that is not possible in any other facility.

The pattern of activity in the Board's psychiatric hospitals has changed considerably in recent decades. The hospitals were originally constructed in the mid 19th century and were expanded later in that century and in the opening decades of the 20th century. Until the 1950's admission to hospital was frequently a long term one with a poor prognosis. However, with the development of specific drugs, it became possible to communicate again with patients and to eliminate or reduce those behaviour difficulties which made hospitalisation essential. This led to the progressive reduction in the numbers of in-patients which has continued during the 1970's as shown in Chapter 1, Table 3.

In 1965 an inter-departmental report entitled "Report of the Commission on Mental Illness" was published in which was set out the elements of the recommended future structure of psychiatric services. The Sub-Committee considers it useful to review the developments which have taken place since that time to date so that its recommendations will reflect the evolution of the services to their present point of development. The Sub-Committee notes that in the period 1965 to 1980 the following trends were apparent :-

1. All admissions including re-admissions, increased by nearly 100% to 3701 p.a.

2. First admissions increased by nearly 60% to 956.

3. Where general hospitals psychiatric units were provided (Clonmel and Waterford), overall admissions rose sharply but admissions to parent psychiatric hospitals *declined.*

4. The average yearly numbers of in-patients in parent psychiatric hospitals declined by 17%

5. The typical length of stay for an admission is now under 1 month (69% of cases) and a further 18% are discharged in less than 3 months.

6. Parent psychiatric hospitals at present are largely inhabited by intermediate and long-term patients over 50 years of age, many of whom are suffering from schizophrenia.

While most acutely ill psychiatric patients respond to treatment and are fairly quickly discharged, there are still some patients who require more prolonged, even indefinite, residential care. The Sub-Committee considers it useful therefore to consider in-patient services in terms of these two categories, short-term and long-term care.

SHORT-TERM CARE

The main development in this area has been the development of psychiatric units in general hospitals. This development reflected the growing recognition of the links between psychiatry and general medicine. It also provided an improved psysical environment in which people could seek treatment more comfortably. Such units exist in Clonmel and Waterford and it is evident from the usage statistics that the community supported them very strongly. Although they have only 100 beds in aggregate, i.e. 4% of total, they account for 36% of all admissions in the region.

The following statistics give some further appreciation of the role of the general hospital unit and the parent psychiatric hospital.

TABLE 7

ADMISSIONS TO PSYCHIATRIC UNITS IN GENERAL HOSPITALS ASSOCIATED WITH PSYCHIATRIC HOSPITALS

Hospital/Unit	Beds	All adms. 1979	1st adms. 1979	re-adms. 1979
St. Luke's Hospital, Clonmel	500	662	129	533
St. Michael's Psychiatric Unit	50	905	306	599
Total of hospital and unit	550	1567	435	1132
St. Otteran's Hospital, Waterford	450	442	119	323
St. Declan's Psychiatric Unit	46	451	140	311
Total of hospital and unit	496	893	259	634

It is clear from this table that the general hospital units with about one tenth of the beds, are coping with more psychiatric patients than the parent hospitals.

The Sub-Committee notes however that in 1979 the numbers of admissions to the parent mental hospitals for patients was 856 compared to 910 in the general hospital psychiatric units. This indicates a continuing high level of acute psychiatry being practiced in the parent hospital reflecting those branches of psychiatry dealing with chronic conditions of elderly patients, patients whose behaviour patterns make them unsuitable for short-stay units and persons who are detained for their own security.

The Sub-Committee notes in particular that patients are not being admitted to long -stay wards in parent hospitals because of the absence of sufficient beds in the general hospital units. The level of provision recommended by the 1965 commission of Enquiry on Mental Illness is therefore verified by experience and can serve as an acceptable guide for the provision of further units of this kind.

The Sub-Committee re-iterates current attitudes in relation to the operation of general hospital units as one element in a comprehensive integrated system of care and notes that the common medical direction of these units and the long-stay parent hospital, ensures that the dangers of a two-tier system of care resulting in a disadvantageous approach to the traditional mental hospital, will not prevail.

The Sub-Committee considers that these units have demonstrated their value and their acceptability to the community and therefore RECOMMENDS as follows :-

1. *Kilkenny* The proposed acute psychiatric unit of 30 beds and 30 day places should proceed as soon as possible.

2. *Wexford* The proposed acute psychiatric unit of 40 beds and 20 day places should proceed as soon as possible.

3. *Carlow* In the absence of a large general hospital, The Sub-Committee RECOMMENDS that the admission facilities in St. Dympna's Hospital be upgraded to match the facilities which will be available in the other areas of the region.

The Sub-Committee also RECOMMENDS that, while there is a continuing substantial acute psychiatric practice in the parent hospitals, these hospitals should be equipped to cope adequately with it. It is therefore RECOMMENDED that the admission units in these hospitals should provide a high standard of facilities for the treatment and rehabilitation of acutely ill persons.

