Chapter 12

Services for Children and Adolescents

Introduction

12.1 While the childhood origin of adult relationship and behavioural patterns has long been recognised, child psychiatry as a specialty within the medical field evolved only in the latter half of the 19th century. It has been closely linked with child neurology, developmental paediatrics, community medicine, and mental handicap. As a specialty, it has increasingly focused on prevention and early intervention, and has developed a broad community orientation.

12.2 The multidisciplinary approach to child psychiatric practice was adopted in the first child guidance clinics, which were established by William Healy in the United States in the early years of this century. These clinics with a nucleus of child psychiatrist, child psychologist, and psychiatric social worker were soon set up in many European countries, and by 1927 those in the United Kingdom were co-ordinated by the Child Guidance Council. By the 1930's child psychoanalysts had demonstrated that play was a natural investigative and therapeutic medium of great potential. In that and subsequent decades the upsurge of interest in the behavioural sciences as well as child psychiatric research, contributed greatly to theory and established a scientific base for practice. This pattern has continued, with an intensification of child psychiatric research and expertise and the incorporation of contributions from new fields of study such as psycho-linguistics, ethology and systems theory.

12.3 These developments have been paralleled by a growth in the variety of professionals treating children with problems. In addition to child psychiatrists and paediatricians, there are educational and clinical psychologists, social workers, remedial teachers, nurses, speech therapists, child psychotherapists, educational welfare officers, probation officers, play group leaders, occupational therapists and art therapists. While these specialists may work in a variety of settings there is a general acceptance of the crucial importance of co-ordination of the services they provide.

12.4 Traditionally in Irish families a high value has been placed on education and on helping children to realise their potential. In recent years more attention has been focused on the quality of children's lives. This has led to an increasing demand for appropriate support and advisory services, and for specialised help for children with difficulties. Up to recently, child and adolescent psychiatric services have developed here in an unplanned way. Services are largely concentrated in Dublin and Galway while there is no provision in many parts of the country.

12.5 The Commission of Inquiry on Mental Illness, 1966,[1] made enlightened recommendations in relation to child and adolescent psychiatric services, some of which have been implemented. In the main, our recommendations are in line with those of the Commission, allowing for the demographic changes and the developments in child psychiatry which have taken place since it reported.

The Scope of Child Psychiatry

12.6 Child and adolescent psychiatry caters for children from birth until they reach the age at which second level education normally finishes. The majority of the children treated are not mentally ill in the sense in which this term is used for adults and, in consequence, the treatment centres are usually described as child guidance clinics, family guidance clinics or child and family centres. A broad definition of the conditions involved is "abnormality of behaviour, emotions or relationships . . . sufficiently marked and sufficiently prolonged to cause handicap to the child himself and/or distress or disturbance in the family or community".[2]

12.7 Childhood emotional difficulties become evident in many ways. While there are some children with definable mental illness, in the great majority of cases the symptoms reflect an interaction of factors specific to the individual child. A diagnostic list would include childhood anxiety and phobias; depression and compulsive disorders; conduct disorders including truancy, stealing and running away from home; developmental delays and disorders; habit disorders; hyperactive children; children with psychosomatic disorders and some with specific educational disorders associated with emotional problems. There is also a small number of children with psychotic disorders, including autism and childhood schizophrenia. However, no list of conditions can encompass the range of emotional distress, damaging relationships and impaired capacity to achieve potential which characterise the young people and their parents who are seen at child and family psychiatric centres.

12.8 Children are best understood in their everyday environment of home and school, and assessment and treatment should be carried out in these

settings. The practice of child psychiatry, therefore, is based in the family and community, and admission to residential settings is rarely necessary.

Prevalence of Childhood Emotional Disorders

12.9 There have been no epidemiological surveys of the prevalence of child psychiatric disorders in this country, except for childhood autism.[3] In the United Kingdom estimates of the proportion of children in the community suffering from psychiatric disorders (including maladjustment) range from 5%[4] to 18%.[5] The variation has been attributed to differing ascertainment procedures[2] as well as to regional variations.[6] In the rural community of the Isle of Wight[2] a prevalence of 6.8% was reported in 10 to 11 year old children, whereas in the London borough of Camberwell the rate was doubled, using the same survey techniques.[7] We have no reason to believe that prevalence in Ireland differs greatly from that in the United Kingdom and it is likely that the urban/rural differences are similar. However, in view of the greater proportion of children in our population, it is likely that the number with emotional problems relative to the total population is greater in Ireland than in the United Kingdom.

Prevention

12.10 By the nature of its work, child psychiatry is preventive and its emphasis is on early intervention. The child psychiatric team also undertakes direct preventive work through liaison, consultation and intervention in a variety of settings, for example:

—by working with the staff of maternity hospitals advising them on the identification of "at-risk" parents and on how to support parents of stillborn children or children who are severely ill;

—by giving guidance on good child rearing practice to the community in general and to key professionals;

—by providing a liaison psychiatric service to staff and to children and their families in a variety of medical settings such as paediatric units or general medical and surgical wards. Up to recently, the emotional needs of many hospitalised children frequently went unrecognised with the result that some children acquired additional emotional and adjustment problems;

—by treating children from broken or unhappy marriages. These children are particularly at risk of developing emotional and relationship problems and may require specialist psychotherapeutic help;

—by providing a consultation service to child residential centres;

—by providing a consultation service to the courts and to detention centres in the case of young offenders;

—by advising the community care teams on specialised areas such as child abuse, adoption and fosterage;

—by co-operating with the general psychiatric service particularly with regard to the emotional needs of children whose parents are mentally ill. In families where there is more than one patient, new approaches in family therapy warrant increased consideration;

—by adopting a wider preventive role in the community generally through participation in health education programmes in schools and liaison with teachers, probation officers, youth club leaders and other people who work with children.

Diagnosis and Early Intervention

12.11 There is considerable potential for overcoming the emotional problems of childhood if the nature of the problem is detected in time and appropriate corrective action taken. The two places in which these problems can most easily be recognised are the home and the school. In the home, parents will continue to play the central role and their capacity for identifying problems and referring them for attention must be developed. The family doctor and the public health nurse, through their professional expertise and their access to the family circumstances, are well placed to recognise when intervention may be required. We consider that the training of general practitioners and of public health nurses should have a greater emphasis on psychology to help them recognise a developing emotional problem and to take appropriate action. In addition, we recommend that at least one of the medical schools consider establishing an academic Child and Adolescent Psychiatric Department to encourage training and research.

12.12 At school, the main scope for early detection of emotional problems is in the primary classes. Teachers are in a key position to identify children with emotional problems which may be the result of factors in the home. Teachers have an important preventive role in ensuring that children with a learning disability are identified as early as possible so that appropriate measures can be taken before secondary emotional difficulties develop. The staff involved in school medical examinations should be fully aware of the potential for successful treatment of these problems if they are identified in time and examinations should be sensitive to the possibility of such problems existing. Ideally, there should be a comprehensive school psychological service at primary school level and the psychologists, irrespective of whether they are

employed by the education authorities or the health authorities, should form part of the child guidance teams.

The Child Guidance Team

12.13 A typical child guidance team comprises the child psychiatrist, child psychologist and the family social worker. Depending on local circumstances, various ratios of these professional workers have been recommended.[8] The membership of the child guidance team is a matter for the employing authority, having regard to local circumstances. If the team is responsibile for school psychological work, the psychological input to the team has to be increased.

12.14 The Royal College of Psychiatrists' recommendations on staffing are as follows:

> "We have come to the conclusion that at an irreducible minimum we need two child and adolescent psychiatrists for a population of 200,000. . . . . .We consider that a realistic desirable level should be three per 200,000 population. However, the staffing of regional and supra-regional units needs to be additional to this suggested allocation"[9]

We recommend that these ratios should be taken as guidelines for this country. However, as there are no services whatever in some parts of Ireland we must plan the development of our services in a phased way. In the first instance we recommend that each health board should develop one child guidance team per 200,000 population. In health board areas where two teams are set up we recommend that one of them should develop a special interest in adolescent psychiatry. The present provision of child psychiatric services in each health board area is outlined in Appendix 5.

12.15 We recommend that there should be at least one child and family guidance centre in each health board area which would serve as the team's headquarters and where children referred could be assessed and treated as out-patients and day-patients. The child guidance team would also hold regular clinics in health centres and county clinics throughout the region. Little by way of drugs or equipment is required in these centres since milieu therapy is the main method of treatment. Consideration should therefore be given to good design and furnishings to facilitate the clinical work in these units. In particular, attention should be given to the design of eating and living accommodation and to playrooms and group therapy rooms with the incorporation of audio-visual systems as required. Child and family guidance centres do not always have to be purpose-built and it has been found that residential premises can be modified satisfactorily.

12.16 The team should also be associated with a general hospital. For some

cases the child psychiatrist needs ready access to medical diagnostic facilities and consultation with paediatric, medical and other specialist colleagues. The team should develop close links with the paediatric department of the hospital. It should also be associated with the adult psychiatric department to meet the special needs of the children of psychiatric patients. The child guidance team should hold clinics in the out-patient department of the hospital. Joint child psychiatric/paediatric clinics could also be held if required.

12.17 Some health boards have arranged that outside child psychiatrists hold clinics within the region. While these provide a useful screening and referral service, they cannot provide the type of comprehensive child and family psychiatric service which we recommend.

In-Patient Services

12.18 At present there are regional in-patient units as part of the child guidance service in Dublin, Cork and Galway. This provision is in line with the recommendations of the Commission of Inquiry on Mental Illness, 1966, which also included Limerick as a centre.[1] In view of the long distances involved, we consider that small in-patient units may also be needed at other centres, for example Limerick, Sligo and Waterford. We agree with the Royal College of Psychiatrists' recommendation that consultant staffing of residential units needs to be additional to the basic allocation of psychiatrists in those areas.[9]

Services in the Eastern Health Board Area

12.19 Within the Eastern Health Board area, the rapidly expanding population and the severe social and environmental problems have resulted in a large number of highly vulnerable families where children are at considerable risk of emotional maladjustment. We agree with the general approach to developing the services which is outlined in the Eastern Health Board's report "Development of Community Mental Health Services — Planned Evolution" 1978.[10] However, there have been considerable demographic changes since this report was prepared and it would seem necessary to review current services with the aim of achieving better co-ordination and rationalisation. In addition, if our recommendations for regional services are implemented, the services in Dublin would be able to switch from providing a national to a regional service. We recommend that formal arrangements be made, involving representatives from the existing services, both health board and voluntary, to develop a co-ordinated policy for the delivery of child and adolescent psychiatric services for the area and to monitor its implementation.

Services for Adolescents

12.20 In paragraph 12.14 we recommended that in health boards where there are two child guidance teams, one of these should develop a special interest in adolescent psychiatry. We consider that adolescent psychiatric teams are needed urgently in the larger cities, particularly in Dublin and Cork. There is widespread public concern at the increase in disturbed behaviour among this age group. While the community as a whole should develop a wide range of social, educational and recreational facilities in response to this problem, there is also a need for specialised services. At present there are very few in-patient psychiatric facilities catering specifically for adolescents and they are usually assessed and treated by the adult service.

12.21 In the Eastern Health Board Area, there is a specialist adolescent team offering an out-patient service at Cluain Mhuire, Blackrock. We recommend that initially residential treatment facilities for adolescents be developed at Dublin, Cork and Galway. It may be that these treatment facilities can be developed in association with the existing regional child psychiatric residential units. However, clinical experience suggests that they function best as separate units with their own staff.

Community Adolescent Psychiatry

12.22 The child and adolescent psychiatric team and the specialised adolescent team, where developed, does much of its work through offering a consultation and support service to many agencies in the community. In addition, the teams see referred adolescents at community-based out-patient clinics. It has been found, however, that many adolescents are impatient with bureaucratic referral procedures, and as a result, self-referral clinics have been developed in some countries. Many of the teenagers presenting at these centres do not require highly specialised help but are in need of information, counselling and perhaps referral to the appropriate services. We recommend that "walk-in" centres should be developed in urban and suburban communities. They should be under the professional guidance of the specialist child and adolescent psychiatric service. They can be staffed by voluntary and statutory agencies from the preventive primary care service, but will need quick access to specialist opinion.

12.23 There is a growing awareness among social and other youth workers of a gap in community services for the increasing numbers of teenagers who have left home for a variety of reasons. These teenagers often sleep rough and are generally at risk. There are very few hostels where such teenagers can

stay. There is a need for hostels where homeless teenagers can receive shelter and guidance. These could appropriately be set up by voluntary agencies.

12.24 Conduct disorder may be a symptom of emotional disturbance or psychiatric illness. This question has been considered by the Interdepartmental Committee on Mentally Ill and Maladjusted Persons ("the Henchy Committee")[11]. Many emotionally disturbed adolescents come before the courts on various charges. We understand that the legislative procedures for juvenile offenders are being reviewed and will be incorporated in one of the proposed new Children Bills. In the interim, we recommend that the courts, particularly through their Welfare Officers, should have much greater access to child and adolescent psychiatric services for making assessments and recommendations. Where a child or juvenile requires such assessment he or she should continue to live at home unless residential assessment is required for specific purposes. In addition, where a child or juvenile charged with an offence is already attending a child guidance clinic, we recommend that any further assessment should be entrusted to that clinic unless the court considers that custodial care is required. These recommendations are in line with the Henchy Committee's recommendations 5.1 and 5.5, (IV) of its First Interim Report of August 1974.[12]

12.25 We welcome the support given by the Department of Justice to the various agencies that are developing community workshops and resource centres for adolescent offenders. We recommend that formal links be established between these centres and the local child and adolescent psychiatric service so that those with emotional problems can be identified and treated.

12.26 We welcome the present policy of regionalisation of children's homes. This will enable supportive work to continue with families and closer links to be maintained between the child and his or her family. We recommend that a similar policy for the special residential centres at Scoil Ard Mhuire, Lusk, St Laurence's, Finglas, Trinity House, Dublin and St Joseph's, Clonmel should be considered. Likewise, we recommend that these centres and the new Youth Development Centre in Dundrum should make full use of psychiatric staff not only for direct work with teenagers, but also for policy development and staff support.

Autistic Children

12.27 We have considered the special needs of autistic children. The appropriate treatment and educational services for these children have been the subject of some controversy. This has been due to a lack of knowledge of this relatively new syndrome and, in particular, insufficient information concerning treatment approaches and prognosis.

12.28 Childhood autism, as a distinct syndrome, was first described by Leo Kanner in 1943.[13] Since then there has been widespread discussion about the aetiology and natural history of the condition, which has at times caused confusion. The earlier psychogenic hypothesis, which implied that the condition was a reaction to the quality of parenting, is fortunately no longer upheld. It has also been shown that childhood autism is not a childhood version of adult schizophrenia.[14,15] There is now an awareness that the condition is primarily of organic origin and is associated with language disorder. The relationship between autism and mental handicap has also been researched. While autism does seriously affect the learning capacity of children, it is distinct from global mental handicap. Some autistic children are mentally handicapped as well as being autistic, but most mentally handicapped children do not have autism. While between a quarter and a third of autistic children have been shown to have an I.Q. within the normal range, they frequently do poorly on verbal tasks and on those requiring abstract thought and logic. Some of these children display special abilities in computation and at rote memory, as well as puzzle-type tests, and others can have special artistic or musical abilities.

12.29 In addition to the core of children with the classical features of childhood autism, there are others who may display only some of the features and often to a lesser extent. This is one of the reasons why there are sometimes difficulties in establishing early diagnosis causing distress to some parents. The group of children displaying autistic features can include children with sensory impairments as well as some mentally handicapped children and others with whom satisfactory channels of communication have not been established. The prevalence of childhood autism in Ireland appears to be the same as that for other countries i.e. between 2.5 and 4 per 10,000 children.[3] The male to female ratio of the condition is approximately four to one.

12.30 It is important that childhood autism is diagnosed at an early stage so that treatment can get under way. Children in whom the condition is suspected should be referred to a centre familiar with the syndrome and which has access to specialised medical and psychological investigative procedures. Assessment requires a multidisciplinary approach and, following diagnosis, therapy can be started.

12.31 Treatment requires the establishment of a relationship with the child within which learning can occur. Regular skilled counselling sessions are held with family members, and parents are regarded as co-therapists. As the child gets older, he or she meets other members of the therapeutic team, such as the remedial teacher and speech therapist. The syndrome is severely incapacitating and special educational and treatment facilities are almost always required, in many cases on a residential basis. Programmes which are

behaviourally oriented have to be developed for each individual child, requiring a high staff/child ratio.

12.32 In some areas, treatment services have been developed by psychiatrists specialising in mental handicap, and in others by child psychiatrists. It is demanding and painstaking work and requires a sensitive awareness of the emotional reactions on the part of families during various phases of the child's development. Some of the children may have their educational needs met in special schools for the mentally handicapped and in time some, with support, may be able to move to ordinary classes in national schools. However, a considerable number continue to require intensive treatment and care during adolescence and adult life. The resources of the treating centres, therefore, have to include provisions for social skills and vocational training as well as sheltered workshops and recreational facilities.

12.33 There has been some discussion of the service appropriate to treating children with autism and similar conditions. The environment necessary is similar to that obtaining in many mental handicap centres. As long as the appropriate resources are provided by way of staff and facilities, it would seem immaterial whether they are developed by child psychiatrists or by specialists in mental handicap. In some cases it may be appropriate to individual children's needs to share resources, underlining the need for flexibility and good liaison between the two services. We recommend that each health board should assess the services it has available for autistic children. Following this review, a plan for the development of a comprehensive service should be drawn up. Each health board will need to decide whether this service should be provided by the mental handicap or child psychiatric service or whether an adequate level of service would best be provided by utilising the resources of both specialties.

Third Level Students

12.34 While the psychiatric needs of third level students are normally met by adult psychiatric units, it is appropriate to deal with the needs of this group in this chapter. Third-level students have a tendency to conceal or explain away psychiatric symptoms. The reluctance to seek expert help can have particularly severe effects because of the impairment of intellectual work caused by even a slight emotional disability. It is hard to form an accurate estimate of the numbers of students so affected because of mislabelling (some are thought to be academic failures) and a well-intentioned conspiracy to conceal emotional illness and treatment. Nevertheless, a widely accepted, if conservative, estimate of the proportion of students requiring professional

help is 14%.[16] Working from various data available, Farnsworth[17] estimated that for every 10,000 students:

—1,000 will have emotional conflicts of sufficient severity to warrant professional help;

—300 to 400 will have feelings of depression severe enough to impair their efficiency;

—100 to 200 will be apathetic and unable to organise their efforts — "I can't make myself want to work";

—20 to 50 will be so adversely affected by past family experiences that they will be unable to control their impulses;

—15 to 25 will become ill enough to require treatment in a mental hospital;

—5 to 20 will attempt suicide, of whom one or more will succeed.

