



Mental Health Commission
Annual Report 2003

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South Tipperary
Mental Health Services



Mr. Joe Casey
Mental Health Ireland



Mr. Gerry Coone
Psychiatric Nurse
East Galway Mental
Health Services



Mr. Pdraig Heverin
Clinical Nurse
Manager II, Mayo
Mental Health Services



Mr. Diarmaid
McGuinness,
Senior Counsel



Dr. Deirdre Murphy
General Practitioner



Dr. Finbarr O'Leary
Consultant Child &
Adolescent Psychiatrist,
Child and Adolescent
Psychiatric Services
Southern Health Board



Mr. Diarmuid Ring
Lecturer on Mental
Health Issues and
service user



Ms. Annie Ryan
Campaigner on Mental
Health Issues



Ms. Vicki Somers
Principal Social
Worker, Dublin
West/South West
Mental Health Services



Mr. Mike Watts,
National Co-ordinator,
GROW and former
service user



Ms. Maureen Windle,
CEO, Northern Area
Health Board

The Commission has 13 members.

In accordance with the provisions of the Mental Health Act, 2001, members include:

- A lawyer
- Three registered medical practitioners of whom 2 are consultant psychiatrists
- A social worker
- A psychologist
- A health board representative
- A representative of the general public; and
- Three representatives of voluntary bodies (at least two of whom must have or have had a mental illness).
- Two registered psychiatric nurses

Membership of Committees 2003

Mental Health Tribunals

Dr. John Owens (Chair), Ms. Vicki Somers, Dr. Anne Byrne-Lynch, Mr. Gerry Coone,
Mr. Diarmaid McGuinness, Ms. Bríd Clarke

Intellectual Disability & Mental Health Services

Dr. Deirdre Murphy (Chair), Mr. Joe Casey, Ms. Annie Ryan, Dr. Verena Keane (Irish College of
Psychiatrists), Ms. Vicki Somers, Ms. Bríd Clarke

Audit Committee

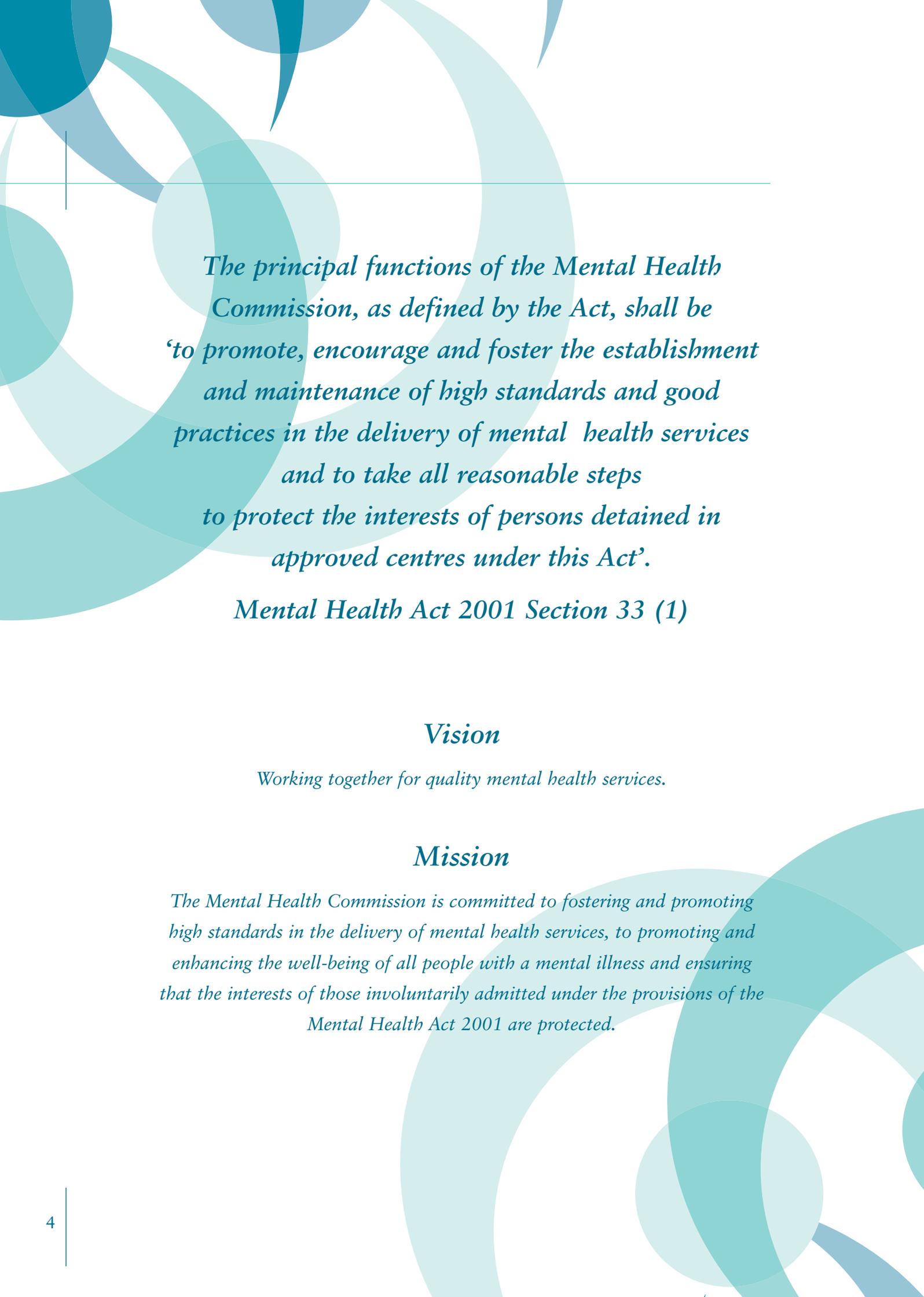
Ms. Maureen Windle, Ms. Annie Ryan, Dr. Finbarr O'Leary, Mr. Pdraig Heverin

Criminal Law (Insanity) Bill 2002

Dr. John Owens (Chair), Dr. Anne Byrne-Lynch, Mr. Diarmaid McGuinness, Ms. Bríd Clarke

World Mental Health Day 2003

Ms. Vicki Somers, Dr. Finbarr O'Leary, Ms. Bríd Clarke



The principal functions of the Mental Health Commission, as defined by the Act, shall be ‘to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act’.

Mental Health Act 2001 Section 33 (1)

Vision

Working together for quality mental health services.