The Sub-Committee further RECOMMENDS that in these psychiatric hospitals which do not presently have access to general hospital units, the interim admission facilities should also be of a high standard including, in particular, freedom from overcrowding and from the need to have undesirable proximity of incompatible patient groups. It is RECOMMENDED also that where possible these units should be fully integrated.

The Sub-Committee notes the large elements of re-admissions in the total admissions to psychiatric hospitals and units, reflecting the intractable nature of some of the more serious illnesses.

It is RECOMMENDED that this area of the service should receive serious study and research in order to determine more precisely the factors which bring about the re-currence of admission.

The Sub-Committee considers that apart from the inherent difficulty of totally eliminating deep seated illness, it may be that patients' needs for support outside hospital are not being fully met and that an improved level of provision in this respect is desirable. Such measures would have to be based on an assessment of :-

(a) family circumstances;

(b) employment status of the patient;

(c) physical and mental health of the patient;

(d) residential facilities of patient.

The Sub-Committee considers that re-admission may be averted in a number of cases if the following measures are adopted. These have already been adverted to and recommended elsewhere in this report (Chapter 4).

(a) Day hospitals ;

(b) Day care centres;

(c) Additional hostels.

LONG-TERM CARE

The Sub-Committee notes that the following major groups of patients require long -term support :-

1. Patients who are growing old in the hospital are the most numerous group. These have probably had schizophrenia in the past and have become dependent on the hospital for their home. These would also include those who, while non-resident, have deteriorated over a long period during which there were recurring episodes of illness and admissions culminating in the need for long-term residential care.

2. New long-stay cases of all ages who have not responded quickly or sufficiently to treatment. These would not be as numerous as in the past.

3. Elderly patients suffering from dementia.

4. Mentally handicapped patients who were admitted due to the absence of suitable residential facilities. About 17% of patients are in this group.

5. A small group of severely disordered patients who require custodial care.

The Sub-Committee notes that the gradual decline in the number of in-patients has continued at the rate of about 1% p.a. This is expected to continue as existing long -term elderly patients are more numerous than new admissions of long-stay cases. This reduction may however be offset by trends in the numbers of new elderly patients seeking admission, unless alternative facilities are provided. Similarly, the trends in chronic

alcoholism are giving rise to increased numbers of long-stay cases. It is not expected that there will be any significant change in the numbers of mental handicap patients.

The Sub-Committee notes that no standard exists as to the ratio of beds required to match the above patient categories and therefore, RECOMMENDS that regional planning norms be established to guide provision of psychiatric beds and other related facilities for this group.

Notwithstanding the absence of these norms, the Sub-Committee RECOMMENDS that the number of beds should not be increased and that advantage be taken of reducing numbers of in-patients to reduce the numbers of existing beds while improving their quality. The Sub-Committee in making this recommendation, is convinced that this policy is conduc ive to good patient care and good staff morale.

The Sub-Committee RECOMMENDS that resources should be directed towards ensuring that the following objectives are achieved :-

(a) replacement of grossly sub-standard accommodation where it exists;

(b) elimination of overcrowding if and where it exists;

(c) introduction where appropriate of separate facilities for different classes of patients whose needs vary, e.g. psycho-geriatrics, mentally handicapped, admission units, rehabilitation patients, etc.;

(d) adequate provision of day space and dining facilities;

(e) provision of more privacy in wards;

(f) adequate provision of sanitary facilities;

(g) provision of ground floor accommodation for frail elderly patients;

(h) improvements in general internal standards of decoration;

(i) provision of suitable training and activation facilities for patients who can be rehabilitated in some degree, including pre-hostel training units;

(j) improving fire standards;

(k) reduction of ward sizes.

To facilitate this approach, the Sub-Committee conducted a survey of all hospital wards and associated day and dining space and facilities generally. The Sub-Committee was impressed by the measures that had been taken by the Board during the 1970's in improving the facilities notwithstanding the absence of capital funds. However, there are still a number of measures which require to be taken before an acceptable standard of service can be provided.

Accordingly, the Sub-Committee decided that it should identify the major specific priority measures for incorporation into a programme for physical and service improvements during the 1980's as resources become available. These measures are contained in Chapter 8 of the report. In addition it is RECOMMENDED that each hospital should prepare a five year plan for the upgrading of the hospital's defective areas, based on the above principles.

While placing due emphasis on the standard of physical accommodation, the Sub -Committee considers that the really crucial factor in delivering a good standard of care is the calibre of the professional caring staff in the hospital and their relationships with the patients and each other and the standards which they set themselves.

This vital element has a two fold aspect, viz.

(a) The standard of care for long-term patients who live in the hospital and are unlikely to be discharged. These include those who have grown old in the hospital, new elderly chronic patients and those requiring secure custodial care. Obviously the standards required here are for a comfortable environment as well as continuous nursing care and attention to personal comfort of the patient, including an appropriate degree of activation. This is increasingly a major aspect of the nurse's workload and one which requires the assiduous interest of supervisory nurses to ensure that standards are maintained and improved.