12.35 Most Irish universities have a psychiatrist attached to the student health service. We consider that this arrangement should be extended to all third level educational establishments. The most important form of treatment for students is psychotherapy conducted either individually or in groups. This requires extensive training of therapists and is very time-consuming. Like other mentally ill patients, some students benefit from medication. Psychiatric involvement must however be broader than merely treating referred students. To prevent problems arising, the psychiatric service should attempt to change the attitudes of students and staff towards emotional problems by promoting understanding, tolerance and co-operation in the management of emotional problems. Such an approach is best pursued through consultation with all appropriate groups with the aim of creating a system for advice on, or referral of, emotional problems, co-ordinating and integrating counselling services within the college and improving relations between students and college management. One way these goals can be achieved is through the establishment of a tutorial system whereby all students have an expert adviser who is concerned with their academic performance. Regular consultation should take place between tutors and staff of the student health service. This arrangement provides an early warning system, and makes professional advice available at the earliest possible stage.

12.36 It is essential that professionals (psychiatrists, clinical psychologists and counsellors) should work as a co-ordinated team in the student health service. This facilitates consultations and allows for the service to be used to the maximum. It also makes possible the collection of information about factors causing mental disturbance and areas of greatest need.

12.37 **Recommendations**

1. **The child psychiatric team should undertake direct preventive work through liaison, consultation and intervention in a variety of settings (para. 12.10).**

2. **The training of general practitioners and of public health nurses should place a greater emphasis on psychology so that they will be able to recognise, treat and refer where appropriate, emotional problems arising in families (para. 12.11).**

3. **At least one of the medical schools should consider establishing a Department of Child and Adolescent Psychiatry (para. 12.11).**

4. **There should be a comprehensive psychological service in primary schools and the psychologists should form part of the child guidance teams (para. 12.12).**

5. **The child guidance team should consist of a child psychiatrist, child psychologists and social workers in the appropriate ratio (para. 12.13).**

6. **The staffing ratios for child psychiatrists which have been devised by the Royal College of Psychiatrists should be taken as guidelines for this country. As a first step each health board should develop one child guidance team per 200,000 population and there should be at least one child and family guidance centre in each health board area (para. 12.14 and 12.15).**

7. **The child guidance team should be associated with a general hospital (para. 12.16).**

8. **In addition to the existing in-patient units in Dublin, Cork and Galway, small in-patient units should be provided as part of the child guidance service in Limerick, Sligo and Waterford (para. 12.18).**

9. **In the Eastern Health Board, representatives from the existing services, both health board and voluntary, should develop a co-ordinated policy for the delivery of child and adolescent services in the area (para. 12.19).**

10. **In health boards where two child guidance teams are set up, one of these should develop a special interest in adolescent psychiatry (para. 12.14 and 12.20).**

11. **Residential treatment facilities for adolescents should be developed at Dublin, Cork and Galway (para. 12.21).**

12. "Walk-in" centres should be developed under the guidance of the child and adolescent psychiatric service (para. 12.22).

13. Hostels where homeless teenagers can receive shelter and guidance should be set up (para. 12.23).

14. We agree with the Henchy Committee's recommendations 5.1 and 5.5 (IV) in the First Interim Report in regard to assessment of emotionally disturbed adolescents coming before the courts and recommend formal links between services for juvenile offenders and the child and adolescent psychiatric service (para. 12.24).

15. Formal links should be established between community workshops and resource centres for young offenders and the local child and adolescent psychiatric service (para. 12.25).

16. The regionalisation of the special residential centres at Scoil Ard Mhuire, Lusk, St. Laurence's, Finglas, Trinity House, Dublin and St. Joseph's, Clonmel should be considered. These centres and the new Youth Development Centre in Dundrum when it comes into operation should avail of the expertise of adolescent psychiatric teams (para. 12.26).

17. Children in whom autism is suspected should be referred to a specialised centre where assessment can take place (para. 12.30).

18. Health boards should assess the services which they have available for autistic children. A plan for the development of a comprehensive service should then be drawn up (para. 12.33).

19. All third level colleges should have a psychiatrist attached to the Student Health Service (para. 12.35).

Chapter 13

Alcohol and Drug-Related Problems

Introduction

13.1 This chapter deals with psychiatric services for persons with alcohol-related problems (paragraphs 13.2 to 13.25) and with psychiatric services for persons with drug-related problems (paragraphs 13.26 to 13.43).

Alcohol-Related Problems

The Nature of Alcohol Problems

13.2 Until recently, the generic term "alcoholism" has been used to refer to a variety of problems resulting from alcohol abuse. However, because the word is difficult to define satisfactorily and because it suggests a particular type of alcohol problem to the exclusion of others, it is limited in what it covers. The term "alcohol-related problems", although more cumbersome, is more accurate. This term acknowledges that alcohol can cause, or at least contribute to, an assortment of social and physical problems which include public drunkenness, family violence, absenteeism, road traffic accidents, liver and heart disease and disorders of the central nervous system.

Size of the Problem

13.3 Alcohol-related problems make a heavy demand on the psychiatric services. There were over 7,000 admissions for alcohol abuse and alcoholic psychosis to our psychiatric hospitals and units in 1982,[1] which accounted for 26% of total admissions. The number of patients with alcohol-related problems resident in psychiatric hospitals and units on 31st March 1981 was 688 or about 5% of all resident patients.[2] This disparity between the large number of admissions and the small proportion of residents emphasises the relatively short stay in hospital of such patients. The census of patients in psychiatric hospitals and units on 31st March 1981 showed that 44% of patients with

alcohol-related problems had been in hospital for less than one month compared with only 8% of all other patients. Of patients admitted for alcohol abuse and alcoholic psychosis in 1982, 81% were male while the highest admission rate was in the 35-44 year age-group.

13.4 Alcohol abuse also accounts for a large number of admissions to general hospitals, for example through casualty departments as a result of traffic accidents and to general medical and surgical wards for treatment of alcohol-related illness.[3]

13.5 Alcohol-related problems also take up the time of general practitioners, social workers and the Gardai and they often lead to psychiatric disturbance in other family members. The disturbed child and the depressed spouse are the most obvious examples of this problem.

The Trend of Alcohol-Related Problems

13.6 Alcohol-related problems in Ireland have been increasing consistently and steeply in the past 15 years. In 1966 the number of admissions to psychiatric hospitals because of alcoholism was 1,757[4] or one quarter of the 1982 level. It cannot, however, be inferred that the large increase in hospital admissions reflects a corresponding increase in the prevalence of alcohol-related problems. It is likely that at least some of the increase is due to greater acceptance of the psychiatric hospital as a treatment centre for such problems. Public opinion has also increased pressure on people to seek treatment in hospital in the belief that the problems can be cured.

13.7 Other indices of alcohol-related problems, such as mortality from cirrhosis of the liver[5] and convictions for drunkenness and drunk driving,[6] have all increased during the past 15 years. Even though some of these indices, particularly the drunk driving offences conviction rate, are open to qualification, it is clear that the overall trend of alcohol-related problems in recent years has been unequivocally upwards. This is evident from Table 13.1 which shows the relationship between alcohol consumption and various indices of harm.

The Reasons for the Increase in Alcohol-Related Problems

13.8 It is now accepted that there is a close relationship between national per capita alcohol consumption and the extent of alcohol-related problems. This is certainly borne out by recent Irish experience. Since 1950 there has been an approximate doubling of alcohol consumption in Ireland — from 4.7 litres of 100 per cent alcohol per person aged 15 and over in 1950 to 9.0 in 1982.[7] The most likely explanation for this increase is the growth in disposable

TABLE 13.1

Relationship between Alcohol Consumption and Various Indices of Harm.

	Consumption: litres of 100 per cent alcohol per head of population aged 15 or over	Drunkenness: Number of prosecutions for drunkenness per 100,000 persons aged 15 or over	Cirrhosis Deaths: Death rate per 100,000 population aged 15 and over	Admissions to Psychiatric Hospitals and Units Number of admissions with a Primary Diagnosis of Alcoholism or Alcoholic Psychosis
1950	4.7	152.0	2.9	
1951	4.9	151.0	2.8	
1952	5.2	152.0	3.3	
1953	4.5	163.0	2.2	
1954	4.7	143.0	2.3	
1955	4.7	151.0	3.2	
1956	4.8	157.0	3.3	
1957	4.7	137.0	3.1	
1958	4.5	120.0	3.6	
1959	4.4	118.0	3.1	
1960	4.6	121.0	2.9	
1961	5.2	133.0	3.4	
1962	5.7	135.0	4.1	
1963	5.5	163.0	3.2	
1964	5.8	177.0	3.9	
1965	6.1	188.0	4.5	1638
1966	6.1	176.0	2.9	1757
1967	6.1	178.0	3.8	2013
1968	6.4	179.0	4.6	2526
1969	6.8	158.0	5.1	2886
1970	7.4	144.0	4.8	3073
1971	7.5	163.0	3.6	3720
1972	8.2	161.0	5.4	4143
1973	8.8	218.0	5.1	4846
1974	9.7	178.0	5.6	5355
1975	10.2	183.0	4.5	6003
1976	10.1	176.0	5.6	6101
1977	10.5	221.0	4.7	6765
1978	11.3	221.0	5.4	7293
1979	10.3	220.0	4.3	7158
1980	10.0	207.0	5.6	7021
1981	9.4	202.0	4.8	7345
1982	9.0	197.0	4.3	7189

Source: Medico-Social Research Board (Unpublished)

personal income in Ireland over the same period. This belief is supported by the downturn in alcohol consumption since 1979 when there was a simultaneous fall in disposable income. There has also been a decline in alcohol-related problems during this period. Mortality from cirrhosis of the liver[5] and convictions for drunken driving[6] have decreased since 1979. Admissions to psychiatric hospitals and units for alcohol abuse and alcoholic psychosis

decreased from 7,293 in 1978[8] to 7,021 in 1980.[9] The number of admissions increased slightly again in 1981 to 7,345 and in 1982 the figure was 7189.[10]

The Management of Alcohol-Related Problems in Ireland

13.9 The traditional response in Ireland to alcohol-related problems has been predominantly treatment-oriented and it is only recently that preventive measures such as health education have gained prominence. In international public health circles on the other hand, the emphasis has passed from treatment to prevention. This is reflected in the first recommendation of a World Health Organisation Expert Committee Report on "Problems Related to Alcohol Consumption" (1980):

> "In view of the wide diversity of medical and social ills and human suffering resulting from the consumption of alcoholic beverages, the limited efficacy and high cost of the existing treatment and management of most of these problems, and their high prevalence in many parts of the world, the Committee recommends that (a) prevention should be given clear priority; (b) further investment in treatment should be concentrated on developing inexpensive cost-effective services".[11]

13.10 Recent trends in Ireland in the management of alcohol-related problems have been towards greater specialisation, often involving costly in-patient care which has tended to separate the treatment and management of alcohol-related problems from community medical and social services. The wisdom of this approach is questionable on at least two grounds:

1. The effectiveness of specialised alcohol treatment programmes has been seriously questioned.[12] There is no evidence that intensive, high-cost in-patient treatment is in any way superior to simple, inexpensive community-based intervention. Compared with the latter form of management, the intensive approach is not considered to be cost effective.[13]
2. The over-specialised approach to alcohol-related problems is also a separatist approach. It draws the problem away from the community and family and tends to exclude the contribution of primary care and community medical and social services from the management of the problem. To that extent, it runs counter to the general principles of the delivery of health care which stress that help to individuals and families should be as near to their communities and homes as possible.

Prevention

13.11 In accordance with World Health Organisation opinion, we believe that in future the emphasis should be on prevention rather than treatment of

alcohol-related problems. We acknowledge that prevention must involve a multi-faceted approach which is integrated, co-ordinated and comprehensive. We recommend that consideration should be given to appropriate preventive measures such as:

—higher taxation of alcohol and ensuring that the real price of alcohol is not reduced by inflation

—stricter enforcement of the laws against drunken driving and under-age drinking

—restrictions on drink advertising

—restrictions on availability of alcohol.

We recognise that the effectiveness of such measures is open to debate[7] and that the drawing up of an appropriate policy is a complex matter. In paragraph 13.25 we recommend that an inter-departmental body should be set up in order to establish a national alcohol policy.

13.12 We emphasise the importance of the general practitioner's function in the prevention of alcohol-related problems. This is referred to in the recent Report of the Working Party on the General Medical Service:

> "The general practitioner is also in a position to identify cases of alcohol dependence in his practice, directly and through the care of the alcoholic's family. He is thus in a position to intervene in a major source of physical, mental and social hardship in the community".[14]

Health Education

13.13 Preventive approaches to alcohol-related problems have focused largely on health education which has tended to concentrate on the repetition of messages to young people on the dangers of alcohol. Experts now agree that such an approach, although it may be useful in informing persons, is less effective in influencing their behaviour.[15] We consider it important that teachers, including primary school teachers, should instruct their pupils in health education, including the healthy use of alcohol in everyday life. The Health Education Bureau is expected to develop teacher training programmes in health education and we welcome this development.

Health Promotion

13.14 It is now believed that health education, i.e. the transmission of isolated pieces of information concerning various kinds of health-damaging behaviour, cannot effectively stand on its own but must be part of a wider approach designed to influence behaviour. This wider approach is called health promotion. Essentially, health promotion consists of the promotion of

health-enhancing activities and the suppression of health-damaging ones. It includes not only the actions and attitudes of individuals but also the policies and activities of industries, corporations, governments and other public authorities.

13.15 While there are limits to the extent to which interventions or prohibitions can be implemented effectively, nevertheless there would seem to be a conflict between the health education message and the apparent lack of concern about alcohol abuse as evidenced by, for example, the non-enforcement of the laws concerning under-age drinking, the recent reduction in the cost of spirits and the proposed extension of opening hours. From the health promotional point of view, we consider that a national commitment to a policy on alcohol consumption and to the implementation of that policy is essential. In the words of the 1980 WHO report referred to in paragraph 13.9:

> "there is ample evidence that the damage caused by the consumption of alcoholic beverages is closely related to the level of consumption both of individuals and of the population as a whole. Indices of alcohol-related damage, biomedical as well as social, tend to rise when per capita consumption rises."

This point is illustrated in Table 13.1. The WHO report recommended that governments should take immediate steps to prevent any further increases in consumption and should begin to reduce per capita consumption by reducing the availability of alcoholic beverages and by taking educational and other measures to reduce demand.

Importance of a Community-Based Approach

13.16 While we emphasise the fundamental importance of prevention of alcohol-related problems, we acknowledge that there are no preventive measures immediately in sight which would completely abolish the occurrence of such problems. Therefore, treatment will continue to be necessary. As far as possible, these problems should be dealt with at a community level by the primary health care and social services. One reason for this is that the problems occur in local and family settings and therefore the community-based response will be earlier. It will take into account all aspects of the drinker's immediate environment, including his family, and will therefore be comprehensive in its scope. In addition, a community-based approach is more likely to be cost-effective.

Need for a Local Alcoholism Service

13.17 Notwithstanding the considerations outlined in paragraph 13.16, there is still a need for some specialisation in the field of alcohol-related problems

and we put forward the following guidelines for the development of local alcoholism services:

1. As part of a comprehensive psychiatric service, each sector should develop a local alcoholism service. This service should be community-based and the major emphasis should be on out-patient treatment.

2. The sector service should have access to a small number (2 or 3) of beds. This in-patient component might be used for patients who could not attend the out-patient service due to the long distances involved or for social reasons. The question of location should be decided locally.

3. Each hospital catchment area should arrange to have one consultant psychiatrist take special responsibility for the organisation and operation of services for persons with alcohol-related problems in the area.

4. The sector service should act as a resource centre for all the services concerned with alcohol abuse in the sector. It is important that alcoholic counsellors should get involved in educational and preventive work, for example educating people to see the contribution of alcohol to work difficulties, teaching personnel managers how to deal with employees who have alcoholic problems, lecturing local groups about the nature of alcoholism. The staff in the alcoholism service should use their expertise to support others who may in the course of their work come in contact with persons with alcohol problems and to further the prevention of alcohol abuse.

5. The psychiatric team should provide a consultation service to general practitioners and other primary health care personnel concerning the treatment and management of persons with alcohol-related problems and their families. This is particularly important in the case of general practitioners.

6. We acknowledge the major contribution made by voluntary groups such as Alcoholics Anonymous to the support and treatment of persons with alcohol-related problems. We recommend that the service provided by voluntary agencies should be integrated with the local health board service, and that there should be full co-operation and flexibility of arrangements. The nature of alcohol-related problems requires a broadly based approach to prevention and treatment. There is considerable scope for voluntary groups and members of the general public to become involved at a local level in helping persons with alcohol-related problems and their families.

Homeless Alcoholics

13.18 Special provision will be required for vagrant alcoholics. Because of excessive alcohol consumption over the years or for other reasons combined with, or separate from, alcohol consumption these people have become socially detached and homeless. This group was described in the report "Medical Services for Homeless People" as follows:

> "There is a group of people whose physical and mental health is in a state of abject ruin. Their lives revolve around a culture whose focus is cheap alcohol. Many have become timeless and spaceless. Most suffer from chronic ill-health which is rarely given constructive attention. Their life pattern oscillates from the street to the prison or casualty department and back to the street again".[16]

13.19 In their report "Homeless and Vulnerable"[17] the Simon Community estimate that there are about 3,000 homeless people in Ireland to-day. This report concludes that the homeless population suffers from an abnormally high rate of illness, far above that of the housed population. In addition to medical problems such as malnutrition, tuberculosis and bronchitis, many homeless people develop alcohol-related problems.

13.20 Even though it may not be possible to alter substantially their underlying personality and behavioural problems, there is a need to provide homeless people with shelter, food and clothing. These services are now provided by organisations such as the Simon Community. We recommend that local health and social services should strengthen their co-operation with voluntary organisations in providing care for these people. Hostels, soup-runs and other support services should be developed so that the basic living needs of these people are catered for. In addition, some homeless people will need to avail of the alcoholism service and day facilities provided by the psychiatric service.

Other Facilities for Persons with Alcohol-Related Problems

13.21 In addition to health board services for persons with alcohol-related problems, a treatment service is provided by a number of private psychiatric hospitals. The main private hospitals are St. Patrick's Hospital, Dublin, St. John of God's, Stillorgan, Co. Dublin and Belmont Park Hospital, Waterford. In 1982, there were 1,843 admissions for alcohol abuse and alcoholic psychosis to these hospitals which accounted for 26% of such admissions to all psychiatric hospitals and units.[1] In general, these hospitals, particularly the two Dublin hospitals, admit people from all over the country. The two Dublin

hospitals are also paid by the Eastern Health Board to provide a local catchment area service in general psychiatry.

13.22 One disadvantage of having centralised treatment centres for alcohol-related problems is that it is not always conducive to family intervention as part of the treatment programme. In addition, the availability of these services has lessened the demand for local services. Many people prefer to be admitted to a hospital far away from their local area as they want to hide the fact that they have a drink problem.