Mission

The Mental Health Commission is committed to fostering and promoting high standards in the delivery of mental health services, to promoting and enhancing the well-being of all people with a mental illness and ensuring that the interests of those involuntarily admitted under the provisions of the Mental Health Act 2001 are protected.



Chairman's Statement

There is momentum for radical change and improvement in the nature and quality of mental health services. This has been manifested, in particular, by the Mental Health Act, 2001. This Act was long anticipated and there is understandable impatience to fully commence and implement this Act to facilitate the necessary change. The Mental Health Commission is the body charged with this responsibility. The Commission has two broad functions: to protect the rights of detained persons and to foster and encourage high quality in the delivery of mental health services. Since its establishment in April 2002, the Commission has been working to the maximum extent possible to fulfil its mandate. There have been perhaps inevitable delays in setting up the staffing structure of the Commission and the public sector staffing embargo was not helpful in this regard. Over the last year, however, these problems have been progressively resolved.

The Commission recognises the urgency of commencing Part 2 of the Act which, for the first time in Ireland, provides for an independent review of detentions and is working diligently to achieve this if possible before the end of 2004.

The Commission will be developing and implementing its policies for quality of service provision with the support of the Inspectorate and the staff of the Commission and the radical nature of the service changes that are required are documented in the accompanying report of the Inspector of Mental Health Services. The Mental Health Commission recognises the importance of developing the standing and status of the Commission to the extent that it is accepted as the primary body in the protection and advocacy of user rights and in promotion of high quality in the delivery of mental health

services. The Commission views that these aims can best be achieved by working collaboratively with users, carers and the whole range of service providers. In this regard, the Commission anticipates working very closely with the Expert Body on Mental Health Policy currently elaborating a new national mental health policy.

There can be no illusions that the aims of the Commission can only be achieved by a high level of commitment by members and staff of the Commission and other agencies working in the provision of mental health care. One can be optimistic however that there is widespread acceptance of the need for major change in mental health care delivery. This was very evident during the recent visits by various representatives of the Commission to the providing agencies around the country.

I wish to thank the members of the Commission for their dedication and hard work in the past year. In particular, I want to acknowledge the competence and commitment of the Chief Executive Officer, Ms. Bríd Clarke and the Commission staff.

I would also like to thank the Department of Health and Children for their continued support of the Commission particularly in regard to the provision of funding.

Dr. John Owens
Chairman

30th June 2004



Introduction - Chief Executive Officer

I am pleased to introduce the second annual report of the Mental Health Commission for the year ended 31st December, 2003 as specified in section 42 of the Mental Health Act, 2001.

This year's annual report for the first time includes the report of the Inspector of Mental Health Services. This report, unlike future reports from the Inspector of Mental Health Services, does not incorporate reports on mental health services inspected in 2003. These inspections were completed by the former Inspector of Mental Hospitals and will be issued separately.

In 2003, work has advanced on establishing the infrastructure of the Mental Health Commission. Premises were identified and refurbished, and the recruitment of personnel, in particular, the senior management team, was commenced. The Commission also continued its work in relation to policy development and defining the strategic direction of the Commission. These developments are outlined further in the Annual Report.

The development and enhancement of relationships with the stakeholders in mental health services was also a key priority in 2003. The Commission is committed to ongoing partnership, consultation and joint working to achieve quality mental health services.

I would like to thank the Commission members for their guidance and advice throughout the year. I also wish to thank personnel from the Department of Health and Children especially the Mental Health Division, for their support and assistance. Many people have assisted the Commission in its various activities during the year and I am very grateful to them for their input and advice. Finally, I wish to thank Commission personnel who through their commitment, good will and team spirit have contributed to the development of this relatively new and evolving organisation.

Ms. Bríd Clarke
Chief Executive Officer

31st December 2003

Mental Health Commission: Membership and Functions

The Mental Health Commission, an independent statutory body, was established in April 2002 under the provisions of the Mental Health Act, 2001.

The Commission consists of 13 people, including the chairman, who are appointed by the Minister for Health and Children. The composition of the Commission is as follows:

- A person who has had not less than 10 years experience as a practising barrister or solicitor in the State ending immediately before his or her appointment to the Commission.
- Three shall be representative of registered medical practitioners (of which two shall be consultant psychiatrists) with a special interest in or expertise in relation to the provision of mental health services.
- Two shall be representative of registered nurses whose names are entered in the division applicable to psychiatric nurses in the register of nurses maintained by An Bord Altranais under section 27 of the Nurses Act, 1985.
- One shall be representative of social workers with a special interest in or expertise in relation to the provision of mental health services.
- One shall be representative of psychologists with a special interest in or expertise in relation to the provision of mental health services.
- One shall be representative of the interest of the general public.
- Three shall be representative of voluntary bodies promoting the interest of persons suffering from mental illness (at least two of

whom shall be a person suffering from or who has suffered from mental illness)

- One shall be representative of the chief executives of the health boards.
- Not less than four shall be woman and not less than four shall be men.

Members of the Commission shall hold office for a period not exceeding 5 years.

The principal functions of the Commission, as specified in the Mental Health Act, 2001, are to promote, encourage, and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres (Section 33).

The Commission shall undertake or arrange to have undertaken such activities as it deems appropriate to foster and promote these standards and good practices.

In particular the Commission shall:

- i) Appoint persons to be members of tribunals, and provide staff and facilities for the tribunals.
- ii) Establish a panel of consultant psychiatrists to carry out independent medical examinations of those admitted involuntarily under the provisions of the Mental Health Act, 2001.
- iii) Make or arrange for the making, with the consent of the Minister and the Minister for Finance, of a scheme or schemes for the granting by the Commission of legal aid to patients.

- iv) Furnish, whenever it so thinks fit or is so requested by the Minister, advice to the Minister in relation to any matter connected with the functions or activities of the Commission.
- v) Prepare after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services and ensure implementation and compliance with the codes of practice.
- vi) Establish the inspectorate of mental health services.

The Mental Health Commission is required to submit an Annual Report to the Minister for Health and Children. The Annual Report shall include the report of the Inspector of Mental Health Services. Copies of the Annual Report are laid by the Minister before each House of the Oireachtas.

The remit of the Commission incorporates the broad spectrum of mental health services including general adult mental health services, mental health services for children and adolescents, older people, people with learning disabilities and forensic mental health services.

Programme of Work in 2003

The Mental Health Commission held eleven meetings in 2003.