(b) The second aspect affects in a special way patients who have the potential to resume community life or who, while remaining associated with the hospital, can assume increasing responsibility for the organisation of their lives or who can avoid further deterioration.

The Sub-Committee considers that this latter group represents in a special way the group which will determine the reputation of the service in the public mind. These are the patients whom it is expected will be helped to overcome their mental, social and occupational disabilities to the maximum extent possible and thereby leave the hospital for a more independent life, perhaps at home or in some interim sheltered environment. These are the people for whom a community psychiatric service derives much of its rationale.

It was of interest then to the Sub-Committee to consider the typical day of a long-stay patient in hospital. Obviously the position varies with the patient's condition and there are different degrees of emphasis from hospital to hospital. Nevertheless, the following pattern would be reasonably representative.

TYPICAL PATTERN OF INSTITUTIONAL LIFE OF A PSYCHIATRIC PATIENT

Approximate timing of activity	Brief description of activities	Categories of patients who participate
7.30 a.m. - 8.00 a.m.	Patient rises, washes and dresses. Some patients require nursing assistance to achieve this.	All patients except bedfast cases.
8.30 a.m.	Holy Mass	Available to most patients.
9.00 a.m.	Breakfast	All patients.

Approximate timing of activity	Brief description of activities	Categories of patients who participate
9.30 a.m. - 12.30 p.m.	Supervised presence in secure day areas	All patients from secure wards
	Rest in day rooms	Significant numbers of patients. Also influenced by weather.
	Occupational/Industrial therapy	Varies in each hospital from small numbers up to about 200.
	Ward duties (cleaning) Light kitchen duties	Small numbers who are willing and able. Mainly female.
	Pass from hospital	Reliable patients only.
	Baths as arranged by nurses	
11.00 a.m.	Mid morning tea	General
12.30 p.m.	Lunch	All patients. Some require assistance and careful supervision by nurses.
1.00 p.m. to 4.30 p.m.	Resumption of activation programmes in occupational therapy.	
	Walks on grounds	Varies with weather
	Rest in day rooms	Significant numbers of patients.
	Visit to cafe or pass from hospital	Can be significant.
4.30 p.m. to 5.00 p.m.	Tea	All patients.
After 5.00 p.m. up to 11.00 p.m.	T.V.	Available to all interested patients.
	Occasional outings	Suitable patients only.
	Occasional concerts	Available to all interested patients.
6.30 p.m. approx. (commencing night shift)	Bedtime	Old patients. Disturbed patients.
7.00 p.m. - 11.00 p.m.		Remaining patients

The Sub-Committee noticed the propensity of some patients to remain relatively inactive in day rooms. It is RECOMMENDED therefore that as far as possible each patient should have a personal programme of suitable activation measures prescribed for him which nursing staff could organise, encourage and assist the patient to do.

The Sub-Committee also RECOMMENDS that the range and frequency of recreational activities be increased where necessary including the introduction or re-introduction of art therapy, music, physical training, etc. In this context also, it is worth expressing caution about reliance on television alone as a recreational measure.

The Sub-Committee also noted that some patients are seldom visited by their families or friends. In this regard the role of the community nurse in encouraging contacts with families is worth reviewing and it is RECOMMENDED that a policy to encourage visiting be developed with the assistance of community nurses and/or psychiatric social workers. Pleasant facilities for visitors away from wards and day rooms may be a necessary measure in this regard.

In view of the foregoing the Sub-Committee feels that special consideration should be given to the measures which will ensure the best results from efforts to rehabilitate patients from dependence on the hospital or from a level of existence in the community which is unacceptable and would result in re-admission to hospital.

The Sub-Committee recognises that the following key elements must be identified and RECOMMENDS that they form the basis of a future management policy :

(a) The Board itself must set a major value on this rehabilitation programme and provide the necessary will and resources.

(b) There must be identification at the highest management levels with the programme. Accordingly, it should become a recurring item on the agenda of the Special Hospitals Committee and also for hospital visiting committees.

(c) Rehabilitation must become a major organisational aim of each area's service to which the interdisciplinary senior management of the service should direct its attention.

(d) Each major caring profession must ensure that the highest professional standards are sought from its members on behalf of these patients.

(e) This programme involves major personnel management policy changes which unless adopted, may vitiate the effort. This area must be tackled in a spirit of goodwill towards the patient by all parties involved. The Sub-Committee proposes to discuss this issue in a later chapter.

(f) The special role of the nursing profession in this area is evident. The Sub-Committee heard with concern evidence of inadequacies in the basic training syllabus for the nurses in the skills which are required in modifying patients attitudes and behaviour and encouraging them by training and support to resume their former activities with confidence and greater self esteem.

(g) It is essential that adequate training be provided for nurses and the Sub-Committee RECOMMENDS that the matter be taken up with An Bord Altranais in the first instance and that local measures be also pursued in relation to training of staff.