13.23 Treatment services for persons with alcohol-related problems at private psychiatric hospitals grew mainly as a result of a demand for services which was not being met within the public psychiatric service. It is only recently that such specialised services have been developed at health board psychiatric hospitals. In view of the increasing attention by the public psychiatric service to this problem, there is a need for closer liaison between the public and private services. We recommend that the private psychiatric hospitals should be linked in with the health board's policy on alcohol-related problems and we endorse the practice whereby these hospitals provide services for the health boards on an agency basis.

Centres Set up by Voluntary Groups

13.24 In recent years a number of centres for the treatment of persons with alcohol-related problems have been set up by voluntary groups. A number of different approaches are used in these centres. It is probable that they were set up because of the lack of local services. Some of the centres receive funding from the Department of Health or from the health boards. We recommend that the services provided in these centres should be monitored and evaluated on an ongoing basis. This should include the collection of statistics on criteria for admission, numbers of patients treated, length of time in attendance at the centre, etc. so that the cost-effectiveness of the services provided can be measured.

An Inter-departmental Monitoring Group on Alcohol Consumption and Problems

13.25 Because of the involvement of alcohol in many aspects of our society ranging from trade to health, a national alcohol policy can be instigated only by an inter-departmental body, representative of all Government departments concerned. Not alone must the Department of Health be involved but also the Departments of Social Welfare, Justice, Industry, Trade, Commerce and Tourism, Environment, Labour, Finance and Education, all of which have substantial inputs into areas of responsibility concerning alcohol. The Irish

National Council on Alcoholism (I.N.C.A.) is the primary advisory body in the field of alcohol-related problems in this country, and this organisation should be involved in the formulation of a national alcohol policy. In view of the important role of Alcoholics Anonymous in the support and treatment of persons with alcohol-related problems, this organisation should also be represented. We recommend that steps be taken to set up an inter-departmental committee which will be responsible for drawing up a national alcohol policy.

Drug-Related Problems

Introduction

13.26 Misuse and abuse of barbiturate and morphine-like drugs have been a concern of the medical profession for a long time. Until comparatively recently the problem was a circumscribed one and was generally seen among persons who, by reason of their occupation, had easy access to drugs. Doctors, pharmacists and nurses were, therefore, the persons most often affected. The use of barbiturate drugs for their sedative and hypnotic properties and amphetamines for weight-reducing during the 1950s and 1960s resulted in an increasing dependence on these drugs which at that time were freely medically prescribed. During the 1960s the abuse of drugs, barbiturates and amphetamines, particularly by young people, became relatively common. This led to the growth of preventive measures as society and the professions responded to the problem. Increasing recognition of the dependence-forming properties of barbiturates and amphetamines and of their potential for causing severe withdrawal symptoms, including psychosis, led to gradually more stringent legal safeguards being taken which limited their availability.

13.27 In Ireland, abuse of amphetamines leading to psychosis and requiring hospitalisation was first reported in 1966.[18] Two years later a Working Party on Drug Abuse was established by the Minister for Health and presented its report in 1971.[19] The Working Party attempted to review the extent of drug abuse in Ireland and concluded that in September 1969 there were approximately 350 persons abusing drugs in the Dublin area who were known to the Gardaí. This number had, by December 1970, increased to 940. Drugs most commonly abused at the later date were believed to be cannabis and lysergic acid diethylamide (LSD). The Working Party declared that there was "no evidence of any significant use of heroin". They added, however, that "the position should not be viewed with complacency". The Working Party recommended various measures: the prevention of illicit acquisition of drug supplies, control in the prescription and supply by doctors of drugs and increased education and publicity concerning the dangers of drug abuse.

Finally they made recommendations for treatment and rehabilitation of drug abusers.

13.28 In June 1969 a National Drug Advisory and Treatment Centre was opened in Jervis Street Hospital as a service to drug abusers and their families. In 1975 an in-patient detoxification unit was provided at the centre. In 1974 a Committee on Drug Education which had been set up by the Minister for Health, presented its report.[20] It recommended drug education through seminars, lectures and booklets and by local health board education teams. The Committee also indicated that evaluation of all programmes should take place.

13.29 There were also initiatives in the areas of crime-prevention and legislation. In 1968 the Garda Drug Squad was established. In 1977 the Misuse of Drugs Act became law, incorporating a comprehensive list of measures regulating possession, cultivation, importation and dissemination of specified drugs. The Misuse of Drugs Act, 1984, was introduced primarily to update the penalty provisions of the 1977 Act, and to introduce some technical amendments to that Act which would allow easier enforcement of its provisions.

13.30 In 1983 a special Government Task Force on Drug Abuse was established. Their recommendations were released in September 1983 and covered the areas of law enforcement, education, community and youth developments, health and research.[21] The Task Force considered that one of the main problems in the area of drug abuse was lack of information about what causes it and also about its true incidence in the community. Arising from the Task Force's recommendation that there should be reliable information on the drug problem, the Medico-Social Research Board was requested to carry out four research projects. The Government has also decided to establish a National Co-ordinating Committee on Drug Abuse on a formal basis which will submit a report to the Minister for Health annually. This committee will be empowered to make recommendations to the relevant Ministers and will assume responsibility for the implementation of the Task Force's recommendations.

Definition

13.31 To define a "drug" is no easy task. To say that a drug is something which alters the physiology of a metabolism is too broad because that includes, for example, water. We are mainly concerned here with drugs which affect mood or sleep. A distinction should be made between "licit" drugs (that is medically prescribed drugs or drugs for which no medical prescription is necessary), and "illicit" drugs (drugs for which a prescription is required but

which have not been properly prescribed by a medical practitioner for the person taking them, or drugs such as cannabis whose prescription is prohibited by law). The words "abuse and misuse" are also difficult to define. A recent W.H.O. publication commented:

> "abuse" and "misuse" are unsatisfactory concepts within a scientific approach. Because the terms involve value judgments they are impossible to define in such a way that they are appropriate for different drugs in different contexts".[22]

Although aware of the limitations of the expression, we use the global term 'drug abuse' to cover all "illicit" drug use and the use of "licit" drugs inappropriately, such as in higher dosage than prescribed or beyond their period of efficacy or necessity, whether so prescribed or not.

13.32 Drug abuse may be episodic, intermittent or continuous depending on the pattern of usage and the damage resulting. When describing abuse the drug category involved should be stipulated. This is best done on a hierarchal basis when more than one drug is involved so that a polydrug abuser taking both cannabis and opiates is classified as an opiate abuser and a cocaine and cannabis abuser is classified as a cocaine abuser.

Extent of the Problem

13.33 The Working Party on Drug Abuse reporting in 1971 was not optimistic about the potential for measuring the extent of the drug problem.[19] It declared that "there is no practical method of measuring precisely the prevalence of drug abuse in the community". Unfortunately, most of the data available to us concerning drug abuse in Ireland, as elsewhere, suffers from imprecision of definition. In addition, some of the surveys carried out tell us little concerning trends in abuse. A report by Byers[23] to the Eastern Health Board Task Force on Drug Abuse in November 1982 examined the extent and type of drug abuse prevalent in the Eastern Health Board area. This report was based on evidence from health professionals, legal sources, educational sources and voluntary organisations and concluded that drug abuse had increased in the Eastern Health Board area in the eighteen months preceding completion of the report. Surveys of school children have focused simply on whether they have been offered or have tried drugs.[24, 25] A survey in 1983[26] of an unrepresentative area of Dublin showed high drug abuse among a substantial portion of the young people in this socially deprived population. A more recent study by the Medico-Social Research Board[27] on heroin use in a Dún Laoghaire borough area estimated that 2.2% of people aged 15-24 had used heroin in the one year period under study. This percentage of heroin use was considerably lower than the corresponding 10% in the same age range reported in the Bradshaw study and the authors commented that

"This finding offers some hope that intensive local efforts, over the past year and a half, to counter experimentation with dangerous drugs among the young have not gone in vain".

13.34 Indirect evidence, however, does suggest that there has been a substantial increase in illicit drug use in Dublin in recent years. There has been a considerable increase in the numbers treated at the National Drug Advisory and Treatment Centre including many stated to be abusing heroin. For the period January to December 1983, inclusive, a total of 1,515 patients attended the Centre and 841 of these patients were new patients. Heroin was the most frequently recorded drug of abuse (1,006 cases).[28] In addition the number of convictions for drug abuse and of seizures by the Gardaí and customs officers of heroin and other drugs has greatly increased.[29]It can, therefore, be concluded that there has been a substantial increase in illicit drug use in the Dublin area.

Prevention

13.35 There are currently two approaches to prevention of drug abuse. The first of these is the law enforcement approach. This is concerned with preventing the importation of drugs such as heroin and cocaine. It also involves the detection, prosecution and conviction of "pushers" i.e. those who market the drug for profit. If the law enforcement measures are effective, this constitutes a vital preventive measure. However, there are difficulties. In many cases the Gardaí claim that, while they are aware of the identity of pushers, there is substantial difficulty in obtaining convictions.

13.36 The other approach to prevention of drug abuse is education. As in the case of alcohol, there is little solid evidence to show that school educational programmes are effective in the prevention of drug abuse. There are suggestions that they may be counter-productive by stimulating interest in drugs. In any case, heroin abusers tend to be those who leave school at 14, who are of poor intelligence and who have a record of primary school non-attendance.[25] Therefore, it appears that school programmes often do not reach the high risk group at which they should be aimed. For these reasons, we are reluctant to advocate the commitment of substantial funds to drug education programmes. However, we consider that, as in the case of education about alcohol, the contribution of teachers is important. Teachers should provide general health education in schools including the dangers of drug abuse. Education about drug abuse should take place in the context of an overall education for life programme which would cover education on both illicit drug use and the improper use of licit drugs, as well as alcohol, tobacco and other substance abuse.

Treatment Approaches

13.37 In considering therapeutic approaches to drug abuse, it must be remembered that in the case of serious abuse such as that relating to heroin, many social factors are involved. For example, drug abuse may be just a symptom of multiple community difficulties and disadvantages. Thus, centre city drug abuse is usually related to crime either directly or indirectly. While in an in-patient unit and in the short term, it may be a simple matter to withdraw a heroin addict from his dependence, keeping him abstinent is more difficult. The social network in which he exists is likely to absorb him again when he returns to it and indeed he may himself be involved in drug-related crime. For these and other reasons, the data from such specialist treatment centres as provide figures do not tell the full story. As in the case of alcohol dependence, there is no convincing evidence that highly specialised, costly and sometimes residential approaches to drug problems are cost-effective for the community as a whole. Treatment programmes which, prima facie, have good results may be dealing with only a selected part of the problem. It is questionable whether most drug abusers would derive benefit from such programmes. We consider that the Department of Health should arrange that all programmes of treatment for drug abuse should be independently evaluated as to their cost effectiveness.

Drugs and the Psychiatric Service

13.38 The 1945 Mental Treatment Act envisaged psychiatric involvement in drug abuse when it made provision for the compulsory hospitalisation of "addicts to drugs" for a maximum period of one year. However, the role of the psychiatric hospitals in this field was minimal. In 1965 there were 84 admissions to psychiatric hospitals and units in Ireland for drug addiction.[4] Yet, despite the probable increase in the drug problem in the ensuing 15 years, the number of comparable admissions in 1982 was still only 223.[1]

13.39 We consider that the sector psychiatric team has an important function in the prevention of drug abuse. This should include:

—supporting law enforcement agencies via consultation with Gardaí and prison authorities;

—education of professionals such as teachers and general practitioners;

—adopting a responsible approach through health education to avoid sensationalism about drug abuse.

13.40 In the light of the considerations set out in previous paragraphs, we would not feel justified in recommending greatly increased residential facilities

for treatment of drug abuse. Rather, we feel that the approach must be community-based with inputs from both medical and social personnel together with the voluntary organisations. Because of the relationship between criminality and heroin abuse, community workers will have to work closely with probation officers and the Gardaí.

13.41 We are not in favour of the treatment by general practitioners of drug addicts. We consider that the role of the general practitioner is in early detection, education and prevention and provision of follow-up services. Increased vigilance on the part of general practitioners may permit intervention before dependency has been established. General practitioners can also educate parents in the early detection of drug abuse.

13.42 The psychiatric service has an involvement in problems arising from both the illicit use of drugs and the improper use of prescribed drugs. The official classification of psychiatric disorders of the American Psychiatric Association classifies drug abuse and drug dependence as psychiatric disorders.[30] If drug abuse escalates, psychiatrists will have the main responsibility for dealing with this problem.

13.43 A cause for more immediate concern is the number of persons attending general practitioners or the psychiatric service and licitly taking prescribed psycho-active drugs, who are psychologically dependent on these drugs. The volume of prescription of sedatives and hypnotic psycho-active drugs by general practitioners is clearly evident from the General Medical Services (Payments) Board data.[31] The psychiatric service has an important role to play in preventing licit drug dependence by more careful prescribing and by the use of alternative treatment methods and in reducing the number of those already dependent.

13.44 **Recommendations**

Alcohol-Related Problems

1. **The approach to alcohol-related problems should be based on prevention rather than treatment (para. 13.11).**
2. **Health promotion should form the basis of a preventive approach to alcohol-related problems. This will involve a commitment to a national policy on alcohol consumption and the implementation of that policy (para. 13.14 and 13.15).**
3. **The emphasis in the management of alcohol-related problems should be on community-based interventions rather than on specialised in-patient treatment. This approach involves a major**

input from general practitioners and the social services as well as the local psychiatric service (para. 13.16).

4. Local alcoholism services should be developed in accordance with the guidelines set out in para. 13.17.
5. Health boards should co-operate with voluntary organisations in providing special services for homeless alcoholics (para. 13.20).
6. There should be closer liaison between the public and private services for persons with alcohol-related problems. Private psychiatric hospitals should be linked in with the local health board's policy on treatment and management of persons with alcohol-related problems (para. 13.23).
7. Centres for the treatment of persons with alcohol-related problems which have been set up by voluntary groups and which receive public funding should be monitored on an ongoing basis (para. 13.24).
8. A cross-sectoral body comprising representatives from all Government departments concerned with alcohol, the Irish National Council on Alcoholism and Alcoholics Anonymous should be set up to draw up a national policy on alcohol consumption and problems (para. 13.25).

Drug-Related Problems

9. Teachers should give their pupils instruction on the dangers of drug abuse as part of a wider health education programme (para. 13.36).
10. The Department of Health should arrange that all programmes of treatment for drug abuse should be independently evaluated as to their cost effectiveness (para. 13.37).
11. The psychiatric team should play an active part in the prevention of illicit drug abuse as outlined in para. 13.39.
12. The approach to the drug problem should be community-based and general practitioners, social workers and voluntary organisations have an important function in this regard. Community workers should work closely with the Gardaí (para. 13.40).
13. The psychiatric service has an important role to play in preventing licit drug dependence and in reducing the numbers of people already dependent (para. 13.43).

Chapter 14

Organisation and Management

Introduction

14.1 The development of a comprehensive community-based psychiatric service has major implications for the staffing and management of the service. The basic unit of service will be the sector team. The team should be located in the sector, involving a move away from the traditional centralisation of services in the psychiatric hospital. The primary commitment of the members of the sector team will be to the community they serve, that is to the population of the sector and not to a particular institution. There should be much more movement of staff, with members of the sector team moving freely from one service component to another to ensure continuity of care for the patient.

14.2 The services provided in a sector should include out-patient clinics, day care facilities and community residential accommodation. In some areas the day facility may be shared by a number of sector teams. In these cases, it is important that there is continuity of care and that the same psychiatric team should continue to have clinical responsibility for patients. The in-patient service, whether this is in a psychiatric or general hospital, will serve a number of sectors. This means that several psychiatric teams will share responsibility for the beds in the hospital. A number of specialised services will also be shared, for example high intensity rehabilitation programmes for old long-stay patients and educational programmes for medical and nursing staff.

Sector Team

14.3 Each sector team will be led by a consultant psychiatrist and include psychiatric nurses and an administrator. The team should have access to a psychologist, social worker and an occupational therapist. The headquarters of the sector team should be located where they do most of their work and in many cases this will be in the day facility.

Teamwork

14.4 The psychiatrist has ultimate clinical responsibility for the mentally ill patient and, as team-leader, has overall responsibility for the functioning of the multidisciplinary team. Each member of the team should have his or her own particular area of professional responsibility and expertise but there will be considerable overlap of roles. It is important that the members of the sector team appreciate the value of working together as a team and that they are prepared to adopt a multiprofessional approach whenever this is to the patient's benefit.

14.5 At present there is a scarcity of psychologists, social workers and occupational therapists in the psychiatric service and there is a need for health boards to expand the numbers employed. In some parts of the country at present psychologists and social workers working in the psychiatric service are part of the community care programme or the general hospital programme. This arrangement has caused problems in the co-ordination of activities by the members of the psychiatric team and in the delegation of duties. We consider that the psychologists and social workers attached to one or more sector teams should be part of the psychiatric service i.e. special hospital programme but, for promotion purposes, they should be allowed to compete with members of their own profession in other areas of the health service.

Role of Psychiatric Nurses

14.6 At present some 6,000 psychiatric nurses work in hospitals and units[1] and about 169 psychiatric nurses work outside the hospital setting. The transition from a hospital-oriented to a community-oriented psychiatric service, with a consequent reduction in the range of in-patient facilities, will entail a redeployment of nursing resources to the community. To equip them for this new role existing hospital-based nurses will require continuing training and education. They will need to acquire the knowledge and skills necessary to operate a community-based psychiatric service. Otherwise, established practices of hospital care will be transferred inappropriately into a different setting. As stated in paragraph 4.1, rather than separate "hospital nurses" and "community nurses", we recommend that nurses should be able to work in any component of a comprehensive psychiatric service. This will mean that nurses may have the opportunity to work in a hospital or community setting and may also be able to rotate from one setting to the other.

14.7 The need for psychiatric nurses to take on a more therapeutic role in the implementation of rehabilitation programmes was referred to in Chapter 10. This is a pre-requisite to moving old long-stay patients (as defined in

Chapter 7) to residential accommodation in the community. The role of the psychiatric nurse should evolve in accordance with developments in the psychiatric service. In most parts of the country, it will take some time to build up a community psychiatric service and the intervening period should be used to organise programmes of training and education for nurses. These programmes should be geared to teaching skills necessary for rehabilitation and for community work. As the in-patient component of the service declines, it should be possible to convert a number of existing posts, based solely in hospitals, into posts for paramedical and other grades, where there are few approved posts at present.