Minister Tim O'Malley, Minister of State at the Department of Health and Children addressed a meeting of the Commission on 30th January, 2003. The Minister, in his address, referred to the changing and challenging times in the mental health services in Ireland and described the Mental Health Act, 2001 as the most significant legislative provision in mental health services in Ireland in over fifty years. He referred to the Commission's statutory

responsibilities in relation to the independent review system for those involuntarily admitted and the Commission's role as registration authority for hospital and in-patient facilities providing care and treatment for people with a mental illness.

During the year the Commission gave detailed consideration to the proposed smoking ban in the workplace and its applicability to premises used within the mental health services. The Commission support the smoking ban in the workplace, including all mental health facilities. At a meeting with the Minister for Health and Children on 23rd September, 2003 the right of people with a mental illness to be treated in a smoke free environment was emphasised. This remains an ongoing concern for the Commission.

The Commission met with members of the Prison Health Working Group in relation to the provision of mental health services for people in prisons. Members of the Commission also met with Dr. Dan Fisher, Director, National Empowerment Centre, USA (and a member of the White House Commission on Mental Health) on 13th November, 2003.

Work was advanced in relation to the preparation of the Commission's Strategic Plan for 2004 – 2005. Preparatory work commenced on a discussion paper on a quality framework for mental health services, establishing the register of approved centres and establishing the independent review system for those admitted involuntarily to approved centres.

The Annual Report 2002 was launched on 17th July, 2003. The launch of the first annual report of the Commission was attended by a wide cross section of the partners within the mental health services and attracted wide media interest.

The Commission welcomed the appointment of Dr. John Owens, Chairman, to the Expert Group on Mental Health Policy established by the Minister.

- Committees established by the Commission

The committees, established by the Mental Health Commission in 2002, in relation to Mental Health Tribunals, and Intellectual Disability and Mental Health Services continued their work in 2003 and reported to the Commission.

Three further committees were established by the Commission in 2003: Audit Committee, World Mental Health Day Committee, and Committee on Criminal Law (Insanity) Bill 2002.

The Mental Health Commission established a committee to prepare a response to the Criminal Law (Insanity) Bill 2002 in January 2003. This committee reported to the Commission in March 2003. The committee recommended a number of significant amendments to the Bill and these were adopted by the Commission and forwarded to the Minister for Justice, Equality and Law Reform. The submission from the Commission in relation to the Criminal Law (Insanity) Bill 2002 is available on the Commission's website www.mhcirl.ie. The Commission remains concerned about a number of the provisions contained in this Bill.

The committee, established in 2002 by the Commission, to prepare recommendations in relation to the mental health tribunals presented a report to the Commission in June 2003.

The committee's report, which was endorsed by the Commission included recommendations in relation to the recruitment and appointment of persons to the mental health tribunals, training requirements of mental health tribunal members and an initial estimate of the levels of activity and locations of hearings. The committee had also identified the need for further analysis of the data available in relation to current involuntary admissions. A research study – An Audit of the Pathway to Involuntary Admission in 2002, commissioned by the Mental Health Commission with the Health Research Board was agreed and this was commenced in late 2003. The Commission also considered the report prepared by the Legal Aid Board at the request of the Mental Health Commission on the model for a scheme of legal aid for people who will be admitted involuntarily under the provisions of the Mental Health Act, 2001.

The committee on Intellectual Disability and Mental Health Services reported to the Commission in October 2003. Issues identified by the committee included the following:

- Considerable variation in language and clinical definitions
- Substantive issue of capacity and the legal and clinical protections for those unable to make an informed decision
- Assessments of people with an intellectual disability and a mental illness should be completed by multidisciplinary teams.
- Relative dearth of information available in Ireland in relation to learning disability and mental health services.

- Current service provision. In particular the committee recommended that service provision on the catchment area model, as is applied in the general adult mental health services, should be introduced for those with significant intellectual disability as defined by the Mental Health Act, 2001.

The provision of mental health services for those with an intellectual disability has been identified as a key priority for the Commission.

World Mental Health Day, which takes place on 10th October each year, was established by the World Federation for Mental Health in 1992. Each year a specific theme is selected by the Federation.

It was decided that in 2003 the theme would focus attention on the identification, treatment and prevention of emotional and behavioural disorders in children and adolescents. The Commission decided to organise a public seminar on childhood, adolescence and mental health, which was held in the National Concert Hall, Dublin on 10th October, 2003.

There were two speakers – Professor Angeles Cerezo, University of Valencia, Spain who spoke on the Parent Child Psychological Support Programme, which is being conducted in Dublin West and Professor Fiona McNicholas, Child & Adolescent Psychiatrist, Our Lady’s Hospital for Sick Children, Crumlin and Lucena Clinic, Tallaght and UCD, who spoke on Childhood Mental Illness – The Problems and Solutions. There was considerable public interest in the seminar and a performance by the Lassus Scholars provided a most apt conclusion to a well received and successful seminar.

The audit committee which was established in May 2003 is a permanent committee of the

Mental Health Commission, whose remit is to advise the Commission on internal control and audit matters.

- Research

In order to promote service research in relation to the mental health services in Ireland, the Commission commissioned three research projects in 2003. The Audit of the Pathway to Involuntary Admission, as previously mentioned, was commissioned with the Health Research Board. The Commission commissioned Dr. Elizabeth Dunne, Department of Applied Psychology, University College Cork to conduct a research study of users’ views on public funded mental health services. Persons who have used or are currently using mental health services are key stakeholders within the mental health system, and their views, concerns and recommendations are essential in identifying and planning service provision.

The research study consists of two parts – focus group meetings with service user representative groups and individual interviews with persons not associated with a user representative group. The research study should be completed in late 2004.

In December 2003, the Commission agreed to fund a research proposal submitted by the Health Research Board on an evaluation of high and medium support community residences in the Irish mental health services.

The aim of the study is to describe and review the function of community residences with specific focus on the appropriateness of the premises, staffing, structures, programme of care and in particular the views and recommendations of the residents.

Management Systems and Structures

The non-capital allocation to the Mental Health Commission in 2003 was €2.24 million. The provisional outturn was €1.7 million. Key items of expenditure included salaries, recruitment costs, office rental, refurbishment of the new offices for the Mental Health Commission, and ongoing organisational costs.

The Mental Health Commission complied with the statutory obligations in relation to the reporting, preparation and auditing of the financial statements for the year 2003.

In late 2002 it was decided that the offices of the Mental Health Commission would be located in St. Martin's House, Waterloo Road, Dublin 4. As these offices required redesigning and refurbishment, the Commission continued to operate from 14 Baggot Court, Dublin 2 during 2003, with the intention of moving to St. Martin's House in January 2004.

