

TRINITY COLLEGE
UNIVERSITY OF DUBLIN

**A STUDY TO ESTABLISH THE EXISTING MENTAL HEALTH DATA
COLLECTED IN THE HEALTH SERVICE EXECUTIVE AND THE
INFORMATION SYSTEMS USED.**

BY

CAROL IVORY

A DISSERTATION SUBMITTED TO THE FACULTY OF HEALTH SCIENCES IN
PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE
OF MASTER OF SCIENCE IN HEALTH SERVICES MANAGEMENT

DUBLIN
SEPTEMBER, 2008

DECLARATION

This dissertation has not been submitted as an exercise for a degree at this or any other University. This dissertation is entirely the work of the student named on the cover.

The candidate agrees that the Library may lend or copy the dissertation upon request.

This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Signed _____

ACKNOWLEDGEMENTS

Taking on a course of study at postgraduate level is never undertaken by an individual alone. In my case I was lucky to have the support of my husband and family who were always willing to listen to real and imagined woes and to provide the necessary advice and counselling.

I was also fortunate in the support I was offered, and took full advantage of, from my supervisor, Professor Charles Normand, and from all of the staff in the School of Health Services Management. I would particularly like to thank Charles, Mandy, Stephanie and Donna for their support at key times with help, advice and kind words.

I would like to acknowledge the considerable support I received from my colleagues in the HSE, particularly those working with me in Naas without whom this work would not have been concluded.

Finally, I want to thank my fellow students on the course, particularly John, Elizabeth and Mags for their good humoured friendship throughout the two years on the course

Carol Ivory

September 2008.

SUMMARY

In order to reduce the burden of mental health issues, it is important to obtain valid and reliable information about the mental health system. Problems caused by a lack of information include a deficient planning process, impeded accountability, incapacity to monitor change promoted by mental health reforms, and the potential for developing ad hoc solutions before understanding the situation (Saxena et al. 2007). In Ireland, most of the activity of mental health services is carried on in the community. Unfortunately, most of the data collected on mental health service provision in Ireland relates to inpatient settings. It is timely therefore to look at the pattern of data collection within the Irish Mental Health Services, to identify the nature and type of information gathered and by whom it is used. It is also opportune to paint a picture of the information systems currently in place.

The literature confirms that there is some limited information available relating to activity in the mental health services and information collected by agencies other than the service provider, i.e. the Health Research Board and the Mental Health Commission. It is not clear what data is collected across all mental health settings in Ireland, nor how detailed nor how complete it may be. The literature notes the types and kinds of data that can be used to plan, manage and develop health services, but not whether there is sufficient data collected by the mental health services in Ireland to support the services to deliver quality.

A Descriptive Study using Quantitative methods was undertaken by taking a Census of all mental health services using an Anonymous Survey Questionnaire. The participation of those with the knowledge and expertise of producing or using the data, and/or managing the services was sought and the Area Administrators were identified as having the requisite knowledge. An alternative approach was required to ensure the inclusion in the study of all of the sub-specialties, and acknowledging the potential for some duplication, it was decided to contact all of the consultant psychiatrists in each of these sub-specialties. Appropriate Ethical Approval and Gatekeeper access permission was obtained. The draft data collection instrument and associated documentation was piloted with a combination of experts and pseudo-participants and amendments to the data collection instrument made as a consequence.

As a courtesy, a letter introducing the study was sent to each of the Local Health Managers seeking their support for the participation of the services in the survey. A total of 175 surveys issued to the participants and the response rate was 34% ranging from between 65% for the Area Administrators to 1% from the mental health intellectual disability services. A total of 82 service settings are represented by the respondents.

Data relating to the management of the care of individual service users is collected by almost all of the respondent mental health services. Other information collected is limited to that required by the Health Research Board and the Mental Health Commission. There is a focus on budget, activity information and staffing levels but little information on outcomes or costs. Services rely on the Health Research Board and the Mental Health Commission for any analysis of the information provided and for comparison information with other services in Ireland. Many mental health services only collect service level information when required by regulation or an agency external to the organisation. Less than 50% of services reported on a range of information to their immediate line management. 80% of services report to the Local Health Manager on progress on new developments, with information on budget, expenditure, staff number, types and grades and vacancies also provided by about 50% of services. Less than 50% of all of the respondents provide information to the HSE at a national level.

This study provides a comprehensive picture of the landscape of data collection across the mental health services nationally. It identifies the data elements collected at case level, episode level, facility level and system level and highlights the deficits at facility and system level. It provides an indication of data collection practice across all of the mental health specialties. It confirms the expectation raised in the literature that the data is collected by manual means and suggests that where electronic systems are used it is to support the provision of care to the individual.

The pattern of data collection identifies a systemic issue of confusion in relation to accountability and confirms the isolation of mental health service provision within the health services. It clarifies that there is no information system within the mental health services, rather the system is a reporting system with all of its associated issues, including unreliable and inconsistent data collection, disinterest and lack of understanding of its purpose among the staff required to carry out the work and, most significantly, the abdication of responsibility to agencies with no role in the planning, management and delivery of mental health services.

CONTENTS

Declaration	iii
Acknowledgements	v
Summary	vii
Table of Contents	ix
List of Tables	xiii
List of Appendices	xv
Introduction	1
The Irish Position	1
Literature Review	4
Introduction	4
Literature Search Strategy	4
Review of Literature – The Policy Context	6
<i>Health Policy in Ireland</i>	6
<i>Performance Measurement in Ireland – The Quality Agenda</i>	7
<i>Quality in Mental Health Services – Measurement</i>	8
<i>Health Information in the Irish Context</i>	9
<i>Information about Mental Health Services in Ireland</i>	11
<i>A Mental Health Information System?</i>	13
Review of the Wider Field of Literature	14
<i>Information Systems</i>	14
<i>Issues with Data Collection</i>	15
<i>Developing and Implementing Datasets</i>	17
<i>Perceptions in use of indicators for performance measurement</i>	20
<i>Postal Surveys – implications of the methodology</i>	20
Gaps in Literature	21
Methodology	22
Introduction	22
Research Methodology	22
Participant Identification	23
Access Negotiation	24
Ethical Approval Processes	24

<i>Trinity Ethical Approval Application</i>	24
<i>Local Ethical Approval Process</i>	25
Pilot Phase	25
Data Collection	26
Data Analysis	27
Limitations of Study and Implications for Future Research	27
Results	28
Introduction	28
Survey Sample	28
Profiles of Services/Services	29
What data is currently collected?	31
<i>Service User Data</i>	31
<i>Clinical information</i>	34
<i>Activity Information</i>	35
Information collected by other Agencies	36
<i>Data collected by the Health Research Board</i>	36
<i>Data collected by the Mental Health Commission</i>	37
Waiting List Information	39
Purpose and Use of Data	40
Data collected by Mental Health Services for any purpose	45
Planning and managing the delivery of the service	48
What information is needed to plan services?	50
The management of information	51
Methods of Data Collection	53
Discussion	56
Introduction	56
Supporting Service Delivery	56
<i>Management of the Service User Journey – Episode and Case Level Data</i>	57
<i>Management of Mental Health Service – Facility Level</i>	58
<i>System Level Data Collection</i>	59
<i>Information needs at National Level</i>	60
Why Collect Information?	61
Views of Mental Health Services	62

Systems by which data is collected in the Mental Health Services	63
Where next for Data Collection in the Mental Health Services – a Proposal for a National Minimum Dataset?	64
Conclusion and Recommendations	67
References	69

LIST OF TABLES

Table 1 – Survey Returns per Sub-Specialty	29
Table 2 – Mental Health Service Settings	30
Table 3 – Service User Information collected by Service Type	32
Table 4 – Percentage of each type of Service User Data collected by Mental Health Service	33
Table 5 – Clinical Information collected by Mental Health Services	34
Table 6 – Clinical Information by Service Type	34
Table 7 – Activity Information by Mental Health Service	35
Table 8 – Information submitted to Health Research Board (HRB) by Mental Health Services	36
Table 9 – Data provided to Mental Health Commission (MHC)	38
Table 10 – A comparison of the data collected by the HRB and MHC	38
Table 11 – Waiting Time Information collected by Mental Health Services	39
Table 12 – Detail of services which collect waiting time information	40
Table 13 – Data provided to Mental Health Services Catchment Teams	42
Table 14 - Data provided to Local Health Managers	43
Table 15 – Data provided to HSE Corporate	44
Table 16 – Data collected by between 100% and 70% of Mental Health Services	46
Table 17 – Data collected by between 60% and 20% of Mental Health Services	47
Table 18 – Format in which information is returned to Mental Health Services	48
Table 19 – Format in which information is returned by Service Type	49
Table 20 – How best might information usefully be returned to Mental Health Services	50
Table 21 – Information needed to plan and deliver Mental Health Services	50
Table 22 – Who collates the information in Mental Health Services	52
Table 23 – Administrative Support available to Mental Health Services	52
Table 24 – Information Systems used	53
Table 25 – Paper Systems used	54
Table 26 – Types of Electronic System used.	54

LIST OF APPENDICES

Appendix 1- Search Criteria	72
Appendix 2 – Ethical Approval Documentation	77
a. Letter to Gatekeeper and Data Controller	77
b. Reply from Gatekeeper and Data Controller	78
c. Letter requesting permission to contact Mental Health Services	79
d. Letter granting permission to contact Mental Health services	80
e. Letter to Participants	81
f. Participant Information Leaflet	83
g. Letter to Local Health Managers introducing the study	85
h. Letter from Faculty of Health Sciences, TCD granting Ethical Approval	86
Appendix 3 – Data Collection Instrument	87
a. Draft Data Collection Instrument	87
b. Data Collection Instrument	92

INTRODUCTION

The World Health Organization (WHO) estimated that 450 million people world wide experience mental health difficulties (Health Service Executive, 2008) or, alternatively, that one quarter of those using the health services have a mental health problem, many of which are undiagnosed.

When measured by years lived with disability and years lost as a result of premature death in disability-adjusted life years, psychiatric and neurological conditions accounted for 13% of the global burden of disease in 2002, because many of these conditions are chronic, recurring and quite disabling. These figures, however, do not capture other types of burden associated with mental disorders, including the burden of caregiving for family members, financial costs, stigma, human rights violations (Saxena et al. 2007).

In order to reduce the burden of mental health issues, it is important to obtain valid and reliable information about the mental health system. Unfortunately a number of countries are handicapped by the lack of information available on their mental health systems. Some countries have information systems, but these systems are typically neither comprehensive nor appropriate for mental health planning. Problems caused by a lack of information include a deficient planning process, impeded accountability, incapacity to monitor change promoted by mental health reforms, and the potential for developing ad hoc solutions before understanding the situation (Saxena et al. 2007).

The Irish Position

Mental health services in Ireland began in the 18th Century with the establishment of the first asylums, one in Dublin, St Patricks, founded by Dean Swift and one in Cork, founded by Dr William Saunders Hall Aran. The 19th Century began with a recommendation in 1804 for the building of four provincial asylums in Ireland, each to have 250 beds. Legislation was enacted to establish asylums for the “lunatic poor” in Ireland (Health Service Executive, 2008). The period of expansion of the asylum can be attributed to the effect of very broad admission policies which saw large numbers of people who had nowhere else to go being admitted. These included those with behavioural problems, the aged, the infirm, and those with physical and intellectual disabilities. “These admission policies were still in place quite recently in Ireland, at least into the middle of the twentieth century” (Department of Health and Children, 2006: 241).

The survival of this hospital oriented approach is largely due to the absence in Ireland of a social care system. Therefore “from a societal perspective, the institutions represented an economic way of dealing with a whole range of social problems” (Department of Health and Children, 2006:242). This culminated in a situation where “the institution as a means of dealing with

illness or infirmity in any form became a deeply rooted Irish practice which still leaves its influence despite the modern development of alternative methods of care” (Robins, quoted in Department of Health and Children, 2006; 242).

The modernisation of the mental health services in Ireland began with the introduction of the Mental Treatment Act, 1945 which aimed to address what were perceived as the abuses of the system and was considered a progressive piece of legislation for its time. However, it did not address the trend to institutionalisation. From 1966, with the Report of the Commission of Inquiry on Mental Illness, through the policy shift to community based services outlined in 1984 by Planning for the Future (Department of Health and Children; 1984) and most recently in the Report of the Expert Group on Mental Health Policy - A Vision for Change (Department of Health and Children, 2006); a substantial transformation has taken place in Irish mental health services, reflecting the international focus of mental health best practice.

“Most of the activity of mental health services is carried on in the community, in publicly funded mental health services. This means that people with mental health problems are typically seen in outpatient settings, in day hospitals and day centres and at home. Only a small minority of these individuals are admitted to inpatient care” (Department of Health and Children, 2006; 53).

Unfortunately, most of the data collected on mental health service provision in Ireland relates to inpatient settings and there is a dearth of information as to what happens within mental health services other than in terms of the number of admissions or attendances.

The absence of concrete information relating to the provision of mental health services in Ireland has limited the ability of providers to advocate for additional funding as they are unable to adequately demonstrate the efficacy of the services being delivered. For service users and carers, the absence of reliable information on the quality of services delivered and the impact of interventions received makes it difficult to navigate the services. This militates against the development of evidence-based service planning, management and delivery and impacts on service user involvement in the provision of services. It is difficult to hold services accountable for the public funds which they receive and almost impossible to demonstrate inequities in service provision.

From a management perspective, it is difficult to get an accurate picture of the nature and efficacy of the mental health services provided in Ireland. Historically, the mental health services developed within the asylum and psychologically this inward focus and self reliance remains in the culture of the mental health services wherever care is delivered. Recent reform in

the health service has moved health care to a single delivery system, yet the information necessary to support a national delivery system is unavailable or fragmented and unreliable.

It is timely therefore to look at the pattern of data collection within the Irish Mental Health Services, to identify the nature and type of information gathered and by whom it is used. It is also opportune to paint a picture of the information systems currently in place. This study proposes therefore to establish the nature and level of data collected by the public mental health services, the systems by which this data is collected and the uses to which this information is put in planning and managing the services.

LITERATURE REVIEW

Introduction

Mental health information, and the systems to handle that information, are essential for all aspects of the mental health care system. For policy makers and planners, accurate and comprehensive mental health information provides the means for establishing goals and quality indicators for mental health care in the country, and assessing whether these are being achieved. For mental health professionals providing mental health services, this information is essential for assessing the needs of service users and for monitoring their response to interventions. For people using mental health services, and the wider population, the availability of mental health information means they can be informed about the services they can receive and their likely outcomes (WHO, 2005).

In order to establish what is currently known about what data is captured by the mental health services and the uses to which it is put, I have reviewed the Irish health policy documents relevant to the area and in particular the recent policy developments within mental health. I have also looked for international comparisons and identified work carried out in other jurisdictions on the development of mental health datasets and/or information systems. Finally I looked to source studies in Ireland, Europe and in the wider international academic field where researchers had sought to establish information systems within the mental health service.

Literature Search Strategy

I approached the search for literature relevant to the proposed study by identifying the relevant policy literature in the area. I began by reviewing the published policy literature such as the National Health Strategy - Quality and Fairness (Department of Health and Children, 2001) and Health Information – A National Strategy (Department of Health and Children, 2003). I then narrowed the focus to consider specific mental health policy, the Report of the Expert Group on Mental Health Policy – A Vision for Change (Department of Health and Children, 2006), and the Quality Framework for Mental Health Services (Mental Health Commission, 2007). In addition I reviewed the unpublished work that PA Consulting carried out for the Mental Health Commission – A Scoping Exercise on Mental Health Information Systems in Ireland, 2006. I also had regard to the unpublished Proposal for a Mental Health Minimum Dataset Document prepared jointly by the Mental Health Commission and the Health Research Board. These last two documents were specifically concerned with my area of interest, the information needs of the Irish mental health services to support them in planning, managing and delivering services.

I also identified internal policy and discussion documents within the HSE which discussed performance indicators and minimum datasets and reviewed them where they were available (Reid; 2006, ERHA; 2004). I had discussions with senior managers familiar with the area of

performance indicator reporting and reporting on the service plan which gave me background to the history of the area in relation to mental health services.

From this reading I identified a number of topics which I used as keywords to search the academic databases for research and discussion documents.

The main databases searched were ABI Inform/Global, ATHENS, CINAHL, ProQuest, PubMed, Cochrane and Web of Science. I used the following keywords in varying combinations: “Performance Indicators”; “Performance Measurement”, “Public Sector”, “Mental Health”, “Minimum Dataset”; “Performance Evaluation”, “Information”, “Information Management”, “Quality Measurement” as I considered that they adequately reflected my area of interest.

The only other criterion I used was to look for full text English language articles within the last 10 years.

Other than the declared mental health policy documents, the searches of the academic literature did not identify many articles relevant to my area of interest. Combinations of search terms such as “Performance Indicator”, “Public Service”, “Mental Health” and “Minimum Dataset” produced no results from Athens database and a very small number of relevant articles from CINAHL, Web of Science and ABI Inform. Using substitute terms such as “evaluation”, performance management” and “quality measurement” also returned little of relevance, the bulk of the articles treating performance and evaluation in human resource terms. Use of the terms in combination with “information systems” produced literature relating to technological developments and informatics, much of which is not relevant to the environment within which the mental health systems operate at present.

I was directed to other articles and papers of interest from the examination of the policy document references and related websites, particularly those of the Mental Health Commission, the Department of Health and Children, the Health Research Board, the Institute of Public Administration, the Economic and Social Research Institute, and the World Health Organization. I was also directed to further academic articles of relevance to the study by forward and backwards tracing the articles identified in the searches.

The full search criteria and results are in Appendix 1 attached.

Review of Literature – The Policy Context

I will now consider recent health policy developments in Ireland and in particular, the centrality of information to delivery of quality health services.

Health Policy in Ireland

“Quality assessment, measurement and improvement combined with professional development are now an integral part of most Western health systems and services” Mental Health Commission (2006;8).

Across Europe, different countries are looking at different ways to demonstrate the impact of, and measure the improvement in, the delivery and management of health services.

In Ireland, this approach has been firmly at the heart of government policy since the 1990s. Quality was one of the principles of the 1994 health strategy, *Shaping a Healthier Future* (Department of Health and Children, 1994). The theme was developed in the 2001 strategy document *Quality and Fairness* (Department of Health and Children, 2001) in the four stated goals:-

1. Better Health for Everyone
2. Fair Access
3. Responsive and Appropriate Care Delivery
4. High Performance.

In the context of the Health Service Reform programme, responsibility for the delivery of health and personal social services nationally were placed on the Health Service Executive (HSE) under the Health Act, 2004. The HSE in its Corporate Plan 2005-2008 has stated -

“Our Mission for the future is to provide high quality, integrated health and personal social services built around the needs of the individual and supported by effective teamworking” (HSE; 2005; 17).

This thinking is developed as follows:

“We will:-

- Promote health and empower people to maintain their own health
- Provide easily accessible services
- Take decisions based on evidence
- Deliver the best possible care within available resources” HSE (2005;17).

This focus on delivery of quality services based on evidence-based decision making, by implication requires a system by which information relating to the performance of the health system can be collected, analysed and evaluated. The focus on quality has been paralleled by an expectation that performance will be measured.

The National Health Strategy - Quality and Fairness (Department of Health and Children, 2001) and Health Information – A National Strategy (Department of Health and Children, 2004) place health information centrally in the delivery of quality health services. Quality information on health across the spectrum of health services, but also on the health of the population, will support evidence-based decision-making in the health sector.

Performance Measurement in Ireland – The Quality Agenda

Performance monitoring has been a key focus of government, via the Department of Finance, in respect of public expenditure, particularly in the last 15 years. Various monitoring frameworks have been used to access information to demonstrate the return on the increased investment in public health services. Michelle Butler, in her discussion paper Performance Measurement in the Health Sector (Butler;1999), concluded that a range of approaches are being taken in Ireland to develop performance measurement, along similar lines to those across other health systems. She also notes that the development of performance measurement is generally being driven from the centre. She considers that performance measurement currently appears to be very focussed on acute health care but interest is being expressed in looking at other healthcare settings. (Butler;1999).

Before we can take steps to improve the quality of healthcare, we need to define what quality care means and how best it can be assessed and measured. “Quality is a difficult concept to define, and an individual’s perception of what constitutes a quality service is likely to differ depending on whether they are users, providers or are involved in the allocation of resources. One comprehensive definition of service quality is that of Ovretveit ...Fully meeting the needs of those who need the service most, at the lowest cost to the organisation within limits and directives set by higher authorities. Implicit in this definition is the assumption that service quality must be viewed from at least three perspectives; the consumer perspective, the professional health care perspective and the managerial perspective” Quinn (1992).

An Irish study noted the importance of measurement in providing a quality service: “Quality in health care services is neither a simple or apolitical issue. Quality is a complex concept and how it is defined and measured has important consequences for the services. The definition and measurement of service quality in health care has slipped from the professional toward managerial control. Professionals such as nurses have an absolute concept of quality which is

part of their value system and based upon their training and experience. Managerial concepts of quality may be influenced by other organisational concerns such as the pursuit of efficiency” Shaw (1997). He further noted that “...the form service evaluation takes can have a major impact upon service quality. In particular...current systems of evaluation have the potential of mistaking quality for efficiency” Shaw (1997).

Therefore, “the design of a performance measure and how good it is depends on several factors; the purpose of the measure, the entity whose quality is being measured, the dimension of quality being measured, the type of measure and who will use the measure” Eddy (1998).

Michelle Butler (1999) carried out a comparative review of the development of performance measurement systems in Australia, New Zealand, the UK, the USA and Canada. The report concluded that the focus of performance measurement across these countries is on improving health outcomes, improving quality of care, achieving national priorities and reducing inequalities in health. “The concepts of performance measured include health improvement/outcomes, effectiveness and quality, the patient orientation of services, access and financial/resource management...In terms of the development of performance measures, the findings emphasise the need to move beyond an emphasis on finance and activity towards more balanced sets of measures and to focus on generating information that is useful to decision makers. The findings also highlight the need to shift the emphasis from compliance with processes to focusing on results” Butler (1999).

Quality in Mental Health Services - Measurement

The Mental Health Commission has recently published its Quality Framework for Mental Health Services in Ireland (Mental Health Commission, 2007). Its aim is that the mental health services will use the standards as a guide to good service delivery and quality improvement. The framework also facilitates the mental health service to monitor its own performance against the standards and to act as a driver for change in mental health policies, practices and standards at local and national level.

The Framework is set around eight Themes which reflect different aspects of service provision and quality standards. Theme 8 is “Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services”.

This is subdivided into three sub-themes or objectives:-

- 8.1 “The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols.

- 8.2 Mental Health Services are supported and informed by an integrated mental health system
- 8.3 Corporate Governance underpins the management and delivery of the mental health service” Mental Health Commission (2006; 17).

While all of the sub-themes reflect the need for performance measurement, 8.2.1 recommends the development of a National Mental Health Information Framework that will ensure coherent, efficient and effective management of mental health information for policymakers, government departments, mental health service providers, service user representatives, advocacy groups and non-governmental organisations (Mental Health Commission, 2006).

Sub-theme, 8.2.2, adapts the steps recommended by the World Health Organisation (WHO, 2005) which state that the development of an integrated mental health system needs to start small and build incrementally while keeping the big picture aims in focus. One of the initial steps is to establish a minimum data set, which a mental health information system with an agreed governance framework would collect. Another key standard is consultation with stakeholders to ensure buy in (Mental Health Commission, 2006).

In July 2007, the Mental Health Commission and the Health Research Board produced a Proposal for a Mental Health Minimum Dataset. A small working group was asked to consider literature and best practice internationally, to draw together the main datasets currently in use in Ireland, define the function of the minimum health data set and produce governance guidelines for such a dataset.

“Using the recommendation of the World Health Organisation’s Package on Mental Health Information Systems (2005), the group then considered what the main indicators for mental health services in Ireland might be. Indicators determine what data should be collected, and this exercise helped to clarify what the items in the dataset might be” Mental Health Commission and Health Research Board (2007:6).

The proposed dataset includes 48 items in total, 28 relating to individual service user level, 19 at service/facility level and 2 at systems level in respect of general adult mental health services, rehabilitation and mental health service for older people. The document does however recommend that data items also be collected for the other services not included in their recommendations. It is suggested that one national minimum dataset with subsets as required for particular specialties would be appropriate. In addition, the working group did not consider the issue of implementing the recommended dataset (MHC/HRB, 2007). My study partially

addresses this deficit by looking at issues arising for the implementation of this proposal.

Health Information in the Irish Context

“There is a perception that health information is a bureaucratic activity, peripheral to the provision of health care, and that money spent on the people and technology needed to support health information would be better spent on providing “real” health care. This has impacted spending on health information and as a consequence, Ireland, as a nation, suffers from a deficiency of health information” Department of Health and Children, (2006: 202).

Demonstrating performance in health service delivery has been a recurring theme in government health strategy. Consideration has been given to the information available to the system to demonstrate performance against set government targets and to provide the evidence for the planning, managing and evaluation of health services. This fundamental dependency was formalised in the National Health Information Policy published by the Department of Health and Children in 2004. However, the pace of implementation of the Strategy has been impeded by a number of controversies such as that around PPARS (Personnel and Payroll System for HSE) and, more recently, the electronic voting system.