14.8 The National Union/Management Forum on psychiatric nursing is currently dealing with issues such as the status of trainee psychiatric nurses, recruitment, promotion to supervisory posts and integration of male and female staff. We consider that the immediate implementation of the agreements reached on these issues in relation to psychiatric nursing is essential to future developments in the psychiatric service.[2]

Review of Organisation of the Psychiatric Service

14.9 The organisational structure we have proposed in this report requires the continued existence of a separate health care programme for the psychiatric service. We suggest that the term Special Hospital Programme be changed to Psychiatric Programme as the present term ignores the many community facilities in the psychiatric service. We recognise that this structure has a disadvantage in that it creates a boundary between the psychiatric service and other health services. It is essential that this separation of the psychiatric service does not result in the delivery of psychiatric services in isolation from the community care service and the general hospital service. We have already emphasised that there should be close working links between the psychiatric service and general practitioner and community care services and that the in-patient service for all admissions should be provided in general hospitals. We consider that a separate programme structure for psychiatry is necessary now in order to bring about in an ordered way the major transition to the community-oriented psychiatric service we have recommended. A unified management and organisational structure for both community and in-patient services will facilitate the redeployment of resources from the hospital setting to the community service. However, when the stage is reached where most psychiatric care is being delivered in the community, we consider that the position of the psychiatric service in relation to other health service care programmes should be re-assessed.

14.10 In the meantime, community psychiatric services should be so organised that the amalgamation of these services and other community care services

will be facilitated. For example, in Chapter 4 we recommended that psychiatric sectors should share the same boundaries with Community Care areas. Sectors for the delivery of psychiatric services and catchment areas for general hospital services should also be aligned with each other. In addition, the possibility of locating the psychiatric team on the same campus as a community health centre should be examined.

Catchment Area Management Committee

14.11 The term "catchment area" refers to the area served by a psychiatric hospital or general hospital psychiatric unit. Each health board will therefore contain a number of catchment areas and the catchment areas will be further sub-divided into sectors. We recommend that catchment area management committees should be set up by each health board. These committees should be representative of the sector teams in that area and should also include representatives of the local community care teams. The catchment area management committee should be chaired by a Clinical Director/Resident Medical Superintendent/Chief Psychiatrist who will have overall responsibility for the service in the catchment area.

14.12 The membership of the catchment area management committee should include the following:

—Chief Psychiatrist

—Sector Psychiatrists

—Chief Nursing Officer and sector nursing representatives

—Senior Administrator

—Senior Psychologist

—Senior Social Worker

—Senior Occupational Therapist

—Representatives of Community Care teams.

The committee should be responsible for both community and in-patient psychiatric services. It will advise on the planning and development of local services with particular regard to the transition from a hospital-oriented to a community-oriented service organised on a sector basis and the changes entailed for the psychiatric hospital. We recommend that the committee should meet at least once a month.

Chief Psychiatrist

14.13 We favour the retention of the system whereby a Chief Psychiatrist/Resident Medical Superintendent/Clinical Director is appointed on a permanent basis. However, the role of the Chief Psychiatrist will change as the pattern of services changes. We would stress the importance of good leadership by the Chief Psychiatrist and of a clear plan of priorities for the development of services. He or she will need to motivate the staff and gain their co-operation and commitment in achieving the changes required. Chief Psychiatrists/Resident Medical Superintendents/Clinical Directors should be encouraged to acquire and develop administrative skills and in particular have some familiarity with epidemiology, health economics and health planning.

Hospital Management Team

14.14 While the Catchment Area Management Committee will have an important role in relation to the development of all psychiatric services in the area, we recommend that the day-to-day management of the psychiatric hospitals should be the responsibility of a small management team in each hospital. The hospital management team should consist of:

—Chief Psychiatrist

—Senior Administrator

—Chief Nursing Officer.

14.15 **Recommendations**

1. **The services provided in a sector should include out-patient clinics, day care facilities and community residential accommodation (para.14.2).**
2. **The sector team should be multidisciplinary. The headquarters of the sector team should be where they do most of their work and in many cases this will be in the day facility (para. 14.3).**
3. **Psychologists and social workers on the sector teams should be part of the psychiatric service but, for promotion purposes, they should be allowed to compete with members of their own profession in other areas of the health service (para. 14.5).**
4. **To avoid having separate "hospital nurses" and "community nurses", nurses should be able to work in any component of a comprehensive psychiatric service (para. 14.6).**

5. **Programmes of training and education for nurses in rehabilitation and in community work should be organised in all parts of the country (para. 14.7).**

6. **The term Special Hospital Programme should be changed to Psychiatric Programme (para. 14.9).**

7. **When the stage is reached where most psychiatric care is in the community, the organisational position of the psychiatric service in relation to other health services should be re-assessed (para. 14.9).**

8. **Community psychiatric services should be so organised that the amalgamation of these services and other community care services will be facilitated (para. 14.10).**

9. **Catchment area management committees should be set up by each health board (para. 14.11).**

10. **The composition and function of the catchment area management committee should follow the guidelines set out in para. 14.12.**

11. **The day-to-day management of the psychiatric hospitals should be the responsibility of a small management team in each hospital (para. 14.14).**

Chapter 15

Cost Implications

Introduction

15.1 In drafting this report we were primarily concerned to set out an overall policy framework for the future planning and development of the psychiatric service. The main thrust of our recommendations centres on the simultaneous building up of services in the community and reduction of the current over-reliance on the psychiatric hospital. At present, the bulk of resources is spent on the psychiatric hospitals. In assessing the likely cost implications of our recommendations, it is necessary to take account of the considerable scope for redeployment of existing revenue resources which will become possible as the new pattern of services takes shape. It is also necessary to take account of the expenditure which will arise in maintaining the existing service if our recommendations are not implemented.

15.2 In looking at the funding which will be required over the coming years, a distinction should be made between the capital resources which will be needed for any new or adapted buildings and the on-going, revenue resources which will be needed to run the services envisaged in this report.

Capital Resources Required

15.3 The capital resources required will fall under the following main headings:

In-patient services for short-stay and medium-stay patients.

In-patient services for new long-stay patients.

Day facilities.

Community-based residences.

Minor capital improvement schemes.

In-patient Services for Short-stay and Medium-stay Patients.

15.4 The continued development of psychiatric units in general hospitals, which is recommended in Chapter 7, would represent the greatest single element of capital expenditure on in-patient accommodation. If all short and medium-stay bed requirements were to be located in the general hospital setting a total of about 1,700 beds would be required nationally. This figure is based on the planning guideline of 0.5 beds per 1,000 total population recommended in paragraph 7.16. At present, there are about 700 such beds available or being built outside the public psychiatric hospitals. The capital cost of providing the balance of 1,000 beds is estimated to be in the region of £34 million. This estimate is based on the latest available cost (£34,000) of providing a psychiatric bed, together with associated day hospital places, in a new purpose-built general hospital unit. While the total figure of £34 million may appear daunting, the cost of an individual 50 bed unit would be about £1.7 million. This amount would represent a relatively small proportion of the overall cost of the major capital development schemes at present in progress or being planned in a number of general hospitals.

In-patient Service, New Long-stay Patients

15.5 The planning norm for accommodation for new long-stay psychiatric patients is 0.5 beds per 1,000 population. This consists of 0.4 beds in high support units and 0.1 beds in separate small nursing units for elderly persons who are demented and disturbed.

15.6 The planning guideline of 0.5 beds per 1,000 total population means that some 1,700 places are required nationally. It is not possible at this stage to give a precise indication of the capital resources which would be required to develop these facilities, as much will depend on local circumstances and on the type of accommodation used. Some options include the

—construction of purpose-built units

—purchase and adaptation of existing buildings

—use of existing health board properties

—leasing of suitable premises.

On the basis of present building costs, the construction of purpose-built units could cost £12,000 — £15,000 per place. If all the places needed were to be provided in purpose-built units, the maximum capital required would be in the region of £25 million. This sum would be required if existing health properties could not be used or if renting or leasing suitable properties was

not an option. In practice, because of the potential for leasing and adapting existing premises, the actual expenditure required would probably be less than half this figure.

Day Facilities

15.7 In paragraph 6.15, we suggest that a target of 0.75 day places per 1,000 population served should be the immediate aim for local services. On a national basis this would involve a total of 2,600 places. At present there are some 1,180 places available throughout the country in a variety of day hospitals and day centres. The capital investment involved in the provision of the shortfall of 1,420 day places is difficult to estimate because these facilities, like many already available, can be partly provided by renting properties or by adapting existing health board premises. If new purpose-built accommodation was necessary in all cases, the maximum capital investment required would be in the region of £8 million based on the estimate of £5,500 per place for such accommodation. The actual sum required for extra accommodation should be much less. A figure of this order, however, would also enable a certain amount of existing day facilities, which are in substandard accommodation, to be improved or replaced by better buildings.

Community-Based Residences

15.8 In Chapter 9 we have set out policy guidelines on the development of community-based residences. There are some 950 places available in various types of hostels throughout the country at present. It is difficult to state precisely the total number of additional places which will be required nationally. The initial requirements will vary from one area to another and will depend on the backlog of existing long-stay patients. In addition, the number of domestic residences required will be affected by the success rate in placing patients in flats or lodgings. As set out in Chapter 9, we consider that health boards should give preference to renting suitable accommodation and, with the increased involvement of local housing authorities, the capital requirements should be limited. Where such resources are required, health boards may be able to use monies from their European Social Fund allocations for this purpose.

Minor Capital Improvement Schemes

15.9 In paragraph 10 of the Summary of Main Findings we referred to the valuable work undertaken in recent years with the special minor capital allocations for improvement works which have been approved for each district mental hospital. Between 1982 and 1984 a total of £6 million was allocated by the Department of Health for these schemes which have, amongst other

things, facilitated the development of special rehabilitation units and hostel training facilities in many hospitals. The allocation of a similar amount in the period 1985 to 1987 will facilitate further progress and ensure an improved standard of accommodation for those long-stay patients who will spend the rest of their lives in psychiatric hospitals.

Total Capital Requirement

15.10 The total capital required to implement the recommendations of this Report could be in the region of £50 million, spent over a period of 10 to 15 years. While this is a substantial level of expenditure, we consider that there are compelling reasons why it should be committed. If the psychiatric service is not developed along the lines indicated in this Report, then the psychiatric hospitals will continue to accommodate a large number of patients. Most of these hospitals date from the middle of the last century and are now approaching the end of their lifespan. If they are to provide tolerable living accommodation for patients, an extensive programme to restructure and replace the existing stock of buildings must be undertaken. This would require a much larger investment of capital funds than would be involved in implementing the recommendations of this Report. If the existing hospital buildings were to be brought up to acceptable modern standards, or to be replaced where necessary with purpose-built in-patient units, the capital required could be in the region of £150 million.

15.11 Apart from the question of cost, we consider that investing on such a scale in psychiatric hospitals would be a disastrous path for this country to follow. It would perpetuate a pattern of care and treatment which is increasingly irrelevant to the real needs of the majority of the mentally ill in our society. It would, furthermore, be contrary to the main thrust of present psychiatric policy in other developed countries where the decentralisation of services and the move away from large psychiatric hospitals is continuing to gain momentum. We are firmly of the view that the money required to enable our recommendations to be implemented should be made available. We would emphasise that, while the main source of capital funding will continue to be allocation by the Department of Health to the health boards, other sources of capital funding, such as the sale of surplus psychiatric hospital land and the European Social Fund are also available and should be fully utilised.

Revenue Resources Required

15.12 The capital investment which we recommend over the coming years for the psychiatric service will not, in general, involve any additional revenue expenditure over and above the £145 million of revenue expenditure being

spent on the psychiatric service for 1984. The implementation of our recommendations will involve the development of new community psychiatric facilities, including the provision of high support hostels for new long-stay patients. In addition, the potential of the community care services, general practitioners and families to cope with persons with mental illness will be improved by increased liaison with the psychiatric service. This building up of services in the community will allow much of the specialised psychiatric service to be transferred from the hospitals, while the availability of residential accommodation in the community will allow many old long-stay patients to be discharged. In view of the age distribution of old long-stay patients, the numbers remaining in hospital can be expected to decline steadily as a result of death.

15.13 As in-patient numbers decline, there will be considerable potential for redeploying both staff and revenue resources from the hospitals to the new community services. This will be achieved by progressively closing down wards and sections of hospitals. There will be no need to increase the overall number of staff employed. However, as the service develops alone the lines we recommend, it will be necessary to convert a number of existing posts, at present based solely in the hospitals, into posts for specialised medical and paramedical staff, including posts in child psychiatry.

15.14 The redeployment of resources from the hospital has already started and new day services and other community facilities are being developed without incurring any additional revenue expenditure. We feel that this transfer of revenue resources will be the main challenge facing health boards and hospital managements over the coming years.

15.15 **Recommendations**

1. **There are compelling reasons why the money required to implement our recommendations should be made available (para. 15.10 and 15.11).**
2. **There should be a redeployment of revenue and staff resources from the hospitals to the new community services over the coming years (para. 15.13).**
3. **There should be a gradual conversion of a number of existing posts, based solely in the hospitals, into posts for specialised medical and paramedical staff, including posts in child psychiatry (para. 15.13).**

Chapter 16

Planning and Evaluation

16.1 The controlled implementation of the recommendations outlined in this Report requires that each health board draws up a realistic plan which will determine how the various parts of the service will inter-relate and the timescale for action. Local circumstances will determine much of the content of the plans and what is set out here are broad guidelines for planning. A number of stages may be identified in the planning process:

—identify the policy and objectives of the service;

—assemble the relevant information;

—draw up a plan of action for the specified time scale;

—implement the components of the plan in appropriate sequence;

—monitor progress in drawing up and implementing the plans;

—evaluate the benefits being achieved.

Policy Objectives

16.2 All actions designed to influence the health of the population rest on implicit or explicit policy objectives. The basic policy objectives of the psychiatric service might be regarded as the prevention of mental illness and, where this fails, the reduction as far as possible of impairments and disabilities which may result from illness.

16.3 Health strategy is the means by which these policy objectives are translated into action. In the case of the psychiatric service, the national strategy would be to move the care of the mentally ill away from large institutions to smaller, more manageable units in the community. The evidence available to us suggests that this is the most important single step which could be taken towards improving the delivery of mental health care.

Assemble Relevant Information

16.4 Good information is a necessary first step towards effective planning. The information required for planning the psychiatric service includes data on patients receiving services and on available services and their utilisation. We have substantial knowledge of the numbers and characteristics of patients in the various treatment facilities in this country and summaries of this information are contained in Appendix 3. It is essential, however, that each health board and each hospital should look carefully at its own patients to ascertain the degree of their impairments, the potential for rehabilitation and the type of facility needed for their rehabilitation. Guidelines for a survey of hospital patients are set out in paragraph 7.20. The survey should also include information on the staff and the buildings of each psychiatric hospital.

16.5 Information such as this, carefully collected and analysed, will make it possible to determine which patients are:

—primarily mentally handicapped,

—primarily geriatric,

—potentially suitable for discharge to community residence,

—actively disturbed patients with a low probability of being able to live in the community.

This information can be used to draw up programmes of rehabilitation and training and to provide guidance on the number of community residential places required. It will enable estimates to be made of the number of patients who will reside in the hospital at different points in the future. When this survey has been completed, arrangements should be made to collect a similar set of information on a regular basis for monitoring and planning purposes. The survey on hospital buildings, together with the information on patients, will allow plans to be made for structural improvements to selected parts of the buildings.

Draw up a Plan of Action

16.6 The compilation of good information on patients and resources will make it possible to design local plans of action. These plans should specify objectives which are realistic to the relevant sector, catchment area, or health board. They should also indicate the time scale within which the objectives should be reached. The following is a broad outline of what we consider should be the main features of a health board's plan:

1. divide the health board area into sectors;

2. assign responsibility for the psychiatric needs of each sector to a multidisciplinary team;

3. categorise patients in the psychiatric hospital or hospitals according to their varying needs and indicate how the hospital buildings will be used to accommodate them;

4. provide for programmes of training and rehabilitation both for patients who are resident in hospital and for those living in the community;

5. indicate the numbers and location of domestic scale residences required and the steps being taken to acquire them;

6. provide for a full range of community psychiatric services such as out-patient clinics, day care facilities, and supervised hostels, stating location and size together with the steps required to bring them into operation;

7. analyse different options for the location of the hospital in-patient service for short-stay and medium-stay patients;

8. specify the arrangements required to prevent inappropriate admissions to hospital and to ensure that patients are not admitted to long-stay wards;

9. include provision for high support hostels for new long-stay patients, indicating location, size and staffing;

10. indicate the means of establishing and strengthening links between the psychiatric and the community care services;

11. indicate, in broad outline, the steps to be taken to establish procedures for mental health consultation and for family support services;

12. indicate the expected shortages and surpluses in the different grades of staff as the psychiatric service evolves;

13. provide for programmes to retrain psychiatric nurses for their new role in:

    —rehabilitating and training patients to live in community settings, and

    —providing a community-based service.

16.7 Careful consideration should be given to the sequence of events in the plan. Some actions can take place immediately; others may depend on prior action on a related issue. For example, it will not be possible to discharge many patients to community residences until they have first completed a programme of training.

Implement the Plan

16.8 As soon as the outline of what is to be done is clear, there should be no delay in putting the plan of action into effect. Many components of the plan can be put into operation immediately and at little or no extra cost. For example, sectors can be designated by each health board and responsibility assigned to selected teams; programmes of patient training and rehabilitation can be put into operation; a number of community services can be established in existing facilities.

16.9 In formulating and implementing the plan, special attention must be given to the future role of the psychiatric hospitals and to the patients and staff of these hospitals. They must become active places, providing programmes of training and rehabilitation, to meet the varying needs of resident patients. All staff in the hospitals must be closely involved in achieving the ultimate objective of the hospital, which is to restore patients to as normal a life as possible in their own communities. An approach along these lines will ensure that the decline in the number of patients living in the hospitals will continue. Overcrowding has already been greatly reduced and should soon be eliminated. This will be followed by the closure of wards and a reduction in the number of beds available in the hospitals. This chain of events, together with the establishment of community facilities as outlined in this Report, must result in a transfer of activity from the hospitals to a variety of community-based facilities.

Monitor Progress

16.10 The process of planning is of little value unless it contains provision for ensuring that the plans are implemented and kept up to date. Planning must be a continuous process with changes being made in the light of new information as appropriate. There should be organisational arrangements which will ensure that:

—realistic plans are drawn up;

—the plans are implemented in a rational way and without unnecessary delay;

—there is continuing review of the plans and their implementation, with adjustments as need arises.

16.11 Each health board has primary responsibility for planning the service in its area, subject to overall guidance from the Department of Health. We do not propose any change in this division of responsibility but we do consider

that arrangements should be made to ensure that plans are drawn up and implemented. In this context, the Department of Health might consider setting up an advisory body which would consist of field workers in psychiatry, psychiatric nursing, psychiatric social work, clinical psychology and health administration. This body could have the role of assisting the Department in monitoring:

—the current state of the psychiatric service in each area;

—the formulation of plans for the future of the service and the revision of these plans as required;

—the implementation of these plans.

It could provide encouragement, guidance and assistance to the sector teams and to health board officials in designing and bringing about the required changes in the service.