(h) The Sub-Committee considers that this commitment to rehabilitation will be successful only if it is :-

(i) maintained over the requisite (and possibly long) period of time;

(ii) based on thorough individual assessment, setting of objectives and regular review;

(iii) led by a consultant psychiatrist supported by a selected team drawn from all relevant disciplines and including a senior administrative nursing officer.

(iv) provided with appropriate accommodation facilities, equipment and trained non-professional staff to allow patients access to a wide range of occupational retraining.

(v) based on a rehabilitation programme designed to bring the patient from small successes to more ambitious tasks as self confidence and self esteem develop. Undue emphasis on production targets should be avoided in the earlier phases of growth of the patient's capability but facilities must include access to more disciplined industrial environments.

(vi) each hospital should prepare an annual statement of its programme plan indicating specific objectives and the officers responsible for their implementation.

(vii) there should be an annual report produced by the hospital management on the execution of the annual plan and this report should be submitted to the Board.

(viii) patients should receive financial reward, proportionate to their achievements.

(ix) as part of the incentive for effort by patients, consideration should be given to providing higher standards of private accommodation in hospitals together with access to personal choice of clothing and a wider range of recreational opportunities.

CARE OF ELDERLY PATIENTS

In addition to the mentally handicapped, chronic psychiatric patients and those with some some prospect of discharge, there are the psycho-geriatric patients who are being admitted in increasing numbers. As a result of improvements in preventive medicine generally, many people will now survive to old age, when they become more vulnerable both to physical and mental illness. It is reckoned that up to 10% of elderly persons may develop senile dementia. Only a very small fraction of these have sought admission in the past but the trend is upwards and if carried to a conclusion, it would fill all our institutions with elderly patients. The Sub-Committee considers it essential therefore that the community strategy recommended elsewhere in the report be carried out and that admission to hospital be regarded as a last resort.

It will also be vital to improve early detection of deterioration in the elderly so that the severity of the illness can be reduced thereby obviating long-term residential care. The Sub-Committee considers that even allowing for the provision of adequate community based services for the elderly mentally ill patients, there will still be an increased number of persons requiring admission to hospital and this will require a planned response.

The Sub-Committee believes that elderly patients are currently being admitted to psychiatric hospitals unnecessarily because of the absence of adequate screening measures and due to the relatively underdeveloped state of community based geriatric services. The expected growth of this problem makes it essential that appropriate screening mechanisms be established.

The Sub-Committee, therefore, RECOMMENDS that except in an emergency, no elderly patient should be admitted to a psychiatric hospital for psycho-geriatric care without having first been examined by a consultant psychiatrist. In addition, the Sub -Committee RECOMMENDS that a consultant psychiatrist be added to the existing community geriatric assessment teams which screen patients for admission to geriatric hospitals.

The Sub-Committee also RECOMMENDS, in particular, that the region acquire posts of geriatrician attached to the sector general hospitals where assessment beds would be available to assess the physical and mental well being of elderly patients in co-operation with the psychiatric service. Pending the provision of this general hospital unit, it is RECOMMENDED that interim assessment units, separate from other admission facilities, are required in the psychiatric hospitals and should be provided.

In relation to the special accommodation requirements of the elderly patients, the Sub-Committee RECOMMENDS that : -

(a) accommodation should be provided at ground floor level particularly for non -ambulant patients. Ambulant patients accommodated above ground floor level should be provided with lifts for access to and egress from wards in normal circumstances. They must also have adequate egress routes in the event of fire.

(b) special bathing and toilet facilities suitable for elderly patients should be provided.

(c) physiotherapy, chiropody, occupational and recreational therapy services should be developed and also sight and hearing testing services.

(d) special aids such as wheelchairs, walking aids, hearing aids, spectacles, etc., should also be supplied.

The other major group of long-stay patients are the mentally handicapped adults of whom there are 422. Many of these are severely handicapped cases who were admitted due to the absence of suitable facilities elsewhere. For purposes of their management in the hospitals they cannot be regarded as a homogeneous group. Some are docile while others are overactive. As many of these patients are not ill, their needs require a different environment. Their life expectancy is normal and since it is unlikely that they can be accommodated outside the psychiatric hospitals, long-term arrangements for their care are required. Some hospitals have achieved some degree of segregation whilst in others patients are dispersed through the hospital.

The Sub-Committee RECOMMENDS that where possible separate upgraded accommodation be provided for mentally handicapped patients. In addition, a special unit within this separate accommodation may be necessary to care for small numbers of disturbed cases. This recommendation will in some hospitals require construction of new buildings.

It is also RECOMMENDED that each patient's handicap be re-assessed by a team specialising in mental handicap in order to define the degree of handicap and other problems so as to facilitate a reformulation of suitable individual programmes of activation for selected cases. The Sub-Committee considers also that the achievement of the programmes referred to would be enhanced by the presence of nursing staff trained in mental handicap and with the requisite personality attributes. Measures to promote this deserve consideration.

New admissions of handicapped patients to psychiatric hospitals have not occurred very often in recent years in recognition of the fact that these persons, while disabled, were not necessarily ill. The Board's policy as set out in the report "Care of the Mentally Handicapped" is to provide separate long-term accommodation for the adult handicapped. The Sub-Committee endorses this policy.