Commitment to the aims of the Strategy was restated recently in the National Agreement – Towards 2016 “the implementation of the National Health Information Strategy recommendation in respect of the use of a system of a unique patient identifier and the development of an electronic healthcare record will contribute to establishing an holistic picture of individual need as well as providing data to aid the development of high quality and cost effective health services to address those needs” Department of Finance, (2006:52).

Despite the slow pace of implementation of the Strategy it would appear that the focus on information is being maintained. Peter Lennon considers the role of information in his seminal book on the impact of Freedom of Information and Data Protection legislation on the sector. “The Irish health system is an information intensive sector. Daily, there are thousands of contacts between members of the public and health service professionals, with personal health information being collected in a variety of settings over the lifetime of the individual for a number of specific and general health-related purposes. These contacts invariably give rise to some record for clinical, management, insurance, legal or other purpose” Lennon (2005:12).

Despite the recent structural and organisational reform within the health services, service providers are not integrated, parts of the service being delivered by independent contractors or organisations and parts by public providers directly. In such an environment, it is not possible for any one organisation or government department to determine the nature and quality of the

information to be collected (Lennon, 2005). However, “common to all the new bodies – and the reform process generally – is the unequivocal recognition that better healthcare must be built on improved information systems and greater use of technology” Lennon (2005; 14).

This is echoed by the National Health Strategy, itself, “To meet the objectives of the Health Strategy and to deliver the quality of health services that people require, information is needed which is appropriate, comprehensive, high quality, available, accessible and timely. Good information systems based on fast, effective flows of shared information are, therefore, essential to the success of the Strategy” Department of Health and Children (2001).

The National Health Information Strategy also acknowledged that “there are many barriers to finding, accessing and using information, especially due to the fragmented, non-standard and incremental way in which information is collected and processed by the agencies involved. Client/patient care records still continue to be mainly paper based” Department of Health and Children (1994;8).

“It is of critical importance that available health information, especially information that flows from operational sources (i.e. data routinely collected as an intrinsic part of service delivery) is properly integrated and firmly embedded, as the evidence base is the mechanism that has the greatest impact on the health of the nation.” Department of Health and Children (2004;9).

Yet, “ensuring that the necessary information is properly collected, used, managed and disclosed to greatest effect poses a challenge that goes far beyond the administrative and technological structures in the health system” Lennon (2005;27).

It is clear therefore that Irish health policy recognises the pivotal role of information within the planning, management and delivery of health services and acknowledges the deficits overall within the existing system. I will now consider how far this is reflected within my specific area of interest, the mental health services, and what information is currently available within those services to plan, manage and deliver a quality service.

Information about Mental Health Services in Ireland

There are a number of sources of information published in respect of mental health services, through the auspices of the Health Research Board. The Health Research Board’s mission is to improve people’s health through research and information. The National Psychiatric In-Patient Reporting System (NPIRS) has provided information on the inpatient mental health services for the last thirty years. The data is provided to the Health Research Board (HRB) directly from the

acute in-patient facilities .

A small amount of community based activity is also returned to the HRB from the sites piloting its COMCAR (Community Care) system. This is in the process of complete revision in conjunction with HSE.

In addition a national psychiatric census annually gathers data relating to in-patients in psychiatric facilities and high support community residences nationwide.

The Mental Hospitals Inspectorate, now under the aegis of the Mental Health Commission, has also gathered information on the mental health services while carrying out its inspections. It has published in its annual reports, details of the sectors covered by the mental health services, the annual budget (as provided by the services), and the specific developments in each mental health service and specialty.

“These reports have been the only published source of information on community mental health services nationally. The information is of variable quality and doesn’t generally address the needs of services for broader information of high quality delivered in a timely manner. In particular, none of these reports have the individualised data required to report on service outcomes.” Department of Health and Children (2006:205).

The Mental Health Commission has also begun to collect information directly from the services, and it records activity within the Tribunals, the numbers of service users detained involuntarily, the numbers of children in adult approved centres and other activity such as the use of ECT.

Having reviewed the available information in respect of the mental health services, the Report of the Expert Group on Mental Health Policy – A Vision for Change (Department of Health and Children, 2006) makes specific recommendations in respect of actions that need to be taken to address the information deficit which it identified. It does acknowledge that only a small number of mental health services have computerised mental health information systems and notes that “mental health services are provided differently around the country according to local and historical circumstances, [and therefore] a nationally defined mental health information IT system may be too unwieldy to develop and implement” Department of Health and Children, (2006). However, it makes the following recommendation “A national mental health minimum data set should be prepared in consultation with relevant stakeholders” Department of Health and Children, (2006: 208). It describes the proposed minimum data set as a nationally agreed data set that is designed to meet national needs for information required to plan, monitor and evaluate services. It recommends that this be formulated in conjunction with the relevant

stakeholders but that policy makers and planners have central input. (Department of Health and Children; 2006:208).

A Mental Health Information System?

“Information systems are an essential planning tool: They are a way of providing accurate, consistent information about a mental health service; they assist with coherent planning; and they are essential for policy implementation and evaluation. Information systems are also a service delivery tool to assist service providers with recording and monitoring the needs of individual service users; they provide a means of reporting the interventions that are used, and can be linked to the ongoing improvement of service quality. Information systems improve effectiveness by enabling the measurement of indicators explicitly determined by the policy framework of the mental health service. They also enable effective monitoring of the clinical interventions that are used. In addition, they improve efficiency by measuring how well a service is using its resources. As a tool for measuring need and coverage, the MHIS addresses a central challenge facing the mental health service, namely, providing equitable care with scarce resources (WHO, 2005;3).

In 2005, the Report of the Inspector of Mental Health Services highlighted a number of issues that were having a negative effect on the range and quality of services available to service users. The lack of information management capabilities within the mental health services was one of the central issues highlighted.

The 2006 Report commissioned by the Mental Health Commission, and carried out by PA Consulting, identified that “the current approach to knowledge and information management within the mental health service results in a number of issues that limit or hinder the effective delivery of services to service users. These include:-

- Information which is inaccessible or unrecorded;
- Islands of information within and across service providers;
- duplication of data and information;
- inaccuracies and data errors;
- data and statistics that are not shared or cannot be shared between agencies” PA Consulting, (2006:1).

PA Consulting were asked to complete a scoping exercise on mental health information systems in Ireland (in both inpatient and community mental health services) with a limited consideration of mental health information systems elsewhere. The aim was “to provide an objective account of issues surrounding the implementation, development and use of mental health information systems with recommendations on the most effective way to implement such a system,

identifying potential pitfalls and highlighting benefits. It was intended to provide a framework for the development of a national mental health information system” P.A. Consulting; (2006, 2).

While acknowledging that information was required on all mental health services, this study limited itself to the general adult mental health services on the basis that information systems in the specialties such as child and adolescent mental health services and psychiatry of old age among others were in their infancy, if existing at all. The study also acknowledged the different management structures for some of these services and so decided to exclude them from the scope of the study (PA Consulting, 2006;2). I have identified this as a gap I hope to address in my own study.

Review of Wider Field of Literature.

Having considered the policy situation in Ireland, I will now consider the articles and international policy literature related to my area of interest. In particular I will look at how other countries approached the issue of data collection and how it related to the development of information systems in healthcare environments. In that context I will look at other academic studies in the area of data collection and measurement and consider if any of the methods used could contribute to my own work.

Information Systems

The literature in the area of information systems tends not to distinguish between types of systems which collect information. The World Health Organisation’s work on developing a Mental Health Information System (WHO, 2005;24) suggests that a distinction needs to be drawn between reporting systems, research projects and information systems as methods of collecting data. A *reporting system* is where data is collected from the bottom up, from local areas to central government and there is little or no data or information return to the providing services. “As a result, those who gather the data feel undervalued and exploited and frequently express their resentment by returning incomplete forms and poor quality data” WHO, (2005; 24).

Research Projects are unable to be information systems because they are usually stand alone projects and often the data relates only to a specific area or issue.

“*Information Systems* are sustainable methods of gathering, analysing, disseminating and using information that are built into the workings of a mental health services and are designed and implemented by those who continue to participate in mental health services, its planning, management, delivery and evaluation” WHO (2005;24).

In the 1998 study “The importance of developing an informatics framework for mental health”, Rigby, Lindmark and Furlan looked at identifying the opportunities and related development work associated with applying informatics to mental health. They noted that “although mental health services are important in human terms and account for a tenth of health expenditure, they are not well serviced in informatics developments....There are clear benefits to holding records in an integrated, patient-based format but the information contained therein is relatively inaccessible unless it is held to a common structure and purpose”. They noted the need to develop a common language of care. Mental health records need to aggregate data from multiple locations and to be available immediately in multiple locations. Means of representing the needs of patients and nature of resources such that matching can be optimised need to be addressed from the information viewpoint (Rigby et al, 1998).

Issues with data collection

The literature identifies a range of issues to be considered in developing information systems.

Data Collection:- Often the purpose for which the data is being collected is unclear both to the people gathering and collating the information and the recipient of the information which tends to be, at present, at a national level. “This contributes to the problem of unreliable and inconsistent data returns. Data collected are often of poor quality. Sometimes, clinicians are not informed as to why they are required to gather data and how it will be used.”(Robey & Lee, 1990 quoted in WHO, 2005; 20).

It also can lead to situations where data collected for one purpose is used for a different purpose entirely. This situation is noted in an article by Miriam Wiley (2005) relating to the use of HIPE (Hospital Inpatient Enquiry System) data in which she responds to criticism of the system. She reiterates that much of the criticism arises from an erroneous view of the purpose of the HIPE data collection system. It is tempting in the absence of information to use the information available without having regard to the reason for which it was gathered. This can lead to bad decision making.

Processing. “A large proportion of the data collected goes straight to the national level without being used locally (De Kadt, 1989). Frequently, information systems are designed primarily for senior managers and policy-makers and not for use by the service staff and managers at the recording and reporting level” WHO (2005;20).

Analysis. “Much of the data collected and processed remains unanalysed. If it is analysed, the analysis often consists of simple aggregations that lack denominators or are inaccurate. The

aggregation of data at higher levels often prevents data from being sufficiently specific for appropriate local application” WHO (2005;20).

When information is available, it is tempting to assume that it gives a complete picture of what is being assessed. There is a reason for accumulated data being called “indicators”. This is because many of the important inputs are intangible and difficult to count. As Einstein said “Not everything that counts can be counted, and not everything that can be counted, counts” (as quoted in Freedman; 2006:59).

Sometimes data is collected but not used or analysed. This can often be a consequence of reporting systems where data is collected for a particular purpose but when focus shifts the system continues to collect data because it has always been collected.

Dissemination. “There is an oversupply of inappropriate data; health service supervisors and peripheral health workers rarely receive feedback on the data reported to higher levels (Robey & Lee, 1990); and often, report findings are not accessible to policy-makers and planners” WHO (2005;20).

Use. Information may be available but is not used. At the managerial level, training is needed on how to use the information and to generate appropriate and relevant questions (Finau, 1994). There is often a lack of information-sharing and coordination within the health sector (Robey & Lee, 1990) and between sectors” WHO (2005).

Resources. Information systems are often overcentralised, and not enough staff time is devoted to information collection and management. Often, the resources allocated to information systems are insufficient. In some instances, limited resources are spent on inappropriate systems, which could be worse than not using any resources at all (WHO, 2005).

“These problems are made worse by changes in the health system as a whole, in terms of both structure and staff turnover. With regard to structure, many health service systems are undergoing considerable reform, reorganization and decentralization, including changes in funding sources and mechanisms. Information systems should therefore be designed to take into account such changes, yet rarely is there a detailed definition of the new functions and responsibilities resulting from systems reform. This results in the information systems seldom serving the new management’s requirements” WHO (2005;20).

Developing and Implementing Datasets

In scanning the literature on the topic I identified a number of studies which looked at developing or implementing minimum datasets or information systems for health organisations or systems.

In 2000, the development of a national agreed diabetes minimum dataset for New Zealand was reported. The study was rooted in facilitating quality initiatives and consisted mainly of reviewing existing datasets and proposing a draft dataset for consultation with the provider organisations. The objective in the final instance was to “determine, finalise and gain widespread agreement on a recommended minimum diabetes dataset for New Zealand” Simmons, Coppel and Drury (2000;44).

The methodological approach was to review existing diabetes datasets and identify elements which included process, intermediate and outcome measures. These were identified as being more suitable for paper audit and benchmarking work with limited resources. A second more comprehensive dataset was identified including more measures which would be suitable for electronic audit and detailed benchmarking. Other measures that could prove useful locally or regionally were also identified. Each of the data elements was defined and the completed proposals were distributed to providers. The material returned was collated by one individual and the numbers agreeing or disagreeing with each data element were counted. Note was also taken of the comments made. In total 147 agencies were contacted, with only 18% responding (Simmons et al, 2000).

There are a couple of interesting aspects to this approach to developing a minimum dataset. The study built on previous work which had delivered a number of competing datasets. The researchers clearly were familiar with the systems, manual or electronic, available to the provider agencies and tailored the proposed minimum dataset accordingly. Unfortunately, either from lack of interest or the material being distributed inappropriately, the return results were very disappointing. The details of the person or section within the agencies targeted with the survey are not given in the report, so it is difficult to assess if another approach would have a better return.

The issues raised in the comments or feedback from respondents echo those identified in much of the material on data collection. A clear purpose for the collection of the information was identified as important. The size of the dataset was important as it impacted on ability to collect, willingness to collect and accuracy of returned information. Conversely, the dataset was criticised for too narrow a focus; clearly a balance needs be drawn between competing needs.

Also, one respondent noted that a lot of the information was already accessible. At no stage was the basic concept of a minimum dataset challenged (Simmons et al; 2000).

At around the same time as the work was being undertaken in New Zealand, work was being carried out in England looking at creating a computerised information system for English mental healthcare providers (Glover, Sinclair-Smith; 2000). The study formed part of the background work for this. The paper described a survey carried out to indicate the feasibility of using current systems to produce patient centred statistics about the work of the service. The work built on a previous survey which indicated that many of the NHS Trusts at the time collected different items of information on different computer systems which meant that collation of the information collected would be a complex task. The survey described in this paper set out the proportion of trusts that had some data collection mechanism for each area of data, whether that collection was computerised, how many different computer systems were involved and how readily data from them could be combined (Glover, Smith, 2000). The study also identified other aspects of the organisations' activities which could influence their ability to produce the dataset, including imminent organisation changes and restructuring.

Aspects of this study could be useful in trying to carry out similar work in the Irish context. I propose to survey the HSE service providers to establish the data collection mechanisms in place, whether manual or electronic and the types of data currently being gathered. From this perspective I think that the methodology used in this study could inform my study.

Glover and Sinclair-Smith defined their study population as the English NHS Trusts providing significant mental health services but excluding learning disabilities and child and adolescent services. They identified that they would survey the heads of information in the Trusts and ask them to nominate a general manager or clinical director for further discussion. Preliminary enquiries identified the heads of information and a letter introducing the study and signed by a senior official in the Department of Health issued. Telephone interviews were conducted which covered the Trusts operational scope, the degree of formulation and standardisation of clinical policies, current and planned information systems and the use of numerical measures of patients condition and progress. Information systems held on paper only were also covered, as the existence of these makes computerisation easier and were clearly identified as such. The general manager or clinical director was also interviewed about policy areas in the Trust. Interviews were semi-structured and additional probe questions were asked to establish the depth and robustness of developments as appropriate (Glover, Sinclair-Smith, 2000;519).

The response rate was 77% in this study which contrasts sharply with the response rate in the New Zealand study. In my view the careful preparation for the study in writing the introductory

letter supported by the senior official in the Department of Health was key. Further, the researchers also followed up intensely with the Trusts slow in responding but they note that they did not always succeed in interviewing both heads of information and general managers for each Trust.

The outcome of the study was to present a picture benchmarking each of the Trusts against the requirements to introduce an information system to return patient centred information. The study identified broad timelines within which each of the Trusts should be in a position to implement the requirements in full. However, as with the study in New Zealand, participants in the survey also made general observations. They identified difficulties in developing systems for use by all clinical staff because of the “democratic” culture where all clinical groups had a voice in what systems should do. The adversity of clinicians to what is perceived as bureaucracy was also noted. Further a sense was given that developments in information gathering did not support the task of looking after people. As with the earlier study, it was considered that government had limited appreciation of the complexities of gathering information in the diverse and geographically dispersed activity of mental health care. The study concludes that “clear consistent messages about what information the Department needs are wanted” (Glover, Sinclair-Smith, 2000;521).

For the purposes of my study, I think that some of the elements of this work could support my methodology. I want to describe the landscape within which it is proposed to introduce a national minimum dataset, I also want to elicit the views of service professionals as to what information is important to them to collect in order to support them to plan, manage and deliver mental health services.

It is worth noting that a sister paper to the one considered above describes a pilot project for the development of a mental health clinical database to cover all aspects of the care of the patient and to accommodate the complexity of care which may last from weeks to years (Glover, 2000). “Those managing and planning health services are increasingly being called upon to ensure optimal clinical outcomes and a good experience of treatment for patients, while using resources parsimoniously. In England, this new agenda is termed “clinical governance” (Glover, 2000; 523). This accurately reflects the requirements and expectations on the Irish mental health services arising from the Report of the Expert Group – A Vision for Change (Department of Health and Children, 2006) and the Quality Framework for Mental Health Services (Mental Health Commission, 2007). For my study, I propose to survey the services to identify what, if any, clinical measurements are currently in place reflecting the outcome of mental health service intervention.

Perceptions in use of indicators for performance measurement

Valenstein, Mitchinson, Ronis, Alexander, Duffy, Craig and Barry (2004) surveyed frontline mental health care providers to elicit their perceptions of widely used indicators for quality monitoring in mental health services. A survey was distributed to a stratified random sample of 1,094 eligible mental health care providers at 52 Department of Veterans Affairs' facilities and elicited perceptions of 21 widely used indicators in five quality domains (access, utilization, satisfaction, process and outcomes). The data was analysed with descriptive and multivariate methods. Most of the mental health care providers (65%) felt that feedback about these widely used indicators would be valuable in efforts to improve care; however only 38% felt able to influence performance related to these monitors and just 13% were willing to accept incentives/risk for their performance. Providers were most positive about satisfaction monitors and preferentially included satisfaction, access and process monitors in performance sets to measure overall quality.

Commonly used monitors for mental health services include measures of access (eg time to first appointment after hospital discharge), utilisation (eg average length of stay), care processes (eg adequate trials of anti-depressants for patients with major depression), and outcomes (eg changes in scores on standardised psychiatric rating scales). (Valenstein et al; 2004;147). I drew on some of the measures identified in this study in drafting my data collection instrument.

Postal Surveys – implications of the methodology

In a 1997 US Study, Asch, Jedrzejewski and Christakis looked to characterise response rates for mail surveys published in medical journals; to determine how the response rate among subjects who are typical targets of mail surveys varies; and to evaluate the contribution of several techniques used by investigators to enhance response rates.

The mean response rate among mail surveys published in medical journals is approximately 60%. However, response rates vary according to subject studied and techniques used. Published surveys of physicians have a mean response rate of 54% and those of non-physicians have a mean response rate of 68%. Another US study looking at indicators for quality monitoring in mental health services noted that "Psychiatrists were less likely to return the survey than psychologists, nurses and social workers. Providers at small teaching hospitals were more likely and those at large teaching hospitals less likely to return the survey, compared with providers at other hospitals. There were no differences between respondents and non-respondents in gender, individual facility or region of the country" Valenstein et al. (2004; 150).

Asch et al also found that multivariable models suggest that written reminders provided with a copy of the instrument and telephone reminders are each associated with response rates about

13% higher than surveys that do not use these techniques. Other techniques, such as anonymity and financial incentives are not associated with higher response rates.

Bearing in mind the associated limitations, I consider that an anonymous survey questionnaire mailed to participants is the most relevant instrument for my study.

Gaps in Literature

A policy objective to address the dearth of information in relation to the mental health services in Ireland has been identified. The literature confirms that there is some limited information available relating to activity in the mental health services and arising from the implementation of the provisions of the Mental Health act, 2001. We have some understanding of the information collected by agencies other than the service provider, i.e. the Health Research Board and the Mental Health Commission.

What we do not know is what data is collected across all mental health settings in Ireland, nor how detailed nor how complete it may be. Although the literature comments on the types and kinds of data that can be used to plan, manage and develop health services, it is not clear whether there is sufficient data collected by the mental health services in Ireland to support the services to deliver quality.

Emphasis is placed in the literature on the timeliness and appropriateness of the information necessary to support evidence based decision-making and comment is made on the lack of integration in service delivery in the health services in Ireland. While some work was done by PA Consulting in establishing existing mental health information systems, this was limited to general adult mental health services in order to reduce complexity in carrying out the study .

In carrying out my study I hope to describe the data activities of all of the mental health services, including the specialties. I will be looking for information relating to their data collection methods, the uses to which the data is put, the feedback loop relating to information provided to management, nationally, and to other agencies and also the systems by which this information is gathered, whether manual or electronic. On the basis of the information provided by the mental health services, I will consider the likely implications that arise for the mental health services from the proposed minimum dataset. In so doing, I aim to address some of the knowledge gaps highlighted in this Review.

METHODOLOGY

Introduction

The objectives of the study are:-

1. To establish the existing level of data relating to Mental Health Services in HSE, to identify gaps and common features;
2. To establish the purpose and use of that data and the methods by which the data is collected;
3. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

The research is intended to answer the following Research Questions:-

1. What data is currently collected and by what method?
2. For whom and to what purpose is the data collected and what use is made of the data?
3. Does it measure what it was intended to measure and can it be used to assess service delivery?

This chapter sets out in detail the research methodology followed and the processes used to carry out the research.

Research Methodology

Having considered the various research methodologies, I have chosen to do a Quantitative study. The purpose of the study is to present a clearer picture of the existing pattern of data collection, the ways in which the data is collected, and for whom, and to what purpose, the data is collected. This study is not attempting to assess the quality of the service provided from any perspective but is seeking to identify the data which the service collects and the purposes for which that is collected. Current data collection and information systems can then be considered in light of the recommendations in the literature relating to a mental health information system and the information required by the mental health services to plan, manage and deliver quality services. The implications of these findings will be relevant for the implementation of the Proposed National Minimum Data Set for Mental Health (Mental Health Commission, 2007).

Having reviewed the policy documents and literature available in the area and identified the gap in available knowledge about the data used by the mental health services in Ireland in planning, managing and delivering services, I am seeking to identify the data by which the mental health service is currently described and an objective viewpoint is fit for my purpose. I will carry out a

Descriptive Study using Quantitative methods. I will take a Census of all mental health services using an Anonymous Survey Questionnaire.

A census of all of the mental health services would help identify what the different types of mental health service collect as data. Because of the historical development of the mental health services both in the context of the old health board structure and the tendency towards specialisation within the mental health service itself, there is no information nationally to indicate if there is data held in common.

An Anonymous Survey will encourage a greater participation in the research and achieve as wide a representation of all aspects of the mental health services as possible.

Participant Identification

From the researcher's experience and from discussions with people involved in the collection and analysis of data within the Primary, Community and Continuing Care Directorate of the Health Service Executive, it was decided to invite the participation of those with the knowledge and expertise of producing the data or using the data, and/or managing the services. The Area Administrators were identified as a cohort of individuals with the requisite knowledge. These senior managers form part of the of the mental health services catchment management teams. A list of the mental health catchment management teams is held in the Office of the Assistant National Director, Mental Health, Office of the CEO and permission was given by the Assistant National Director to access the contact details available. However, it became clear that the list needed to be validated. Each catchment management team was contacted by phone to verify contact details.

One of the interesting outcomes of the exercise was the difficulty that was encountered in getting verification of the names and contact details of the clinicians and members of the catchment management teams. Contact was made through secretarial support in the main and a reluctance to give the details was encountered in many of the contacts. However, fully verified contact lists were finalised and it was decided to issue an invitation to participate to each of these teams.

Another outcome of the exercise was the understanding that the catchment area management structure did not comprehensively cover the mental health services nationally and that an alternative approach was required to ensure the inclusion in the study of the child and adolescent mental health services, the psychiatry of later life services, forensic, rehabilitation and intellectual disability mental health services, around the country.

In order to address this deficit, and in full knowledge of the potential for some duplication, it was decided to contact all of the consultant psychiatrists in each of these sub-specialties. These participants also represent those who produce the data and are responsible for managing the service. A process was required to validate contact details for these services as well.

Access Negotiation

The establishment of the Health Service Executive has meant a restructure of responsibility for the mental health services within the Primary, Community and Continuing Care Directorate. Day to day management is the responsibility of the local service within the Local Health Office with budgetary responsibility held by the Local Health Manager. In some cases, mental health services catchments straddle county and local health office boundaries. In order to access the services, permission was sought from the Assistant National Director with lead responsibility for mental health in the Primary, Community and Continuing Care Directorate and was granted by letter dated 14th January 2008.

It was also necessary to seek Data Controller permission to use the contact details for the services held in the Office of the Assistant National Director, Mental Health, Office of the CEO. This was granted by letter dated 14th January 2008.

As the mental health services fall under the line management of the Local Health Manager, a letter was written to each of the Local Health Managers advising them of the intention to contact the mental health services in their area, seeking their support for the aims of the study and asking them to encourage the mental health services to participate in the survey, where appropriate.