Evaluate Benefits

16.12 Evaluation is an essential part of any health board or national plan. The process of evaluation should examine what has been achieved locally and nationally by the use of agreed indicators and by a comparison of indicators both within regions and between regions. Such indicators would include the number of occupied beds, the rate of decrease of occupied beds, the number of admissions and contacts with specialist psychiatric care, and the number of day places and hostel places. Evaluation should also focus on the quality of patient care provided.

16.13 To enable appropriate evaluation to take place, each health board or hospital will need to assemble and study more data than are currently being provided. These data will include information on in-patients and out-patients and a variety of other information concerning the operation of the psychiatric service. In parallel, budgetary and accounting information relating to costs of items of services provided for each patient need to be collected and studied. Finally, experimental studies of a cost-benefit or cost-effective nature, comparing the costs and benefits of alternative methods of treatment and rehabilitation, need to be undertaken.

16.14 We consider that the process of evaluation should include a self-evaluative check-list drawn up for the services in each sector. The items on the check-list could be based on the recommendations in this Report and should relate to the particular circumstances of the sector. It would be invaluable if an annual report was produced for each sector or catchment area, indicating the services provided and the progress being made in drawing

up and implementing the plans. Evaluation on a national basis should be carried out by the Department of Health.

Staff Involvement

16.15 To the maximum extent possible, the staff providing the service should be involved in planning the future service for their locality. This might be done by way of formally established staff committees or more informally. The participation of staff in the early stages of planning ensures that their knowledge and experience are taken into account and helps to overcome the reservations which are inevitably associated with change.

Research

16.16 In Ireland, the level of resources devoted to psychiatric research is very small. In the United States, on the other hand, there is a requirement to set aside at least 2% of the psychiatric service budget for research and development. From a purely clinical standpoint, it is essential to have current and local epidemiological information on the illnesses being treated as well as up-to-date information on service utilisation. We welcome the recent, comprehensive survey of the practice of electroplexy in the Republic of Ireland[1] which represents the sort of research we have in mind. The Medico-Social Research Board has done important work in gathering data on the psychiatric services on a national basis. In child and family psychiatry, however, the basic epidemiological information on the situation in this country is lacking. In Chapter 12 we have recommended that an academic department of child and family psychiatry be established in one of our medical schools. We would envisage that such a department would undertake research in the specialty. We recommend that there should be more funding for research in both adult and child psychiatry.

16.17 Because many of the components of the psychiatric service we recommend are innovative, there is scope for many research projects to improve the current state of knowledge about their impact. For example, it will be necessary to evaluate the quality of care provided for patients at the different types of day care facilities and the need for separate day centres and day hospitals. In the course of this Report we have identified various gaps in information as well as the need for continuing research to provide more definite guidance on norms for service provision. We recommend that a number of studies should be carried out, as follows:

1. review of the norms recommended for day care services, in-patient services and community residential facilities;

2. study based on a sample of general practitioners to determine the number of patients they treat for mental illness;
3. effectiveness of general hospital psychiatric units;
4. feasibility of lodgings to house psychiatric patients;
5. prevalence by diagnostic category of mental infirmity in elderly people;
6. need for a specialised psychogeriatric service in different demographic circumstances.

16.18 A good information system will be essential to carry out the necessary research work. We recommend that steps be taken by the Department of Health to introduce a standard record for each patient which would be suitable for computer processing. In this regard the following recommendation which was contained in the World Health Organisation report "Changing Patterns in Mental Health Care"[2] is relevant:

> "A single type of documentation should be developed in each area, with careful regard for the confidentiality of personal data, so as to permit monitoring of the activities and utilisation of different parts of the service and reliable computing of basic statistics on patient care in all parts of the system e.g., for in-patients, day patients, out-patients, prevention, rehabilitation and after care".

16.19 There is also a need for a standardised patient record in child and family psychiatry. As well as providing a basis for a good information system, such standardisation will enable international comparisons and application of research findings to be made. Some of our child and family psychiatric services are already using a multi-axial classification scheme[3] based at present on the ninth edition of the World Health Organisation International Classification of Diseases. We recommend that this scheme, which is used internationally, should become the standard for all centres in Ireland.

16.20 **Recommendations**

1. **Plans should be drawn up by each health board to implement the recommendations of this Report (para. 16.1).**
2. **A survey of patients, staff and the buildings should be carried out in every psychiatric hospital (para. 16.4).**
3. **Health board plans of action should follow the guidelines set out in para. 16.6 of this Report.**
4. **The implementation of the plan should begin without delay. Particular attention should be given to the future role of the**

psychiatric hospitals and to the patients and staff of these hospitals (para. 16.8 and 16.9).

5. Each health board should have monitoring arrangments to ensure that plans are drawn up and implemented effectively (para. 16.10).
6. The Department of Health should consider setting up an advisory body to assist the Department in monitoring the changes occurring in the psychiatric service (para. 16.11).
7. Each health board should evaluate the benefits being achieved by the implementation of the plan in its area (para. 16.12).
8. As part of the process of evaluation, a check list should be drawn up for each sector based on the recommendations in this Report (para. 16.14).
9. As far as possible, staff should be involved in planning the future service for their locality (para. 16.15).
10. There should be more funding for research in both child and adult psychiatry (para. 16.16).
11. A number of research projects should be carried out as outlined in para. 16.17.
12. A standard record for each patient which would be suitable for computer processing should be introduced by the Department of Health (para. 16.18).
13. A multi-axial classification scheme should become the standard for patient records in child and family psychiatry (para. 16.19).

Signed:

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Appendices

Appendix 1

The Epidemiology of Mental Illness

1.1 Various methods have been tried over the years to build up a picture of the extent of mental illness in a community. The main sources of this information which have emerged are:

—Hospital Data

—Psychiatric Case Registers

—Key Informant Surveys

—Community Surveys.

Hospital Data

Particulars will be given firstly about the resident patient population, secondly about admissions to hospital.

Resident Population

1.2 Despite the shift from residential treatment to community care which has been taking place since the report of the Commission of Inquiry on Mental Illness in 1966, our psychiatric hospital population remains notably higher than in most other countries. For example, in March 1981 the number of patients resident in Irish psychiatric hospitals and units, expressed as a rate per 100,000 population, was 406. The most up-to-date information available indicates corresponding rates for the following countries as follows:

England — 176[1]
France — 228[2]
Denmark— 166[3]

1.3 Table 1 shows how the Irish hospitalisation rates compare with those of England by age.

TABLE 1

Number of patients resident in psychiatric hospitals and units in 1981, expressed as rates per 100,000 population for Ireland and for England, with ratio of rates

Age Group	Ireland	England	Ratio of Ireland to England
Under 15	7.4	5	1.5
15-19	46.0	22	2.1
20-24	142.7	49	2.9
25-34	275.2	88	3.1
35-44	517.3	94	5.5
45-54	792.4	144	5.5
55-64	1,036.8	240	4.3
65-74	1,229.3	382	3.2
75 and over	1,608.6	832	1.9

Note: The Irish rates are from the Irish Psychiatric Hospital Census 1981.[4] The English rates are estimates which have been supplied by the Department of Health and Social Security.

It is clear from this table that the Irish hospitalisation rates are greatly in excess of those in England.

1.4 The most relevant comment of the Commission of Inquiry on Mental Illness1966 on this state of affairs is worth quoting here:

> "Statistics in respect of different countries may not be directly comparable, but, even if allowance is made for this, the number of in-patients in Ireland seems to be extremely high — it appears to be the highest in the world. It is hard to explain this. There are indications that mental illness may be more prevalent in Ireland than in other countries; however, there are many factors involved, and in the absence of more detailed research, the evidence to this effect cannot be said to be conclusive. Special demographic features, such as the high emigration rate, the low marriage rate and problems of employment, may be relevant to the unusually high rate of hospitalisation. In a largely rural country with few large centres of population, social and geographic isolation may affect both the mental health of individuals and the effectiveness of the mental health services. The public attitude towards mental illness may not be helpful to the discharge of patients and their reintegration in the community".

1.5 The major developments in drug treatment in the 1950s enabled doctors to treat the disturbed behaviour of psychiatric patients, so admission for long-term in-patient care became less necessary. These and other developments are reflected in the decline in the number of in-patients in public psychiatric hospitals in the 1960s and 1970s. In 1960 this number stood at 19,442; by 1970 it had fallen to 15,392 and in 1980 it was 12,212. The last detailed census of patients in Irish psychiatric hospitals and units was carried out in 1981 by

the Medico-Social Research Board (M.S.R.B.).[4] Table 2 gives a percentage distribution of these patients by age and by length of stay.

TABLE 2

Percentage distribution of patients resident in psychiatric hospitals and units in 1981 by age and by length of stay

Age \ Length of stay	Less than 1 year	1-5 years	More than 5 years	All lengths of stay
Under 25	2.3	0.9	1.1	4.3
25-44	8.3	3.6	9.7	21.6
45-64	8.3	5.7	24.8	38.8
65 or over	6.0	7.0	22.2	35.2
All Ages	24.9	17.2	57.8	99.9

Hospital patients are often divided into two categories according to their length of stay in hospital. On the one hand there is the group comprising short-stay patients (i.e. those in hospital for less than one year) and, on the other hand, the balance who constitute the long-stay group. Table 2 shows that 75% of the resident population is in the long-stay category and that most of the patients in this category have been in hospital for more than 5 years. Furthermore the long-stay population tends to be older than the short-stay population; 39% of the long-stay patients were aged 65 or over; the corresponding proportion for the short-stay group was 24%.

Admissions

1.6 The other type of information that is available in relation to hospital statistics is that which relates to individual admissions and discharges. Here the trend is one of increasing activity. Table 3 illustrates this trend.

TABLE 3

Admissions to psychiatric hospitals and units — 1969 to 1982

Year	Number of Admissions	Percent First Admissions
1969	19,697	38.6
1970	20,343	37.7
1971	21,351	37.7
1972	22,964	37.4
1973	24,036	37.5
1974	24,964	35.7
1975	25,892	34.3
1976	26,434	33.8
1977	26,385	33.3
1978	27,662	31.4
1979	27,358	31.5
1980	27,098	31.2
1981	28,685	29.6
1982	28,778	30.2

There are also some psychiatric patients who are treated in general wards of general hospitals. On the basis of returns made to the Department of Health and to the Medico-Social Research Board under the Hospital In-Patient Enquiry Scheme, it has been estimated that the number of admissions involved could be of the order of 7,000 in a year. Accordingly, the total number of admissions to hospital for psychiatric conditions in 1982 was probably in the region of 35,000.

1.7 The set of patients admitted to hospital for the first time in any year is a subset of the total admissions for that year. Table 4 presents fairly clear evidence that Irish first admission rates[5] are considerably in excess of those for England.

TABLE 4

Ireland and England. First Admissions 1981.
Rates per 100,000 population with ratios of rates

Age Group	Male			Female		
	Ireland	England	Ratio of Ireland to England	Ireland	England	Ratio of Ireland to England
Under 15	9	15	0.6	6	12	0.5
15-19	144	66	2.2	113	86	1.3
20-24	373	118	3.2	241	126	1.9
25-34	484	120	4.0	334	143	2.3
35-44	562	115	4.9	391	131	3.0
45-54	453	95	4.8	345	119	2.9
55-64	379	93	4.1	343	122	2.8
65-74	365	139	2.6	351	171	2.1
75 and over	512	352	1.5	392	384	1.0
All age-groups	284	97	2.9	219	127	1.7

The trend in first admissions to Irish psychiatric hospitals and units from 1969 to 1982 is given in Table 5.

TABLE 5

First Admissions to psychiatric hospitals and units 1969 to 1982

Year	No. of First Admissions
1969	7,597
1970	7,673
1971	8,058
1972	8,598
1973	9,018
1974	8,914
1975	8,873
1976	8,939
1977	8,788
1978	8,678
1979	8,631
1980	8,459
1981	8,480
1982	8,702

No statistics are available on the extent to which first admissions occur in general hospitals.

Characteristics of patients admitted

1.8 *Sex.* In 1982 male admissions to psychiatric hospitals represented 55% of the total while in 1969 it was 52.4%. In every year since 1969 male admissions exceeded female admissions. The same pattern of male predominance emerged for first admissions, with males accounting for 55.6% in 1982 compared to 53% in 1969. One explanation for this phenomenon is the higher incidence of alcohol-related problems among males.

1.9 *Marital Status.* Table 6 gives a breakdown of the admissions to psychiatric hospitals in 1982, by marital status and sex.

TABLE 6

Admissions to psychiatric hospitals and units 1982 classified by marital status and sex

Marital Status	Male	Female	Total	Total rate per 100,000 population
Single	8,827	4,919	13,746	707.4
Married	5,633	6,068	11,701	938.6
Widowed	524	1,774	2,298	1,287.5
Unspecified	688	345	1,033	—
Total	15,672	13,106	28,778	854.3

Almost twice as many single men as single women were admitted but there was very little difference between the number of married men and married women. Rates per 100,000 relevant population were substantially greater for the widowed than for either the married or the single.

1.10 *Age on admission.* The greatest number of admissions to psychiatric hospitals and units in 1982 occurred between ages 25 and 34. The highest admission rate for males was in the age group 35 to 44 whereas the highest rate for females was in the 55 to 64 age group.

1.11 *Socio-economic groups.* The highest admission rates to psychiatric hospitals have been consistently recorded over the years by the "unskilled manual", "other agricultural" and the "non-manual" groups. If occupation is taken as a proxy for social class it is clear and that there is an inverse relationship between social class and psychiatric illness, that is the lower the social class the higher the rate of admission.

1.12 *Diagnosis.* In recent years depressive disorders have emerged as a major cause of admission to psychiatric hospitals. In 1982 this condition accounted for 26.5% of all admissions. Alcohol abuse and alcoholic psychosis

accounted for the next largest category at 25.0%, and schizophrenia was the third largest, contributing 22.9%.

Case Registers

1.13 In considering the question of the extent of mental illness in the Irish community it is necessary to enquire beyond the level of the hospital. It could be, for instance, that the in-patient component in our psychiatric service is bigger than it is in other countries but that our total level of morbidity might not be all that excessive. The "case register" method is designed to record the numbers and characteristics of persons from defined catchment areas who come to any form of psychiatric treatment such as in-patient, hostel or out-patient care. A register is simply a list of the people concerned and of their relevant characteristics. A good example of this approach is the Three County Register set up in 1973 by the Medico-Social Research Board — one for each of counties Carlow, Westmeath and Roscommon. These counties were chosen because they best represented the spectrum of psychiatric morbidity and socio-demographic characteristics in Ireland.

1.14 The fairly detailed data required for the register are gathered by trained interviewers who use agreed standardised terms. The first step in building up the registers was to take a census of all the patients who were in psychiatric care in each county on 31 March 1973. After this date, as patients came into care they were added to the register and information up-dated as former patients returned to care. In addition, the registers contain information about persons from these counties who get their treatment from private psychiatric hospitals outside the three areas. In this way a broad picture is built up of all psychiatric illness that comes to the specialised psychiatric services from these three counties.

1.15 In Table 7 the one year prevalence rate for the three counties combined in 1981 is compared with those of the English registers in Southhampton, Nottingham, Oxford and Aberdeen in 1982. It may be seen from this table that the one year prevalence rate for the three counties combined in 1981 was greater than those of the English registers.

TABLE 7

One-year prevalence. Register rates per 100,000 population aged 15 or over.

Register	Register rate per 100,000 population
Three Counties (1981)	2295
Southhampton (1982)	2037
Nottingham (1982)	1905
Oxford (1982)	1644
Aberdeen (1982)	1986

1.16 Table 8 gives the rates for "one-day prevalence" for persons on the registers on 31 December 1982. These rates are calculated by relating the number of persons in psychiatric care to the population being served. For in-patients the relevant number of patients is the number in hospital at midnight on 31 March 1982 including patients 'on the books' or absent on leave. For out-patients the definition of being 'in care' on the census day is that of having made a contact with the psychiatric services at any time during the 90 days preceding census day.

TABLE 8

One day prevalence 1982 Register rates per 100,000 population aged 15 or over (1981 Census of population).

County	Register Rate per 100,000 population
Carlow	1989
Westmeath	1655
Roscommon	1706

An analysis of one-day prevalence data for the Three County Case Register on 31 December 1982 is contained in paragraphs 1.17 to 1.23.

1.17 *Age and Sex.* Table 9 presents the Three County data in the form of rates per 100,000 population (1981 Census) aged 15 or over by age and sex. In general the rates increase with age.

TABLE 9

Number of persons in the Three Counties who were in care on 31/12/82 expressed as rates per 100,000 population aged 15 or over — by age and sex.

Age \ Sex	Male		Female		Total	
	Nos	Rates	Nos	Rates	Nos	Rates
15-19	10	128	10	137	20	132
20-24	41	646	27	475	68	565
25-34	126	1131	90	892	216	1018
35-44	145	1704	130	1678	275	1692
45-54	207	2664	173	2404	380	2539
55-64	223	2858	240	3232	463	3041
65+	302	3157	321	3152	623	3155
Total 15+	1054	1788	991	1782	2045	1785

1.18 *Diagnosis.* Table 10 sets out the age-specific rates for the three counties combined for the principal diagnostic categories. In general the rates for schizophrenia and depressive disorders tend to increase with age and, as expected, the rates for organic psychoses are higher in the elderly.

TABLE 10

Number of persons in care on 31/12/82 expressed as rates per 100,000 population aged 15 or over — by age and diagnosis.

Diagnosis	15-24	25-44	45-64	65+	Total
Organic Psychosis	18	45	66	375	101
Schizophrenia	88	539	1103	1271	707
Depressive Disorder	44	163	480	613	296
Mania	7	53	242	268	129
Neurotic/Personality Disorder	70	200	374	278	229
Mental Handicap	66	219	278	172	190
Other Diagnoses	29	91	248	177	133
All Diagnoses	322	1310	2791	3154	1785

1.19 *Length of Stay.* Table 11 shows the age and length of stay data. The highest rates are in the long-stay category.

TABLE 11

Number of persons in care on 31/12/82 expressed as rates per 100,000 population aged 15 or over — by age and length of stay.

Age	Under 1 month	1-6 months	6 months-1 year	1 year or over	Total
15-19	20	40	13	60	133
20-24	42	141	108	274	565
25-34	57	188	137	636	1018
35-44	86	246	178	1181	1691
45-54	107	381	214	1837	2539
55-64	118	387	223	2312	3040
65+	66	243	167	2679	3155
Total 15+	71	233	150	1331	1785

1.20 *Length of Stay and Diagnosis.* Table 12 shows the length of stay rates for the chief diagnostic groups.

TABLE 12

Number of persons in care on 31/12/82 expressed as rates per 100,000 population aged 15 or over — by length of stay and diagnosis.