Following the appointment of the Chief Executive Officer in December 2002, attention was then concentrated on the recruitment of the Inspector of Mental Health Services, senior management and administrative personnel within the Commission.

Following approval from the Department of Health & Children and Department of Finance, four posts were advertised in April 2003: Inspector of Mental Health Services, Director - Mental Health Tribunals, Director - Standards and Quality Assurance and Director - Corporate Services and subsequently the post of Executive Assistant. Approval was received in October 2003 to appoint three Assistant Inspectors of Mental Health Services, an Information and

Training Officer, and two administrative/secretarial personnel.

By the end of 2003, the Inspector of Mental Health Services, Director Mental Health Tribunals and Director Standards and Quality Assurance and an Executive Assistant were in post. Personnel had been selected for the remaining posts or selection procedures were being undertaken. It had also been agreed to engage a research consultant to prepare a research strategy for the Commission and facilitate the establishment of a research infrastructure for mental health. Legal advisers to the Commission, Accountants, and Public Relations Consultants were also appointed in 2003.

External Relationships

Liaison and joint working with the mental health providers, service users, families and carers, primary care sector, other statutory agencies, government departments and non statutory agencies, have been identified by the Commission as key factors to ensure the successful implementation of the Mental Health Act, 2001 and the development of quality mental health services.

The Commission focused on establishing these key alliances during 2003. Regular meetings were held with the service providers (health boards, independent hospitals) and the Department of Health & Children.

The Commission participated in conferences/ meetings organised by such groups as The Irish Advocacy Network, Irish College of General

Practitioners, Grow, Schizophrenia Ireland, Senior Mental Health Nurse Managers, Association of Community Nurses of Ireland, Irish College of Psychiatrists, Irish Psychiatric Association. Meetings have also been held with a number of organisations including the National Disability Authority, Health Research Board and Human Rights Commission. The Commission is represented on the Accreditation Advisory Committee of the Irish Health Services Accreditation Board. The Commission also had ongoing and valuable contact with the Mental Health Commission Northern Ireland and Northern Ireland Mental Health Review Tribunals.

Report of the Inspector of Mental Health Services 2003

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Status and Scope of the Report

This first report of the Inspector of Mental Health Services differs from future reports as it is not based on the inspection of services that is required under the Mental Health Act, 2001. The inspections for 2003 have been carried out by the past Inspectorate set up under the 1945 Mental Treatment Act and will be reported on by them. The inspections for 2004 will be commencing shortly and will form part of the 2004 report of the Inspector of Mental Health Services.

Section 51 (1) (a) of the Mental Health Act, 2001 requires the Inspector of Mental Health Services to visit and inspect every approved centre each year and to visit and inspect any other premises where mental health services are being provided as he/she thinks appropriate. Section (1) (b) requires that the Inspector carries out a review of mental health services in the State and furnishes a report in writing to the Mental Health Commission on (i) “the quality of care and treatment given to persons in receipt of mental health services, (ii) what he or she has ascertained pursuant to any inspections carried out by him or her of approved centres or other premises where mental health services are being provided, (iii) the degree and extent of compliance by approved centres with any code of practice prepared by the Commission under section 33 (3) (e), and (iv) such other matters as he or she considers appropriate to report on arising from his or her reviews”. The annual report from the Inspectorate will therefore serve a number of functions. It will inform the Commission on the current state of affairs within the Irish mental health services. It will facilitate the Commission and the Inspectorate in discussing with service providers the priorities for their service development in the year ahead. It will

assist the Commission in contributing to mental health service developments nationally and will also assist the Commission in satisfying its statutory obligations to promote and encourage high standards and good practice in the delivery of mental health care. While health authorities have a statutory obligation to deliver services, the Mental Health Commission has a statutory obligation to ensure the quality of all mental health services and it is anticipated that agencies will welcome the advice and guidance of the Commission in modernising their services.

In the absence of a comprehensive review of services based on inspections, and without having yet had the opportunity to engage in in-depth discussion with service planners, providers, users and carers, this report relies on other sources of information. The reports of the previous Inspectorate are an invaluable source of information. Other sources of information have also been used. These include the ‘Activities of Irish Psychiatric Hospitals’, the end-of year returns from Health Boards, Health Boards’ strategic plans for their mental health services, published and unpublished service research, and planning and discussion documents from professional groups and voluntary bodies.

The aim of this more limited report is to inform the Commission on the role of the Inspectorate and how the Inspectorate plans to carry out its duties. It will describe current issues within the Irish mental health service, international trends in quality mental health service delivery, and the Inspectorate’s views on priority areas that need to be addressed in modernising the Irish mental health services.

The Inspectorate of Mental Health Services wishes to pay tribute to the work and commitment of the past Inspector of Mental Hospitals, Dr. Dermot Walsh and his assistants Dr. Liam Hanniffy and Mr. Michael Hughes. They have provided one of the few protections for those detained under the 1945 Act and their work has made a major contribution to improving standards of care for those who use the mental health services. Their annual reports have regularly highlighted deficiencies in current service provision and stimulated necessary service developments. Their reports are also an invaluable source of information on the state of mental health services, both locally and nationally.

The Inspectorate also wishes to pay tribute to the Health Research Board. Their work in publishing the annual 'Activities of Irish Psychiatric Hospitals' and in carrying out service research has made valuable contributions to knowledge within the mental health service.

This report should not be seen as a blanket criticism of existing services, but rather as a proposed blueprint for further service development. That those working within the service recognise the need for major change was evident in the recent visits by the Commission to all Health Board areas. Ireland is fortunate in having highly skilled, committed professionals employed within the mental health service and any changes recommended should result in supporting these individuals in the more effective use of their skills. In turn, this will directly impact on the quality of care available to users of the service.

The implementation of the Mental Health Act, 2001 and the establishment of the Mental Health Commission have been widely welcomed by both service providers and users as having the potential to mark the beginning of a new era for the Irish mental health services. The Inspectorate looks forward to working with the Commission in realising this potential.



Dr. Teresa Carey
Inspector of Mental Health Services

June 2004

The Structure and Functioning of the Inspectorate of Mental Health Services

The Inspectorate of the Mental Health Services comprises the Inspector, Dr. Teresa Carey, and Assistant Inspectors drawn from consultant psychiatry, psychiatric nursing, clinical psychology, occupational therapy and social work. All Assistant Inspectors will have taken up office by June 2004 and the necessary posts for administrative and clerical support have received Departmental clearance.