The majority of participants were invited to participate through their employment. However, in respect of the consultant psychiatrists working in the area of intellectual disability, contact was made with an individual consultant psychiatrist known to the researcher and his advice was to request a contact list from the Faculty of Learning Disability Psychiatry of the Irish College of Psychiatrists. Permission was granted for the Faculty Administrator to circulate the data collection materials on the researcher's behalf.

Ethical Approval Processes

Trinity Ethical Approval Application

An application was made to the Faculty of Health Sciences Ethics Committee on 30th November 2007 for consideration at the meeting of the Committee on 18th December 2007. The application was submitted on the approved form with copies of the draft data collection instrument, a draft Participant Invitation Letter, a draft Participant Information Leaflet and copies of letters seeking Gatekeeper permission to access the mental health services from the Assistant National Director,

Primary, Community and Continuing Care Directorate with responsibility for mental health and Gatekeeper permission to access the contact information held by the Office of the Assistant National Director, Mental Health, Office of the CEO.

Feedback was received on 8th January 2008 and on 5th February 2008, an amended participant invitation letter was submitted. Approval to carry out the Study without further audit was granted by letter dated 22nd February 2008 from Dr Orla Sheils, Chairperson of the Faculty of Health Sciences Ethics Committee.

Local Ethical Approval Process

On 4th December, 2007, contact was made with all of the non-hospital based ethics committees listed as approved under the clinical trials legislation, by letter and email. Contact was also made with any ethics committee whose details had been provided following informal enquiries in the mental health services. The following ethics committees were contacted:-

1. HSE-Midland Area Ethics Committee
2. HSE- Mid-Western Area Ethics Committee
3. HSE- North Eastern Area Ethics Committee
4. HSE South Eastern Area Ethics Committee
5. Letterkenny General Hospital Ethics Committee

These Ethics Committees covered the proposed area of study.

Between January 2008 and March 2008 each of the ethics committees responded in turn. Approval was granted from all of the ethics committees except where the Ethics Committee confirmed that ethical approval was not necessary.

In respect of the HSE-North Eastern Area Ethics Committee, as the pilot was to be conducted in that area, it was excluded from the scope of my survey.

Pilot Phase

In order to test the approach to the identified group, the draft data collection instrument and associated documentation was piloted with a combination of experts and pseudo-participants.

A number of experts in the area of mental health service delivery and data collection and analysis were identified, including a number of pseudo-participants from HSE-North East and the draft materials were circulated by email on 22nd February, 2008. The participants in the pilot were asked to review the materials in light of their experience of the services. They were invited

to give their views on the survey instrument, how it was to answer, whether they considered the questions relevant, clear and easily understood, whether any questions were unnecessary in light of the objectives of the study, and whether they had any suggestions to improve it as an instrument.

Of the original seven participants in the pilot, six responded in detail with suggestions relating to the ordering of the questions, clarification of terminology and additional questions to be considered. One respondent suggested asking the survey participants to identify themselves to facilitate follow up on responses. The draft survey questionnaire and revised questionnaire are provided at Appendix 3 for reference.

As a consequence of the pilot, some questions and vocabulary in the draft questionnaire were modified to ensure that it was understandable. Also, additional questions were added relating to the waiting list information collected by each team, the administrative support available to each team and how information requests to the team were responded to and by whom. Further opportunity for the views of the participants relating to the use of the information, waiting lists and administrative support was provided in the form of free text space on the questionnaire.

Data Collection

On 11th April, 2008, a letter to thirty Local Health Managers nationally (excluding two in the pilot area) was issued, introducing the research and advising them that it was planned to contact the mental health services in their area by survey. Some background to the study aims and objectives were provided and their support in encouraging the involvement of the mental health services in their area was requested. In response the researcher received a number of telephone calls and letters from Local Health Managers, agreeing to support the study and looking forward to the findings of the study.

On 18th April, 2008, twenty-six surveys were issued to the Area Administrators of the general adult mental health services nationally (excluding the pilot area). On 23rd April, seventy-eight surveys were issued to the Consultant Child and Adolescent Psychiatrists identified from the Consultant Appointment Unit list. On the same date, seven issued to Consultant Liaison Psychiatrists, nine to Consultant Psychiatrists in Rehabilitation, twenty-two to Consultant Psychiatrists of Old Age and three to Consultant Forensic Psychiatrists. A further eighteen surveys were issued to Consultant Psychiatrists working with adults with Intellectual Disability.

In line with the permission received from the Faculty of Learning Disability Psychiatrists of the Irish College of Psychiatrists, thirty surveys were sent to the Administrator of the Irish College of Psychiatrists with an undertaking that they would issue the week beginning 5th May.

On 6th May, 2008, reminders were issued to the one hundred and sixty-three contacts made directly by the researcher, requesting a response by 23rd May, 2008.

Data Analysis

The data provided in the returned surveys will be analysed using the statistical package SPSS Version 14. The expected output is tables and figures of descriptive statistics using frequencies and cross tabulation.

RESULTS

Introduction

The objectives of the study are:-

1. To establish the existing level of data relating to Mental Health Services in the HSE, to identify gaps and common features;
2. To establish the purpose and use of that data and the methods by which the data is collected;
3. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

The research is intended to answer the following Research Questions:-

1. What data is currently collected and by what method?
2. For whom and to what purpose is the data collected and what use is made of the data?
3. Does it measure what it was intended to measure and can it be used to assess service delivery?

Survey Sample

As mentioned in the Methodology Chapter, participants in the study were invited from those with responsibility for providing the data from the mental health services or those who were responsible for managing the services or both. In order to canvass the widest representation of services to participate in the study, all of the Area Administrators and all of the Consultant Psychiatrists in the sub-specialties of mental health were asked to participate. A total of 175 surveys were issued, 163 directly from the researcher and a further 12 through the Irish College of Psychiatrists (number adjusted to account for possible duplication). 66 surveys were returned of which 6 were invalid being incomplete. The valid response rate was 34% and the response rate between sub-specialties varies between 65% among the Area Administrators, to 1% response from the mental health intellectual disability services. A full breakdown of the responses is in Table 1 below.

Table 1 – Survey Returns per Sub-Specialty

Service Type/Catchment	No. Surveys Issued	No. Returned completed	Percentage
Catchment Management Teams	26	18	65%
C&A Psychiatrists	78	28	35%
Liaison	7	1	14%
Psychiatry of Old Age	22	5	22%
Rehabilitation	9	5	55%
Forensic	3	1	33%
ID (adjusted for duplication)	30	2	1%
Total	175	60	34%

The mental health catchment teams mainly cover general adult mental health services, psychiatry of old age services and rehabilitation services. However, in some areas of the country, as with the other sub-specialties of psychiatry, different management structures prevail. The responses received represent a total of 82 mental health service settings nationally.

Profiles of Services/Service

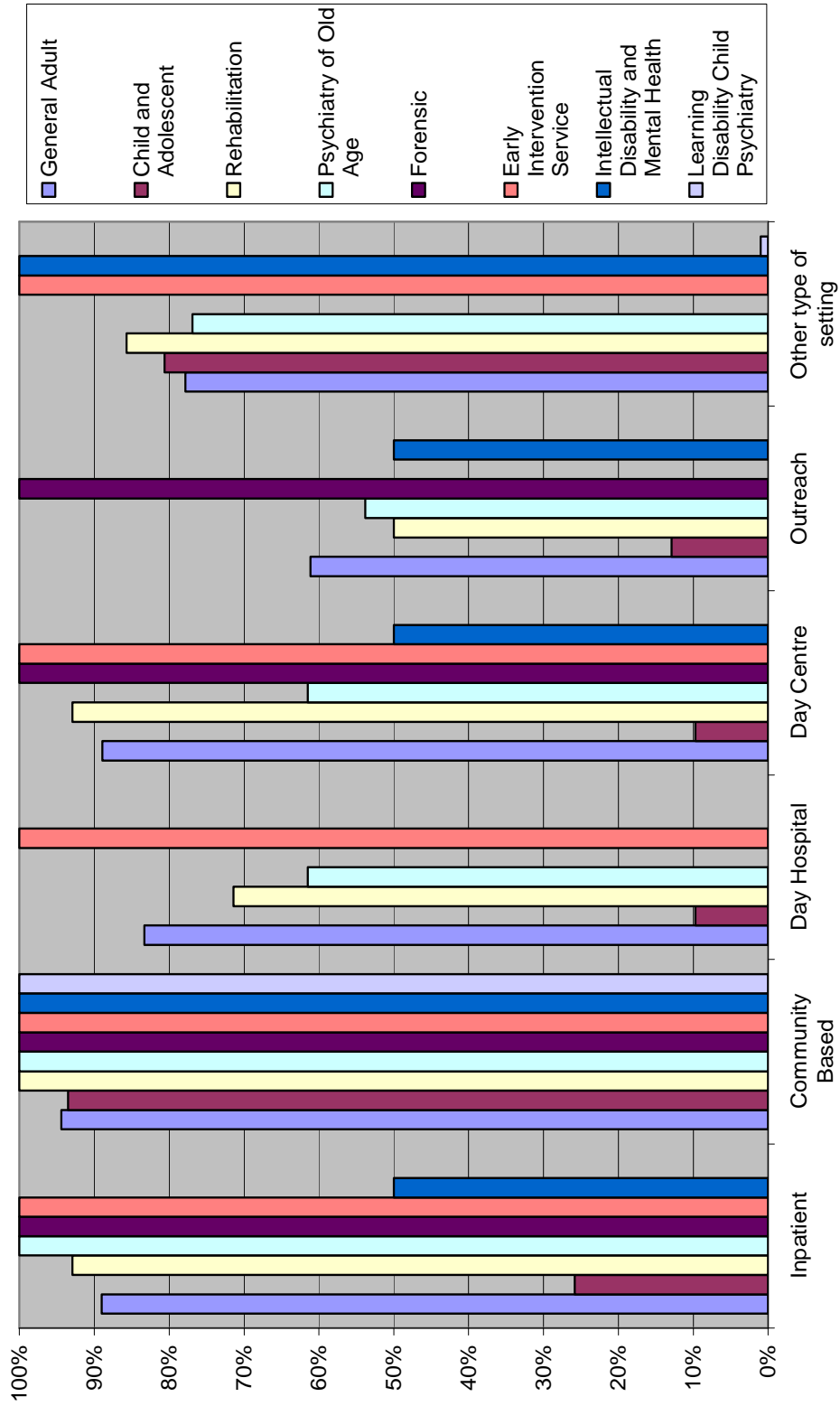
Of the respondent services, 31.7% had a mainly urban population base, 16.7% had a mainly rural population and the remainder, 51.7%, reported a mixed rural/urban population.

Each of the mental health service types reported the main settings in which services are delivered and the composition of these is outlined in Table 2 below.

The category Other Type of Setting includes long stay units, hostels, general hospitals and prisons. However, the numbers reporting such settings are very small.

A total of 82 service settings are represented by the respondents to the survey. The majority of service types represented are; General Adult Mental Health Services (18), Child and Adolescent Services (31), Rehabilitation Services (14), and Psychiatry of Old Age (13). Of the following services; Forensic, Early Intervention, Liaison and Child Psychiatry Intellectual Disability, only one service setting responded while in Adult Intellectual Disability and Mental Health, there were two. In presenting the results, it should be noted that the information relating to those settings where there were only one or two of that type among respondents can only be considered indicative of the practice of data collection in those settings.

Table 2 - Mental Health Service Settings



What data is currently collected?

Having detailed the profile of the respondent services, I will now consider how the information provided addressed the first objective of my research which was to establish the existing level of data relating to the Mental Health Services in the Health Service Executive, and to identify gaps and common features.

Service User Data.

Table 3 shows the types of service user information collected by the General Adult Mental Health Services, the Child and Adolescent Services, the Rehabilitation Services and Psychiatry of Old Age. These services represent a national geographic spread and can be considered to represent the practice of the majority of these types of service setting.

The Child and Adolescent Services reported collecting a range of other information relating to the service user including referral date, date of first appointment, whether they were emergency, priority or routine appointments, details of school attendance and personnel, and gender. A small number of the General Adult, Rehabilitation and Psychiatry of Old Age services reported collecting details of the sector team treating the service user, religion and gender.

Table 4 below shows the percentage of all the respondent services which collect each type of service user information.

From the small number of respondent Forensic, Early Intervention, Liaison and Mental Health and Intellectual Disability services, similar patterns of information collection is indicated although the information collected is not as extensive in these areas. Between 90% and 100% of services collect the name, address, date of birth, next of kin, GP details, discharge diagnosis and discharge date while over 50% collect all of the data types suggested.

Table 3 – Service User Information Collected by Service Type

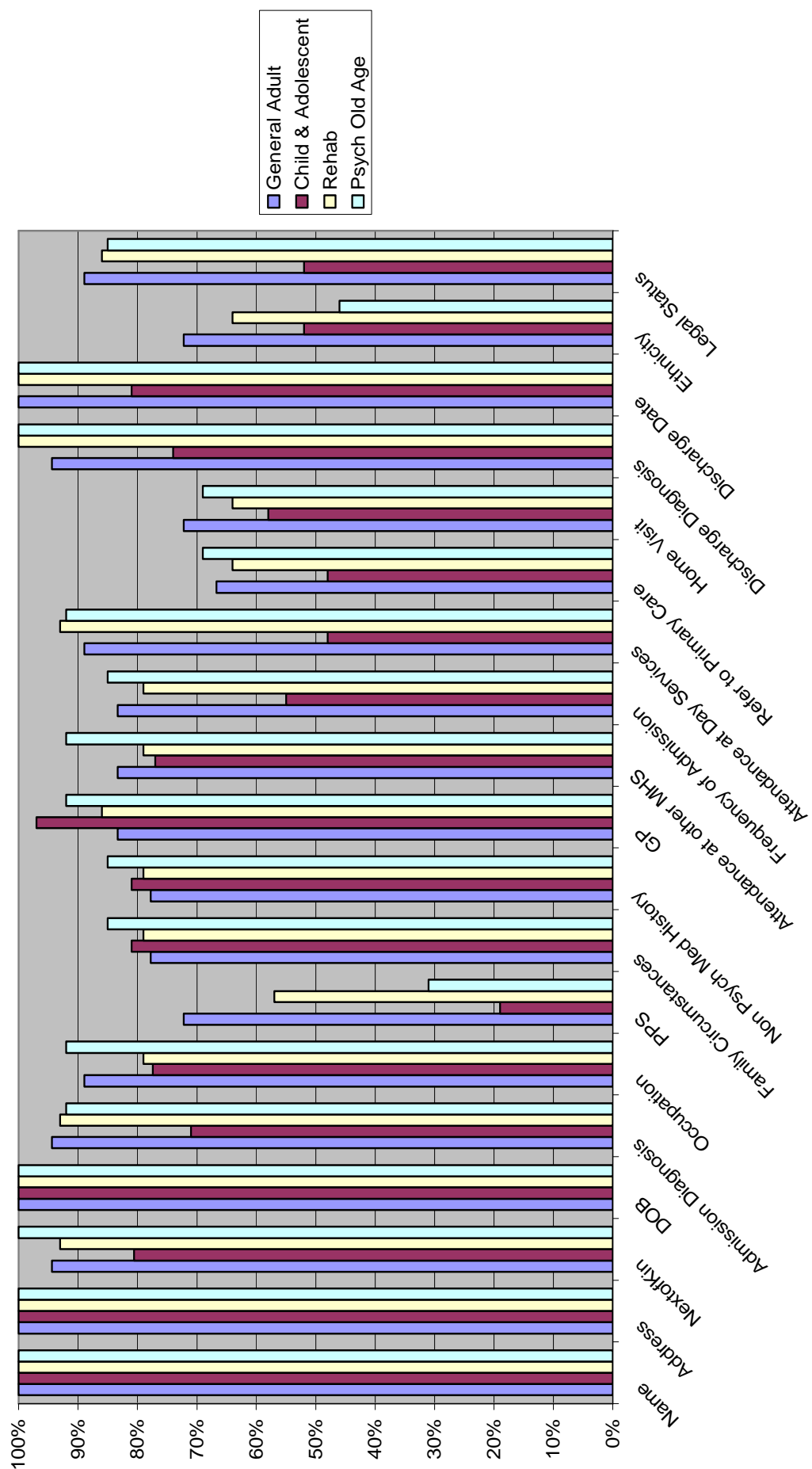
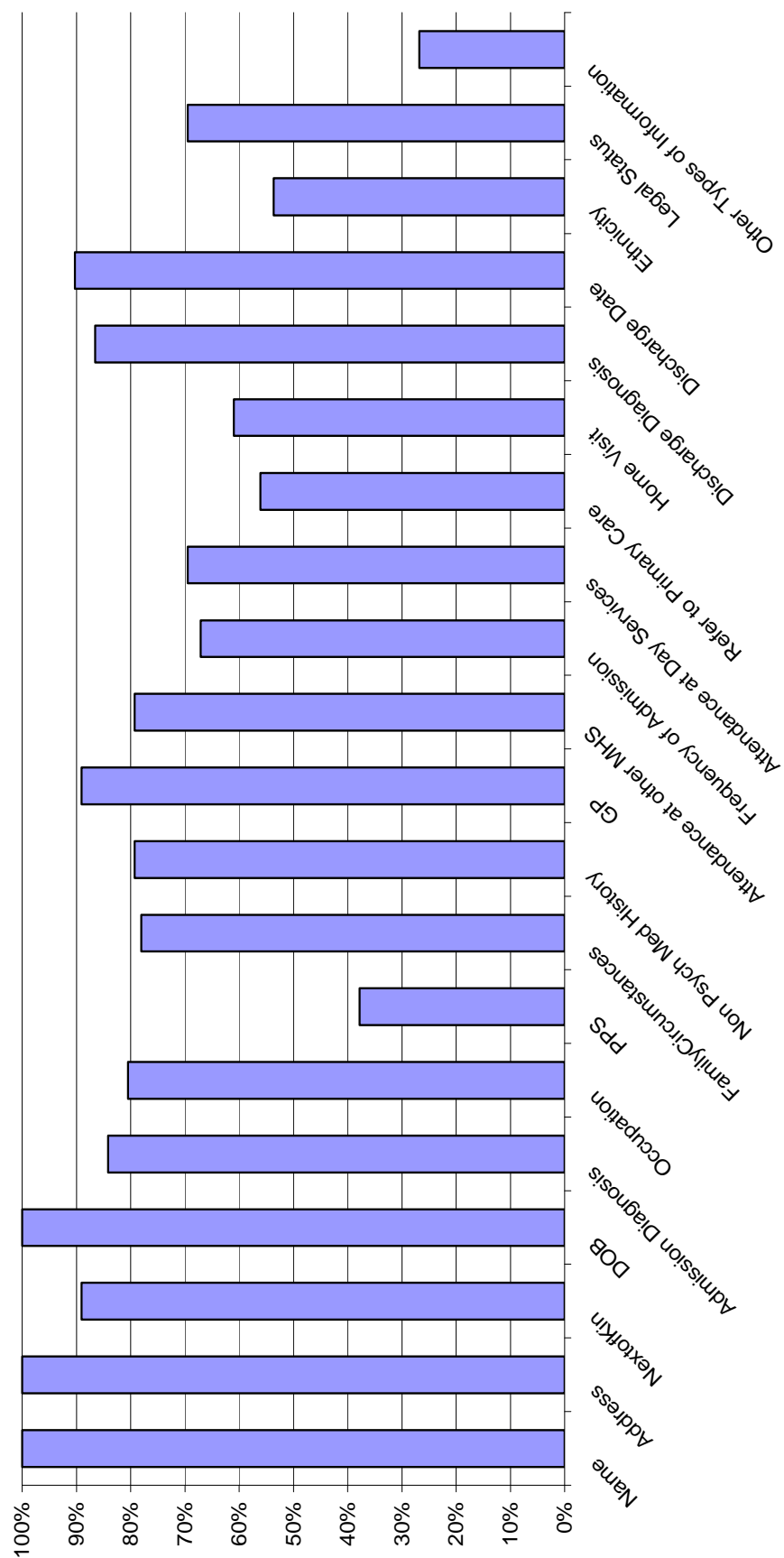


Table 4 – Percentage of each type of Service User Data collected by Mental Health Services



Clinical Information

Table 5 below shows the percentage of all of the respondent mental health services who collect each type of clinical information.

Table 5 – Clinical Information Collected by Mental Health Services

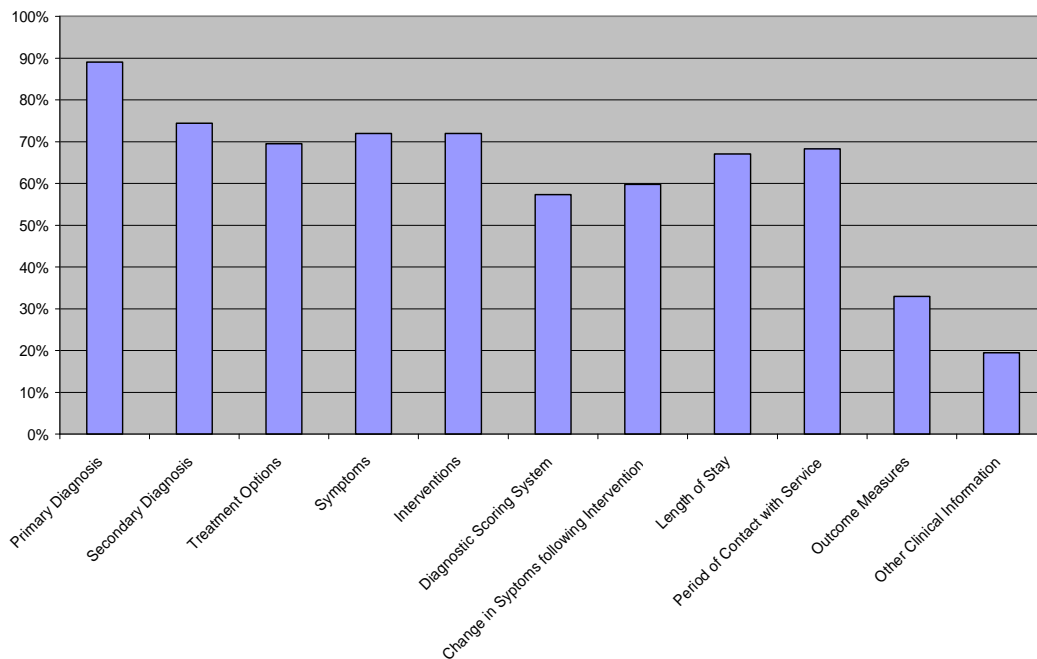


Table 6 – Clinical Information by Service Type

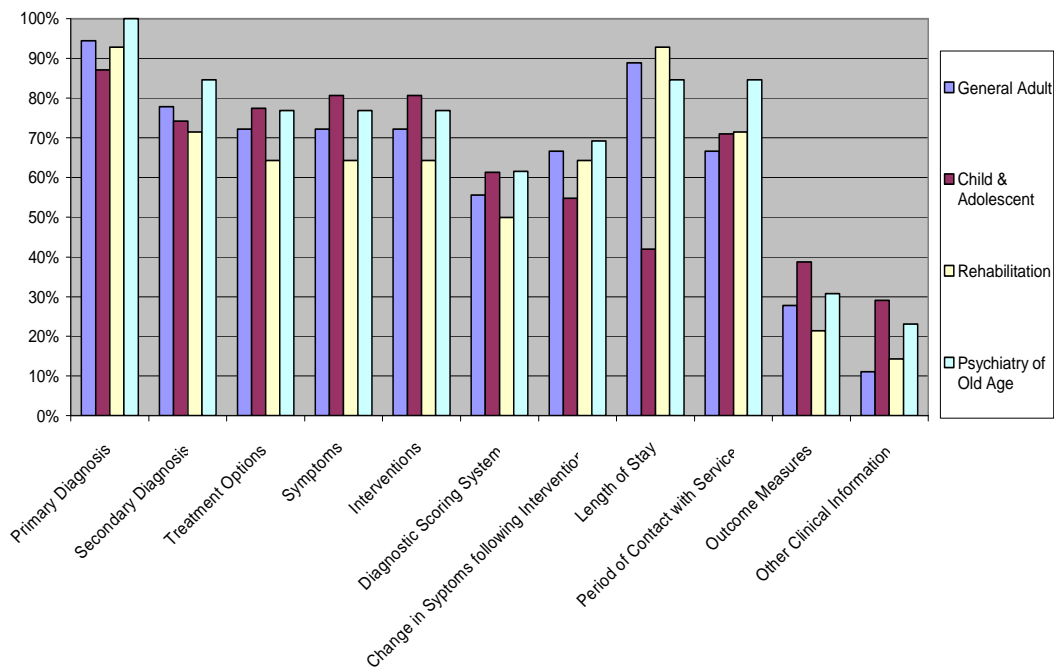


Table 6 displays the percentage of General Adult, Child and Adolescent, Rehabilitation and Psychiatry of Old Age Services which collect the different items of clinical information.