Diagnosis	Under 1 month	1-6 months	6 months-1 year	1 year or over	Total
Organic Psychosis	6	8	10	78	102
Schizophrenia	15	72	48	572	707
Depressive Disorder	19	51	38	187	295
Mania	8	31	20	70	129
Neurotic/Personality Disorder	11	38	17	162	228
Mental Handicap	—	4	3	182	189
Other Diagnoses	11	27	14	80	132
All Diagnoses	70	231	150	1331	1782

Table 12 shows that the greatest contribution to long-stay care in the three counties is made by schizophrenia. The proportion of all patients in long-term care in the three counties is quite large. It appears that, once in the psychiatric network, many patients never leave or leave only after prolonged periods of care.

1.21 *Diagnosis and Type of Care.* Table 13 presents the rates for the major diagnostic groups by type of care.

TABLE 13

Numbers in care on 31/12/82 expressed as rates per 100,000 population aged 15 or over — by diagnosis and type of care

Diagnosis	In-patient	Out-patient	Total
Organic Psychosis	74	27	101
Schizophrenia	401	305	706
Depressive Disorder	76	220	296
Mania	50	79	129
Neurotic/Personality Disorder	56	173	229
Mental Handicap	167	24	191
Other Diagnoses	63	70	133
All Diagnoses	887	898	1,785

The broad distinction in Table 13 is between hospital in-patients and those in other forms of care e.g. hostels, day centres etc. who have been classified as out-patients. The in-patient rate for organic psychosis is higher than the out-patient rate. The in-patient rate for schizophrenia is also somewhat higher than the out-patient rate while more patients with depressive disorders are in out-patient care. Table 13 suggests that it is possible to treat persons with severe mental illness on an out-patient basis. Patients with neurotic and personality disorder are commoner as out-patients.

1.22 *Length of Stay by Type of Care.* Table 14 gives the rates by length of stay and by type of care.

TABLE 14

Numbers in care on 31/12/82 expressed as rates per 100,000 population aged 15 or over — by length of stay and type of care

Length of Stay	In-patient	Out-patient	Total
Under 1 Month	31	40	71
1-6 Months	51	182	233
6 Months-1 Year	24	126	150
1 Year and over	781	550	1,331
All Lengths of Stay	887	898	1,785

This table shows that the out-patient rate is higher than the in-patient rate for each length of stay category up to one year. Chronicity is noticeable and

this is, somewhat surprisingly, true of out-patient illness as well as in-patient. About 88% of in-patients and 61% of out-patients are long-stay.

1.23 *Socio-Economic Groups* The prevalence date from the Three County Register tend to confirm the position outlined in paragraph 1.11 in relation to the incidence of mental illness viz. the lower the socio-economic group the higher the rate of prevalence. This is clear from Table 15.

TABLE 15

Number of persons in care on 31/12/82 expressed as a rate per 100,000 population aged 14 or over in selected socio-economic groups

Socio-Economic Group	Rate
Higher Professional	472
Employers and Managers	538
Salaried Employees	707
Other non-manual	2,102
Other agricultural	2,756
Unskilled manual	3,633

1.24 The analysis in paragraph 1.17 to 1.23 highlights some important features of psychiatric illness in Ireland.
These are—

1. Most treated psychiatric illness is long-stay (para. 1.19).
2. About a third of patients in care are elderly (para. 1.17).
3. Most in-patients suffer from severe or psychotic forms of illness (para. 1.21).
4. Expansion of services outside of hospital attracts a newer group of persons suffering from less severe illnesses many of whom eventually become long-stay in out-patient care (para. 1.21-1.22).
5. Development of out-patient and other community services appears to provide alternative care for some patients with severe illnesses such as schizophrenia and manic depressives who otherwise would be dealt with exclusively by hospitalisation (para. 1.21).

Key Informant Surveys

1.25 One of the limitations of the case register approach is that it deals only with cases of psychiatric illness attending the specialised services. It does not include cases of psychiatric illness treated by general practitioners or illness that is undetected and not being treated at all in the community. One approach to tapping this source of illness is to use the "key informant" method whereby those people in the community who are likely to know, such as general practitioners, public health nurses, teachers, and gardaí are asked to report on anyone whom they think may be suffering from mental illness.

Community Surveys

1.26 Large-scale studies of community morbidity are the most comprehensive way of measuring the prevalence of psychiatric illness but these are beyond the resources of all but a minority of research groups. No such type of survey has ever been attempted in Ireland. However, small scale community surveys of severe psychiatric illness in Ireland have been carried out.[7,8]

1.27 An example of a community survey is the work which has been carried out by Bebbington and his co-workers concerning psychiatric disorders among the population aged 18-64 of Camberwell in London.[9] The survey consisted of two stages. A random sample of names was drawn from the relevant electoral register. In the first stage 800 interviews were carried out by trained interviewers who administered the short form (40 items) of a psychiatric questionnaire called the Present State Examination (PSE). By analysing the PSE data from this first interview it was possible to establish a threshold level for psychiatric illness. The second stage consisted of a more detailed interview involving the full 140 item PSE and the group interviewed this time consisted of 310 persons including most of those who were determined on the basis of the first interview to be above the threshold i.e. "psychiatric cases". The prevalence of psychiatric disorder as defined in this study was 10.9% of the population aged 18-64 and this reflected rates of 6.1% for men and 14.9% for women.

1.28 Several other prevalence estimates derived from surveys carried out in the 1970s in Europe and the United States have worked out in the range 4-8% for men and 8-15% for women. Nearly all the surveys demonstrate a prevalence in women about twice that in men despite the wide differences in methods of case finding and sampling. These estimates tend to support the British National Morbidity Survey carried out in 1970-71 which showed that on average over the year, 7% of males and 14% of females consulted their general practitioners for some form of mental illness. Very recently what is probably the most extensive and comprehensive community survey on mental illness ever undertaken has been set up in the United States.[10] Preliminary results from this study are beginning to appear and suggest that when alcohol and drug abuse are taken into account there may be no difference between the sexes in prevalence rates for mental disorder.

Number of Mentally Ill Persons

1.29 The estimates in the preceding paragraph seem to suggest that the prevalence of mental illness could be of the order of 10% of the population aged 18 to 64. If this were to be applicable in Ireland it would be equivalent to about a fifth of a million people nationally (excluding children). For prevalence rates in children, see paragraph 12.9.

Appendix 2

Psychiatric Services for the Adult Deaf

(Prepared by Dr. Jim O'Boyle)

Introduction

2.1 During the last twenty-five years provision of specialised services for deaf adults has been a feature of the development of comprehensive psychiatric services in many countries, particularly in North America. In this country we have not, as yet, developed such a service. Deaf adults requiring psychiatric treatment are assessed and treated in a setting which is not equipped for those who are suffering from severe hearing impairment. The objective in setting up specialised psychiatric services for the deaf in other countries has been to provide assessment, diagnosis and treatment at a centre where all staff members are skilled in communicating with the deaf.

Definition of Deafness

2.2 Deafness is a term which includes all types of hearing impairment due to a defect in the hearing mechanism. The degree of deafness ranges from total loss of hearing for any kind of sound in any circumstance to a mild degree of deafness which may be almost imperceptible.[1] Prelingual deafness is present from birth, or occurs in the early years of life before the development of speech and language. Post-lingual deafness occurs after the acquisition of language. Post-lingual deafness occurs after the acquisition of language. The term prelingual profound deafness should be confined to hearing impairment which is profound and cannot be alleviated to any useful degree by hearing aids, and which is either congenital or acquired in early life before the development of speech and language.[2]

2.3 Severe hard of hearing is the term used for children who have had considerable speech experience, but are so handicapped by defective hearing that they require to be educated in small classes by a teacher of the deaf using modern electronic equipment.[1]

2.4 A deaf person is not necessarily mute. Speech proficiency is related to the age of onset of deafness in addition to the opportunities which the deaf person has received for special training and the acquisition of language.

Incidence of Deafness

2.5 There are no statistics available for the incidence of deafness in the adult population in this country. The incidence of profound deafness between 3 and 18 years of age is of the order of 4 to 4.5 per 10,000 of the school-going population. The incidence of severely hard of hearing children is estimated to be 5 per 10,000.[1] It is estimated by the National Association of the Deaf that the incidence of profound deafness is 1 per 1,000 of the general population.

Complications of Deafness

2.6 Social isolation is recognised as one of the principal complications of profound or severe hearing impairment.[3] The primary cause of social isolation in the deaf is the sensory defect which interferes with normal communication and social interaction.[4] The problem of social isolation is reinforced in the deaf patient if he is admitted to a large psychiatric hospital, because he cannot communicate through speech and lip-reading if he is not in a unit with other deaf patients with whom he might be able to communicate by using sign-language. The stress of this situation for the deaf patient is further increased by the lack of communication skills in the medical and nursing staff caring for him.[5] People generally have little difficulty in understanding and identifying with those who are blind, whereas deafness is a handicap which is much less readily understood because it is not visible.[7]

2.7 In a British study of 170 deaf adults, the majority of whom were profoundly deaf, attending a special psychiatric service for the deaf, the patients were divided into a number of diagnostic groups. The largest group consisted of 72 patients who were diagnosed as suffering from behaviour and maladjustment problems related to their deafness. They were not considered to be suffering from a formal psychiatric illness. Problems of maladjustment are recognised as being extremely common in the deaf.[3] A second group of 56 patients were diagnosed as suffering from mental illness which was coincidental with deafness. A diagnosis of schizophrenia was made in 36 of these patients. Many of the signs of psychiatric illness e.g. the thought disorder of schizophrenia, are appreciated through normal spoken language. Any communication difficulty will interfere with this appreciation.[6] A third group of 22 patients were diagnosed as suffering from what was termed a development disorder of communication, and of this group, 9 patients were suffering from deafness and mental handicap and a further 5 patients suffered from deafness and autism.

2.8 Research studies in the U.S.A. suggest that the prevalence of schizophrenia in the prelingually deaf is similar to that in the hearing population. There is, however, some evidence that paranoid schizophrenia may be more

prevalent among the post-lingually deaf and the hard of hearing than in the general population.[5]

2.9 The characteristics of deafness which are likely to be significant in the causation of paranoid psychosis are:—

early age of onset

long duration

severity of deafness.

The mode of action of deafness in the genesis of paranoid psychosis is most likely to be one in which psychological function and social function change over an extended time-span of years.[4]

2.10 There is a high risk of mis-diagnosis in deaf adults suffering from psychiatric illness who are treated in a setting where the staff are not skilled in the use of sign-language. Abnormal behaviour arising from a psychotic illness may erroneously be ascribed to deafness or vice versa i.e. abnormal behaviour resulting from deafness may be considered to be due to a psychosis.[7]

2.11 A study[9] of six large psychiatric hospitals in this country, undertaken in 1983, by a teacher for the deaf skilled in sign-language, identified a total of 23 (15 male and 8 female) deaf adult in-patients. Each hospital was visited and each patient and the respective medical and nursing staff caring for the patients were also interviewed. Twenty-one of the patients were suffering from severe hearing impairment. The remaining two patients had never attended any special school for the deaf, but were considered to have needed special education, and as a consequence had not developed any expressive means of communication. The age range of the patients was as follows:—

Under age 30 — 4 patients

31-35 — 11 patients

Over 50 — 8 patients

Length of stay in hospital was as follows:—

Less than one year — 2 patients

Between 1-10 years — 4 patients

Period of 11-20 years — 9 patients

More than 21 years — 8 patients

One patient had spent thirty nine years in hospital.

2.12 It is significant that in discussion with the medical staff in the different

hospitals, only seven of the 23 patients were considered by the medical staff to be suffering from a form of psychiatric illness. This did not include four patients who were diagnosed as suffering from mental handicap. There was only one patient given a definite diagnosis of schizophrenia. Twelve of the 23 patients had good sign-language skills and could also communicate adequately by writing. The remainder of the patients had varying degrees of skill in communication. None of the medical staff in the hospitals had any special skills in sign-language. This study suggests the need for a survey in our other psychiatric hospitals to establish the prevalence of severe deafness in the in-patient population, and the presence or absence of an associated formal psychiatric illness.

Support Services For the Adult Deaf

2.13 The principal voluntary organisation providing a support service for the deaf is the National Association for the Deaf (N.A.D.). A social worker who is employed by this association provides a service to the deaf and their families, but is also available on a national basis for the law courts if a communication problem should arise.

2.14 The National Rehabilitation Board employs a youth employment officer to work with school-leavers in special schools for the deaf, the majority of whom finish school aged 15 or 17 years, having completed either the Group or Leaving Certificate Examination. The function of the youth employment officer is to help in placing young deaf adults in suitable employment or in training courses/third level education on leaving school. In addition, each health board area has the services of a placement officer, who is employed by the National Rehabilitation Board, each of whom has a number of deaf adults who are his responsibility. There is also a special placement officer for the deaf, based in Dublin, who acts in an advisory capacity to the regional placement officers working with the health boards throughout the country. The Department of Education employs a special teacher for the deaf who acts as a liaison person and who helps to resolve difficulties between trainees and their supervisors/employers.

2.15 The only hostel accommodation which caters specifically for the adult deaf is at St Joseph's House for Adult Deaf/Deaf Blind, at Brewery Road, Stillorgan, Co Dublin. This hostel was founded in 1965 by the Catholic Committee for the Deaf and its principal objective was to cater for deaf geriatric adults who were living in isolated situations in the community. In recent years, a number of younger people have been admitted to St Joseph's and at present of the total of 37 residents, 17 have formerly been in-patients in psychiatric hospitals for varying lengths of time. The hostel is supervised by the Dominican Sisters from the Dominican Convent in Cabra, who specialise in

the care of the deaf and the deaf blind. The staff includes: resident house-parents, one of whom is a trained teacher of the deaf, visiting medical officer, visiting speech therapist, occupational therapist and teacher of the deaf/blind. The majority of residents are profoundly deaf. One of the criteria for admission to this hostel is that the applicant should be free of any anti-social behaviour, because of the limited supervision available and the number of elderly residents.

Conclusions

1. **There is a need for a survey to be undertaken of all psychiatric hospitals using researchers who are highly proficient in communication skills with the deaf to determine the prevalence of severe hearing impairment and the presence or absence of a formal psychiatric illness in the in-patient population. This survey would give an indication of the number of patients who have been inappropriately placed in our psychiatric hospitals in the absence of suitable alternatives.**
2. **A separate out-patient service should be available in each health board area to the adult deaf presenting for a psychiatric consultation. All staff working in this service should receive special training in sign-language.**
3. **There is a need for supervised hostels for the adult deaf. These would be set up on a pilot project basis, when the results of the in-patient deaf survey have been completed. In association with the establishment of such special hostels for the deaf, a supporting rehabilitation programme will be required so that residents may be trained for placement in open employment. An important member of any rehabilitation team will be a teacher for the deaf who will provide classes to improve the communication skills of both the deaf patients and the staff.**
4. **The staff in the out-patient special service for the deaf should be available to follow-up patients who may be admitted to a psychiatric unit for further assessment and treatment.**
5. **A social worker from every community care programme should be seconded for special training in sign-language with a view to having the social worker available to liaise between the deaf adults, their employers, and family.**
6. **Where a number of deaf patients are resident in a large psychiatric hospital, steps should be taken to ensure that these patients are, wherever possible, brought together in the same unit to reduce the risk of social isolation and to encourage interpersonal communication.**

Appendix 3

Statistics on Psychiatric Services and Staffing

3.1 In this Appendix statistics are presented on:

(a) In-Patient Services

(b) Community Services

(c) Staffing.

(a) In-Patient Services

3.2 Three tables are presented on individual psychiatric hospitals and units. Table 1 deals with health board hospitals and units and shows the number of patients in residence at the end of 1981, 1982 and 1983 together with a break-down of the number of admissions during 1982 in 3 age-groups. Similar statistics in respect of private and special hospitals are given in Tables 2 and 3 respectively. Table 4 summarises Tables 1 to 3 and presents the national picture.

TABLE 1
Health board psychiatric hospitals and units: numbers of admissions during 1982 by age and number of in-patients at 31 December, 1981, 1982 and 1983

Health Board and Hospital	Number of Admissions during 1982				Number of patients in hospital at 31 December		
	Under 45 years	45-64 years	65 years and over	Total	1981	1982	1983
EASTERN							
St. Brendan's	830	469	265	1,564	953	947	932
St. Ita's	361	167	58	586	974	967	930
St. Loman's	840	353	83	1,276	169	172	163
St. Dympna's Alcoholic Unit	172	83	4	259	12	14	11
Unit at Vergemount, Clonskeagh	103	63	27	193	25	29	23
Unit at St. Vincent's, Fairview	326	196	105	627	N.A.	N.A.	N.A.
St. James's	138	121	61	320	45	50	49
Newcastle Hospital, Co. Wicklow	181	136	60	377	103	108	89
Cluain Mhuire	221	111	34	366	79	67	71
St. Patrick's (health board)	N.A.	N.A.	N.A.	N.A.	56	50	61
St. Vincent's, Elm Park	N.A.	N.A.	N.A.	N.A.	24	23	20
Total — Eastern	3,172	1,699	697	5,568	2,440	2,427	2,349

Health Board and Hospital	Number of Admissions during 1982				Number of patients in hospital at 31 December		
	Under 45 years	45-64 years	65 years and over	Total	1981	1982	1983
MIDLAND							
St. Fintan's, Portlaoise	380	251	105	736	406	396	405
St. Loman's, Mullingar	587	423	201	1,211	742	732	719
Total — Midland	967	674	306	1,947	1,148	1,128	1,124
MID-WESTERN							
Our Lady's, Ennis	296	229	102	627	626	609	567
Unit at Regional General Hospital, Limerick	288	194	78	560	23	32	28
St. Joseph's, Limerick	985	481	165	1,631	694	707	640
Total — Mid-Western	1,569	904	345	2,818	1,343	1,348	1,235
NORTH-EASTERN							
St. Brigid's, Ardee	232	141	94	467	235	209	192
St. Davnet's, Monaghan	333	360	152	845	416	389	378
Total — North-Eastern	565	501	246	1,312	651	598	570
NORTH-WESTERN							
St. Conal's, Letterkenny	478	350	179	1,007	502	502	470
Unit at General Hospital, Letterkenny[a]	—	—	—	—	N.A.	N.A.	N.A.
St. Columba's, Sligo	390	291	169	850	587	567	542
Total — North-Western	868	641	348	1,857	1,089	1,069	1,012
SOUTH-EASTERN							
St. Dympna's, Carlow	321	216	80	617	366	392	374
St. Canice's, Kilkenny	168	114	85	367	346	368	323
St. Luke's, Clonmel	315	182	118	615	476	491	450
Unit at St. Joseph's, Clonmel	385	301	185	871	37	43	43
St. Otteran's, Waterford	204	210	76	490	420	390	364
St. Declan's Unit, Ardkeen Hospital	183	140	103	426	29	23	35
St. Senan's, Enniscorthy	228	157	116	501	392	348	327
Total — South Eastern	1,804	1,320	763	3,887	2,066	2,058	1,916
SOUTHERN							
Our Lady's, Cork	547	285	138	970	1,005	1,004	918
Unit at St. Stephen's, Sarsfieldcourt	485	252	113	850	111	113	90
Unit at Regional Hospital, Wilton	408	238	113	759	44	40	52
St. Anne's, Skibbereen	166	145	99	410	12	17	16
St. Finan's, Killarney	355	283	153	791	603	597	605
Total — Southern	1,961	1,203	616	3,780	1,775	1,771	1,681

Health Board and Hospital	Number of Admissions during 1982				Number of patients in hospital at 31 December		
	Under 45 years	45-64 years	65 years and over	Total	1981	1982	1983
WESTERN							
St. Brigid's, Ballinasloe	450	311	126	887	1,030	993	952
St. Mary's, Castlebar	509	316	226	1,051	618	598	583
St. Theresa's Unit at Castlebar General Hospital[b]	N.A.	N.A.	N.A.	N.A.	37	41	43
Unit at Regional Hospital, Galway	291	149	97	537	39	37	38
St. Patrick's, Castlerea	158	163	125	446	264	259	238
Total — Western	1,408	939	574	2,921	1,988	1,928	1,854
TOTAL	12,314	7,881	3,895	24,090	12,500	12,327	11,741

N.A. = not available.