The responsibilities of the Inspector of Mental Health Services differ from the responsibilities of the 1945 Inspector of Mental Hospitals. The Mental Health Act, 2001 recognises that services are no longer delivered predominantly in mental hospitals. Mental health services are defined in section 2 (1) as “services which provide care and treatment to persons suffering from a mental illness or mental disorder under the clinical direction of a consultant psychiatrist”. This definition includes all specialties within mental health care and mental health services for all age groups. It also includes not only approved inpatient centres as defined in Part 5 of the Act, but all other centres where mental health care is provided. To fulfil the requirements in section 51 of the Act, inspections at the point of service delivery will continue and will cover both inpatient units and the range of other locations where care is delivered. The Inspectorate will have particular interest in mental health community residential facilities where residents are receiving 24-hour supervision and care. This interest is based on the concern of the Inspector that residents in such facilities should receive appropriate care and rehabilitation in a way that respects their rights and promotes their independence and quality of life.

The Inspectorate will be building on the work of the previous Inspectorate in developing an inspection template for service providers.

The Inspectorate also plans to liaise with the divisions of health service organisations that are involved in quality management and audit to minimise duplicate inspections and to allow the Inspectorate to concentrate on issues directly relating to service provision.

The purpose of the annual review of mental health services carried out by the Inspectorate (section 51 (1) (b)) is to inform the Commission on service areas that need to be addressed. As a result, a particular type of inspection process is required in which inspection of service delivery has priority over inspection of structures. The availability of resources and the way in which resources are utilised have a major impact on service quality. Reflecting this, a central part of the inspection process will be meetings with service managers and providers to discuss and jointly evaluate local services. The inspection will also involve discussions with General Practitioners, local Gardaí and other referring agents to assess ease of access to services in both routine and emergency situations. The experience of service users and carers is of foremost importance and the Inspectorate will be developing ways of ensuring their views are sought and recognised.

The Inspectorate plans on giving the Commission an initial report on each service following inspections. This will ensure that the Commission is informed on quality issues on an ongoing basis throughout the year. Following discussion of the initial report with the Commission, the Inspectorate will provide feedback to all service providers and, if necessary, make a follow-up visit to discuss issues that need attention. The Inspectorate will engage in discussion with service providers on necessary action to be taken and will require service providers to give clear undertakings to address immediate issues and to put in place

realistic plans to address more long term projects. In subsequent years, services will be required to report specifically on actions they have taken to address identified issues. It is the Inspectorate's hope that this expanded inspection and feed-back process will facilitate local services as much as possible in implementing necessary service development and reorganisation.

In addition to submitting an annual report, therefore, the Inspectorate will be in regular communication with the Mental Health Commission. This will enable the Inspectorate to ensure that Commission priorities and policies are reflected within the inspection process. It will also allow the Commission to be fully informed about issues of quality in service delivery and will facilitate the Commission in its statutory obligations to promote and foster high standards and good practice in the delivery of mental health care.

Child and Adolescent Mental Health Services and Mental Health Services for those with Intellectual Disability

While the previous Inspectorate, under the 1945 Act, was involved only with the registered inpatient components of the mental health services for intellectually disabled individuals, the Mental Health Act, 2001 brings the entirety of mental health services for children and adolescents and for those with an intellectual disability under the remit of the Commission and the Inspectorate. A priority of the Inspectorate for 2004 is to carry out an audit of mental health service provision for these groups and to consult with relevant experts and interested parties on the design of an appropriate inspection template.

The Inspectorate and Mental Health Tribunals

The Mental Health Act, 2001 has addressed the protection of the rights of detained patients through the introduction of an independent second opinion, the automatic right to legal representation and the automatic right to a review of detention by a Mental Health Tribunal. The Inspector of Mental Health Services has no direct role in the functioning of Tribunals but will be keenly interested in the rates of involuntary admissions to individual services. The rate of involuntary admissions cannot be seen as being independent from other service variables.

It is recognised that the majority of patients who currently experience involuntary admission are known to the services involved. The Inspectorate fully accepts that no service will achieve a zero rate of certification.

The nature of mental illness may be such that, at times, the only way to ensure the provision of appropriate and necessary care is to utilise the route of involuntary detention.

Nonetheless, a well-developed community service is well placed to minimise the risk of detention. The home-based and assertive outreach component of multidisciplinary community mental health teams, with their crisis intervention capabilities, are effective in defusing crisis situations that may otherwise lead to involuntary admission. Well resourced community mental health teams are also in a position to actively follow-up vulnerable patients and to address the social, family, personal or illness-related factors that have precipitated crises in the past. A service that is predominantly bed-based, with minimal availability of community-based services, will have little opportunity to address the factors which precipitate crises and will have little to

offer other than admission when an illness crisis develops.

The Inspectorate, therefore, will be tracking the information relating to involuntary admissions. In particular, it will be looking for appropriate service responses which will help to reduce the risk of repeat certifications of vulnerable persons known to the service.

The Inspectorate and the Director of Standards and Quality Assurance

In addition to its general responsibilities in promoting a quality mental health service, the Mental Health Commission has a number of other specific obligations. Among these is the task of developing a code of practice for the guidance of persons working in the mental health service and developing rules governing the use of seclusion, restraint and electro-convulsive therapy. In addition, the Commission may attach conditions to the continued approval of a registered centre.

The Inspectorate will be working closely with the Commission and the Director of Standards and Quality Assurance in the development of these codes, rules and conditions. The Inspectorate is also charged with assessing the degree of compliance with these standards during the inspection process.

Risk Management, Clinical Risk Management and Clinical Audit

Risk management is now standard practice within health organisations. At times, clinical staff may feel that this is in conflict with clinical autonomy and is incompatible with the concept of clinical audit, particularly when auditing adverse clinical incidents. At such times, a lack of confidence in the

confidentiality of the risk management approach can hinder full discussion of surrounding facts, thereby limiting the lessons that can be learned. The introduction of enterprise liability and the Freedom of Information Act are two further factors that may serve to inhibit comprehensive and worthwhile clinical audit.

As with all health services, it is essential for the ongoing improvement of mental health services that a structure is put in place that allows clinical risk management and clinical audit to become integral parts of clinical practice. The Inspectorate is committed to working with clinicians, service managers and other relevant groups to ensure that appropriate systems and structures are put in place that allows clinical audit to occur in an environment of necessary confidentiality.