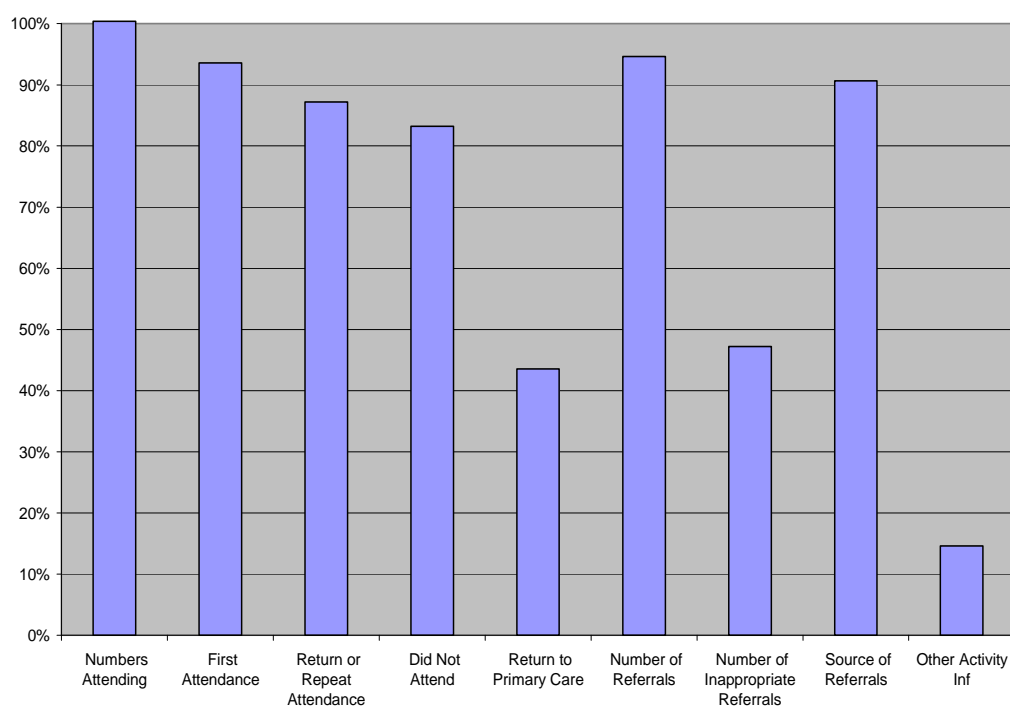
Critically, outcome measures are collected by less than 40% of the respondents. Between 60% and 100% of services however collect details of primary diagnosis, secondary diagnosis, treatment options, symptoms, interventions made, length of stay and period of contact with services. Up to 60% have a diagnostic scoring system in use and monitor the change in symptoms following intervention.

Of the two Mental Health and Intellectual Disability Services who responded, it is worth noting that both reported collecting outcome measures, as did the Forensic Services.

Activity Information

In the survey, mental health services were asked to identify what activity information was collected in the service. Table 7 below describes the activity information collected by all of the respondent mental health services. It is notable that only 40% of services record a return to primary care for their service users and less than 50% record the number of inappropriate referrals.

Table 7 – Activity Information collected by Mental Health Services



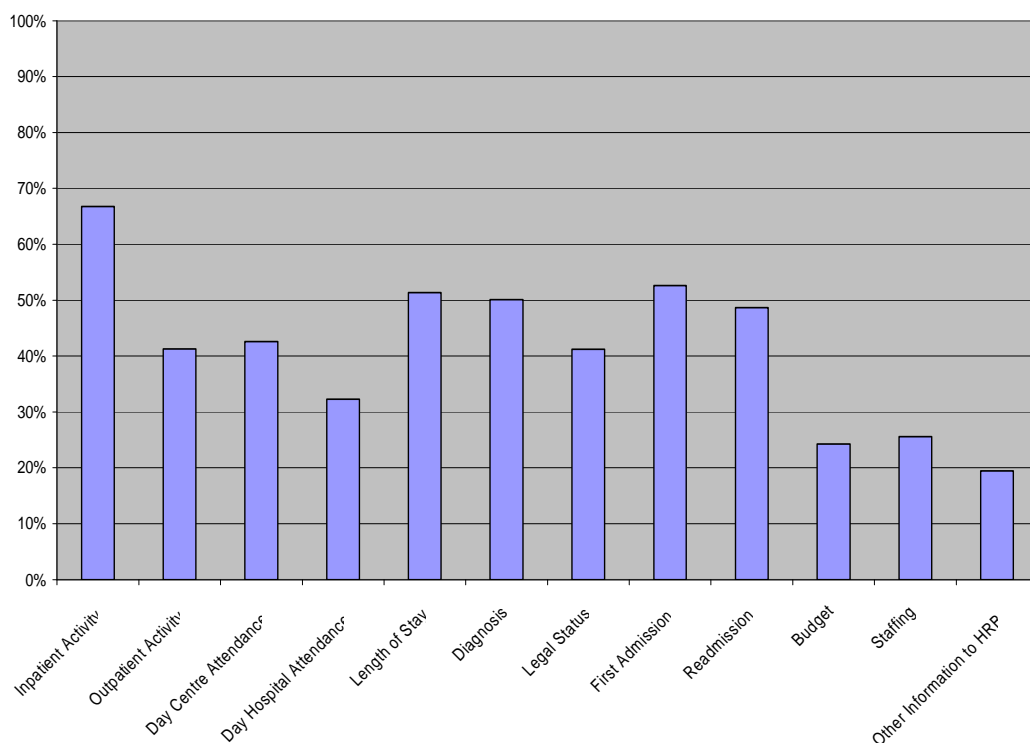
Information collected by other Agencies

As demonstrated in the Literature Review, it is an unusual aspect of the mental health services in Ireland that almost all of the system information collected about the mental health service provision is collected by agencies external to the service provider. In carrying out the survey, I considered that it would be important to capture the nature of the information collected by these agencies, the Health Research Board (HRB) and the Mental Health Commission (MHC).

Data collected by the Health Research Board (HRB).

Table 8 below details the information submitted by all of the respondent services to the Health Research Board (HRB). Less than 60% of the respondents provide information to the HRB and of those who do they mainly report inpatient activity, including length of stay, diagnosis, first admission, and readmission. Up to 20% of the services provide information on budget and staffing to the HRB while between 30% and 40% provide information on outpatient activity, day service attendance, and legal status. The Health Research Board analyses and publishes the information which it collects and has been the main source of system information about the mental health services, nationally, over the last sixty years, until it was supplemented by the information gathered by the Mental Health Commission.

Table 8 – Information submitted to HRB by Mental Health Services



Data collected by the Mental Health Commission

The role of the Mental Health Commission is to act as Regulator of Approved Centres registered under the Mental Health Act, 2001. It also has a role in fostering and promoting the delivery of quality mental health services. The full implementation of the Mental Health Act, 2001 commenced on 1st November 2006 and in the period since then the Mental Health Commission has been collecting data directly from the mental health services. Further, the Mental Health Inspectorate (formerly the Inspector of Mental Hospitals) has been subsumed under the Mental Health Commission. The study aimed to establish the nature and extent of the information supplied to the Mental Health Commission. The results support the view that the information provided to the Mental Health Commission is mainly in support of its functions relating to the new procedures for involuntary admission and tribunals introduced under the Mental Health Act, 2001.

The full range of information provided to the Mental Health Commission is provided from less than 40% of the services. However, of the two intellectual disability and mental health services who participated in the survey, neither service provided information to the Mental Health Commission. All of the other specialties reported some information to the Commission, the greater detail of information coming from the General Adult, Rehabilitation, Child and Adolescent and Psychiatry of Old Age services. In the main, the information provided to the Mental Health Commission comes from adult services across the range of specialties.

A comparison of the information collected by the Mental Health Commission and the Health Research Board confirms the overlap in provision of information (Table 10). Both agencies collect inpatient activity, outpatient activity, day centre attendance, day hospital attendance, length of stay, legal status, first admission, readmission, budget and staffing. It is not possible from the outcome of the survey to establish if the services from which this information is collected differ or whether the information is supplied separately to each agency.

Table 9 – Data provided to the Mental Health Commission

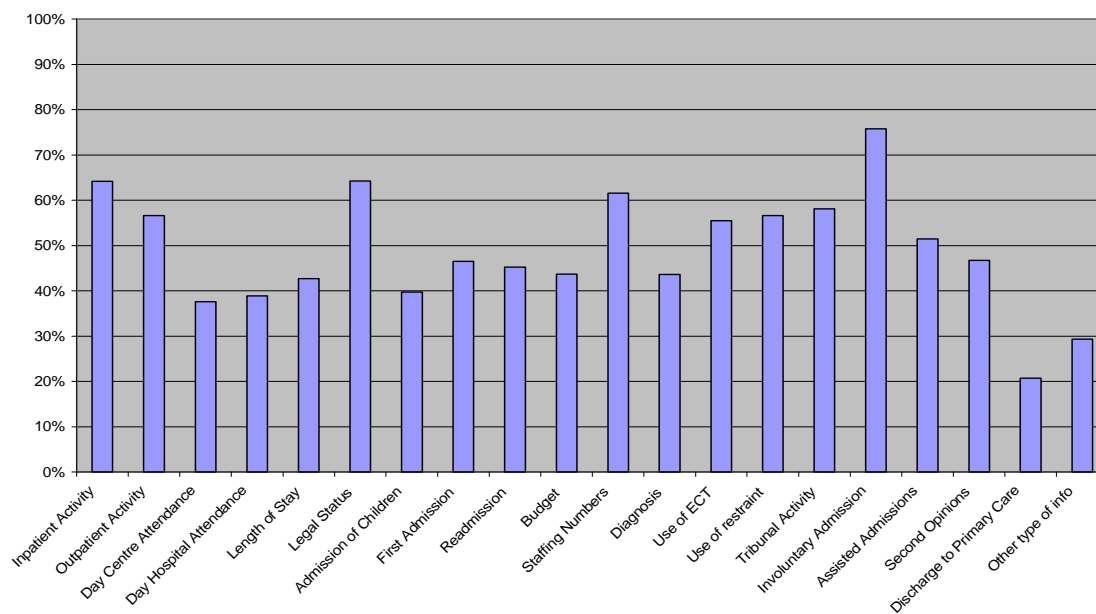
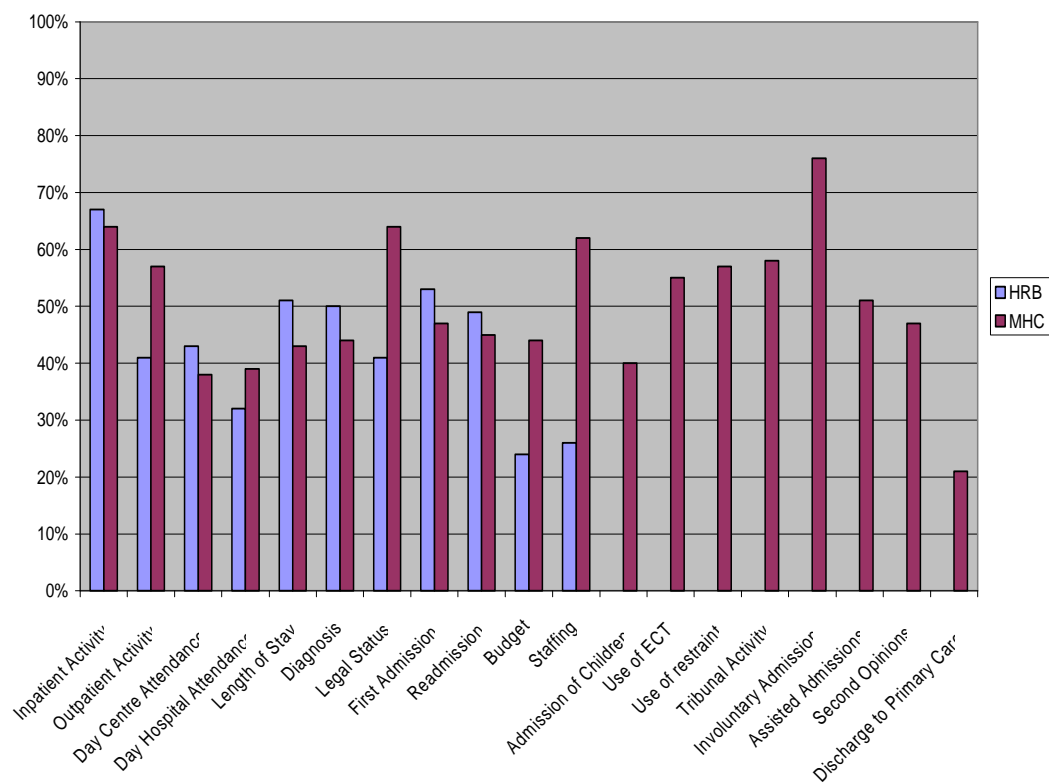


Table 10 – A Comparison of the data collected by HRB and MHC.

Comparison of Data collected by HRB and MHC

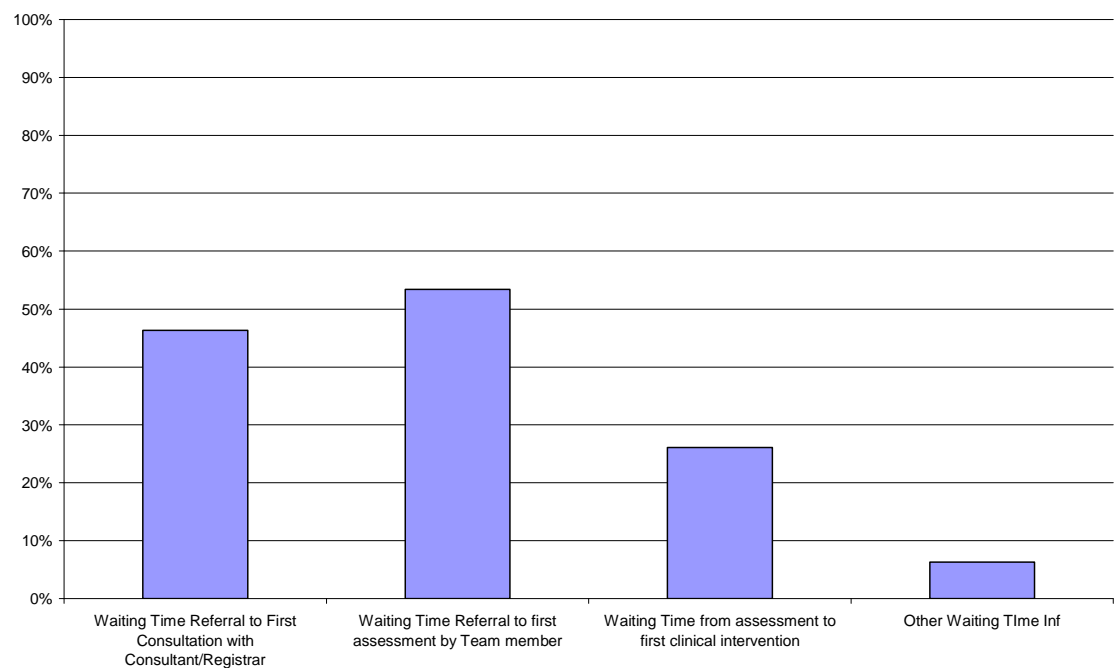


Waiting List Information

Often the waiting list is used as a measurement of the quality of the service delivered and particular focus has been placed politically and in the media on waiting lists for Child and Adolescent Mental Health Services. I hoped to establish as part of the survey what, if any, waiting list information is held by the mental health services and what aspect of “waiting” was measured. Table 11 below shows the type of waiting time information collected across the respondent mental health services which collected this type of information.

Less than 50% of the respondent mental health services collect any waiting time data with the Child and Adolescent Services the main services who reported collecting this information at 27%. Of the General Adult, Rehabilitation and Psychiatry of Old Age services who responded, between 30% and 40% of the services reported collected information about waiting for access to their services. The Early Intervention, Mental Health Intellectual Disability and Liaison services although small in number also reported collecting information about waiting time for access to the services (Table 12 below).

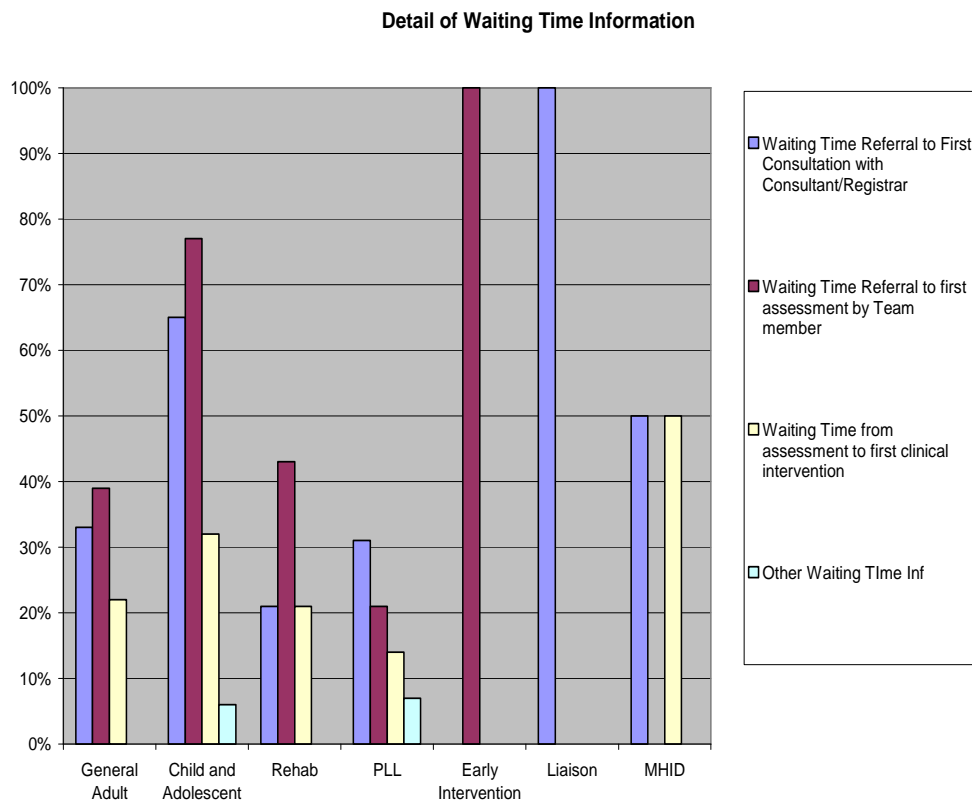
Table 11- Waiting Time Information collected by the Mental Health Services



In the survey, participants were asked to give comments on waiting lists and methods of collecting the information. The majority of the respondents who commented noted that they did not collect waiting list information routinely. Where a participant chose to describe the process, a system where emergency cases are dealt with within the day, and other categories must wait dependent on demand and staffing levels, is in place. Waiting times varying between 2 weeks

and 18 months were mentioned by participants. The study did not canvass existing waiting times and so it is not possible to comment in detail on this.

Table 12 – Detail of Services which collect Waiting Time Data



Purpose and Use of Data

The second objective of the study is to establish the purpose and use of the data collected by the mental health services and by what method the data is collected. I propose now to consider the purpose and use of the data collected by the mental health services and described in the preceding pages.

Participants were asked to identify the information collected by them and provided to their Mental Health Services Management Team (see Table 13). In completing the survey, participants who had a different management structure identified the information provided to the local mental health management whatever that might be. In some instances that was the sector team and in others the question was left blank.

However, 55% of mental health services reported sending information to this group. It is possible that the response to this question may be influenced by the terminology used which may not be widespread in referring to this management structure. This issue was raised in the study

pilot and was addressed by adjusting the vocabulary but it is not clear to what extent it influenced responses.

All mental health services report ultimately to the Local Health Manager who has responsibility for the finance and human resources within the Local Health Office. Respondents were asked to identify the information which they provide to the Local Health Manager and that is detailed in Table 14 below.

Table 15 shows the information provided from the mental health services to the HSE at a national level. Less than 40% of the respondent services provide information to the HSE at a national level. This might be explained by the fact that the line management responsibility lies with the Local Health Manager. However, the survey results show that, of the respondent mental health services, 60% provide information to the Local Health Manager. This is still a greater number than those providing information to the Catchment Management Team (55%).

As the survey was seeking to describe the current environment, it is not possible from the survey results to understand why there is limited contact between the mental health services and the local health manager. It is also interesting that where services do provide information to line management locally, at Local Health Office level or nationally, it is mainly around staffing, budgets and activity. This reflects the data which was reported as being collected by the individual services in the survey. However, where services have indicated that they collect outcome measures, it does not feature as being reported to the line management.