[a]The unit at the General Hospital Letterkenny is used partially by psychiatric patients and the number of patients there is included in those for St. Conals.

[b]The number of admissions for St. Theresa's Unit at Castlebar General Hospital is included with those for St. Mary's, Castlebar.

Source: Number of admissions — Medico-Social Research Board.

TABLE 2

Private psychiatric hospitals: number of admissions during 1982 by age and number of in-patients at 31 December, 1981, 1982 and 1983

Health Board and Hospital	Number of Admissions during 1982				Number of Patients in hospital at 31 December		
	Under 45 years	45-64 years	65 years and over	Total	1981	1982	1983
EASTERN							
Bloomfield, Donnybrook, Dublin	0	0	13	13	57	54	57
Hampstead, Highfield and Elmhurst	4	6	16	26	81	70	68
Kylemore Clinic, Co. Dublin	5	31	34	70	21	24	26
Palmerstown House, Co. Dublin	5	5	0	10	3	5	5
St. John of God, Dublin	663	578	171	1,412	105	117	107
St. Patrick's, James's St. and St. Edmondsbury, Lucan, Co. Dublin[a]	1,000	820	302	2,122	313	322	301
St. Vincent's, Fairview, Dublin[b]	31	31	7	69	160	136	109
Verville Retreat, Clontarf, Dublin	2	5	7	14	50	50	50
Total — Eastern	1,710	1,476	550	3,736	790	778	723
NORTH-EASTERN							
St. Augustine's, Ratoath Co. Meath	0	0	15	15	58	55	56
Total — North-Eastern	0	0	15	15	58	55	56

Health Board and Hospital	Number of admissions during 1982				Number of patients in hospital at 31 December		
	Under 45 years	45-64 years	65 years and over	Total	1981	1982	1983
SOUTH-EASTERN							
Bon Sauveur, Carriglea, Co. Waterford	0	0	0	0	2	2	2
St. Patrick's, Belmont Park, Waterford	361	148	50	559	75	71	79
Total — South-Eastern	361	148	50	559	77	73	81
SOUTHERN							
Lindville, Blackrock Road, Co. Cork	61	60	13	134	36	38	36
Total — Southern	61	60	13	134	36	38	36
TOTAL	2,132	1,684	628	4,444	961	944	896

[a]Number of admissions relate to St. Patrick's only. See Table 1 for health board patients resident in St. Patrick's.
[b]The number of patients in hospital refers to both private and health board patients in St. Vincent's Hospital, Fairview.
Source: Number of admissions — Medico-Social Research Board.

TABLE 3

Special psychiatric hospitals: number of admissions during 1982 by age and number of in-patients at 31 December, 1981, 1982 and 1983

Health Board and Hospital	Number of admissions during 1982				Number of patients in hospital at 31 December		
	Under 45 years	45-64 years	65 years and over	Total	1981	1982	1983
EASTERN							
Central Mental Hospital, Dundrum	162	4	0	166	94	95	96
St. Paul's, Beaumont	8	0	0	8	25	26	27
Warrenstown House, Blanchardstown Road	25	0	0	25	16	14	13
Total — Eastern	195	4	0	199	135	135	136
WESTERN							
St. Anne's, Galway	45	0	0	45	22	[a]22	29
Total — Western	45	0	0	45	22	22	29
TOTAL	240	4	0	244	157	157	165

Notes: The Central Mental Hospital, Dundrum is the national centre for offenders suffering from mental disorders. St. Paul's is a special hospital run by the Sisters of Mercy, Mater Hospital for autistic and emotionally disturbed children and patients are admitted in the same manner as to a general hospital. Warrenstown House, Dublin and St. Anne's, Galway are both centres for emotionally disturbed children run by the Eastern and Western Health Boards respectively.
[a] = Estimate.
Source: Number of admissions — Medico-Social Research Board.

TABLE 4

All psychiatric hospitals and units: number of admissions during 1982 by age and number of in-patients at 31 December 1981, 1982, and 1983 analysed by health board area

Health Board	Number of admissions during 1982				Number of patients in hospital at 31 December		
	Under 45 years	45-64 years	65 yrs and over	Total	1981	1982	1983
Eastern	5,077	3,179	1,247	9,503	3,365	3,340	3,208
Midland	967	674	306	1,947	1,148	1,128	1,124
Mid-Western	1,569	904	345	2,818	1,343	1,348	1,235
North-Eastern	565	501	261	1,327	709	653	626
North-Western	868	641	348	1,857	1,089	1,069	1,012
South-Eastern	2,165	1,468	813	4,446	2,143	2,131	1,997
Southern	2,022	1,263	629	3,914	1,811	1,809	1,717
Western	1,453	939	574	2,966	2,010	1,950	1,883
Total	14,686	9,569	4,523	28,778	13,618	13,428	12,802

Note: This table is a summary of the data contained in Tables 1, 2 and 3. The footnotes relevant to these tables still apply.

Source: Number of admissions—Medico-Social Research Board.

3.3 In Table 5, the number of patients resident in public psychiatric hospitals and units on 31st December, 1983 is summarised by age and length of stay.

TABLE 5

Number of patients resident in public psychiatric hospitals and units at 31 December 1983 by age and length of stay.

Length of stay \ Age	Under 15	15-19	20-44	45-64	65-74	75 and over	All ages	% of Hospital Population
Under 3 months	1	31	587	605	264	122	1,610	13.9
3-12 months	3	10	270	294	154	103	834	7.2
1-5 years	7	18	551	712	412	383	2,083	17.9
Over 5 years	5	11	1,221	3,030	1,674	1,145	7,086	61.0
All lengths of stay	16	70	2,629	4,641	2,504	1,753	11,613*	100.0
% of Hospital Population	0.1	0.6	22.6	40.0	21.6	15.1	100.0	

*The total of 11,613 patients excludes the Health Board patients at Cluain Mhuire Hospital, Dublin and St Patrick's Hospital, Dublin as this information was not available. Patients in special psychiatric hospitals (see Table 3) are also excluded.

Source: Department of Health.

3.4 The decline in the number of patients resident in public psychiatric hospitals and units between 1940 and 1983 is shown in Table 6.

TABLE 6

Number of in-patients in public psychiatric hospitals and units 1940-1983

Year	Number of In-Patients
1940	19,134
1945	17,708
1950	18,677
1955	19,810
1960	19,442
1965	17,594
1970	15,392
1975	13,869
1980	12,212
1983	11,741

Note: In-patients in special psychiatric hospitals are not included.

Source: Department of Health.

3.5 Censuses of patients in psychiatric hospitals and units were carried out in 1963, 1971 and 1981. Table 7 compares the main findings.

TABLE 7

Psychiatric patients in residence by sex, age, marital status, length of stay and diagnosis 1963, 1971 and 1981

		1981	1971	1963
Number of patients in residence at 31 March		13,984	16,661	19,801
Percentage who were:	male	55.3	55.5	54.3
	female	44.7	44.5	45.7
Percentage who were:	aged under 25	4.3	5.9	5.0
	aged 25-64	60.4	63.7	70.0
	aged 65 or over	35.3	30.4	24.9
Percentage who were:	single	79.5	82.2	82.1
	married	13.0	11.8	12.6
	widowed	6.5	5.8	5.3
Percentage who were:	shortstay (less than 1 month)	10.5	7.7	N.A.
	medium stay (1 month to 1 year)	14.4	15.1	N.A.
	long stay (1 year or over)	75.1	77.2	N.A.

	1981	1971	1963
Percentage in each diagnostic category*			
Organic psychosis		10.9	13.8
Schizophrenia		50.1	53.0
Manic depressive psychosis		12.3	12.9
Other and unspecified psychoses		2.1	
Neurosis		3.3	4.9
Personality disorder		1.3	
Alcoholism and alcoholic psychosis		2.4	1.5
Drug addiction		0.1	
Mental handicap		16.1	13.8
Unspecified		1.4	0.1
*Percentage in each diagnostic category			
Organic psychosis	10.2		
Schizophrenia	44.2		
Other and unspecified psychosis	0.4		
Depressive disorders	11.1		
Mania	5.7		
Neurosis	5.7		
Personality disorder	2.1		
Alcohol abuse and alcoholic psychosis	4.9		
Drug dependence	0.1		
Mental handicap	15.5		
Unspecified	0.1		

Note: Some of the diagnostic categories were re-organised for the 1981 Census. The main changes concerned the affective disorders, neuroses and to a lesser extent alcoholism.

Source: Medico-Social Research Board.

3.6 Tables 8 and 9 analyse certain demographic characteristics and the diagnoses of persons admitted to psychiatric hospitals during 1982.

TABLE 8

Admissions to psychiatric hospitals and units, analysed by marital status, age and sex of patients, 1982

	Number	Per cent of all admissions
Total admissions	28,778	100.0
First-time admissions	8,702	30.2
Marital status of patients who were admitted:		
single	13,746	47.8
married	11,701	40.6
widowed	2,298	8.0
unspecified	1,033	3.6

	Number	Per cent of all admissions
Age of patients who were admitted:		
under 25 years	2,760	9.6
25-44 years	11,926	41.4
45-64 years	9,569	33.3
65 years and over	4,523	15.7
Sex of patients who were admitted:		
male	15,672	54.5
female	13,106	45.5

Source: Medico-Social Research Board

TABLE 9

Admissions to psychiatric hospitals and units: Rate per 100,000 population by diagnosis age and sex, 1982

	Sex		Age			
Diagnosis	Male	Female	20-24	35-44	65-74	Total
Organic Psychosis	34.6	38.1	10.8	18.8	169.7	36.6
Schizophrenia	225.2	165.4	224.2	425.5	157.1	195.5
Other and Unspecified Psychoses	2.8	4.4	3.3	7.6	7.6	3.6
Depressive Disorders	162.0	291.3	136.3	368.4	604.9	226.3
Mania	55.9	85.8	48.0	117.7	156.7	70.8
Neurosis	35.3	64.0	54.0	90.5	74.9	49.1
Personality Disorder	40.3	33.7	76.6	57.9	21.9	37.1
Alcohol Abuse and Alcoholic Psychosis	344.8	80.5	112.2	605.4	193.8	213.4
Drug Dependence	8.2	4.7	21.4	11.1	1.6	6.5
Mental Handicap	13.8	10.2	21.7	25.9	5.1	12.0
Unspecified	3.1	3.8	5.6	5.6	4.2	3.4
Total	925.5	782.4	714.6	1,735.4	1,398.6	854.3

Source: Medico-Social Research Board.

(b) Community Services

Day Facilities

3.7 Table 10 compares the number of day facilities for the mentally ill in each health board area in 1981, 1982 and 1983. Table 11 lists the location of these facilities and the number of places in each.

TABLE 10

Day facilities: Comparison of number of day facilities for the mentally ill in 1981, 1982, 1983.

Health Board	Number of Day Facilities		
	1981	1982	1983
Eastern	15	19	20
Midland	—	—	—
Mid-Western	1	1	1
North-Eastern	4	3	4
North-Western	2	2	2
South-Eastern	1	1	1
Southern	3	3	3
Western	6	6	8
Total	32	35	39

Note: The North-Western Health Board also provides limited day care facilities for the mentally ill at 11 geriatric institutions throughout the NWHB area.

TABLE 11

Day Facilities: Location and number of places available in day facilities for the mentally ill 1983

Health Board and Location of Day Facility	Number of Places
EASTERN HEALTH BOARD (a)	
Dun Laoghaire and South East Dublin County	
Centenary House, 35 York Road, Dun Laoghaire, Co. Dublin (St. John of God)	30
Burton Hall, Foxrock, Co. Dublin (St. John of God)	30
Cluain Mhuire Day Hospital, Blackrock, Co. Dublin (St. John of God)	50
Dublin South-East	
Vergemount Day Centre, Clonskeagh, Dublin 6	42
Day Care Centre, 31 Mountpleasant Square, Ranelagh, Dublin 6	40
Dublin South Central	
Day Hospital, Hospital 6, St. James' Hospital, James' Street, Dublin 8 (St. Patrick's Hospital)	50
St. Patrick's Day Centre, St. Patrick's Hospital, James' Street, Dublin 8 (St. Patrick's Hospital)	50
Usher's Island Day Centre, Dublin 8	30
Dublin West and Kildare North	
St. Loman's Hospital Day Centre, Palmerstown, Dublin 20	60
Kilcock Day Centre, Co. Kildare	26
Dublin North West	
St. Brendan's Hospital Day Centre, Grangegorman, Dublin 7	80
Day Centre, 230 North Circular Road, Dublin 7	20
Finglas Training Centre, North Road, Dublin 11	40
Wellmount Park Day Centre, Finglas, Dublin 11	20
St. Dympna's Mews Day Care Centre, North Circular Road, Dublin 7 (Irish Society for Autistic Children)	10
St. Dympna's Day Hospital, North Circular Road, Dublin 7	55

Health Board and Location of Day Facility	Number of Places
Dublin North Central	
St. John's Day Centre, Clontarf, Dublin 3	75
Dublin North East	
St. Francis's Day Hospital, Raheny, Dublin 5	30
St. Ita's Hospital Day Centre, Portrane, Co. Dublin	20
Wicklow	
An Lar Day Centre, Dargle Road, Bray, Co. Wicklow	26
TOTAL EASTERN (a)	784
MIDLAND HEALTH BOARD	
None	—
TOTAL MIDLAND	—
MID-WESTERN HEALTH BOARD	
Day Hospital at Shelbourne Road, Limerick	14
TOTAL MID-WESTERN	14
NORTH-EASTERN HEALTH BOARD	
Day Centre, St. Davnet's Hospital, Monaghan	24
Day Hospital, Cavan, Co. Cavan	35
Day Centre, Dundalk, Co. Louth	26
Day Centre, Drogheda, Co. Louth (held in St. Brigid's Hospital, Ardee pending the opening of a Centre in Drogheda)	17
TOTAL NORTH-EASTERN	102
NORTH-WESTERN HEALTH BOARD	
Day Centre/Day Hospital at St. Conal's Hospital, Letterkenny, Co. Donegal	15
Day Centre/Day Hospital at St. Columba's Hospital, Sligo	20
TOTAL NORTH-WESTERN	35
SOUTH-EASTERN HEALTH BOARD	
Kelvin Grove Day Hospital, Carlow	40
TOTAL SOUTH-EASTERN	40
SOUTHERN HEALTH BOARD	
Ravenscourt Day Hospital, Cork	30
St. Stephen's Hospital Day Hospital, Sarsfieldcourt, Cork	30
Caherina House Day Hospital, Tralee, Co. Kerry	33
TOTAL SOUTHERN	93
WESTERN HEALTH BOARD	
Kilkerrin Support Centre, Co. Galway	7
St. Michael's Day Hospital, St. Mary's Hospital, Castlebar, Co. Mayo	20
Boyle Day Centre, Co. Roscommon	10
St. Patrick's Day Hospital, Castlerea, Co. Roscommon	10
St. Patrick's Day Centre, Castlerea, Co. Roscommon	10
Day Hospital at Regional Hospital, Galway	10
Carraroe Support Centre, Co. Galway	27
Halla Naomh Padraic Support Centre, Galway	18
TOTAL WESTERN	112
GRAND TOTAL	1,180

(a) All of the Day Facilities in the EHB are operated by the Health Board unless otherwise stated.
Source: Department of Health.

Out-Patient Clinics

3.8 Table 12 compares national out-patient statistics in 1975, 1979 and 1983. A breakdown by health board area of the 1983 statistics is given in Table 13.

TABLE 12

Out-patient clinics: comparison of national psychiatric out-patient statistics 1975, 1979 and 1983

Year	Number of Clinic Locations	Number of Patients	Number of Attendances
1975	184	28,054	128,280
1979	205	37,597	183,437
1983	211	45,197	200,321

TABLE 13

Out-patient statistics for year ended 31st May 1983

Health Board	Number of Clinic Locations	Number of Patients	Number of Attendances
Eastern	43	20,991	118,835
Midland	20	2,037	9,189
Mid-Western	17	3,878	17,358
North-Eastern	9	2,161	7,890
North-Western	24	3,824	6,394
South-Eastern	33	3,480	17,936
Southern	28	4,000*	12,781
Western	37	4,826*	9,938*
Total	211	45,197	200,321

*Estimate.

Source: Department of Health.

Hostels

3.9 Table 14 compares the number of hostels for the mentally ill in 1981, 1982 and 1983. A breakdown by health board area of the 1983 statistics is given in Table 15.

TABLE 14

Hostels: Comparison of number of hostels for the mentally ill in 1981, 1982 and 1983

Health Board	1981	1982	1983
Eastern	28	30	32
Midland	3	6	7
Mid-Western	8	8	8
North-Eastern	20	19	20
North-Western	8	9	10
South-Eastern	15	15	16
Southern	8	6	6
Western	5	6	12
Total	95	99	111

TABLE 15

Hostels: Number of hostels for the mentally ill and number of places available 1983

Health Board	Number of Hostels	Number of Places	Number of Places per 100,000 population
Eastern	32	352	29.5
Midland	7	35	17.3
Mid-Western	8	99	32.1
North-Eastern	20	129	44.6
North-Western	10	66	31.7
South-Eastern	16	96	25.6
Southern	6	76	14.4
Western	12	89	26.1
Total	111	942	26.9

Note: The rates for the health boards are based on the 1981 population. The national rate is based on the estimate of the 1983 population.
Source: Department of Health.

Community Workshops/Sheltered Workshops

3.10 Table 16 compares the number of workshops available for mentally ill persons living in the community in 1981, 1982 and 1983.

TABLE 16

Community Workshops/Sheltered Workshops: Comparison of number of workshops available for mentally ill persons living in the community either at home or in a hostel setting 1981, 1982 and 1983.