Complaints

Under section 55 (1) of the Mental Health Act, the Mental Health Commission, on its own behalf or following a request from the Minister for Health and Children, may ask the Inspector or another person to carry out an inquiry into (a) the carrying on of any approved centre or other premises in the State where mental health services are provided, (b) the care and treatment provided to a specified patient or a specified voluntary patient and (c) any other matter in respect of which an inquiry is appropriate. Notwithstanding this requirement of the Act, the Inspectorate will be working with service providers to ensure a transparent, responsive and fair complaints procedure, to ensure that complaints from service users and carers are, as much as is possible, dealt with at local level. The Inspectorate will also be consulting with service providers to ensure an



appropriate system of notification to the Inspectorate of more serious complaints and complaints that cannot be resolved locally.

Information

One of the main functions of the Mental Health Commission is the promotion of quality mental health services. The availability of timely, accurate and complete information is essential for the process of quality improvement. A priority of the Inspectorate, therefore, is to encourage the development of modern information management systems within mental health services. It is clear from the available end-of-year service statistics that there is wide variability in the information management capabilities of mental health services. From the outset, the Inspectorate will require information on both resource availability and activities. Information on resource involves not only budget allocation but staffing, the availability of the required staff mix to provide multidisciplinary services, the deployment of staff in appropriate team structures, the availability of specialist services, the availability of suitable facilities for community-based teams, the availability of the necessary range of supported residences and the availability of an appropriate number of inpatient beds in appropriate settings. Basic activity information required includes the number of people in receipt of mental health services, the number of new referrals annually, the numbers of discharges from mental health services annually, the range of presenting diagnoses and problems, rates of admission and rates of certification. In addition, the Commission has specific responsibility for monitoring ECT (section 59), restraint and seclusion (section 69).

While the collection of such information must respect the right to privacy, this information is fundamental to rational service planning. Additional information relating to clinical outcome is required in order to assess service effectiveness. Mental health services generally are some distance from being able to provide this information. Some start has been made with the development of performance indicators, but even these are still predominantly focussed on activity levels rather than outcome.

Having access to necessary information is a priority that will be ongoing. The Inspectorate recognises that all information required from service providers must be useful to them and support their service audit and development needs. The Inspectorate will be working with service providers, initially to develop a new template for collecting necessary service resource and activity information and will have as a long-term objective the collection of outcome information in a way that supports the work of the Commission in its obligations to promote quality services.

The Gardaí and Mental Health Services

The Gardaí have a unique position in relation to the mental health services. They are often centrally involved in dealing with the social consequences of acute mental illness and have a special role under the Mental Health Act, 2001. At a broader level Gardaí are also involved in dealing with a range of social crises. The Inspectorate recognises that problems can often be encountered by the Gardaí in accessing emergency mental health care for vulnerable people and the Inspectorate will be interested in such issues at local level during the annual inspections. The Gardaí undertake a mental

health module as part of their training, and a further welcome development would be the appointment of Garda mental health liaison officers to liaise with local mental health services and the designation of members of local mental health teams to liaise, in turn, with the Gardaí. Such appointments would facilitate the development of mutually beneficial links between both services.

Service Research in Mental Health Care Delivery

The Health Research Board has carried out valuable research into service issues in the mental health care system, but in general there is a lack of research in Ireland into the epidemiology of mental illness and the effectiveness of models of care. This has consequences for strategic mental health service planning and has led to an undue reliance on research findings from abroad. The Mental Health Commission is developing a research strategy to encourage service research activities and the dissemination of research findings. Particular focus should be given to mental health service development, epidemiology and evidence-based practice.

Public Perception of Mental Health Services

It is evident that there has been, for some time, broad criticism of the Irish mental health services. Indeed the situation has been reached where this low image of services is having an effect on the morale of all those working within the service. This critical view of mental health services is contributed to by the media, user and carer representatives, voluntary organisations, and service providers themselves. While some of this criticism is justified there is

a tendency, particularly in the media, to highlight negative aspects of the service, without balancing this criticism by highlighting areas of high quality service provision. This perceived lack of balance has a negative effect on public perception of services and may well be a factor in the continued stigmatisation that discourages use of services by those who may benefit. The reports of the previous Inspectorate, by their very nature, tended to highlight deficiencies in services and were often interpreted by the public, media and service providers as painting an overall negative picture of service provision and delivery. Clinical service providers, likewise, have tended to be critical of certain aspects of service organisation, particularly of funding and management. Again, while some of this is justified, some may have been defensive in nature, serving to avoid the acknowledgement of professional attitudes which can limit service innovation and development. The Mental Health Commission, with its obligation to promote quality in mental health services, is in a particularly strong position to begin to address this negative perception of mental health services.

Legislation Relevant to the Mental Health Services

The Criminal Law (Insanity) Bill 2002 has been the subject of much discussion, considerable disquiet and many suggested amendments by concerned and interested parties. The Inspector is familiar with the Commission's submission on this matter and fully supports it. While, in law, the Commission may not be responsible for protecting the rights of mentally ill persons detained under new criminal legislation, it is nonetheless a statutory body charged with



protecting the rights of all persons to a quality mental health service. As such, it must be concerned that any new legislation relating to mentally ill offenders provides them with care and treatment of the highest possible standard. It must also be concerned that provisions under new legislation do not transform general psychiatric units into secure facilities, thereby infringing the rights of other persons to treatment in the least restrictive environment. The Inspector is aware that the Commission has requested a meeting with the Minister for Justice, Equality and Law Reform to discuss relevant issues and it is to be hoped that this meeting occurs at an early date.

Legislation Relating to Capacity

The Law Reform Commission is currently preparing a discussion document in relation to updating legislation on the protection of the rights of vulnerable adults. Such adults include those with an intellectual disability, those with Alzheimer's disease and other dementing disorders, and those with acquired brain injury.

An often forgotten group are some with enduring mental illness, where the illness process can impair capacity. Some such people are long stay residents in mental hospitals. Others live in supported accommodation provided and staffed by the health service or voluntary agencies. Others live with family or informal carers. While such people do not fit the criteria for involuntary detention in a mental hospital, they nonetheless may be highly dependent and lack the capacity to make certain decisions regarding the management of their lives and affairs. New legislation is required to protect the rights of such individuals, and also to provide protection for care-givers. The Inspector looks forward to further engagement with the Law Reform Commission on the needs of such people.

Developing a Modern Mental Health Service

Mental health services have been increasingly community-based since the move to community psychiatry began over 30 years ago. While there is now broad acceptance internationally that this is the appropriate model of care, there has been considerable cross-national variation in the degree to which this model has been implemented. There has been criticism of community psychiatry, but such criticisms reflect much more the lack of resource available to the new services rather than the model of care itself. Evidence suggests that both users and carers prefer this treatment model and service research suggests that it is, at the very least, equally effective in its outcome as more traditional bed-based models of care. In this context international service planning documents, such as the Mental Health National Service Framework for England and Wales, emphasise the importance of continued, though well-resourced, community care models.