Table 13 – Data provided to Mental Health Services Catchment Management Team

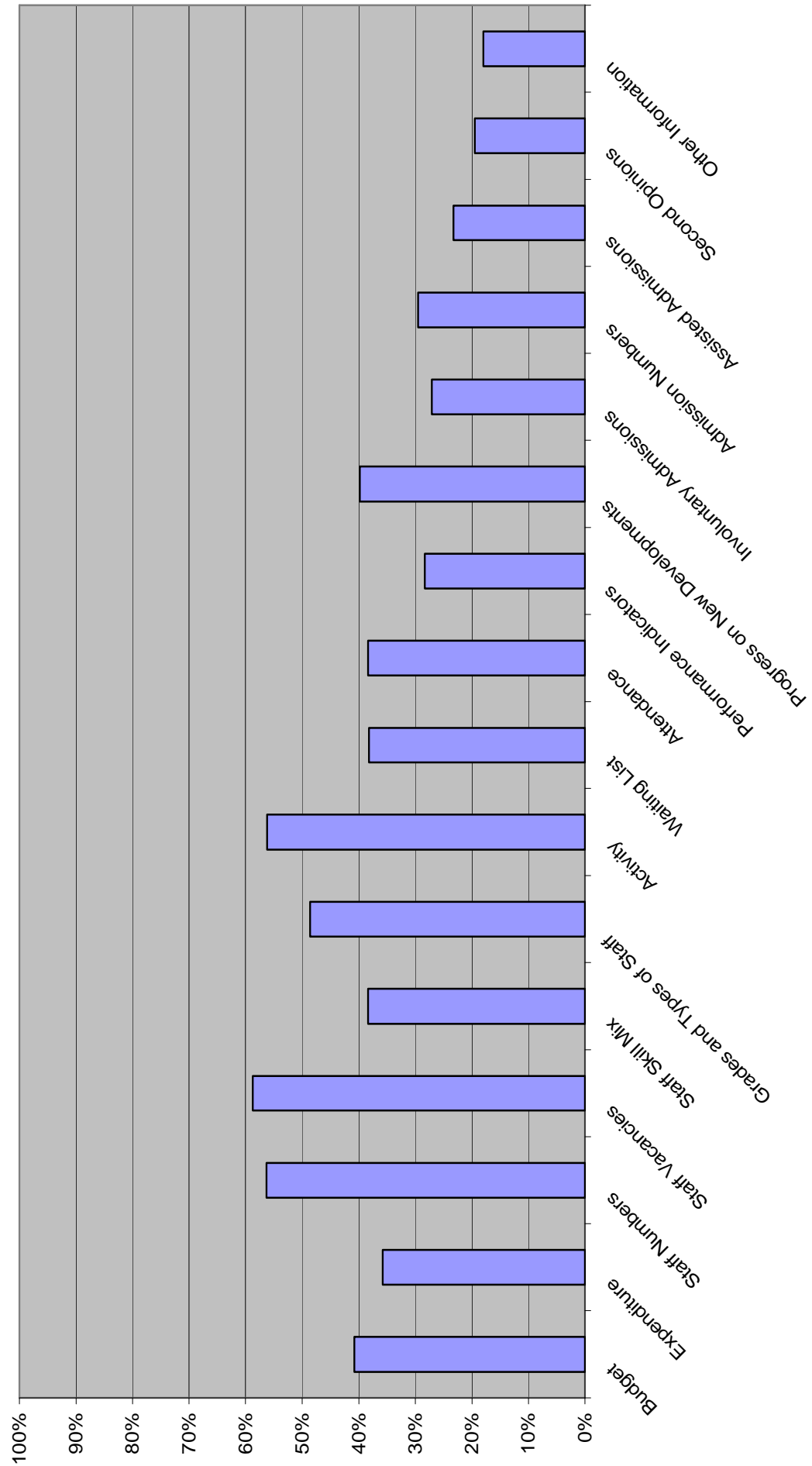


Table 14 – Data provided to Local Health Manager

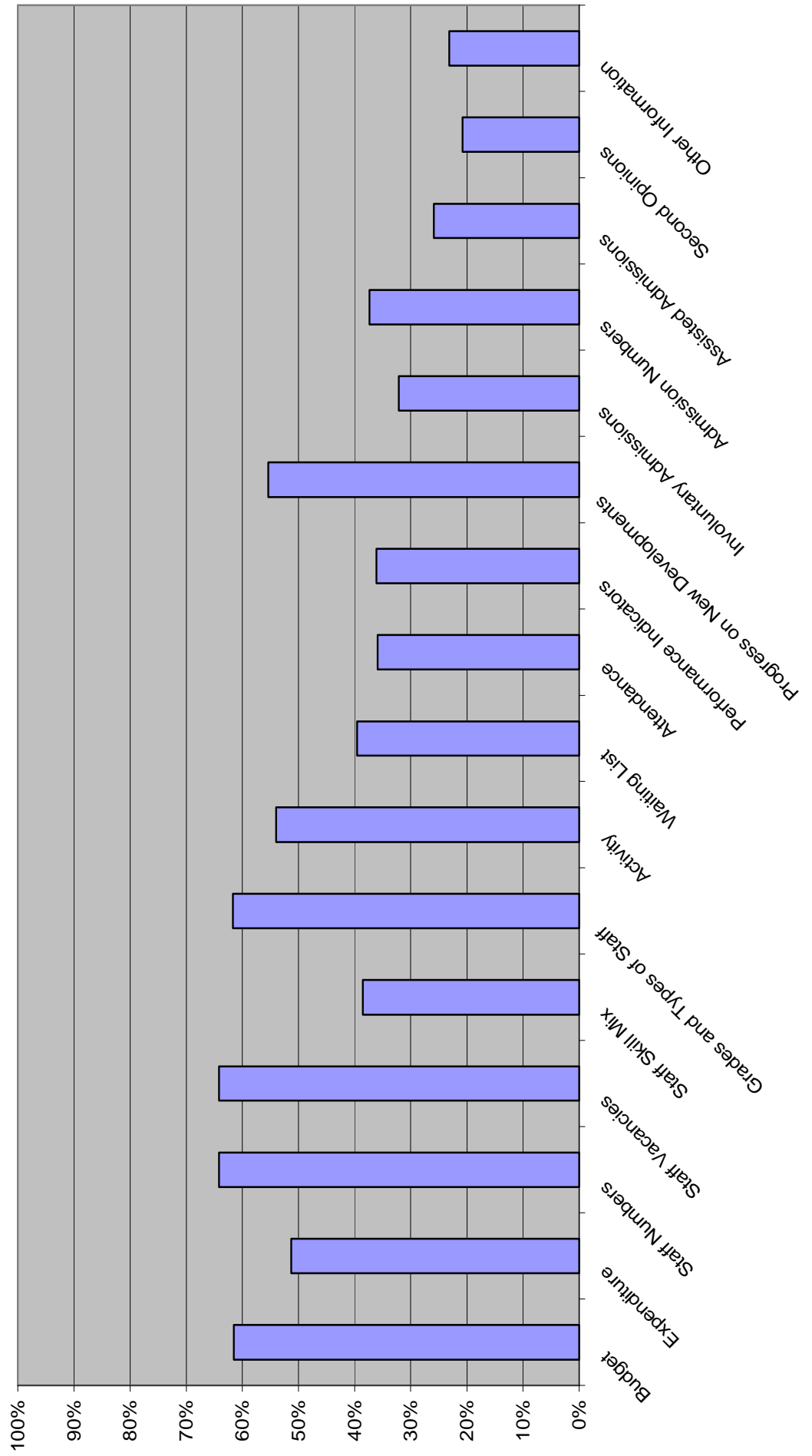
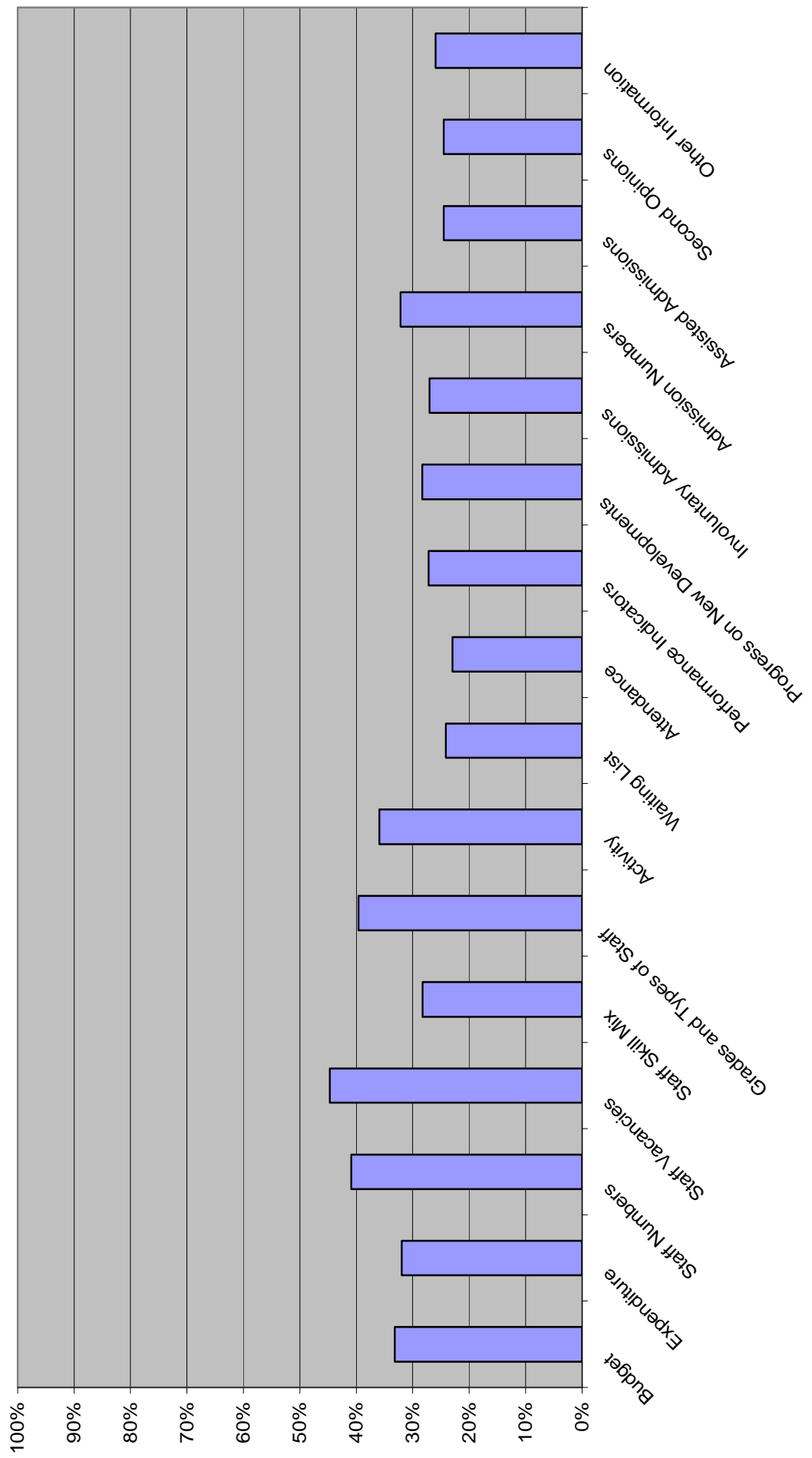


Table 15 – Data Provided to Health Service Executive Corporate



Some indication as to the reasons why there is limited contact from mental health services with line management and also why certain data elements feature in reports but not others can be gleaned from information provided by respondents under the headings of Other Information Provided to Catchment Management Team, Local Health Manager and HSE Corporate. Participants used the free text space in the survey to provide some additional information on how they had responded to these questions as well as describing any other information provided by them to these groups.

Where respondents provided comment, the comments reflected that information is provided to these groupings on request and not in a routine fashion. It was also noted that information is provided via administrators and that national reporting is managed by the Local Health Managers. Two respondents mentioned that their local management team, including the Local Health Manager, were updated at monthly meetings.

One or two of the respondents noted that additional information provided related to progress on the implementation of A Vision for Change.

The responses suggest that routine reporting is limited in scope and that much of the reporting is in response to requests for information from the different management levels. This would support the findings in the Literature Review that much of the data from the mental health services is obtained in an ad hoc manner and dependent on local arrangements. These are the characteristics of a reporting rather than an information system.

Data collected by Mental Health Services for any purpose

The following Tables 16 and 17 list all of the data collected by the respondent mental health services for any purpose and the percentage of the respondent services that collect each data item. It is clear that data relating to the management of the care of individual service users is collected by almost all of the respondent mental health services. The other information collected by the mental health services for the most part is limited to that required by the Health Research Board and the Mental Health Commission. There is little evidence of analysis of the information at facility or local management level and limited information is provided to Local Health Manager and national levels within the HSE.

Table 16 -Data collected by between 100% and 70% of Mental Health Services

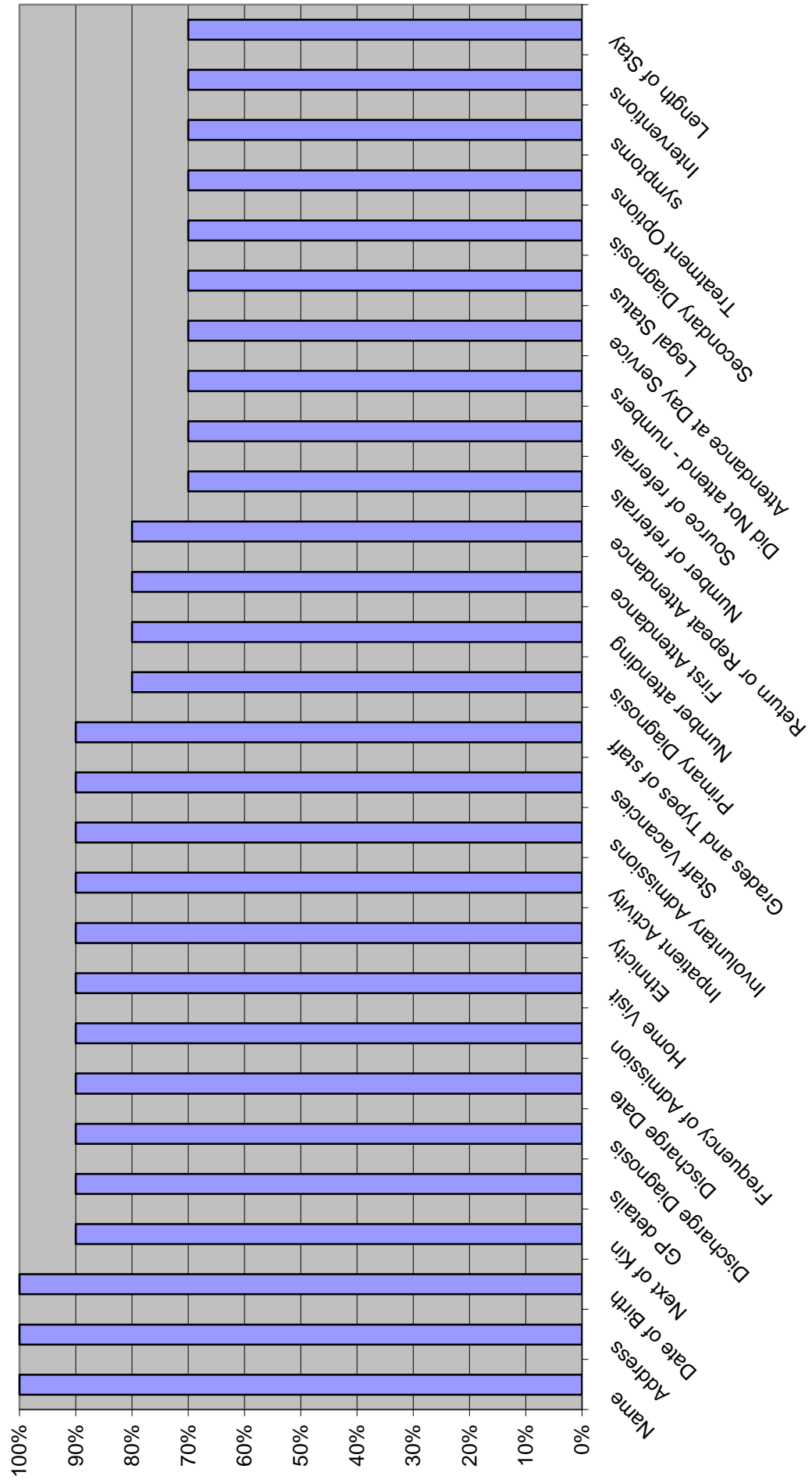
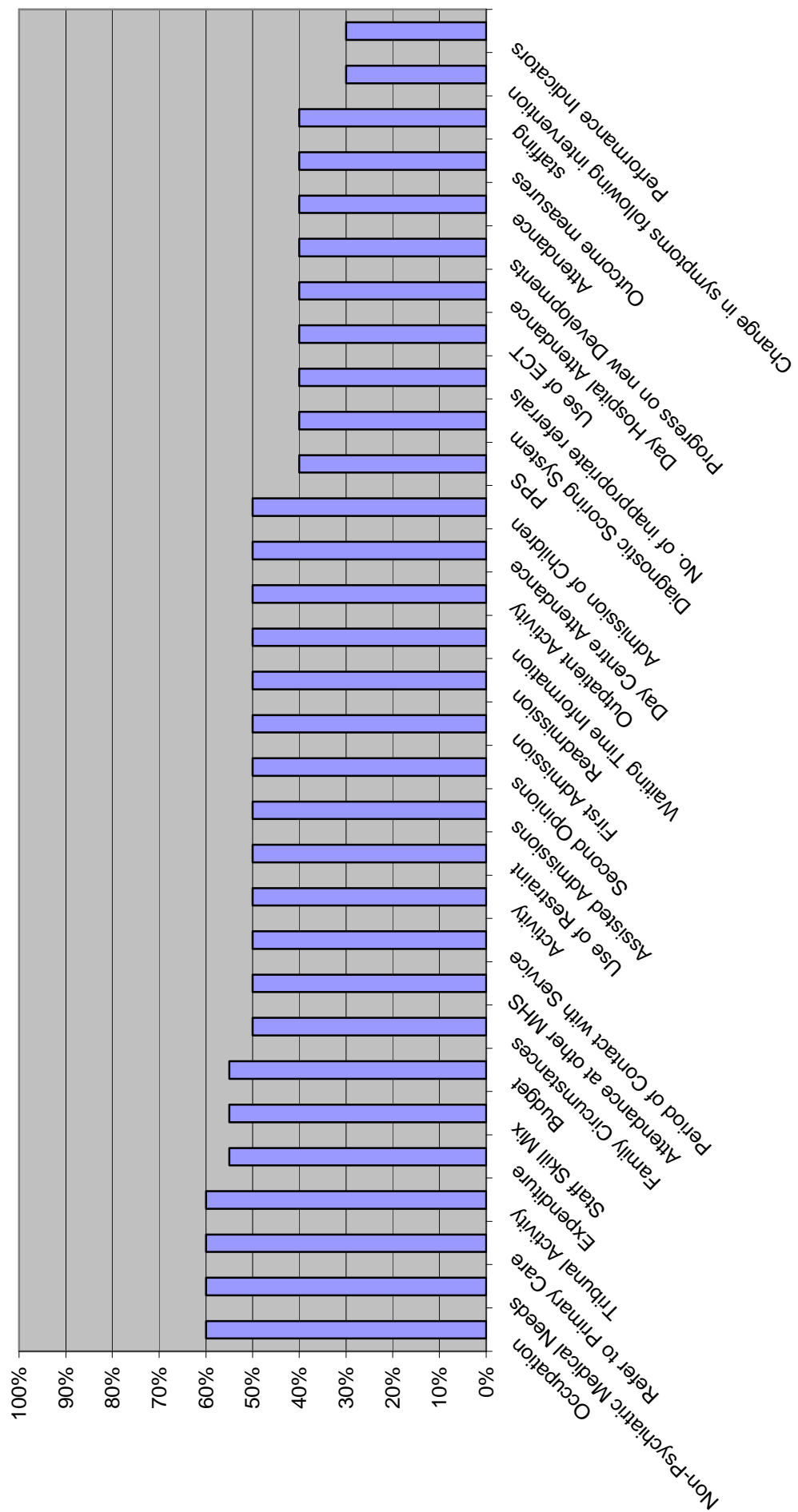


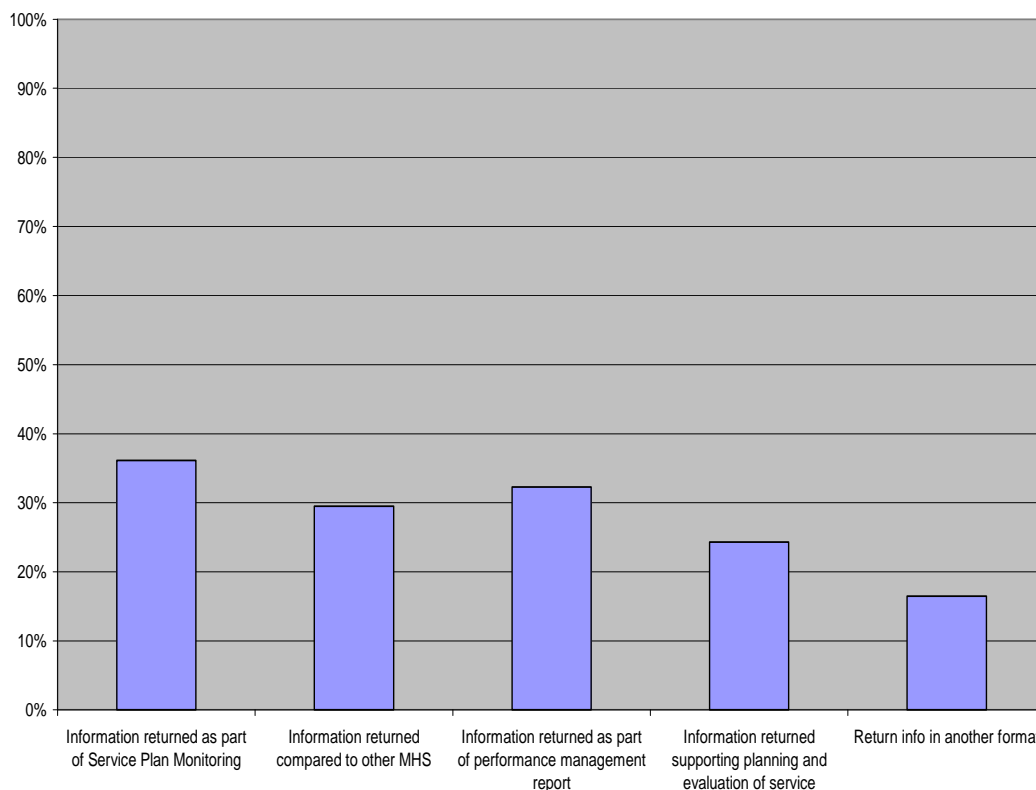
Table 17 - Data collected by between 60% and 20% of Mental Health Services



Planning and managing the delivery of the service

I will now consider how the data provided by the mental health services is made available to those services to support them in the planning and managing of their services. Participants were asked to indicate how information provided by the mental health services to HSE management or other agencies is returned for use by those services. Table 18 describes the format in which information is returned to the services.

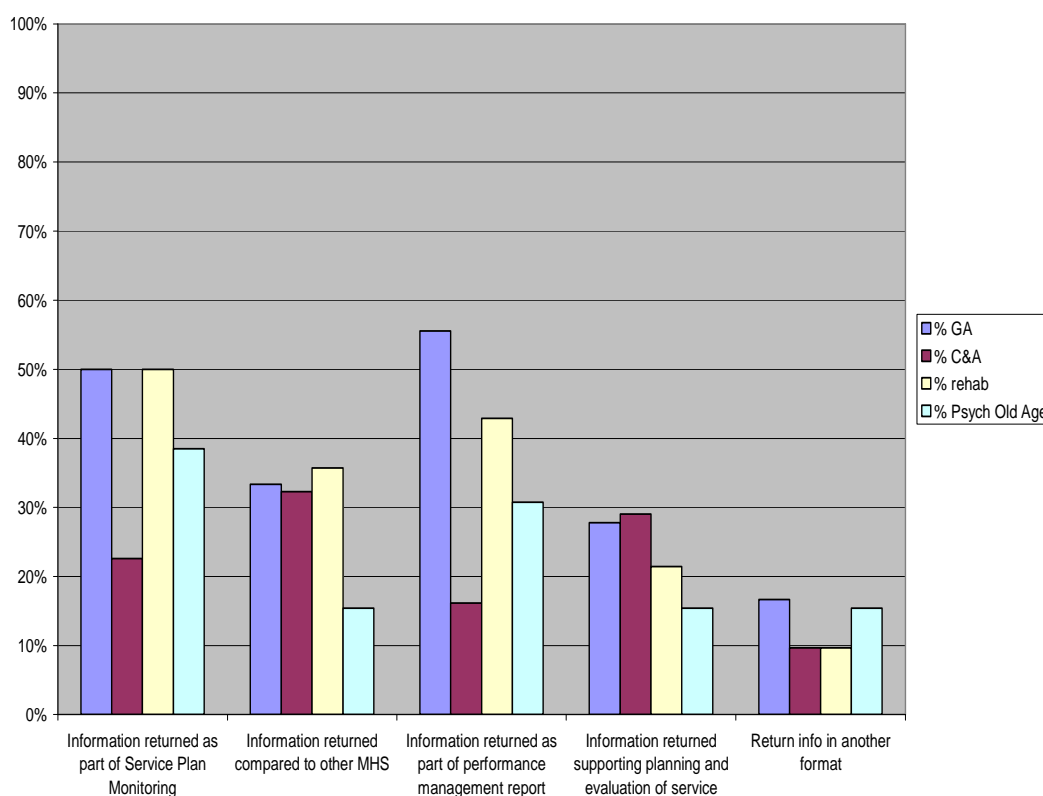
Table 18 – Format in which information is returned – All Mental Health Services



Less than 40% of respondents reported that the information provided by them is returned in any format. Of these, the majority (36%) received the information as part of Service Plan Monitoring. The survey provided an opportunity for respondents to describe other formats in which information is returned to services and these included the Annual Reports issued by the Mental Health Commission (Inspector of Mental Hospitals) and the Health Research Board. Six of the respondents said that they received no feedback from the HSE on any of the information provided by them.

Table 19 gives a breakdown of General Adult, Child and Adolescent, Rehabilitation and Psychiatry of Old Age Services and the way information is returned to each of these specialties. None of the other sub-specialties represented by the respondents indicated that information was returned to them in any format.

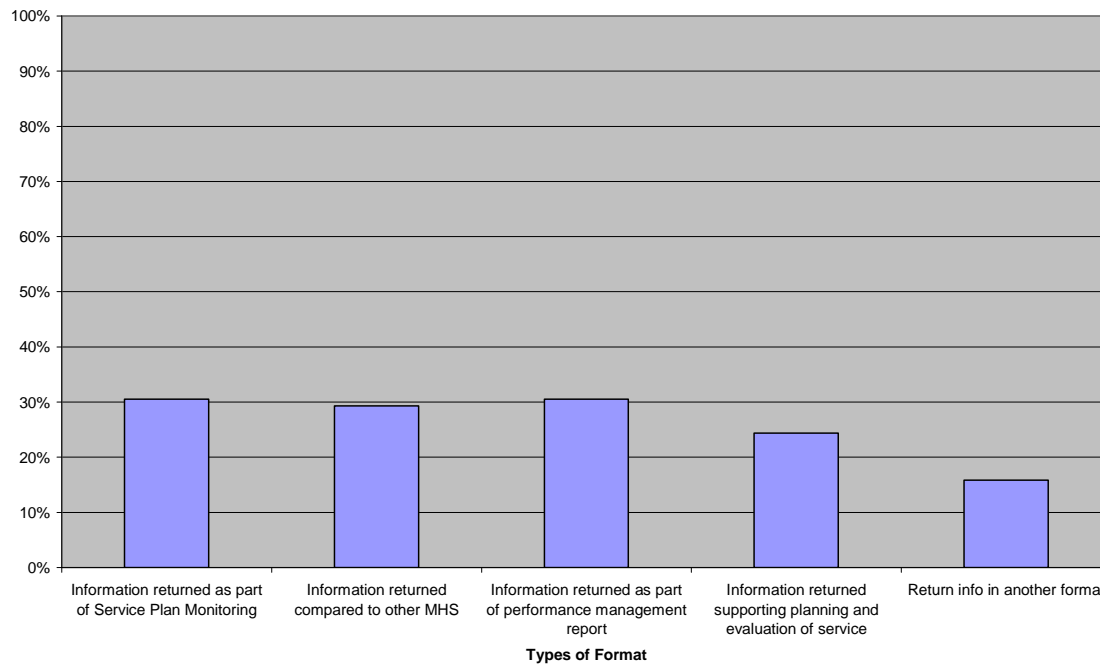
Table 19 – Format in which information is returned by Service Type



Services were asked to identify how best information might be returned to support them in planning and delivering a quality service. Table 20 displays the respondents' recommendations which support Service Plan monitoring, comparison with other mental health services and as part of a performance management report. Respondents made suggestions about other possible useful formats including; benchmarked against other services internationally, meeting with managers to clarify their information needs, through an agreed national minimum dataset, and supporting a negotiated service level agreement.

The survey results relating to the data collected suggested that a reporting rather than an information system is in place in the respondent services. The results of this aspect of the survey would support that contention in that less than 40% of the services report any feedback from information or data provided by their service.