The Sub-Committee RECOMMENDS that the special unit for disturbed handicapped adults envisaged as part of the Enniscorthy Project, proposed in the report "Care of the Handicapped" should be proceeded with as soon as possible.

The Sub-Committee RECOMMENDS that liaison between consultant psychiatrists and the medical directors of special centres for mentally handicapped be encouraged on a reciprocal basis so that mentally handicapped patients in special centres who develop psychiatric illness can be examined by a psychiatrist and treated if necessary as an acute case in the psychiatric hospital and conversely that existing handicapped patients in the hospital can be assessed by the specialists in mental handicap.

CHAPTER 6

PERSONNEL MANAGEMENT IN THE PSYCHIATRIC SERVICE

The Sub-Committee could not avoid the conclusion that personnel management policies are a fundamentally important element in determining the quality of care received by the patient. This is highlighted by the fact that in financial and numerical terms, the service is very staff intensive. Within these staff costs, professional staff are the dominant category. Table 8 below indicates the present numbers and staff categories employed.

TABLE 8

FULL-TIME POSTS

Staff Category	Number of Posts	% of Total Posts
Medical	28	2
Nursing	898	70
Catering/Housekeeping	200	16
Maintenance	55	4
Para-medical	12	1
Medical secretarial/Administrative	42	3
Farm Staff	31	2
Others	26	2
TOTAL	1292	100%

The Sub-Committee accepts that these posts derive their justification from and only from the patients' need for help. It follows that the single greatest management objective must be to deploy these staff so as to achieve the best possible quality of service for these patients. In this regard there is agreement between this management aim and the ethical principles of the caring professions involved.

The Sub-Committee considers however that a continuous effort is needed by all parties concerned to ensure that the basic principle of patient need is the prime organising principle of the service. In this regard, it was noted that the present deployment and training of staff is not always most conducive to the best standard of care. Present arrangements have evolved over long periods of time and result from major decisions arrived at at national level. These arrangements in some instances were compromises arrived at after conflict. The Sub-Committee does not consider industrial relations policies as part of its brief but it feels that identification of areas requiring change is desirable and indeed inescapable if it is to produce a meaningful commentary on the service at present. The Sub-Committee feels also that there may be opportunities for desirable change in the present climate of opinion and that the professions involved are open to progressive proposals for desirable change.

Apart from aspects of personnel policy which require national consultation, there are important areas of local influence also which are worthy of comment. The Sub-Committee therefore decided to identify any areas whether of national or local scope which it feels are important or which require review.

The Sub-Committee considers that in any complex management situation involving inter-professional co-operation, there is an over-riding need for positive co-ordinated leadership from all persons in authority and in positions of influence. The personal example, commitment and perseverance of key groups in each profession can have important psychological and moral influence on all other grades and categories of personnel but of course each person of whatever rank, is fully responsible for his/her own attitudes to the service.

It is sometimes helpful and the Sub-Committee RECOMMENDS that in this context a common task orientated management style be established in hospitals involving the formulation of planned objectives within the hospital with arrangements for a regular review of their implementation.

The Sub-Committee is confident that the calibre of staff in the service makes possible a high degree of leadership.

The Sub-Committee also considers it important that legitimate grievances are not allowed to drift as such grievances can serve as focal points around which negative emotional attitudes can cluster with disproportionate effects on morale and relationships continuing after the issue in dispute is resolved. If such grievances can be disposed of quickly and fairly, the generally good conditions of employment in the service and the fair mindedness of staff, would be conducive to the emergence of positive attitudes generally. The Sub-Committee RECOMMENDS that the Board would therefore ensure that its industrial relations department is adequately equipped in numbers and training to do this important task well.

There are a number of other aspects of staff training which require attention. Many of these affect nurses and will be considered by a special working party on nurse training. The Sub-Committee RECOMMENDS that the following range of training needs should be given early consideration : -

(a) basic organisational arrangements for training student nurses along the lines suggested by An Bord Altranais, i.e. centralised teaching facilities.

(b) the content of the syllabus for nurse training requires to be reviewed to ensure the right emphasis on a full range of nursing skills.

(c) training of post graduate nurses, especially supervisory grades needs improvement.

(d) the special training needs of existing and future community nurses requires consideration.

(e) mentally handicapped patients should be nursed by staff trained in mental handicap nursing skills.

(f) nurse training generally and the standards of nursing practice would be enhanced if senior nursing grades introduced a degree of specialisation into their role, e.g. in training, rehabilitation, the handicapped, the elderly, recreation, etc. while retaining existing general nursing responsibilities.

(g) Nursing training and practice would benefit if there was a more balanced mix of nursing and domestic staff on the wards. To achieve this, additional domestic posts are required.

(h) Catering staff require a programme of training in food preparation and hygiene. They should also be given reasonable periods on these duties so as to allow the development of their skills and to improve the standards of food preparation in the hospitals. At present, some hospitals permit the transfer of domestic staff back and forth between wards and kitchen at short notice.