The mental health strategy document in Ireland, 'Planning for the Future' (1984) chartered a course in the direction of a community care model of psychiatry. The core principles of 'Planning for the Future' remain relevant 20 years later. These principles were that services should be community-based, comprehensive, integrated and closely linked with primary care. Catchments and sectors should be developed and the large mental hospitals should be gradually dismantled. It recommended that acute inpatient beds be located in general hospitals and that community residential facilities be provided as an alternative to long stay institutional care.

However, the concept of community care has further developed since 'Planning for the Future' and more up-to-date service models now emphasise that legitimate alternatives to inpatient care exist for those with acute illness. They recognise the need to develop specialty services to address particular areas of need and emphasise the importance of services being user centred and being responsive to the needs of carers.

It is evident that a new national strategy document is required to bring on board these developments in community-based mental health care. Recently, an expert group has been established to draw up such a strategy and will likely be making recommendations of this nature. Significantly, a similar group has been established in Northern Ireland and there is potential for the establishment of an all-Ireland input into mental health care delivery. This latter development would have particular implications for the development of some of the smaller specialty areas. These reports will likely become available within the next two years, but it would be reasonable for the Commission to anticipate the changes suggested above and the Inspectorate looks forward to advising the Commission in more immediate action in anticipation of a new national strategy on mental health care delivery. It will also be valuable for the Commission, which has long-term responsibilities for quality in service delivery, to have significant inputs into the working of the expert group and the Inspectorate anticipates assisting the Commission in making these inputs.

Current Issues in the Irish Mental Health Services

'Planning for the Future' profoundly influenced the development of the Irish mental health services. Under its influence the number of beds in mental hospitals declined from 12,900 in 1984 to 3,860 in 2002. This decline has been due to a variety of factors. Some has been the result of deaths and dedesignation of units and some has been achieved by the development of community residences for long stay patients. Another factor has been a marked reduction in the numbers entering the new long stay category. The development of other community structures, such as day hospitals and day centres, has also played a role.

To a large extent, however, the Irish mental health services remain influenced by an 'institutional' approach to the delivery of care. The use of beds and community structures still dominate service provision and the move to alternative community-models of care has been slow and piecemeal. Despite the fall in bed numbers following 'Planning for the Future', Ireland still has high psychiatric hospitalised morbidity and high rates of admission. Seventy percent of all admissions are readmissions suggesting that, for many people, admission to hospital brings no obvious lasting benefit. While living conditions in group homes and hostels are undoubtedly superior to conditions in long stay wards, some of these residences are too large to provide domestic-style accommodation and there is concern about the provision of ongoing active treatment and rehabilitation. Similarly, day centres, by and large, have not developed as therapeutic centres for lessening disability and promoting a return to a more independent life, but tend to have relatively static populations who have limited contact with the wider community.

Community alternatives for the treatment of acute illness in crisis have not been developed to

any significant extent. Secondary care mental health services still remain stigmatised and are often used reluctantly by those who could benefit from them. In this regard it is significant that GP referral rates are low by international standards. Few mental health services have developed close links with primary care and this has significant implications for the ascertainment of mental illness, the quality of treatment available to those attending in primary care and the long-term follow-up of individuals with long term illness. It is also evident that models of service delivery vary considerably from region to region, evidenced by significant differences in hospitalised morbidity, admission rates and involuntary detention.

The Irish adult mental health care system remains predominantly a service that is overly bed-based. There is only limited input from allied professionals and limited engagement with community and primary care options. There are substantial problems in the overall management of the service, with no effective management structure to allow regional and national developments. Clinical governance structures are in their infancy and there is clearly a major deficiency not just in resourcing of services but in the appropriate use of available resources.

There is a general perception that the manifest problems in the Irish mental health service relate to lack of resource. In looking at resource, however, it is important to see it as being made up of more than funding. Resource is made up of six major elements; staffing (including the organisation of staff), the availability of specialty services, structures, planning, management and funding. The following chapters look at each of these areas in turn, describing the current situation within the Irish mental health services and the action that needs to be taken to allow appropriate developments to take place.

Staffing of the Mental Health Service

There is a substantial psychiatric nursing resource within the Irish mental health services, with over 5,000 working in the mental health area. There is an adverse age profile within the profession, however, contributed to by the closure of nurse-training schools in the 1980s. Fifty percent of psychiatric nurses are now over the age of 45, a situation which has implications for staffing the services of the future. A significant proportion of the existing nursing resource remains tied up in the residuum of mental hospitals, engaged in predominantly non specialist care duties. There are 276 permanent consultant psychiatrist posts in Ireland. This gives Ireland a ratio of consultant psychiatrists in excess of the UK though still much lower than other advanced western countries. This consultant resource, however, is predominantly generalist in nature with major shortages in specialty areas. It is important, therefore, that in increasing consultant numbers, priority be given to these underdeveloped specialty areas. There are significant deficits in the availability of appropriately trained clinical psychologists, social workers, occupational therapists and other special therapists. This shortage of staffing for multidisciplinary teams can only be resolved by discussion with the professions and their training bodies. In the light of current restrictions on recruitment, the Department of Health and Children and the Department of Finance will need to prioritise the provision of posts and financing to facilitate the appropriate staffing of teams.

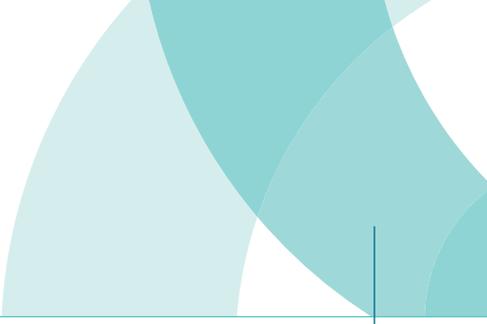
Community Mental Health Teams

It is now internationally accepted that the most effective method of delivering mental health care is through the provision of a range of

specialist, though integrated, multidisciplinary community-mental health teams. The concept of community mental health teams applies across all specialties of psychiatry. It is important, therefore, to recognise how such teams are structured, staffed, and operate and how they link in with each other to provide a coordinated approach to mental health service delivery. The multidisciplinary nature of community mental health teams is central to their function and this, in turn has implications for the role of consultant.