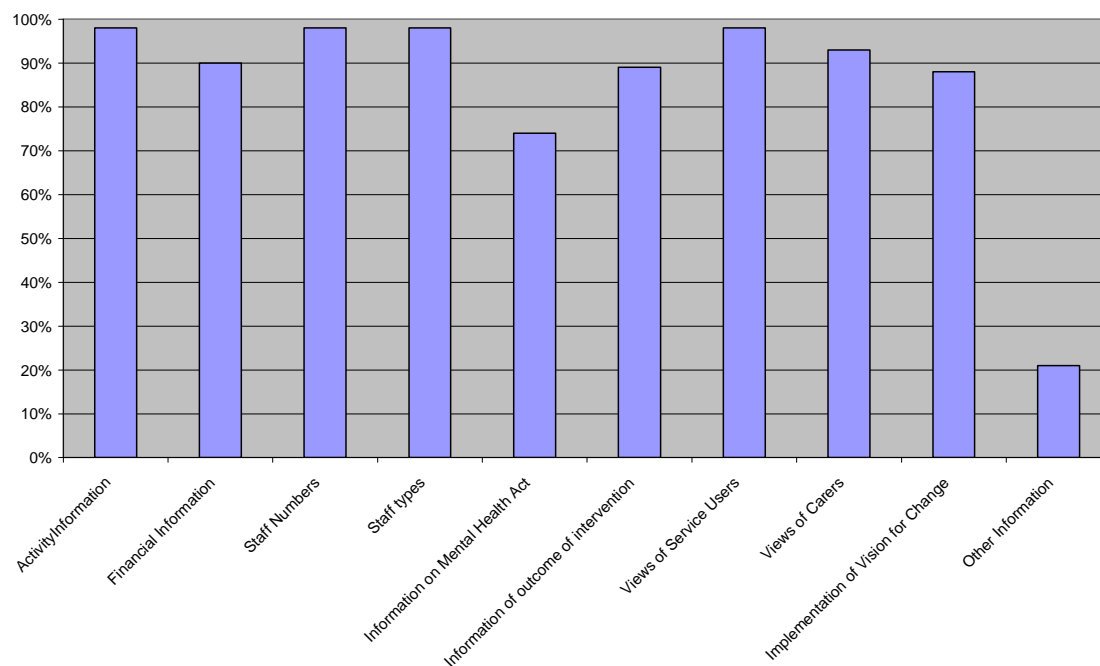
Table 20 – How best might information usefully be returned to Mental Health Service.



What information is needed to plan services?

Survey respondents were asked to identify what information is needed by them to plan and deliver quality mental health services. Table 21 below displays the percentage of all of the respondent mental health services who identified each category of information as necessary to plan and deliver quality mental health services.

Table 21 – Information identified as needed to plan and deliver Mental Health Services



Twelve of the respondents identified other information which they considered important in planning and delivering mental health services. These other categories include; case mix data,

types of service users referred, demands under Disability Legislation, critical incident reporting, root cause analysis, epidemiological information for geographic area, demographics, and inappropriate referrals.

The survey asked for the comments and suggestions of respondents in relation to the information important to support the planning and delivery of a quality mental health service. This part of the survey aimed to try to establish if, in the view of respondents, the data and information currently collected by the mental health services supported their objective to plan and deliver quality mental health services. Fifteen of the respondents chose to comment.

Issues identified as impacting on the planning and delivery of services included;

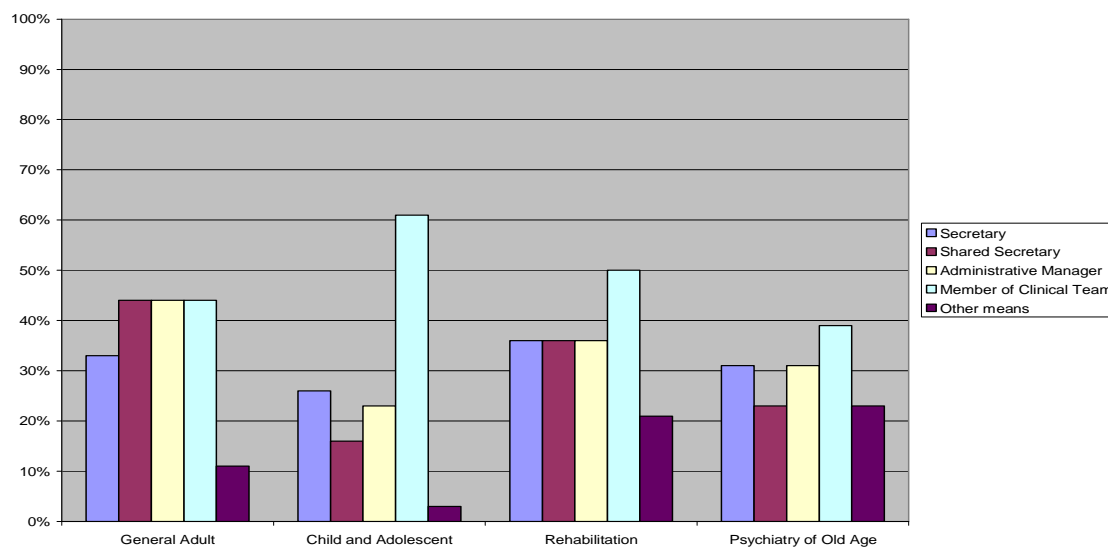
- “the need to clarify referral pathways”,
- “the absence of a HSE database accessible by voluntary organisations providing services on behalf of HSE”,
- “information collected is not comprehensive and analysing activity data but not outcomes is a meaningless exercise from a service user perspective”,
- “to deliver a quality service that is efficient and effective and value for money requires detailed costing information which is not available to services”,
- “the quality and level of interventions need to be recorded to properly interpret activity data”.

The survey responses indicate that while information is collected by the mental health services, there is no agreed structure by which information is channelled to line management and nationally. Information requests tend to be ad hoc and are met in a disjointed manner depending on the information available to the service. There is a focus on budget, activity information and staffing levels but little information on outcomes or costs. There appear to be a number of barriers to the useful application of information in the planning and delivery of services, not least is the fact that information is not routinely returned to the services nor is it analysed. Services rely on the Health Research Board and the Mental Health Commission for any analysis of the information provided and for comparison information with other services in Ireland.

The management of information

One of the main influences on data collection and its validity is who collects the data and this is noted by a number of commentators in the literature review. The survey asked respondents to specify by whom information is collated. Table 22 details the pattern across all of the respondent mental health services.

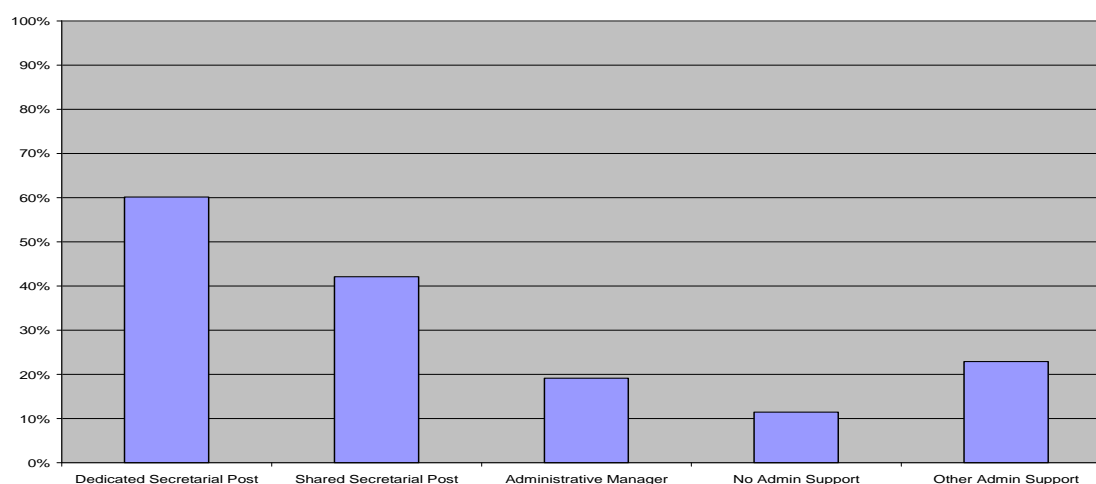
Table 22 – Who collates information in Mental Health Services



It is worth noting that a member of the clinical team for the Child and Adolescent Services, for Rehabilitation and for Psychiatry of Old Age is most likely the person to collate data in response to information requests. In General Adult Services, that function is shared equally between the secretarial staff, administrative manager and the clinicians. Where other means of collating data was used, services reported that the selection of the person to collate the information is dependent on the request and/or is handled by the Mental Health Act Administrator. The other specialties such as Forensic, Early Intervention, Intellectual Disability and Liaison report a similar pattern to that described in Table 22 above.

It is worth considering whether this pattern is due to an absence of administrative support among respondents. The survey asked participants to identify the administrative support available to their service (Table 23 below). Over 50% reported having dedicated secretarial support, 37% had access to shared secretarial support. Only 10% report having no administrative support at all.

Table 23 – Administrative Support available to Respondent Mental Health Services.



Participants were asked for their suggestions and comments about how best requests for information from their mental health services should be managed. The responses can best be divided into three broad categories:-

- “That additional dedicated administrative and business support be made available to the mental health services”
- “The development of appropriate national IT systems to support the management of data, possibly with a centralised unit internal to the HSE to manage data nationally”.
- “Information should be managed as part of a national quality assurance system based on proper measurements, definitions and analysis supported by a robust data collection system”.

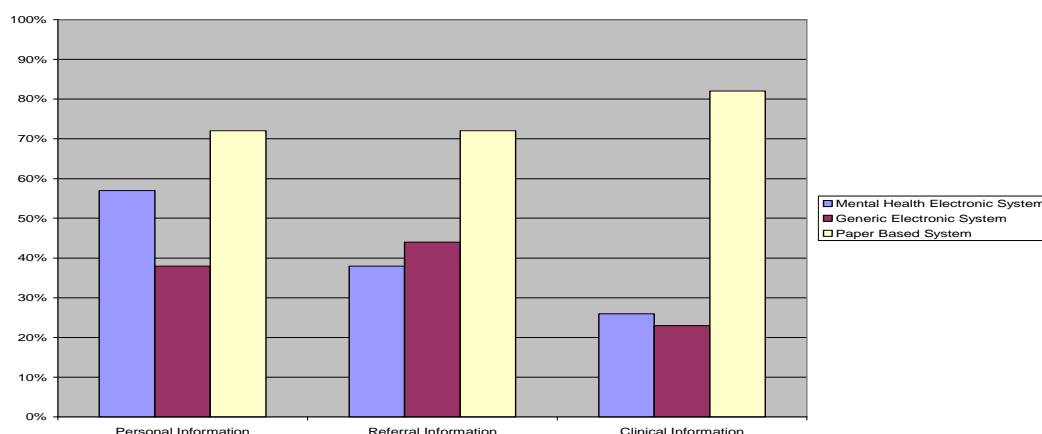
The final objective of the study was to establish by what methods the data was collected by the mental health services and the findings of the survey are detailed below.

Methods of Data Collection

The survey asked participants to identify what methods were used in their services to collect personal information, referral information and clinical information. The broad categories of electronic system and paper based system were used and participants asked to identify within each category the formats in which the information was recorded.

Table 24 shows that 57% of respondents report using an electronic mental health system to record personal information although the majority, over 70%, use a paper based system. Fewer services use an electronic system to record referral information and overwhelmingly clinical information is recorded manually.

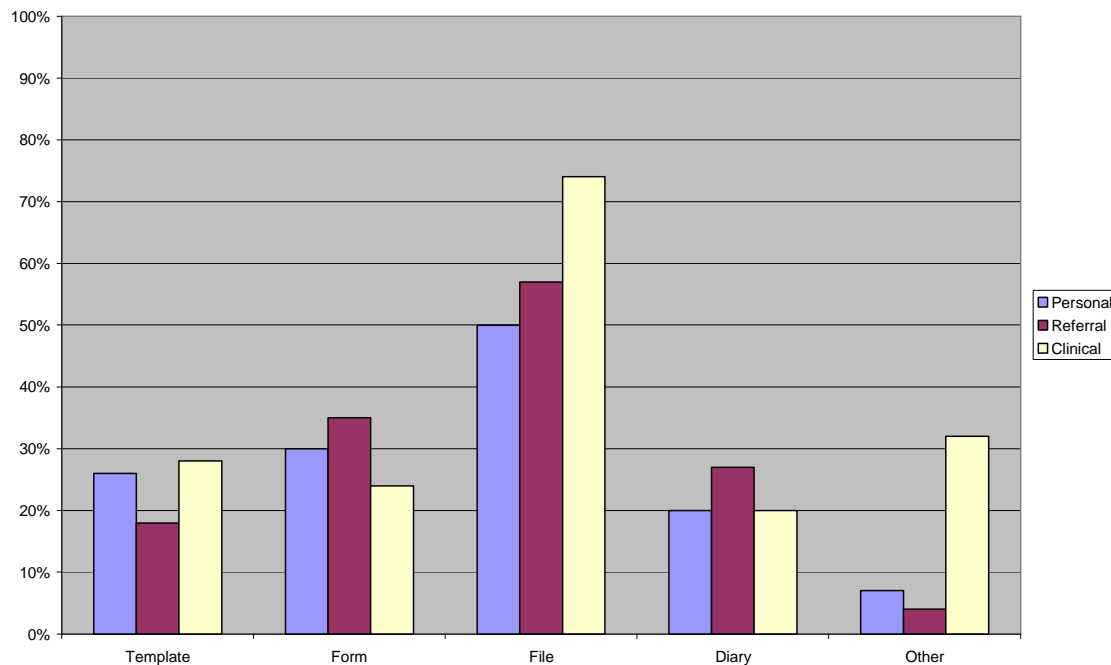
Table 24 – Information Systems Used



The survey responses in relation to the information systems used by the mental health services, electronic or manual, support the suggestions in the Literature Review that much of the information collected by the mental health services is by manual means. The survey findings suggest that the bulk of the information collected is held on a file although other systems such as

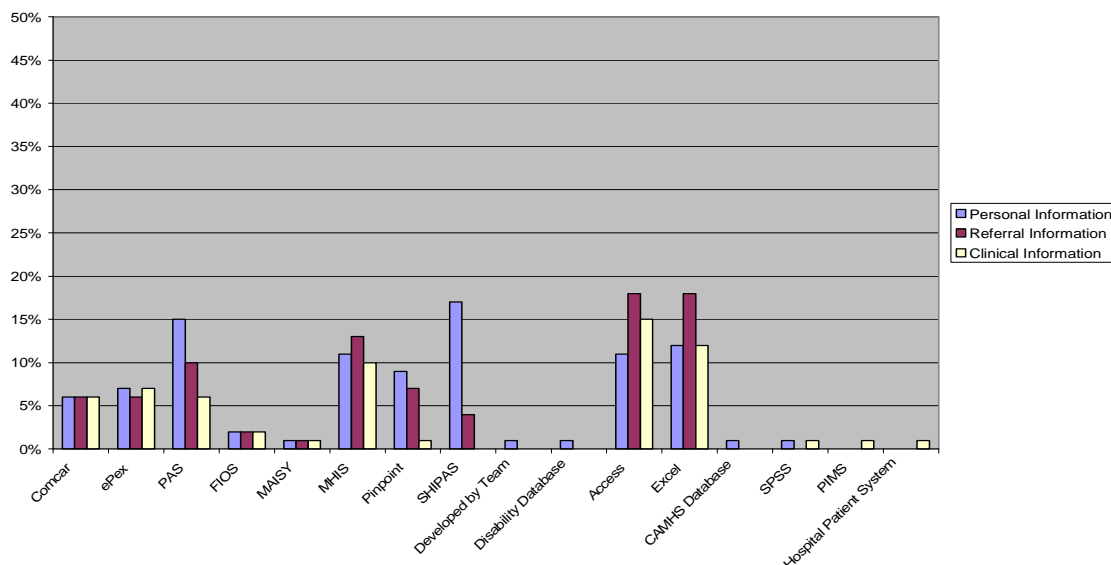
forms and templates are also used (Table 25). It is interesting that for 20% of respondents, referral information is recorded in a diary. The widespread use of manual systems, particularly for clinical information, makes the collation of information a time consuming process.

Table 25 – Paper Systems – Format



Where services have reported using an electronic system, the main ones used are locally developed spreadsheets or databases using Microsoft Excel or Access packages (Table 26). Where a mental health information system is mentioned it is mainly the hospital based PAS/SHIPAS.

Table 26 – Types of Electronic System Used



The survey did not ask about the availability to the respondent services of computers and it is not possible from the results of the survey to determine availability of electronic systems for services. However, it is interesting to speculate that where available, they have been used by services to support their work.

DISCUSSION

Introduction

In this chapter I propose to consider the broad issues arising from the results of the survey. I intend to consider the data which is collected by the mental health services and consider its completeness to deliver the evidence base for planning and managing the delivery of the mental health service.

I intend to consider the patterns of data collection as evidenced by the results of the survey and consider the implications of this in terms of the delivery of care to the service user, the management of the mental health service locally and the support for the planning and development of the service delivery at Local Health Office and national levels.

I will also discuss the systems by which the data is collected and the issues presented.

I propose to consider what this may mean for the implementation of the proposed National Mental Health Minimum Dataset, developed by the Mental Health Commission and the Health Research Board.

Finally, I suggest where the HSE might focus attention in order to support the development of a knowledge base of mental health information which will support its function to plan, manage and deliver quality mental health services.

Supporting Service Delivery

The World Health Organisation outlined the reasons for collecting information about health services:-

“For policymakers and planners, accurate and comprehensive mental health information provides the means for establishing goals and quality indicators for mental health care in the country and assessing whether these are being achieved.

For mental health professionals providing mental health services, this information is essential for assessing the needs of service users and for monitoring their response to interventions.

For people using mental health services, and the wider population, the availability of mental health information means that they can be informed about services they can receive and their likely outcomes” (Mental Health Commission, 2007;8).

These distinctions are helpful in considering the data reported as collected by the mental health services in Ireland.

- “Episode level information is required to manage an individual episode of service contact
- Case-level information is required to care for an individual service user
- Facility level information is required to manage the specific service facility (whether it is a CMHT, ward etc)
- Systems level information is required to develop a policy and plan for the mental health system as a whole” WHO (2005;3).

In considering the structures within the Primary, Community and Continuing Care Directorate, system level information needs to be two-tiered to reflect Local Health Office requirements and the national requirements.

Management of the Service User Journey – Episode and Case Level Data

“At the simplest level, mental health services need information about the people using their services. Detailed information is needed at the individual level to ensure that service users are getting the service they need and are followed up as necessary” (Mental Health Commission, 2007; 14). Having considered the current position in respect of data collection within the Irish Mental Health Services in the Literature Review, it is to be expected that data would be more complete and accurate at service delivery level than at Local Health Manager or national level.

The survey asked what personal and clinical information mental health services collect relating to the individual service user. All of this information relates to the management of the individual service user journey through the mental health services. Despite the limited respondents for some of the sub-specialties, the survey clearly demonstrates that the majority of mental health services collect the name and address of the service user, date of birth, and discharge date. Other information collected by a high proportion of the respondent services (90%+) are occupation, General Practitioner details, and admission diagnosis. It is interesting that the PPS number is collected by a number of services although it is difficult to see how it might be used in supporting the service user to recover. It is noteworthy also that information such as ethnicity, home visit details and referrals back to primary care are noted by less than 70% of services.

It is important to note that there is great variation in emphasis in the information collected across the different types of mental health services with certain commonality between adult mental health services such as General Adult, Rehabilitation and Psychiatry of Old Age and significant variation from that reported as collected by Child and Adolescent Services. The Child and

Adolescent Services demonstrate a focus on outcome measures that is not common to other respondents.

Turning to the clinical information reported as collected, primary diagnosis is the most common piece of information collected by the mental health services, followed by length of stay. This parallels the requirement on the services to return this information to the Health Research Board. Between 60% and 70% of services also collect secondary diagnosis, treatment options, symptoms, interventions, changes of symptoms following intervention and period of contact with the service. Less than 40% of services reported recording outcome measures and less than 60% use a diagnostic scoring system.

While the pattern of data collection is variable across the different mental health service types, there is consistency in the breadth of information collected relating to the individual service users and the clinical care which is received by them. It seems safe to draw the conclusion that the information relating to the service user journey is comprehensive, although somewhat inconsistent.

Management of the Mental Health Service – Facility Level

“At the service level, information is needed on the overall number attending, what services they need and what their outcomes are so that services can be planned and their performance monitored and evaluated” (Mental Health Commission, 2007;14). The survey asked the mental health services to indicate the information which they collected which could broadly be described as activity information relating to the service. Further perspective on this kind of information was sought by asking services to indicate the information which was provided by them to the Mental Health Commission and the Health Research Board.

Of the activity information reported as collected by the mental health services, the majority of services (over 80%) collected numbers attending, date of first attendance and return or repeat attendance. The Health Research Board and the Mental Health Commission also collect this information and it may be that the services only collect this information because of the requirement to report to these agencies.

Over 70% of services report that they record non-attendance at appointments, while nearly 90% record the number of referrals to the service. A slightly smaller number of services collect details of the source of referrals. However, with the exception of Child and Adolescent services (67%) less than 40% of the mental health services record the number of inappropriate referrals. Less than 50% of all services record a return of service users to primary care. The information suggests that, apart from the information required to be provided by the Health Research Board

or the Mental Health Commission, the services note activity details relating to the day to day management of the services, counting numbers, attendances, and referrals.

Other activity information is contained in that which is supplied to the Mental Health Commission. Again this information is limited to the adult mental health services with very few child and adolescent services reporting returns to the Mental Health Commission. All of additional activity information relates to the requirements of the Mental Health Act, 2001 and specifically the Regulations by which certain interventions are regulated such as ECT, Restraint and Seclusion. However, less than 80% of the respondent services provided information to the Mental Health Commission and of these the primary information provided related to attendances, legal status, involuntary admissions and Tribunal activity, although not all services provided all of the information. These services also provided similar information to that provided to the Health Research Board, with the addition of budget and staffing (by less than 60%) of services. It is reasonable to suggest that these findings relate in the main to inpatient units, probably Approved Centres, and that this information is only collected because of the requirements of the legislation.

There is an absence of outcome measures collected by either the Health Research Board or the Mental Health Commission and it is likely that activity numbers and readmission rates are used as the proximate indicators of outcome.

It seems clear that many mental health services only collect service level information when required by regulation or an agency external to the organisation. It appears to be limited in scope as well.

System Level Data Collection.

In considering system level data, it is to be expected that information relating to numbers attending, the needs of the service user and the outcomes delivered is collected to ensure that an appropriate service is being delivered.

The direct line management for most mental health services is the mental health catchment management team although this structure does not apply to some of the sub-specialties in mental health. In that context it is interesting that, disregarding the replies from Forensic and Liaison services where the respondents were only one of each, less than 50% of services reported on a range of information to their immediate line management. Of these, the greater number reported on staff numbers and staff vacancies, activity and budget, with a slightly smaller number reporting on expenditure. Information on involuntary admissions, assisted admissions and numbers admitted were also provided.

However, when services were asked about the information which they provided to their Local Health Manager, a different picture emerges. Since the establishment of the HSE, the majority of mental health services are provided through the Primary, Community and Continuing Care Directorate which has devolved responsibility for services to Local Health Managers for a defined geographic “patch”. This line management structure is common to all the mental health service types and the profile of information provided improves to over 70% of services providing information at this level.

It is interesting that nearer 80% of services report to the Local Health Manager on progress on new developments, with information on budget, expenditure, staff number, types and grades being next most likely to be provided and with staff vacancies also provided by about 50% of services. Slightly more services report providing activity information to the Catchment Management Team than to their Local Health Manager.

It is also worth noting that the Forensic Services and Early Intervention, Mental Health Intellectual Disability and Liaison Services report very little information to the Local Health Manager. This may reflect the fact that these services are provided at a geographic level broader than Local Health Office and/or that these services are delivered outside the Primary, Community and Continuing Care Directorate or by voluntary organisations.

Information Needs at National Level

The survey findings indicate that less than 50% of all of the respondent mental health services provide information to the HSE at a national level. Of these services, there are between 30% and 50% who report on budget, expenditure, staff numbers, staff vacancies, activity and to a lesser degree attendance.

More services provide information relating to staff vacancies than about staff numbers, grades or skill mix.

The Mental Health Commission suggests that, at national level, information is required to monitor and evaluate service performance against policy objectives and to plan for the needs of the population served. As was noted above with the information provided to the Local Health Manager, there is certainly information available about the needs of the service for staffing and funding but little other than activity and expenditure to give a picture of service user need, service outcomes or performance against policy objectives.

It is clear that the information relating to the service user journey through the mental health service at the point of delivery is reasonably comprehensive although varying between specialties. However, information relating to the management of the service and the monitoring and evaluation of service delivery is limited.

Why collect information?

Another aspect impacting on the collection of data in the mental health services is the understanding of the use of such information. In an environment which concentrates on employment control and financial savings, it is interesting to speculate that the reason why it is only staffing and financial information that it provided at Local Health Manager and national level is because this is the information which elicits a response from those entities!

It is also noted by commentators that there is a direct relationship between the validity and accuracy of information provided and the understanding of the usefulness of the exercise by those collecting the information.

Insight into the views of the mental health services in relation to the information collected and the uses to which it is put is provided by the part of the survey which asked how the information provided by the service is returned for use by the service and how usefully could such information be returned. Of the respondents, less than 40% reported information being returned to them in any format, while of those which did receive information back, it was in the main as part of the monitoring of the Service Plan.

When asked how best information might be provided back to the mental health services to support them in planning and managing their services, the services suggested that, as well as part of service plan monitoring, it should also be part of a performance management report. Slightly less services considered that the information would be helpful benchmarked against other mental health services. Less than 25% of the services considered that the information should be returned to support the planning and evaluation of the service.

Perhaps the most noticeable aspect of these survey results is that services do not get, and do not expect to get, feedback on the information which they provide about their service. Their interest is in those aspects of the service where they do get feedback – expenditure and staffing. They are also interested in how they perform against other mental health services, not as against health services generally nor against other services in their geographical area. This suggests an inward focus for the mental health services and they look to themselves to improve.