Health Board	1981	1982	1983
Eastern	5	6	11
Midland	3	3	5
Mid-Western	3	3	4
North-Eastern	1	1	6
North-Western	8	8	9
South-Eastern	4	4	9
Southern	5	7	5
Western	2	3	4
Total	31	35	53

Note: The 1983 summary includes a number of Industrial Therapy Units attached to Psychiatric Hospitals and several Rehabilitation Institute Workshops which are not included in the 1981 and 1982 figures.
Source: Department of Health

(c) Staffing

Nursing Staff

3.11 Table 17 shows the number of staff in the four main nursing grades in each hospital and health board. Table 18 shows the number of senior nursing staff in each hospital and health board. Table 19 summarises the total number of nursing posts in the psychiatric service by grade.

TABLE 17

Nursing Staff employed in health board psychiatric hospitals on 1st April 1984.

Hospital and Health Board Area	GRADE								
	Student Nurse		Staff Nurse		Deputy Charge Nurse	Deputy Ward Sister	Charge Nurse	Ward Sister	Total
	M	F	M	F					
St Brendan's	50	50	164	228	28	23	27	27	597
St Ita's	35	53	157	154	25	25	20	15	484
St Loman's	15	16	43	75	6	8	3	6	172
Newcastle	1	1	20	20	4	2	2	1	51
Eastern	101	120	384	477	63	58	52	49	1304
St Fintan's	1	4	71	61	10	9	9	9	174
St Loman's, Mullingar	7	14	135	124	16	11	14	13	334
Midland	8	18	206	185	26	20	23	22	508
St Joseph's	25	14	101	94	15	10	20	15	294
Our Lady's, Ennis	18	17	86	65	15	15	11	9	236
Mid-Western	43	31	187	159	30	25	31	24	530
St Davnet's	19	9	78	91	14	13	11	9	244
St Brigid's, Ardee	—	—	32	63	6	3	6	3	113
North-Eastern	19	9	110	154	20	16	17	12	357
St Columba's	14	19	86	84	18	10	15	11	257
St Conal's	11	17	71	81	20	18	16	16	250
North-Western	25	36	157	165	38	28	31	27	507
St Canice's	12	15	45	42	8	7	7	6	142
St Dympna's	5	4	34	51	9	7	8	8	126
St. Luke's	11	16	60	58	13	8	11	7	184
St. Otteran's	2	2	52	65	7	6	9	6	149
St Senan's	18	4	51	79	8	7	9	7	183
South-Eastern	48	41	242	295	45	35	44	34	784
Our Lady's Cork[a]	18	33	145	169	62	42	39	26	534
St Finan's	10	12	100	100	14	8	18	16	278
Southern	28	45	245	269	76	50	57	42	812
St. Brigid's, Ballinasloe	7	7	181	172	16	14	19	20	436
St Mary's[b]	4	13	83	98	15	11	16	10	250
St Patrick's	—	—	54	66	8	8	7	7	150
Western	11	20	318	336	39	33	42	37	836
TOTAL	283	320	1849	2040	337	265	297	247	5638
	603		3889		602		544		

[a]Figures include the psychiatric unit, Cork Regional Hospital.
[b]Figures include the psychiatric unit in Castlebar General Hospital.
Note: In addition to the above figures there are approximately 225 nurses working in psychiatric units attached to General Hospitals (excluding Cork Regional Hospital and Castlebar General Hospital).
Source: Department of Health.

TABLE 18

Senior nursing staff employed in health board psychiatric hospitals and units, November, 1984

Hospital/Unit and Health Board Area.	Assistant Chief Nursing Officer	Chief Nursing Officer	Total
St. Brendan's Hospital	13	2	15
St. Ita's Hospital	12	2	14
St. Loman's Hospital	6	2	8
Newcastle Hospital	4	1	5
Vergemount Unit St. Dympna's Unit	Staffed by St. Brendan's Hospital		
St. Patrick's Hospital (H.Bd.) St. James's Unit	Staffed by St. Patrick's Hospital		
St. Vincent's Hospital, Fairview (H.Bd.)	Staffed by St. Vincent's Hospital		
St. John of God Hospital (H.Bd)	Staffed by St. John of God Hospital		
St. Vincent's Unit, Elm Park	1 Unit Nursing Officer	—	1
EASTERN	36	7	43
St. Fintan's Hospital, Portlaoise	7	1	8
St. Loman's Hospital, Mullingar	8	1	9
MIDLAND	15	2	17
St. Joseph's Hospital, Limerick	8	1	9
Our Lady's Hospital, Ennis	8	1	9
Unit at Limerick Regional Hospital	1 Asst. Matron	—	1
MID—WESTERN	17	2	19
St. Davnet's Hospital, Monaghan	8	1	9
St. Brigid's Hospital, Ardee	3	1	4
NORTH—EASTERN	11	2	13
St. Columba's Hospital, Sligo	6	1	7
St. Conal's Hospital, Letterkenny	7	1	8
Unit at Letterkenny General Hospital	Staffed by St. Conal's Hospital		
NORTH—WESTERN	13	2	15

Hospital/Unit and Health Board Area.	Assistant Chief Nursing Officer	Chief Nursing Officer	Total
St. Canice's Hospital, Kilkenny	7	1	8
St. Dympna's Hospital, Carlow	6	1	7
St. Luke's Hospital, Clonmel	7	1	8
St. Otteran's Hospital, Waterford	7	1	8
St. Senan's Hospital, Enniscorthy	7	1	8
St. Michael's Unit, Clonmel	1 Asst. Matron	—	1
St. Declan's Unit, Ardkeen	Staffed by St. Otteran's Hospital		
SOUTH—EASTERN	35	5	40
Our Lady's Hospital, Cork	12	3	15
St. Finan's Hospital, Killarney	6	1	7
St. Stephen's Unit, Sarsfieldcourt	1	1	2
St. Anne's Unit, Skibbereen	Staffed by Our Lady's Hospital		
Unit at Regional Hospital, Wilton			
SOUTHERN	19	5	24
St. Brigid's Hospital, Ballinasloe	12	1	13
St. Mary's Hospital, Castlebar	7	1	8
St. Patrick's Hospital, Castlerea	6	1	7
St. Theresa's Unit, Castlebar	Staffed by St. Mary's Hospital		
Unit at Regional Hospital, Galway.	1 Asst. Matron	—	1
WESTERN	26	3	29
GRAND TOTAL	172	28	200

Source: Department of Health

TABLE 19

Total Number of Nursing Posts Categorised by Grade

Grade	Number of Nurses
Student Nurses	603
Staff Nurses	3889
Ward Supervisory Posts (Including Deputies)	1146
Assistant Chief Nursing Officers	172
Nurses in above grades in general hospital units	225
Chief Nursing Officers	28
Community Psychiatric Nurses	169
TOTAL	6232

Source: Department of Health.

Consultant Psychiatrists

3.12 The number of approved consultant posts in general psychiatry in health board psychiatric hospitals and units in July 1984 is shown in Table 20.

TABLE 20

Number of Approved Consultant Posts in General Psychiatry in Health Board Psychiatric Hospitals and Units

Hospital and Health Board Area	Number of Approved Consultant Posts
St. Brendans (Team 1)	6
St. Brendan's & Vergemount (Team 2)	4
St. Brendan's & St. Vincents Fairview (Team 3)	4
St. Brendan's Special Interest	2
St. Dympna's Alcoholic Unit	2
Garden Hill (Research Unit)	3
St. Ita's, Portrane	5
St. Loman's, Palmerstown	7
Cluain Mhuire	5
Newcastle, Co. Wicklow	3
EASTERN (minus most of Co. Kildare)	41
St. Loman's, Mullingar	7
St. Fintan's, Portlaoise	4
Midland (plus Co. Meath)[a]	11
St. Joseph's, Limerick	5
Our Lady's, Ennis	4
MID-WESTERN (minus Tipperary North-Riding)	9
St. Davnet's, Monaghan	4
St. Brigid's, Ardee	4
NORTH-EASTERN (minus Co. Meath)	8
St. Conal's, Letterkenny	5
St. Columba's, Sligo	4
NORTH-WESTERN	9
St. Canice's, Kilkenny	3
St. Dympna's, Carlow	3
St. Luke's, Clonmel	4
St. Otteran's, Waterford	3
St. Senan's, Wexford	3
SOUTH-EASTERN (plus most of Kildare and Tipperary N.R.)[a]	16
St. Anne's Unit, Skibbereen	3
St. Stephen's, Sarsfieldcourt	4
Our Lady's Hospital, Cork	5
Psychiatric Unit, Cork Regional, Wilton	5
St. Finan's, Killarney	4
SOUTHERN	21

Hospital and Health Board Area	Number of Approved Consultant Posts
St. Brigid's, Ballinasloe	6
Psychiatric Unit, Galway Regional	3
St. Mary's, Castlebar	4
St. Patrick's, Castlerea	3
WESTERN	16
NATIONAL TOTAL	131

Note: Consultant psychiatrists employed in the psychiatric units in Limerick Regional Hospital, Letterkenny General Hospital, St. Joseph's Hospital, Clonmel, Waterford Regional Hospital and Castlebar General Hospital are included with the consultant complement of the psychiatric hospitals in those areas.

[a]The Midland and South-Eastern Health Boards provide psychiatric services for patients outside their areas. St. Loman's Hospital, Mullingar serves Co. Meath (North-Eastern Health Board). St. Dympna's Hospital, Carlow serves most of Co. Kildare (Eastern Health Board) and St. Luke's Hospital, Clonmel serves Tipperary North-Riding (Mid-Western Health Board).

Source: Department of Health.

Clinical Psychologists, Social Workers and Occupational Therapists

3.13 The number of clinical psychologists, social workers and occupational therapists employed in the psychiatric service in each health board is shown in Table 21.

TABLE 21

Number of Clinical Psychologists, Social Workers and Occupational Therapists Employed in the Psychiatric Service, September 1984 by Health Board Area.

Health Board Area	Clinical Psychologists	Social Workers	Occupational Therapists
Eastern	22	13	14
Midland	4[a]	—	1
Mid-Western	4	2	—
North-Eastern	3	—	3
North-Western	2	4	5
South-Eastern	5	—	3
Southern	6	5	12
Western	12	12	7.5[b]
TOTAL	58	36	45.5

[a]Includes one part-time clinical psychologist.

[b]One occupational therapist is assigned 50/50 to Special Hospital Care Programme and Community Care Programme.

Source: Department of Health.

Appendix 4

Estimating the Future Long-term Bed Needs for St. Ita's Hospital, Portrane

4.1 The following approach was adopted by a project team to estimate the bed needs for old long-stay patients at St. Ita's Hospital, Portrane.

4.2 The number of long-stay psychiatric patients, distributed by age, in St. Ita's Hospital at the end of 1982 is shown in Table 4.1.

TABLE 4.1

Existing Long-Stay Psychiatric Patients (excluding mentally handicapped) in St. Ita's Hospital, Portrane 31 December, 1982

Age	Total Number
Under 30 years	3
30-39	12
40-49	46
50-54	26
55-59	56
60-64	73
65-69	58
70-74	78
75-79	70
80-84	46
85 and over	21
TOTAL	489

4.3 The St. Ita's study team considered that, with adequate preparation, about 120 of these 489 patients should be capable of being discharged into a community setting. These would be largely from the under 60 age groups and would leave a total of about 370 long-stay psychiatric patients all aged over 55 years, who would need to remain as hospital in-patients. It could be expected that these would remain in the hospital until they died.

4.4 In order to estimate their life expectancy, age-specific mortality rates were calculated following an examination of the mortality experience of the hospital patients and compared with the mortality rates for the population of the State. The mortality rates used were:

Age	Annual Number of deaths per 1,000 corresponding population
All ages under 60	20
60-64	25
65-69	35
70-74	60
75-79	80
80-84	130
85 years and over	240

4.5 The application of these mortality rates would result in a reduction by death of the remaining long-stay patient population as follows:—

1983 — 369 patients

1988 — 265 patients

1993 — 177 patients

1998 — 107 patients

2003 — 57 patients

Appendix 5

Present Provision of Child Psychiatric Services

Eastern Health Board

5.1 There are three catchment areas for the delivery of child psychiatric services in the Eastern Health Board area, which are assigned to three different services:

1. Eastern Health Board Service, St. James Hospital
2. Mater Hospital Service.
3. Hospitaller Order of St. John of God Service, Orwell Road, Rathgar.

While each area has a comprehensive service, there is some flexibility in relation to the use of specialised units. The Mater Hospital Service and the St. John of God Service also provide a national child psychiatric service.

Eastern Health Board Child and Family Psychiatric Service

Catchment Area: Western County Dublin and South Kildare.

The Eastern Health Board has a Clinical Director in child psychiatry, four consultant child psychiatrists and a full complement of staff on its multidisciplinary teams servicing its out-patient clinics and residential centres. The main services are:

1. Department of Child Psychiatry, St. James's Hospital, Dublin which contains the clinical and administrative base of the service.
2. Ballyfermot Child and Family Centre.
3. Castleknock Child and Family Centre.
4. National Children's Hospital Child Guidance Clinic, Harcourt Street, Dublin.
5. Warrenstown House Residential Treatment Centre for Children and Young Adolescents, Dublin.
6. St. Loman's Hospital Child Psychiatric Unit and Ballyowen Meadows School, Palmerstown, Dublin.

Mater Hospital Child and Family Psychiatric Service

Catchment Area: North East City and County Dublin.

The main assessment and treatment services are:

1. The Department of Child and Family Psychiatry, Mater Hospital, Dublin. This is the clinical and administrative base and also contains a special school.
2. Child and Family Community Clinics, Ballymun.
3. St. Paul's Hospital and Special School, Beaumont.
4. St. Francis's Clinic, Children's Hospital, Temple Street, Dublin.

Assessment and consultative services are delivered to a wide range of medical, community and educational facilities including:

1. Our Lady's Treatment Unit (Community home for adolescent boys).
2. St. Vincent's Children's Home, Goldenbridge, Inchicore, Dublin 6. Group Homes at Phibsboro, Amiens Street and Talbot Houses.
3. Casa Catriona, a special national school at St. Mary's, Cabra, for deaf and language disordered children.
4. Many primary schools throughout the area.

Hospitaller Order of St. John of God

Catchment Area: South East City and County Dublin, Wicklow and North Kildare.

The staff include a Clinical Director, three full-time and two part-time consultant child psychiatrists, and full complement of multidisciplinary staff. Assessment and treatment resources include:

1. Child and Family Services, Orwell Road, Rathgar. This is the administrative and clinical headquarters, and includes a pre-school unit, a special primary school and a residential unit.
2. Child and Family Centre, Tallaght.
3. St. John of God Family Service Cluain Mhuire, Blackrock, Co. Dublin. As well as providing comprehensive psychiatric services to the South County Dublin area, this centre has a pre-school unit and in addition specialises in adolescent psychiatry with access to St. John of God's Hospital, Stillorgan for in-patients when required.
4. Our Lady's Hospital for Sick Children, Crumlin. Out-patient clinic and liaison and consultative child psychiatry to the hospital. Children are admitted to the hospital where required.

Midland Health Board

5.2 The service is provided by the board's consultant child psychiatrist, in association with psychologists and social workers from the community care programme on a part-time basis. The service headquarters is at St. Loman's Hospital, Mullingar, and regular clinics are held in Mullingar and in Tullamore, Athlone, Longford, Navan, Trim and when required in Portlaoise.

Mid-Western Health Board

5.3 The Mid-Western Health Board does not have its own child psychiatric service. Children with emotional problems are seen by the psychiatrists attached to the Brothers of Charity Services in Limerick, and others are referred to the child psychiatric services in Cork, Galway and at times to Dublin.

North-Eastern Health Board

5.4 The North-Eastern Health Board does not have its own child psychiatric service. However, County Meath is served by the child psychiatrist from the Midland Health Board. In addition, a child psychiatrist from Dublin holds a regular clinic in Dundalk.

North-Western Health Board

5.5 The North-Western Health Board does not have its own child psychiatric service. At present patients are referred to the Western Health Board Services, and also to child psychiatrists in Dublin.

South-Eastern Health Board

5.6 The South-Eastern Health Board does not have its own child psychiatric service. Outside child psychiatrists hold clinics within the Health Board area liaising with the board's own community care psychologists and social workers. In this way child psychiatrists from Dublin service clinics in Wexford and Kilkenny, and a child psychiatrist from Cork holds a clinic in Clonmel.

Southern Health Board

5.7 There are two catchment areas for the delivery of child psychiatric services in the Southern Health Board area which are assigned to two different services:

1. Southern Health Board Child Psychiatric Service.
2. Brothers of Charity Service.

Southern Health Board Child Psychiatric Service

Catchment Area: North Lee area of Cork City and North County Cork.

Pending the recruitment of a consultant child psychiatrist, consultants from the Brothers of Charity provide consultant cover to the nuclear child guidance team. Services include:

1. The Young People's Residential Unit at St. Stephen's Hospital, Sarsfieldcourt, for assessment and treatment of emotionally disturbed children and adolescents.
2. Regular child guidance clinics are held in Cork city twice weekly, and on a monthly basis in Mallow and Bantry.

Brothers of Charity Service

Catchment Area: South Lee area of Cork City, West Cork and County Kerry.

The Brothers of Charity have two consultant child psychiatrists with a full complement of staff on the multidisciplinary teams. Services include:

1. Our Lady of Good Counsel, Lota, Glanmire, Co. Cork. This is the clinical and administrative base for this service. There is an assessment and treatment unit with special schools for children with autism, developmental delays, communication disorder and mental handicap. Regular clinics are held.
2. Child and Family Clinic, Victoria Road, Cork. This provides a regular child psychiatric service with a pre-school unit for children with communication disorder, developmental delay and behaviour disorders.
3. Marymount Training Centre, Cork, Residential Unit for Junior Adolescent Girls. In addition, consultative services are offered to a wide range of community and educational facilities, including community hostels for adolescents.

Western Health Board

5.8 The service is delivered by the Western Health Board's child and adolescent pyschiatric staff. These include a Clinical Director, a consultant child psychiatrist with two multidisciplinary teams and other staff.

Assessment and treatment resources include:

1. St. Annes' Children's Centre, Taylor's Hill, Galway. The clinical and administrative headquarters is located here. In addition there is a special primary school. It has a day and residential assessment and

treatment unit for pre-adolescent and adolescent children, and in addition out-patient clinics are held.

2. Lyradoon Family Centre, 65 Lower Salthill, Galway.
3. Department of Child and Family Psychiatry, Regional Hospital, Galway. This provides consultative and liaison child psychiatry in the hospital with access to beds when required. In addition, out-patient clinics are held.
4. Regular out-patient clinics are held in: Health Centre, Ballinasloe; County Clinic, Roscommon; County Clinic, Castlebar; Health Centre, Ballina; Ionad Shlainte, An Ceathru Rua.

Assessment and consultative services are delivered to a wide range of medical, community and educational facilities including:

—St. Joseph's Residential Home, Lower Salthill, Galway.

—Aisling Residential Home, Ballyloughane Road, Renmore, Galway.

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Appendix 2

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