(i) all hospitals should establish themselves as training hospitals for medical staff by collaborating together to mount the necessary facilities.

(j) consideration should be given to enabling consultant psychiatrists to have areas of special interest, e.g. rehabilitation department or psycho-geriatrics, while retaining their full range of professional activity.

The Sub-Committee also RECOMMENDS that attention be given to the following matters which are of national scope but which significantly affect the quality of care given :-

(a) guidelines on acceptable staff/patient ratios for various categories of patient.

(b) the need to reduce the dichotomy between male and female staff and patients in hospitals.

(c) the methods of selecting people for promotion.

(d) the methods of rostering staff.

CHAPTER 7

ALCOHOLISM AND DRUG ADDICTION

Alcoholism means dependence on the drug alcohol. Dependence is a serious disorder which has to be distinguished from heavy drinking problems. While alcoholism is often regarded as a disease, it must be emphasised that it is one which lies within the power of the person himself to cure. Professional staff and treatment facilities may assist the individual in reversing the disease but they can do so only if the person himself actively pursues his own recovery.

The Sub-Committee notes with concern the growing incidence of alcoholism which has now become the largest single cause of admission to psychiatric hospitals. It notes also the lack of sufficient concerted national effort to highlight the number of lives which are being ruined by abuse of alcohol; the many physical, mental and social disabilities which accumulate in the lives of the alcoholics and their families; the catalyst role of alcohol in the incidence of family breakdown and of psychiatric illness in the spouse and children of alcoholics; the numbers of battered wives and babies; carnage on the roads and the rising levels of crime in society at large.

In attempting to formulate an adequate response to this major social evil, the Sub -Committee was forced to recognise the absence of any precise scientific understanding of the causes of harmful drinking. In the present state of knowledge and research, it can only be stated that the causes of this self-inflicted misery are multiple and interactive. There appears however to be a clear corelation between the incidence of alcoholism and the level of consumption of alcohol. There appears also to be a relationship between the level of consumption and the relative real cost of alcoholic drink. The Sub-Committee considers therefore that no fundamental approach to the problem could be formulated by health agencies above. There is clearly a role for a national agency to engage in a comprehensive analysis of the policy instruments needed to halt the present rapid growth of alcoholism. Any such agency should consider, inter alia, the role of fiscal measures and of a broad policy of prevention through education about the harmful attributes of alcohol; the meaning of dependence and the grim possibilities of physical and mental deterioration which accompany dependency. Education for a more responsible method and level of drinking by individuals and encouragement of a less apathetic approach by society at large, would also contribute towards prevention.

The Sub-Committee considered the options available to it in constructing an adequate service for alcoholics. Each patient's programme for recovery is made following assessment and advice from professional staff. The choice of assistance provided may vary from simple counselling or membership of Alcoholics Anonymous, to admission to hospital depending on the severity of the condition and any accompanying physical or mental complications. The duration of assistance will also usually be dependent on the severity of the condition and can last up to one or two years even in "successful" cases.

The Sub-Committee also notes the value of specialised in-patient units for selected cases. The special treatment methods used will include individual and group psycho -therapy or behavioural therapy. These units have achieved improvements in up to 60% of patients. Referral would be from consultant psychiatrists. These units are also seen as valuable centres of research and training for other community based or local hospital staff engaged in the services for alcoholism. It is also desirable that such units would be able to avail of the advantages of being located on the campus of a general hospital.

The Sub-Committee notes the central importance of family involvement in any strategy of supporting the alcoholic's recovery and also the need for continuing support during the post treatment period when relapses may occur.

In conclusion, the Sub-Committee RECOMMENDS the following measures : -

(a) Each psychiatric catchment area should have an initial complement of two trained staff specialising in counselling alcoholics and their families.

(b) These staff would liaise with other primary care staff in the health system including general practitioners, public health staff, community nursing staff, etc. and also with interested voluntary agencies, especially A.A., Al Anon, Al Ateen.

(c) The local psychiatric hospital facilities should be retained and improved to provide facilities for more intensive treatment of alcoholics including emergency treatment.

(d) A special regional 25 bed alcoholic unit should be provided in Ardkeen Hospital, incorporating day care and treatment facilities for 10 day patients designed to provide the optimum conditions for care and rehabilitation of patients referred by consultant psychiatrists from the local psychiatric hospitals. Pending its provision St. Patrick's Hospital, Belmont Park, Waterford which is discharging many of these functions should be supported and developed until the Ardkeen unit is available and the role of St. Patrick's can be again reviewed with the Board.

(e) The special regional unit should engage in a comprehensive range of treatments and provide a full range of specialised professional staff including consultant psychiatrists, psychologists and social workers, etc. This unit would serve as a training unit for local services and also as a research unit for the region.

(f) The Board should encourage the development of national policies of education and prevention.