From the perspective of the mental health services, gathered from the respondents to the survey, line management is interested only in staffing levels, expenditure and progress on new developments, with a lesser focus on activity. There is little focus on the outcomes produced by the service other than the proxy indicators of activity and expenditure and no information relating to the needs of the service user. It is difficult to be clear as to why this may be so, whether it is a pattern developed by the perception that these areas are the only ones of interest to line management or whether these areas are put forward because they support the needs of the service. Some light can be shone on this from the survey when the suggestions and comments of the services in relation to information are factored in. I consider some of these views below.

Views of Mental Health Services

A number of services took the opportunity presented by the free text parts of the questionnaire to give their views on data collection. As this was not a qualitative survey, these comments can only be seen as indicative of the views of the mental health services at present. The following is a selection of the views provided:-

- “Comparison with other services only serves to bring all to common denominator”.
- “Performance management and service evaluation now smack of negative criticism and meeting targets. Health service provision is not an ordinary business. Processes used to assess business in general are too crude to be applied to health”
- “No feedback to local services. Local service no real say. Decisions made on budgetary considerations rather than patient care”

These comments point to a clear disconnect between the mental health services and management within and outside of the mental health services. It confirms the isolation of the mental health services within the overall health service delivery system and identifies that the focus of the services tends to inward self appraisal. It does not take a wider contextual view of the broader health service of which it is part.

The comments also highlight the issue demonstrated by the patterns of data collection, that the mental health services do not attribute a value to the provision of information to line management or to other levels of management. The lack of two-way communication between the services providing the information and the end user of the information compounds this perception. The outcome of this is that services take no interest in providing information or see it as not relevant to their work. As one of the respondents put it “The submission of this type of information can be futile as there are no feedback systems nationally and I doubt if anyone uses the information in planning anything in the context of health service delivery”. For many of the mental health services it seems that, “Completing the returns *[is]* a religious observance, a

periodic turning of the prayer wheels, with no expected purpose or rewards – at least in this life” (King in Mason and Morrison eds. 1985: 3 (my italics)).

Glover’s work in the NHS in the 1990s (Glover, Sinclair Smith 2000;521) also drew on general observations from participants which closely echo the observations made by respondents to this study. The adversity of clinicians to what is perceived as bureaucracy was highlighted. Further, a sense was given that developments in information gathering did not support the task of looking after people. Valenstein et al (2004) “found that the majority of mental health care providers believed feedback about widely used indicators would be potentially valuable in efforts to improve care. However, mental health care providers expressed greater ambivalence about their ability to influence indicators and about the value of current monitoring processes”. The comments of the mental health services surveyed in this study for the most part considered that feedback to their services would improve care. It was however also pointed out that it should not take from clinician time and should be relevant to their service.

Systems by which data is collected in the Mental Health Services

“No new data collection strategy has the luxury of a clean slate of information systems. There is always a legacy of systems designed for different purposes.” (Glover, 2000). “In England the information system arrangements most commonly seen reflect the historical development of requirements for statistical reporting” (Glover, 2000).

As with Glover’s work, this study was not able to go into extensive detail about the nature and extent of the information systems being used in the mental health services in Ireland. Indeed it might be more appropriate to describe them as reporting systems where data flows from the bottom to the top and hardly any data is returned to those who gathered it. Such systems are not sustainable. Information systems imply that data collected is analysed and utilised for use in planning and delivering the services (WHO, 2005).

This survey asked respondents to indicate the methods used by their services to collect personal and clinical information relating to the service user, and referral information. 70% of services reporting using paper based systems to record all three types of information, with less than 60% using electronic systems for this data. Within that 60% of respondents, the electronic systems used were across no less than sixteen different systems, a mix between purpose built mental health system, hospital based systems and databases and spreadsheets using generic software packages. As with the UK, there are a plethora of systems developed for different purposes but, unlike the findings within the NHS, the information systems within the mental health systems in Ireland do not reflect statistical reporting arrangements at service level. The results of this

survey suggest that where electronic systems are used, they support patient management and not the statistical reporting requirements.

The policy documents reviewed in the literature identified that the mental health systems in Ireland are overly reliant on paper based systems to collect information relating to the services. This is confirmed in the survey where over 70% of respondents rely on the file to record service user information, referral information and clinical information. 30% or less of the respondent services used template or forms to record this information which suggests that the data is not collected in any consistent way between services and therefore would be difficult to collate for analysis.

This reliance on manual systems of data collection has implications for the implementation of any proposed national mental health minimum dataset. It raises concern about definition of data elements, ensuring consistency across services and the practical logistics of collecting and collating the information for analysis. However, less than 10% of respondents indicated that there was no administrative support available to them. Also, the findings suggest that for the most part information is collated by a combination of clinical team member and administrative support.

Where next for Data Collection in the Mental Health Services – A Proposal for a National Mental Health Minimum Dataset?

The Mental Health Commission and the Health Research Board in preparing the Proposal for a National Mental Health Minimum Dataset (Mental Health Commission and Health Research Board, 2007) drew heavily on the work of the World Health Organisation's Mental Health Policy and Service Guidance Package on Mental Health Information Systems (WHO, 2005).

The WHO identifies the steps it recommends in designing and implementing a mental health information system. Step 1 is a Needs Assessment where the information that is needed is identified, step 2 analyses the current situation, step 3 looks at implementation and step 4 evaluates how well the new information systems are working.

The Mental Health Commission in commissioning the work by PA Consulting on the existing information systems initiated work on a review of the current system. The work with the Health Research Board in developing the proposal for a mental health minimum data set tries to identify the information needed by the system. However, although there were briefing meetings with the HSE, the mental health services themselves were not included in the process of identifying the information needs to plan and manage the services. Yet, quality monitoring

programmes that carefully consider the views of frontline mental health care providers are more likely to be effective (Valenstein, 2004).

The proposed mental health minimum dataset identifies potential indicators from which the minimum data element requirements were identified. However, Campbell et al (2003) noted that “stakeholders have different perspectives about quality of care. e.g. patients often emphasise good communication skills whereas manager’s views are often influenced by data on efficiency. It is important to be clear which stakeholder views are being represented when developing indicators”.

Although the exercise was conducted by the Mental Health Commission and the Health Research Board with a view to carrying out extensive consultation with all of the stakeholders, it is important to consider that the two stakeholders involved in preparing the proposal have distinct functions. The Mental Health Commission is a regulatory body with a responsibility for ensuring that mental health services are compliant with the Mental Health Act and is also responsible for promoting and fostering quality mental health services. The Health Research Board is primarily a research body which has historically been the single collector and analyst of information relating to the mental health services in Ireland. Neither body has responsibility for the planning and delivery of mental health services. “This data set contains all of the essential data items for the Mental Health Commission and the Health Research Board” Mental Health Commission, Health Research Board (2007,6). In ensuring the inclusion of the current requirements in data of both of these organisations, this exercise assumes that the current mechanisms by which information is collected from the mental health services directly by both of these organisations should continue.

The absence of the body charged with planning and delivering the mental health service from the process of developing the proposed indicators and data elements, combined with the lack of consultation with the mental health services themselves, is likely to reinforce the prejudices among the mental health services, identified in the survey, about the value of information collection to those delivering care. Further, it reinforces the historical position where data is provided by the mental health services to a central agency, outside of the delivery system, and where they have had, in practice, little or no feedback for their services from the exercise. This reporting system has been the main focus of the data collection activities within the services and the resultant abdication of ownership of the information by those services is demonstrated by the patterns of data collection arising in this study.

Therefore, it seems imperative to ensure that appropriate information is provided to those with responsibility for planning, managing and delivering the mental health services in the first instance before the needs of the regulatory and research bodies are considered.

Klein and Scrivens in considering the work of Dame Edith Korner with the NHS in the 1980s comment on the implications of information in terms of the power base within any organisation. They note that “Information of itself has little value. It is a tool to be used to aid decision making and to monitor and perhaps improve performance of tasks. It proves the basis for accountability in an organisation and, as such, is enmeshed in its functioning and management. Therefore, *[it]* cannot be viewed simply as neutral and technocratic but as something which raises fundamental questions about accountability [.....]. Who is accountable to whom; what should the currency of accountability be; and how should power within *[a]* health care system be distributed both between the different levels in the administrative hierarchy and between the different professional groups responsible for running the services?” (Klein and Scrivens in Mason and Morrison eds. 1985;15 *my italics*). The pattern of data collection demonstrated by the survey is indicative of confusion about the accountability within the mental health service delivery system.

The disempowerment of the mental health services in respect of its perceived ability to influence the provision of services, attract investment or demonstrate the quality of care delivered by the services underscores the feedback received in the survey. The premise that knowledge is power has not been demonstrated as relevant to these services in their roles of planning and delivering services. Where it has proved powerful is in the immediate delivery of care to the service user and it is notable that it is in this area that data collection and information systems are best developed.

CONCLUSION AND RECOMMENDATIONS

The objectives of the study are:-

1. To establish the existing level of data relating to Mental Health Services in the HSE, to identify gaps and common features;
2. To establish the purpose and use of that data and the methods by which the data is collected;
3. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

On commencing the study it was clear that there was some limited information available about the mental health services in Ireland. This study has addressed that gap by providing a comprehensive picture of the landscape of data collection across the mental health services nationally. It identified the data elements collected at case level, episode level, facility level and system level and highlighted the deficits at facility and system level. It provides an indication of data collection practice across all of the mental health specialties although there were very few respondents from some of the sub-specialties. It confirms the expectation raised in the literature review that the data is collected by manual means and suggests that where electronic systems are used it is to support the provision of care to the individual.

The pattern of data collection identifies a systemic issue of confusion in relation to accountability within the mental health services and confirms the isolation of mental health service provision within the health services. It clarifies that there is no information system within the mental health services, rather the system is a reporting system with all of its associated issues, including unreliable and inconsistent data collection, disinterest and lack of understanding of its purpose among the staff required to carry out the work and, most significantly, the abdication of responsibility to agencies with no role in the planning, management and delivery of mental health services.

In this context, the implications of the findings of the survey are broader than just addressing the implementation of a national mental health minimum data set as the following recommendations suggest:-

- The Health Service Executive needs to open a dialogue with the mental health services with a view to identifying the information needs at each level of delivery to support it in

the provision of mental health services. The work of the Mental Health Commission and the Health Research Board may prove of assistance in this endeavour.

- The Health Service Executive needs to take ownership of the data and information generated by its services to support its objective of service delivery. This may also generate dividends in terms of engagement by services in the delivery of quality services if associated with an appropriate mental health information system.
- The Health Service Executive needs to consider the arrangements by which information is provided directly from each mental health service to agencies with no responsibility for the planning, managing and delivery of mental health services to provide for their needs to regulate the mental health services or carry out research.
- The evidence of the survey identifies issues relating to confused ideas of accountability for the delivery of quality mental health services and resultant disengagement by mental health services. The consequences include a strong isolationist approach taken by the services, not only from other health services but also from other specialties within the mental health services. This has significant consequences for the Health Service Executives objectives relating to integrated care.
- The Health Service Executive should consider the development of a Mental Health Information System like that proposed by the World Health Organisation in its Service Guidance document (WHO, 2005) suitably supported by appropriate ICT structures. The work already begun by the Mental Health Commission and the Health Research Board, with the assistance of the baseline information arising from this study, could provide a strong basis for a successful project.

Limitations of Study and Implications for Future Research

One of the major limitations of the study was the necessity to address the survey to participants with different roles. Because of the differing management structures nationally and within the specialties of the mental health services, it was not possible using only the area administrators to get a complete spread of the services and using only the consultant psychiatrist contacts was unreliable as the contact lists were incomplete. Consequently it was necessary to risk duplication of results in order to ensure complete coverage of all mental health services.

It was suggested in the pilot that the survey would be more complete if each of the respondents had been asked to identify themselves as it would allow for direct follow up with the services who did not respond. A complete mapping of the data collected by the services could be achieved using the line management structure within the HSE and requiring compliance. However, this is likely to be at the expense of the goodwill of the services and potentially the invaluable identification of issues. This exercise might form the basis of further research in this area.

REFERENCES

- Asch DA, Jedrzejewski MK, Christakis NA. (1997) "Response rates to mail surveys published in medical journals". *Journal of Clinical Epidemiology*. Vol 50 Issue 10 1997 1129-1136.
- Butler, M (1999). *Performance Measurement in the Health Sector CPMR Discussion Paper 14*. Institute of Public Administration. Dublin.
- Campbell, S.M, Braspenning, J., Hutchinson, A, Marshall, M.N. (2003) "Research methods used in developing and applying quality indicators in primary care". *BMJ* 326:816-819.
- Department of Health and Children (2001) *National Health Strategy – Quality and Fairness*. Dublin, Government Publications.
- Department of Health and Children (2003) *Health Information – A National Strategy*. Department of Health and Children. Dublin
- Department of Health and Children (2004) *Health Information A National Strategy*, Dublin, Government Publications.
- Department of Health and Children (2006) *Report of the Expert Group on Mental Health Policy – A Vision for Change*, Dublin, Government Publications.
- Eastern Regional Health Authority *Health Services National Performance Indicators 2002*. Unpublished.
- Eddy DM. (1998) "Performance Measurement; Problems and solutions". *Health Affairs* Vol 17 issue 4 pgs 7-25.
- Freedman, D.H (2006) "Do you manage by numbers? Be careful if you do: Your data may be playing tricks on you". *INC. Magazine* Nov. 59-60.
- Glover, G.R. (2000). "A comprehensive clinical database for mental health care in England", *Social Psychiatry and Psychiatric Epidemiology*, 35:523-529.
- Glover, G.R. and Sinclair-Smith, H (2000) "Computerised information systems in English mental health care providers in 1998". *Social Psychiatry and*

Psychiatric Epidemiology, 35:518-522

Health Service Executive, (2008) Draft Report on Value For Money Review of Residential Service Provision in Mental Health Services. Unpublished Report.

HSE (2005) Corporate Plan 2005-2008. Available from <http://www.hse.ie> [accessed July 2007]

King, D (1985) “Mrs Korner and her Steering Group” in Mason, A. and Morrison V., (eds) (1985). Walk, don’t run – A collection of essays on information issues published to honour Mrs Edith Korner, CBE, Chairman of the NHS/DHSS Health Services Information Steering Group 1980-1984. King Edward Hospital Fund, London. (1985)

Klein, R. Scrivens, E. (1985) “The politics of information” in Mason, A. and Morrison V., (eds) (1985). Walk, don’t run – A collection of essays on information issues published to honour Mrs Edith Korner, CBE, Chairman of the NHS/DHSS Health Services Information Steering Group 1980-1984. King Edward Hospital Fund, London. (1985) .

Lennon, P. (2005). Protecting Personal Health Information in Ireland Law and Practice. Oak Tree Press

Mason, A. and Morrison V., (eds) (1985). Walk, don’t run – A collection of essays on information issues published to honour Mrs Edith Korner, CBE, Chairman of the NHS/DHSS Health Services Information Steering Group 1980-1984. King Edward Hospital Fund, London.

Mental Health Commission (2005) Mental Health Commission Annual Report 2004, including the Report of the Inspector of Mental Health Services. Dublin

Mental Health Commission (2007) Proposal for a Mental Health Minimum Data Set. Unpublished.

Mental Health Commission (2007) Quality Framework – Mental Health Services in Ireland. Dublin.

PA Consulting (2006) A Scoping Exercise on Mental Health Information Systems in Ireland. Unpublished Report.

Reid, V. Mental Health Performance Indicators 2007 – Discussion Document. Unpublished Report.

Rigby M, Lindmark J, Furlan PM. (1998) “The importance of developing and informatics framework for mental health”. Health Policy. Vol. 45 Issue 1 1998 pp 57-67.

Saxena, S., Lora, A., Van Ommeren, M., Barrett, T. et al.(2007) “WHO’s Assessment Instrument for Mental Health Systems: Collecting Essential Information for Policy and Service Delivery”. Psychiatric Services Arlington Vol 58 Iss 6 p 816.

Shaw, I (1997) “Assessing quality in health care services: lessons from mental health nursing”. Journal of Advanced Nursing 26 758-764.

Simmons, D, Coppell, K, Drury PL, (2000) “The development of a national agreed minimum diabetes dataset for New Zealand”. Journal of Quality Clinical Practice, 20; 44-50.

Valenstein M, Mitchinson A, Ronis, DL, Alexander JA, Duffy, SA, Craig TJ, Barry KL, (2004) “Quality Indicators and monitoring of mental health services: What do frontline providers think?” American Journal of Psychiatry Vol 161 Issue 1 Pages 146-153 2004.

Wiley, M.M (2005) “Using HIPE data as a research and planning tool: limitations and opportunities: A Response”. Irish Journal of Medical Science. 174.

World Health Organisation (2005) *Mental Health Information Systems (Mental Health Policy and Service Guidance Package)*. World Health Organisation Press, Geneva.

APPENDIX 1 – SEARCH CRITERIA

Databases	Search Terms	Results	Limits	Relevant Article
Athens	“mental health” AND “dataset”	444	No	1
	“Performance” AND “measurement”	14,587 (no limits)	No	
	“Performance” AND “measurement”	5,308	Yrs 2002-2007	2
	“Performance” AND “indicator”	2283	Yrs 2003-2007	
	“Performance” AND “indicator”	116	Full text Last 12 months	2
	“Performance” AND “indicator” AND “public sector”	1	As above	0
	“Performance” AND “indicator” AND “public sector” AND “mental health”	0		0
	“minimum dataset” AND public sector” AND “mental health”	0	As above	0
	“minimum dataset” AND “mental health”	0	As above	0
Proquest	“mental health”	16590	No limits	Too broad
	“mental health” AND “performance indicators”	4	English Full txt only	4
Web of Science ABI/Inform CINAHL	“Performance measurement” AND “dataset” AND “health”	1	As above	0
Web of Science	“evaluation” AND “dataset” AND “mental	3	As above	0

	health”			
ABI/Inform	“evaluation” AND “dataset” AND “mental health”	0	As above	0
CINAHL	“evaluation” AND “dataset” AND “mental health”	17	As above	0
Web of Science	“quality measurement” AND “mental health services”	4	As above	Older material/other articles cited of interest
ABI Inform	“quality measurement” AND “mental health services”	0	As above	0
CINAHL	“quality measurement” AND “mental health services”	0	As above	0
Web of Science ABI Inform CINAHL	“quality measurement” AND “mental health services” AND “Irish”	0	As above	0
Web of Science ABI Inform CINAHL	“dataset” AND “mental health services” AND “Ireland”	0	As above	0
Web of Science	“evaluation” AND “mental health services” AND “Ireland”	4	As above	0
ABI/Inform	“evaluation” AND “mental health services” AND “Ireland”	1	As above	1
CINAHL	“evaluation” AND “mental health services” AND “Ireland”	21	As above	0
Web of Science ABI Inform CINAHL	“quality measurement” AND “mental health services” AND “Ireland”	0	As above	0

Web of Science ABI Inform CINAHL	“minimum dataset” AND “mental health services” AND “Ireland”	0	As above	0
Web of Science ABI Inform CINAHL	“minimum dataset” AND “mental health services” AND “Ireland” AND “service planning”	0	As above	0
Web of Science ABI Inform CINAHL	“minimum dataset” AND “mental health services” AND “service planning”	0	As above	0
Web of Science ABI Inform CINAHL	“measurement” AND “mental health services” AND “service planning”	0	As above	0
Web of Science	“information” AND “mental health services” AND “service planning”	11	As above	0
CINAHL	“information” AND “mental health services” AND “service planning”	4	As above	0
Web of Science ABI Inform CINAHL	“information system” AND “mental health services” AND “service planning”	0	As above	0
Web of Science	“Information system AND “mental health”	19	As above	1
ABI/Inform	“Information system AND “mental health”	25	As above	0
CINAHL	“Information system AND “mental health”	25	As above	0
Web of Science	“Information system AND “mental health” AND “Ireland”	2	As above	1
ABI/Inform CINAHL	“Information system AND “mental health” AND “Ireland”	0	As above	0

Cochrane PubMed	“performance measurement” AND “dataset”	0	Full Txt, English	0
Cochrane	“evaluation” AND “dataset” AND “mental health”	8	As above	0
PubMed	“evaluation” AND “dataset” AND “mental health”	6	As above	0
Cochrane	“quality measurement” AND “mental health services” (AND “irish”)	0 (0)	As above	0
PubMed	“quality measurement” AND “mental health services” (AND “irish”)	10 (0)	As above	1
Cochrane	“dataset” AND “mental health services” AND “Ireland”	0	As above	0
PubMed	“dataset” AND “mental health services” AND “Ireland”	1	As above	0
Cochrane	“evaluation” AND “mental health services” AND “Ireland”	4	As above	0
PubMed	“evaluation” AND “mental health services” AND “Ireland”	17	As above	0
Cochrane PubMed	“Quality measurement”/”Minimum Dataset”/ AND “Mental health services” AND “Ireland” AND “service planning”	0	As above	0
Cochrane/ Pubmed	“measurement” AND “mental health services” AND “service planning”	1/1	As above	1 relevant
Cochrane	“Information” AND “mental health services”	4	As above	0

	AND “service planning”			
PubMed	“Information” AND “mental health services” AND “service planning”	17	As above	0
Cochrane	“Information” AND “mental Health “	2	As above	0
PubMed	“Information” AND “mental Health “	224	As above	1
Cochrane PubMed	“Information Systems” AND “mental health services” AND “Ireland”	0	As above	0

APPENDIX 2 – ETHICAL APPROVAL DOCUMENTATION

a. Letter to Gatekeeper and Data Controller

7 Riverside Crescent
Kilcullen
Co Kildare

27th November 2007

Mr Martin Rogan
Assistant National Director
Mental Health
Office of the CEO
Millennium Park
Naas
Co Kildare

Dear Mr Rogan,

I am a second year student completing my MSc in Health Services Management in Trinity College. As part of the course requirements, I must complete a Dissertation on a management related topic.

The objectives of my Study are:

4. To establish the existing level of data relating to Mental Health Services in HSE and to identify gaps and common features;
5. To establish the purpose and use of that data and the methods by which the data is collected;
6. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

I propose to collect the data using an Anonymous Survey Questionnaire which I hope to send to the Sectoral Management Teams of the Mental Health Services in the HSE. Contact details for these management teams are held by the Office of the Assistant National Director, Mental Health and I should be obliged if you could, as Data Controller, give me permission to use those details to contact the Sectoral Teams.

I hope that the outcome of my study will support the development of a national minimum dataset for the HSE and the provision of valid reliable and timely information by which the mental health services management teams could plan and develop quality mental health services.

Your support and permission in carrying out the study would be appreciated.

Yours sincerely

Carol Ivory

b. Reply from Gatekeeper and Data Controller



eannacht na Seirbhíse Sláinte
Health Service Executive

Oak House
Lime Tree Avenue
Millennium Park
Naas
Co. Kildare

Tel: (045) 880 400 / LoCall 1890 737 343
Fax: (045) 880 482 / LoCall 1890 200 857

14th January 2008

Ms Carol Ivory
7 Riverside Crescent
Kilcullen
Co Kildare

Dear Carol,

Thank you for your letter dated 27th November 2007 advising me of your dissertation proposal to complete your MSc in Health Services Management in Trinity College.

I am happy to support your Study objectives:-

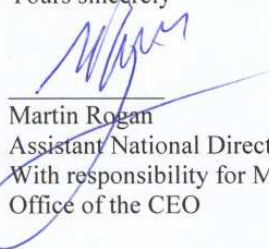
1. To establish the existing level of data relating to Mental Health Services in HSE and to identify gaps and common features;
2. To establish the purpose and use of that data and the methods by which the data is collected;
3. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

I consider that the outcome of the Study in supporting the development of a national mental health minimum dataset for the HSE is very timely in light of the recommendations of the Vision for Change and the HSE's priorities in its Implementation Plan for the Vision for Change.

I give my permission as Data Controller for you to access and use the contact details for the mental health sector management teams held by my Office in order to distribute your Survey and I am happy to fully support your work in this Study..

I wish you every success in this endeavour.

Yours sincerely


Martin Rogan
Assistant National Director
With responsibility for Mental Health
Office of the CEO

c. Letter for permission to contact Mental Health Services

7 Riverside Crescent
Kilcullen
Co Kildare

27th November, 2007

Mr Seamus McNulty
Assistant National Director
PCCC,
Lead responsibility in Mental Health
HSE West
Merlin Park
Galway

Dear Mr McNulty,

I am a second year student completing my MSc in Health Services Management in Trinity College. As part of the course requirements, I must complete a Dissertation on a management related topic.

The objectives of my Study are:

7. To establish the existing level of data relating to Mental Health Services in HSE and to identify gaps and common features;
8. To establish the purpose and use of that data and the methods by which the data is collected;
9. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

I propose to collect the data using an Anonymous Survey Questionnaire which I hope to send to the Sectoral Management Teams of the Mental Health Services in the HSE. I should be obliged if you could give me permission to contact the Sectoral Teams within the Primary, Community and Continuing Care Directorate asking for their participation in the study.

I hope that the outcome of my study will support the development of a national minimum dataset for the HSE and the provision of valid reliable and timely information by which the mental health services management teams could plan and develop quality mental health services.

Your support and permission in carrying out the study would be appreciated.

Yours sincerely

Carol Ivory

d. Letter granting permission to contact Mental Health Services



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the Assistant National Director
PCCC Directorate
HSE West
Merlin Park Hospital
Merlin Park
Galway
☎ (091) 775 417
☎ (091) 752 828

14th January 2008,

Ms Carol Ivory,
7 Riverside Crescent,
Kilcullen,
Co Kildare.

Dear Carol,

Thank you for your letter dated 27th November 2007 advising me of your dissertation proposal to complete your MSc in Health Services Management in Trinity College.

I am happy to support your Study objectives:-

1. To establish the existing level of data relating to Mental Health Services in HSE and to identify gaps and common features;
2. To establish the purpose and use of that data and the methods by which the data is collected;
3. On the basis of (1) and (2) to consider the likely implications of the recommendations of the Mental Health Commission/Health Research Board in the Draft Proposed National Minimum Data Set for Mental Health.

I consider that the outcome of the Study in supporting the development of a national mental health minimum dataset for the HSE is very timely in light of the recommendations of the Vision for Change and the HSE's priorities in its Implementation Plan for the Vision for Change.

I give my permission as Assistant National Director with responsibility for Mental Health in the Primary Community and Continuing Care Directorate for you to seek the participation of the mental health sector management teams to complete your Study. I am happy to recommend that each of the mental health sector management teams participate in the Study which will support the development of a national minimum dataset for the HSE and the provision of valid

reliable and timely information by which the mental health services management teams could plan and develop quality mental health services.

I wish you every success in this endeavour.

Yours sincerely

Seamus McNulty
Assistant National Director
Primary, Community & Continuing Care
Health Service Executive West

e. Letters to Participants

7 Riverside Crescent,
Kilcullen,
Co Kildare.

April 2008

To Area Administrators
Mental Health Services Management Teams

Re: A study to establish the mental health data collected in the mental health services of the Health Service Executive and the information systems used.

Dear Sir/Madam,

My name is Carol Ivory and I am a student in my second year on the MSc in Health Services Management programme in Trinity College Dublin.

I would be grateful if you would take a few moments to read this letter and the enclosed information leaflet which sets out the aims, objectives and benefits of the above study.

In my research study I hope to examine the

- Types of data currently collected by our mental health services,
- Identify any gaps or common features,
- Establish the purpose and use of the data
- Establish the information systems by which this is achieved.

The outcome of the Study will support the development of a national mental health minimum dataset for the HSE and support the provision of valid, timely and reliable information to the mental health services for planning, managing and developing quality mental health services.

I attach for your information a copy of a letter received from Mr Seamus McNulty, Assistant National Director with responsibility for mental health, Primary, Community and Continuing Care Directorate giving his support to the Study and giving permission to contact the mental health sector teams. Mr Martin Rogan, Assistant National Director, Mental Health, Office of the CEO has also written in support.

This research study is being undertaken by me under the supervision of Professor Charles Normand, Trinity College Dublin and with the approval of the Faculty Ethics Committee, Trinity College. If after reading the enclosed information leaflet you are happy to participate, please complete the enclosed questionnaire and return in the stamped addressed envelope also enclosed.

The information sought in the questionnaire is anonymous. All of the data collected will be held securely in accordance with the requirements of Data Protection legislation. No-one other than the researcher will have access to the information provided.

If you have any further questions about the study, or require additional information now or any future time please contact me:

Name: Carol Ivory

Address: 7 Riverside Crescent, Kilcullen, Co. Kildare

Phone No: 087 9273198

I would like to take this opportunity to thank you for participating in this Study and request that you return the completed questionnaire in the enclosed stamped addressed envelope by **Friday 2nd May, 2008.**

Yours sincerely

Carol Ivory

f. Participant Information Leaflet

Participant Information Leaflet

A STUDY TO ESTABLISH THE MENTAL HEALTH DATA COLLECTED IN THE MENTAL HEALTH SERVICES OF THE HEALTH SERVICE EXECUTIVE AND THE INFORMATION SYSTEMS USED.

Principal Investigator's Name: Carol Ivory
Principal Investigator's Title: Student Researcher

Telephone No. of Principal Investigator: 087 9273198

You are invited to take part in a research study carried out as part of the requirements for completion of the MSc programme in Health Services Management run by Trinity College. Before you decide whether or not you wish to take part, you should read the information provided below carefully. Take time to ask questions – do not feel rushed or under any obligation to make a hasty judgement. You should clearly understand the risks and benefits of participating in this study by completing the attached Survey Questionnaire.

You may change your mind at any time for whatever reason without having to justify your decision.

WHY IS THIS STUDY BEING DONE?

The Report of the Expert Group on Mental Health Policy – A Vision for Change, published in January 2006, commented that very little is known about the mental health of people living in Ireland nor is it known the type of mental health care that these individuals receive. The absence of reliable and valid data relating to the planning, management and delivery of mental health services has been noted by the Inspectorate of Mental Health Services and the Mental Health Commission and has been the subject of recommendations in many policy documents. The Health Service Executive was established in 2005 as a single national health care delivery system for the country. This provides the backdrop to the research study which will examine the types of data currently collected by the mental health services, identify any gaps or common features, establish the purpose and use of the data and identify the information systems, either manual or electronic, by which the data is recorded. The outcome of the Study will support the development of a national mental health minimum dataset for the HSE and support the provision of valid, timely and reliable information to the mental health services for planning, managing and developing quality mental health services.

WHO IS ORGANISING AND FUNDING THIS STUDY?

I am a student in my second year of the MSc in Health Services Management Course which is taught by Trinity College. Part of the requirements for completing the course is to complete a dissertation. This Study is the focus of my Dissertation. The study has no financial implication for the HSE.

HOW WILL IT BE CARRIED OUT?

I intend to do a Descriptive Study using Quantitative methods and I will write to all of the Area Administrators of the Catchment Management Teams of the Mental Health Services asking for their participation in completing an Anonymous Survey Questionnaire.

BENEFITS:

My Study will inform the discussion around the development of a national mental health minimum dataset which will support mental health services in the HSE in planning and developing quality mental health services. There will be no inducements offered to participants.

CONFIDENTIALITY ISSUES

The information sought in the questionnaire is anonymous. All of the data collected will be held securely in accordance with the requirements of Data Protection legislation. No-one other than the researcher will have access to the information provided.

I have been given approval by the Faculty of Health Sciences Ethics Committee of Trinity College Dublin to undertake this Study. I have permission and full support from the Assistant National Director, Primary, Community and Continuing Care Directorate with responsibility for Mental Health to contact the mental health services nationally.

It is possible that other researchers may seek to use the information gathered in the Study for further research. You have the option to agree to the use of this data in further studies if you wish.

IF YOU REQUIRE FURTHER INFORMATION

If you have any further questions about the Study, or if you wish to withdraw from the study you may do so without justifying your decision.

For additional information now or any future time please contact:

Name: Carol Ivory

Address: 7 Riverside Crescent, Kilcullen, Co. Kildare

Phone No: 087 9273198

g Letter to Local Health Manager introducing Study

7 Riverside Crescent
Kilcullen
Co Kildare

April 2008

To all Local Health Manager
Not those in former NEHB area

Re: A study to establish the mental health data collected in the mental health services of the Health Service Executive and the information systems used.

Dear Sir/Madam,

My name is Carol Ivory and I am a student in my second year on the MSc in Health Services Management programme in Trinity College Dublin.

I would be grateful if you would take a few moments to read this letter and the enclosed information leaflet which set out the aims, objectives and benefits of the above study.

In my research study I hope to examine the

- Types of data currently collected by our mental health services,
- Identify any gaps or common features,
- Establish the purpose and use of the data
- Establish the information systems by which this is achieved.

The outcome of the Study will support the development of a national mental health minimum dataset for the HSE and support the provision of valid, timely and reliable information to the mental health services for planning, managing and developing quality mental health services.

This research study is being undertaken by me under the supervision of Professor Charles Normand, Trinity College Dublin and with the approval of the Faculty Ethics Committee, Trinity College.

As this is a national study, I will shortly be sending a Survey Questionnaire to the mental health services throughout the country. I attach for your information a copy of a letter received from Mr Seamus McNulty, Assistant National Director with responsibility for mental health supporting the Study and giving permission to contact the mental health sector teams. I would greatly appreciate it if you could give the study every support in your area as the involvement of all of the mental health services would ensure that a comprehensive picture is obtained.

Please contact me on 087-9273198 if you would like further information about the Study.

Yours sincerely

Carol Ivory

h. Letter granting TCD Ethical Approval



THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

Professor Dermot Kelleher, MD, FRCPI, FRCP, F Med Sci
Head of School of Medicine
Vice Provost for Medical Affairs

Ms Fedelma McNamara
School Administrator

Trinity College, Dublin 2, Ireland
Tel: +353 1 896 1476
Fax: +353 1 671 3956
email: medicine@tcd.ie
email: medschadmin@tcd.ie

Ms Carol Ivory
7 Riverside Crescent, Kilcullen, Co Kildare

Friday, 22 February 2008

Study Title

A study to establish the existing mental health data collected in the Health Service Executive and the information systems used

Dear Applicant

Further to a meeting of the Faculty of Health Sciences Research Ethics Committee 2007 - 2008, I am pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Noëlle Costelloe

Dr. Orla Sheils
Chairperson
Faculty of Health Sciences Ethics Committee

cc.
Prof Charles Normand: Staff - Health Policy & Management

APPENDIX 3 – DATA COLLECTION INSTRUMENT

a – Draft Data Collection Instrument

A STUDY TO ESTABLISH THE EXISTING MENTAL HEALTH DATA COLLECTED IN THE HEALTH SERVICE EXECUTIVE AND THE INFORMATION SYSTEMS USED.

SURVEY QUESTIONNAIRE

Thank you for completing the following Questionnaire. The information sought in the questionnaire is anonymous. All of the data collected will be held securely in accordance with the requirements of Data Protection legislation. No-one other than the researcher will have access to the information provided.

It is possible that other researchers may seek to use the information gathered in the Study for further research. You have the option to agree to the use of this data in further studies if you wish.

Service Information

1. **Type of Service provided (eg Adult, Child and Adolescent etc).**_____

2. **Service Setting (please specify)**

Mainly Urban ☐ Mainly Rural ☐ Mixed ☐

3. **Sector Population** (please choose nearest approximation)

10,000 – 20,000 ☐ 21,000 – 30,000 ☐ 31,000 – 40,000 ☐

41,000 – 50,000 ☐ 51,000 – 60,000 ☐ 61,000 – 70,000 ☐

71,000 – 80,000 ☐ 81,000 – 90,000 ☐ 91,000 – 100,000 ☐

Other (please specify) _____

Data Collection

1. **How is service user personal information collected in your service?** (please tick the relevant methods)

a. **Electronic system specifically designed for mental health services**

Yes ☐ No ☐

If YES, please indicate which system :- HRB COMCAR ☐ ePEX ☐

HRB PAS ☐ Other ☐ (please specify)_____

b. **Generic electronic system adapted for your services**

Yes ☐ No ☐

If YES please indicate which system:

Excel spreadsheet ☐ Access database ☐

Other (please specify)_____

c. Paper based information system designed for mental health services

Yes ☐ No ☐

If Yes, please indicate what manual records are used:-

Template ☐ Form ☐ File ☐ Diary ☐

Other (please specify)_____

2. How is service user referral information collected? (please tick)

a. Electronic system specifically designed for mental health services

Yes ☐ No ☐

If YES, please indicate which system :- HRB COMCAR ☐ ePEX ☐

HRB PAS ☐ Other ☐ (please specify)_____

b. Generic electronic system adapted for your services Yes ☐ No ☐

If YES please indicate which system:

Excel spreadsheet ☐ Access database ☐

Other (please specify)_____

c. Paper based information system designed for mental health services

Yes ☐ No ☐

If Yes, please indicate what manual records are used:-

Template ☐ Form ☐ File ☐ Diary ☐

Other (please specify)_____

3. How is service user clinical information collected? (please tick)

a. Electronic system specifically designed for mental health services

Yes ☐ No ☐

If YES, please indicate which system :- HRB COMCAR ☐ ePEX ☐

HRB PAS ☐ Other ☐ (please specify)_____

b. Generic electronic system adapted for your services Yes ☐ No ☐

If YES please indicate which system:

Excel spreadsheet ☐ Access database ☐

Other (please specify)_____

c. **Paper based information system designed for mental health services**

Yes ☐ No ☐

If Yes, please indicate what manual records are used:-

Template ☐ Form ☐ File ☐ Diary ☐

Other (please specify) _____

Types of Data Collected

1. What service user information is collected by your service? (please tick)

Name ☐ Address ☐ Next of Kin ☐ Date of Birth ☐

Diagnosis ☐ Occupation ☐ PPS No. ☐

Family Circumstances ☐ Non-psychiatric Medical History ☐

GP ☐ Attendance at other mental health services ☐

Frequency of admission ☐ Attendance at day services ☐

Home visits ☐ Referral to primary care ☐

Discharge date ☐ Ethnicity ☐ Legal Status ☐

Other ☐ (please specify) _____

2. What clinical information is collected by your service?

Primary Diagnosis ☐ Secondary Diagnosis ☐ Treatment options ☐

Symptoms ☐ Interventions received ☐ Diagnostic Scoring Systems ☐

Change in symptoms following intervention ☐ length of stay ☐

Period of contact with service ☐

Outcome measures ☐ please specify _____

Other ☐ (please specify) _____

3. What activity information is collected by your service?

Numbers attending service ☐ Number first attendances ☐

Number who Do Not Attend ☐ Number referred back to primary care ☐

Number of referrals ☐ Number of inappropriate referrals ☐

Source of referral ☐

Time from referral to first consultation with Consultant/ Registrar ☐

Other ☐ (please specify) _____

4. What information do you provide to the Health Research Board?

Inpatient activity ☐ Outpatient activity ☐ Attendance at day centres ☐

Day Hospital attendance ☐ Length of stay ☐ Diagnosis ☐ Legal Status ☐

Readmissions ☐ Budget ☐ Staffing ☐ Diagnosis ☐

Other (please specify) _____

5. What information do you provide to the Mental Health Commission?

Inpatient activity ☐ Outpatient activity ☐ Attendance at day centres ☐

Day Hospital attendance ☐ Length of stay ☐ Diagnosis ☐ Legal Status ☐

Readmissions ☐ Budget ☐ Staffing ☐ Diagnosis ☐

Use of ECT ☐ Use of Restraint ☐ Tribunal Activity ☐

Other (Please specify) _____

Performance Monitoring

1. What information is provided from your service to your Sector Management Team? (Please tick)

Budget Information ☐ Expenditure ☐ Staffing ☐

Activity ☐ Waiting List ☐ Attendance Data ☐

Performance Indicators as per Service Plan ☐

Progress on New Developments ☐

Other (please specify) _____

2. What information is provided from your service to your Local Health Manager? (Please tick)

Budget Information ☐ Expenditure ☐ Staffing ☐

Activity ☐ Waiting List ☐ Attendance Data ☐

Performance Indicators as per Service Plan ☐

Progress on New Developments ☐

Other (please specify) _____

3. What information is provided from your service to the HSE at national level? (Please tick)

Budget Information ☐ Expenditure ☐ Staffing ☐

Activity ☐ Waiting List ☐ Attendance Data ☐

Performance Indicators as per Service Plan ☐

Progress on New Developments ☐

Other (please specify _____)

Consent to use of information in other studies

Do you consent to the information provided in this questionnaire being made available for other research projects that have received full ethical approval?

Yes ☐ No ☐

Identifying Information (optional)

Name _____ *Grade* _____

Sector Team Location _____

Contact No. _____

Thank you for taking the time to fill out this questionnaire.

Please return it to me in the stamped addressed envelope.

b. Final Data Collection Instrument

A STUDY TO ESTABLISH THE MENTAL HEALTH DATA COLLECTED IN THE HEALTH SERVICE EXECUTIVE AND THE INFORMATION SYSTEMS USED.

SURVEY QUESTIONNAIRE

The information sought in the questionnaire is anonymous. All of the data collected will be held securely in accordance with the requirements of Data Protection legislation. No-one other than the researcher will have access to the information provided.

It is possible that other researchers may seek to use the information gathered in the Study for further research. You have the option to agree to the use of this data in further studies if you wish.

Service Information

4. Please briefly describe your mental health service (please tick all that apply).

- General Adult ☐ Child & Adolescent ☐ Rehabilitation ☐
Psychiatry of Later Life ☐ Forensic ☐ Early Intervention Service ☐
Intellectual Disability (Adult) ☐ Intellectual Disability (Child) ☐
Other (please describe) _____

5. Geographic Setting (please specify)

- Mainly Urban ☐ Mainly Rural ☐ Mixed Urban/Rural ☐

6. Service Settings (please tick all that apply)

- Inpatient ☐ Community based ☐ Day Hospital ☐
Day Centre ☐ Outreach ☐
Other (please specify) _____

7. Catchment Population (please choose nearest approximation)

- 10,000 – 20,999 ☐ 21,000 – 30,999 ☐ 31,000 – 40,999 ☐
41,000 – 50,999 ☐ 51,000 – 60,999 ☐ 61,000 – 70,999 ☐
71,000 – 80,999 ☐ 81,000 – 90,999 ☐ 91,000 – 100,999 ☐
Other (please specify) _____

Types of Data Collected* (*i.e. information collected whether for internal use by the service or collected for use by others)

5 What service user information is collected by your service in any format? (please tick all that apply)

Name ☐ Address ☐ Next of Kin ☐ Date of Birth ☐
Admission Diagnosis ☐ Occupation ☐ PPS No. ☐
Family Circumstances ☐ Non-psychiatric Medical History ☐
GP ☐ Attendance at other mental health services ☐
Frequency of admission ☐ Attendance at day services ☐
Home visits ☐ Referral to primary care ☐ Discharge Diagnosis ☐
Discharge date ☐ Ethnicity ☐ Legal Status ☐
Other ☐ (please specify) _____

6 What clinical information is collected by your service in any format? (please tick all that apply)

Primary Diagnosis ☐ Secondary Diagnosis ☐ Treatment options ☐
Symptoms ☐ Interventions received ☐ Diagnostic Scoring Systems ☐
Change in symptoms following intervention ☐ length of stay ☐
Period of contact with service ☐
Outcome measures ☐ please specify _____

Other ☐ (please specify) _____

7 What activity information is collected by your service in any format? (please tick all that apply)

Numbers attending service ☐ Number first attendances ☐ Return or Repeat ☐
Number who Do Not Attend ☐ Number referred back to primary care ☐
Number of referrals ☐ Number of inappropriate referrals ☐
Source of referral ☐
Other ☐ (please specify) _____

8 What Waiting Time information is collected by your service in any format? (please tick all that apply).

Time from referral to first consultation with Consultant/ Registrar ☐
Time from referral to first assessment by Team Member ☐
Time from assessment to first clinical intervention ☐

Other (please specify) _____

Additional comments: _____

9 What information do you provide to the Health Research Board? (please tick all that apply).

Inpatient activity ☐ Outpatient activity ☐ Attendance at day centres ☐

Day Hospital attendance ☐ Length of stay ☐ Diagnosis ☐ Legal Status ☐

First Admission ☐ Readmissions ☐ Budget ☐ Staffing ☐

Other (please specify) _____

10 What information do you provide to the Mental Health Commission? (Please tick all that apply).

Inpatient activity ☐ Outpatient activity ☐ Attendance at day centres ☐

Day Hospital attendance ☐ Length of stay ☐ Legal Status ☐ Admission of Children

First admission ☐ Readmissions ☐ Budget ☐ Staffing ☐ Diagnosis ☐ Use of

ECT ☐ Use of Restraint ☐ Tribunal Activity ☐

No. of Involuntary Admissions ☐ No. of Assisted Admissions ☐

No. of 2nd Opinions ☐ No. Discharged to Primary Care ☐

Other (Please Specify) _____

Performance Monitoring

- 11 What information is provided from the mental health services/teams in your catchment area to your Catchment Management Team? (Please tick all that apply)**

Budget Information ☐ Expenditure ☐ Staffing nos. ☐
Staff vacancies ☐ Staff skill mix ☐ Grades/Types of staff ☐
Activity ☐ Waiting List ☐ Attendance Data ☐
Performance Indicators as per Service Plan ☐ Progress on New Developments ☐
No. of involuntary admissions ☐ No. of Admissions ☐
No. of Assisted Admissions ☐ No. of 2nd Opinions ☐
Other (please specify _____)

- 12 What information is provided from the mental health services/teams in your catchment area to your Local Health Manager? (Please tick all that apply)**

Budget Information ☐ Expenditure ☐ Staffing nos. ☐
Staff vacancies ☐ Staff skill mix ☐ Grades/Types of staff ☐
Activity ☐ Waiting List ☐ Attendance Data ☐
Performance Indicators as per Service Plan ☐ Progress on New Developments ☐
No. of involuntary admissions ☐ No. of Admissions ☐
No. of Assisted Admissions ☐ No. of 2nd Opinions ☐
Other (please specify _____)

- 13 What information is provided from the mental health services/teams in your catchment area to the HSE at national level? (Please tick all that apply)**

Budget Information ☐ Expenditure ☐ Staffing nos. ☐
Staff vacancies ☐ Staff skill mix ☐ Grades/Types of staff ☐
Activity ☐ Waiting List ☐ Attendance Data ☐
Performance Indicators as per Service Plan ☐ Progress on New Developments ☐
No. of involuntary admissions ☐ No. of Admissions ☐
No. of Assisted Admissions ☐ No. of 2nd Opinions ☐
Other (please specify _____)

- 14 What information do you consider is important to collect to support your service to plan and deliver a quality service? (Please tick all that apply)**

Activity Information ☐ Financial information ☐ Staff nos. ☐
Types of Staff ☐ Information about the Mental Health Act, 2001 ☐

Intervention Outcome measures ☐ Views of Service Users ☐ Views of Carers
☐ Implementation of recommendations of Vision for Change ☐
 Other (please specify) _____

Any comments or suggestions _____

15 How is the information/data submitted from your service to Local, Area or National Management, HSE or to the HRB, MHC or Department of Health and Children returned for use to your Service?

As part of the monitoring report on National Service Plan ☐
 In comparison with other Mental Health Services ☐
 As part of a performance management report ☐
 To support planning and evaluation of the service ☐
 Other (please specify) _____

16 How best might the information/data submitted from your service to Local, Area or National Management, HSE or to the HRB, MHC or Department of Health and Children be returned to support the delivery of a quality Service?

As part of the monitoring report on National Service Plan ☐
 In comparison with other Mental Health Services ☐
 As part of a performance management report ☐
 To support planning and evaluation of the service ☐
 Other (please specify) _____

Data Collection

17 How is Service User personal information recorded in your service? (Please specify)

d. Electronic system specifically designed for mental health services

Yes ☐ No ☐

If YES, please indicate which systems :- HRB COMCAR ☐ ePEX ☐

HRB PAS ☐ Other ☐ (please specify)_____

e. Generic electronic system adapted for your services

Yes ☐ No ☐

If YES please indicate which systems:

Excel spreadsheet ☐ Access database ☐

Other (please specify)_____

f. Paper based information system designed/adapted for mental health services

Yes ☐ No ☐

If Yes, please indicate what manual records are used:-

Template ☐ Form ☐ File ☐ Diary ☐

Other (please specify)_____

18 How is service user referral information recorded? (please specify)

g. Electronic system specifically designed for mental health services

Yes ☐ No ☐

If YES, please indicate which system :- HRB COMCAR ☐ ePEX ☐

HRB PAS ☐ Other ☐ (please specify)_____

h. Generic electronic system adapted for your services Yes ☐ No ☐

If YES please indicate which system:

Excel spreadsheet ☐ Access database ☐

Other (please specify)_____

i. Paper based information system designed/adapted for mental health services

Yes ☐ No ☐

If Yes, please indicate what manual records are used:-

Template ☐ Form ☐ File ☐ Diary ☐

Other (please specify)_____

19. How is service user clinical information recorded? (please specify)

- a. **Electronic system specifically designed for mental health services**

Yes ☐ No ☐

If YES, please indicate which systems :- HRB COMCAR ☐ ePEX ☐

HRB PAS ☐ Other ☐ (please specify) _____

- b. **Generic electronic system adapted for your services** Yes ☐ No ☐

If YES please indicate which systems:

Excel spreadsheet ☐ Access database ☐

Other (please specify) _____

- c. **Paper based information system designed for mental health services**

Yes ☐ No ☐

If Yes, please indicate what manual records are used:-

Template ☐ Form ☐ File ☐ Diary ☐

Other (please specify) _____

Administrative Burden of Data Recording

- 20. What administrative support is available to your Catchment Management Team?**

Dedicated secretarial post ☐ Shared secretarial post ☐

Administrative manager ☐ No admin support ☐

Other (please specify) _____

- 21. Who collates the data in response to requests for information?**

Dedicated secretarial post ☐ Shared secretarial post ☐

Administrative manager ☐ Member of the Mental Health Clinical Team ☐

Other (please specify) _____

- 22. How best might information requests be handled to support the planning and management of a quality service?**

Consent to follow up contact

Thank you for completing this survey. If you are happy to be contacted again please give a contact email/ address/telephone number. You will only be contacted in the event of a necessity to clarify feedback. All of the data provided will be retained in confidence.

Name:- _____

Address:- _____

Email:- _____

Ph. No. _____

Consent to use of information in other studies

Do you consent to the information provided in this questionnaire being made available for other research projects that have received full ethical approval?

Yes ☐ No ☐

Thank you for taking the time to fill out this questionnaire.

Please return it to me in the stamped addressed envelope provided by

Friday 2nd May 2008.