(g) The Board should prepare a policy for internal use in dealing with health board personnel who may have problems in this area and should encourage the Regional Council for Alcoholism in its efforts to promote similar schemes in industry generally.

(h) The Board should encourage the emergence of social organisations whose aims are to provide recreational facilities in the community which exclude the use of alcoholic drink.

During the life of the Sub-Committee, the Regional Council on Alcoholism was established with the following aims :

1. To establish information and education programmes on the prevention, identification and treatment of alcoholism.

2. To act as a referral agency for persons requiring information and support services occasioned by alcohol abuse.

3. To co-operate in the establishment and if required to establish a counselling service on alcoholism involving the employment of trained counsellors.

4. To carry out appropriate research projects on alcoholism and alcohol abuse.

The Sub-Committee welcomes this development and recommends that the above recommendations be implemented in consultation with the Council.

While the abuse of alcohol is the overwhelmingly great problem of drug abuse which impacts on the psychiatric service, there is growing concern in the region among the population at large about the use of illegal drugs such as cannabis, heroin, cocaine, etc. and also about the growing experimentation by young persons with other dangerous substances e.g. glue sniffing.

This widespread concern is frequently reflected in publicity which can at once reinforce parents' anxiety and also risk the introduction of the topic in an unsatisfactory way into the minds of those who had not previously been exposed to it.

The Sub-Committee therefore considers it important to stress not only the fundamentally important difference between isolated use of a drug and addiction to it, but also, that there is only an extremely small number of addicts as such coming to the notice of the psychiatric service in the region at this time.

However while recognising that the addiction problem is not yet serious in the region there is no room for complacency and the dangers of a growing serious abuse are acknowledged by the Sub-Committee, especially if the use of such drugs is being actively promoted among vulnerable groups.

The Sub-Committee considered what action was possible to prevent the abuse of dangerous illegal drugs.

While restriction of supply is essential this is not always successful, however vigilant the Garda Drug Squad may be. It is therefore important to develop resistance to the use of drugs among the general population.

However the problem of motivating the at-risk population groups presents considerable difficulties. Existing users of these drugs are in some cases already experiencing multiple and sometimes intractable social difficulties and are not easily influenced or rescued from this situation. In such cases intensive treatment may be required, and if so, is available from the psychiatric services.

The prevention of further cases of this type is an important aim. In this regard the most vulnerable group is young persons in the post primary school age group.

The Sub-Committee gave considerable thought to how this sensitive group should be approached. Many of these young people may not have been exposed to information about drugs and such exposure wrongly managed may be counter productive.

The Sub-Committee feels therefore that it is important to clarify the proper sources of information, the type of information provided and how it should be conveyed to young persons.

It is considered that the key persons must be the parents assisted by schools and other interested professional staff.

The information to be conveyed includes factual data on the mental and physical consequences of drug abuse and recognition of early symptoms and behaviour patterns. However such information will not be effective unless it is incorporated into a course on acceptable lifestyles, which might in turn form part of subjects such as Religion, Civics, Home Economics, etc. These provide the proper context and the necessary length of time in which this information and the underlying principles of self care can be assimilated into the young person's character and system of values.

In relation to abuse and illegal drugs the Sub-Committee RECOMMENDS that the following ideas should be considered as a means of monitoring the growth of this problem and engaging the support of parents and community leaders, in protecting the young from this social evil :

(i) The appointment of committees in each community care area representing the health, teaching and police professions, also clergy, parents and organisations interested in young people.

(ii) The appointment of Health Education Officers whose remit would include education against drug abuse.

The Sub-Committee further recommends that the Board should encourage where appropriate the provision by the relevant authorities of facilities for the wholesome entertainment and recreation of young people.

CHAPTER 8

DEVELOPMENT PROGRAMME FOR PSYCHIATRIC SERVICES

The Sub-Committee considers that the following priority measures are necessary in order to give effect to the principles of a community psychiatric service discussed in this report.

WATERFORD CATCHMENT AREA

1. A programme for the provision of additional hostel places, supervised and unsupervised, should be drawn up.
2. A day hospital should be provided in Dungarvan with appropriate facilities for treatment, care and activation of patients. A programme of day centres should be prepared for other larger towns in the area in due course.
3. A programme of internal improvements in St. Otteran's Hospital should be prepared including the provision of an integrated admission unit for the severely ill.
4. A separate unit should be provided for the mentally handicapped patients in St. Otteran's Hospital.
5. As part of the new hospital at Ardkeen, the existing St. Declan's Unit should be replaced by an adult unit of 45 beds and day care and treatment facilities for 15 day patients.

TIPPERARY (NORTH AND SOUTH RIDINGS)

1. A programme for additional hostel places, supervised and unsupervised, should be developed.
2. A programme of day centres should be developed in the larger towns to cater for patients in the community, including elderly patients.
3. A replacement unit of 100 beds to be provided for mentally handicapped and other patients at St. Luke's Hospital.

KILKENNY CATCHMENT AREA

1. An acute psychiatric unit should be provided at St. Luke's Hospital consisting of 30 beds and 30 day places.
2. A programme of additional hostels, supervised and unsupervised, should be developed.
3. A separate unit for mentally handicapped patients should be provided.
4. A programme of day centres should be developed in the larger population centres to cater for joint needs of elderly and mentally ill.
5. A programme of internal improvements in St. Canice's Hospital should be drawn up.

CARLOW/KILDARE

1. A programme for the provision of hostels, supervised and unsupervised, should be developed.
2. A programme of day centres should be developed in larger population centres.
3. An integrated admission unit should be provided in St. Dympna's Hospital together with a programme of general upgrading of the hospital.
4. A separate unit for the mentally handicapped should be provided.
5. An activation centre for rehabilitation of patients should be provided at St. Dympna's Hospital.

WEXFORD CATCHMENT AREA

1. An acute psychiatric unit of 40 beds and 20 day places should be provided at the County Hospital Wexford. Pending its provision an interim day hospital and activation centre should be provided in Wexford town.
2. A programme of day centres should be developed in larger population centres in the county.
3. A programme for the provision of additional hostels should also be developed.

REGION

A development centre with adjacent residential facilities should be provided for selected patients based on principles in use in the Toghermore Centre, Tuam, Co. Galway.

FINANCING OF PROGRAMME

1. These proposals in so far as they are for the rehabilitation of patients into the community may be financed from the European Social Fund if funds are available. These include hostels, activation centres, day centres and units for mentally handicapped.
2. A special major capital allocation should be sought from the Department of Health to finance those elements of the plan which are not funded by the European Social Fund.
3. A special minor capital allocation should be sought each year to fund the programme of upgrading in the mental hospitals.
4. Where new units such as day hospitals or day centres require staffing which cannot be met from re-deployment, they should be given high priority in submission of new unit proposals to the Department of Health.
5. Where new units are being developed in Tipperary (N.R.) and County Kildare, a financial contribution should be sought from the respective Health Boards.
6. A special maintenance allocation should be provided for mental hospitals to assist in ensuring a satisfactory environment for patients and a special effort should be made to maintain internal painting programmes in wards to ensure a cheerful atmosphere.

CHAPTER 9

SPECIAL SERVICES

FORENSIC PSYCHIATRY

The Sub-Committee also considered the forensic psychiatric services in the course of its review. The need of the small group of patients who by reason of their illness become involved with the criminal legal code are presently met by the Central Mental Hospital in Dundrum.

While the limited number of places in this central institution sometimes presents difficulty in obtaining urgent transfer of patients, this difficulty is intermittent, affects only very small numbers and therefore does not require the development of any local special facilities within the region to take over its role. Accordingly, the Sub-Committee RECOMMENDS that no change be made in the present arrangements.

PSYCHOLOGY SERVICES

The availability of a clinical psychologist is a valuable aid to the medical and nursing staff in the psychiatric service. Unfortunately, due to the absence of these personnel in any numbers, the service has not developed as the Board would like. It is hoped however to increase the numbers of clinical psychologists in the region to five in the near future and that this will make possible the provision of a basic service to all programmes.

The Sub-Committee RECOMMENDS that an appointment of clinical psychologist be made to each psychiatric catchment area with appropriate opportunities for liaison between the clinical psychologists in the region.

The Sub-Committee recognises that the other programmes, notably community care, also require the services of the clinical psychologist. Accordingly, it is RECOMMENDED that each psychologist should cater for the needs of the other programmes in his area on an arranged basis.

CONCLUSION

In the course of its review the Sub-Committee has been impressed by the quality of the service which has evolved up to the present time, thanks to the interest and commitment of staff from all disciplines.

The Sub-Committee notes in particular the following specific improvements :-

— A general improvement in the physical environment inside the hospital where the patients live, eat and sleep. In some hospitals, striking progress has been made with modest resources and many wards have achieved a very satisfactory level of comfort and cheerfulness.

— Improvements in the staff/patient ratio resulting in more attention to patients and the general standard of personal care.

— Improvements in the facilities and accommodation available for activation of patients - notably the buildings provided with the aid of the European Social Fund.

— An expansion in the numbers and role of community nurses.

— The provision of some hostel places for patients who were capable of living outside wards.

— Improving standards of privacy, day space, toilet accommodation, catering, hygiene, etc.

— Increased numbers of domestic staff in most hospitals.

— Improving arrangements for recreational facilities and opportunities for patients.

The Sub-Committee would like in conclusion to refer to the recurring on-going effort required from the Board's staff in maintaining at its present standard, what is in effect a community of over 2000 dependent people in our psychiatric hospitals.

This achievement is built up from the multiple daily caring acts of individual staff members in an environment which frequently requires high levels of motivation and perseverance.

It is the Sub-Committee's desire to express to the staff its appreciation of this effort and to express its confidence in seeking the staff's further support in achieving the purpose for which this review was undertaken, i.e. to discharge to the best of our ability the task entrusted to the South Eastern Health Board by society at large of caring for those who have been victims of mental illness.