A community mental health team in any specialty would normally have a range of members including; Consultant Psychiatrists, Team Coordinator, NCHDs, Home-based / Assertive Outreach Nurses, Community Psychiatric Nurses, Mental Health Social Workers, Occupational Therapists, Clinical Psychologists, Cognitive / Behaviour Therapists, Family Therapists and a range of additional special therapists depending on the specialty of the team (e.g. Bereavement Counselors, Speech and Language Therapists, Home Support Workers, Care Workers, etc.). Adequate administrative and secretarial support is critical. The teams would also have a range of undergraduate and postgraduate trainees from all the professional disciplines.

The roles of consultant and team coordinator are critical in the functioning of the team. Consultants need to be skilled in facilitating input to care planning and delivery from all professional members of the team, while retaining overall clinical responsibility. The role of team coordinator is also critical in the functioning of the team. The team coordinator manages the day-to-day working of the team and serves as a single point of access for all referrals. In consequence, coordinators have



close working relationships with primary care and other referring agencies. Team coordinators have responsibility for monitoring the workloads of all team members and in ensuring that the consultants are kept fully informed on all relevant clinical matters. The coordinator also has the lead role in auditing team activity. Because of the nature of the responsibilities of team coordinators they must have a background in a senior capacity in a clinical specialty.

Following referral to the team through the team coordinator, assessment and care planning is carried out by all relevant professionals and referral on to appropriate team members is made through team discussion. The concept of the “key worker” is central to patient management. The key worker may be from any professional discipline in the team and is the primary therapist for the patient. The key worker provides the key link to the team for the patient and carers, and has the responsibility of keeping other team members aware of the patient’s progress. Consultants and coordinators of all teams have responsibility for inter-team communication and for ensuring the delivery of a coordinated service.

Multidisciplinary Team Working

Multidisciplinary team working involves more than the availability of a range of therapists. Effective team working requires that all professional members work together to provide a comprehensive and coordinated care programme to individuals. Such team working can be challenging for all team members. Most consultants have been trained to be individual therapists to individual patients and have had little or no experience of working in a setting where the approach to assessment, diagnosis

and management involves disciplines and skills beyond their own area of expertise. This is perhaps, particularly the case with consultants working in general adult mental health services.

The model of multidisciplinary team working, with the shift from an institutional to a community model of care delivery, can also pose challenges to the nursing profession, again, particularly perhaps, for nurses working in the general adult mental health services. This challenge will have to be faced, with recognition that large institutions have no future role in the delivery of mental health care. Some members of the nursing profession have responded to service changes by undergoing further training in areas such as family therapy, bereavement counselling, addiction counselling, cognitive and behaviour therapy, community nursing, home-based nursing and assertive outreach nursing. It remains the case, however, that there are still large numbers of nursing staff involved in care duties that do not take full advantage of their training, skills and experience. A more appropriate skill mix, including the more widespread introduction of care assistants where appropriate, would allow nursing staff to use their skills to their full potential.

The ongoing professional development of psychiatric nursing is essential for the provision of a modern, quality service. The introduction of a graduate training programme in nursing is a significant development. Further developments within the nursing profession are also taking place with the advent of Clinical Nurse Specialists. It is essential that this trend continues and further addresses the new specialist service areas that are part of a specialised, community-based mental health service. The recent legislation allowing for the piloting of nurse-prescribing is highly relevant



to the new model of mental health care delivery. In the context of multidisciplinary care planning it would be particularly advantageous for home-based and assertive outreach nursing staff to be able to make medication decisions within the constraints of an agreed care plan. It is to be hoped that the mental health services take full advantage of this development.

In addition to being seriously under-represented in the Irish mental health service, clinical psychologists, social workers and occupational therapists have had little opportunity to work in a true team setting. More commonly, these professionals either see people on direct referral from outside the specialist service or take referrals from consultants within the service. In both cases, in the absence of a functioning team, they have no option but to work as individual therapists.

The multidisciplinary community mental health team is a model of care delivery that is applicable across all mental health care specialties. Staffing the specialist community mental health services of the future will require a coordinated approach to training, not only in the numbers of the different professional groups that are required, but also in the approach to training. At present, training programmes do not take into account the team system in which all professionals will be working. It will be important in the training programmes of the future to ensure that training is of high quality and reflects the systems approach to the delivery of care.

Specialty Services within a Modern Mental Health Service

Irish mental health services are characterised by serious under-development of specialist services. In particular, there is major under-provision in forensic mental health services, and mental health services in rehabilitation, liaison, substance misuse and psychotherapy. Child and adolescent mental health services and mental health services for those with an intellectual disability are both underdeveloped. While mental health services for later life have expanded in recent years, the staffing of such services are often deficient and additional teams need to be developed.

The traditional catchment populations of 100,000, based on 'Planning for the Future' and the lack of appropriate management and planning structures have not facilitated the development of specialist services. To allow the development of the necessary comprehensive range of specialist services and to allow the efficient use of resources, catchments for mental health services will need to be in the region of 350,000 population size.

It must be recognised that the development of specialist services does not decrease the requirement of general adult mental health teams. Rather, it makes available the range of services that are necessary to allow the provision of comprehensive mental health care. The following are the Inspector's views on the specialty services that must be developed.

General Adult Mental Health Services

Given the range of multidisciplinary therapists required to adequately staff a community mental health team, sector size for community teams in general adult mental health services will need to be increased to 50,000, with a minimum of two consultants in each team. In a catchment of 350,000 there would be a

minimum of seven such community mental health teams. Two consultants per team will have a number of desirable effects. People will have a choice of consultant and consultants will have the opportunity of developing clinical special interests. With a full team in place, there will be a framework for more easily altering consultant: NCHD ratios, as recommendations relating to the European Working Time Directive and medical manpower levels are implemented.

Fully staffed multidisciplinary teams will allow the development of home-based nursing for acute illness in crisis, and the piloting of other alternatives to traditional acute inpatient care, including the use of domestic-style crisis houses. These developments will decrease the demand on inpatient beds. The specialist inpatient beds that will be required would most appropriately be sited in the regional hospitals as described in the Hanly report.

Mental Health Services for Later Life

One specialist community mental health team in psychiatry of later life is generally required for each 100,000 total population. The number of consultants and special therapists on each team would depend on the size and geographical spread of the over-65 population. Three to four such teams would be required for a catchment of 350,000. Beds for this specialty, like the beds for adult services, would be sited in the regional hospital. However, there is a need to develop specialist facilities for those with more long-term disturbed behaviour in the context of dementia.

Mental Health Services in Rehabilitation

Rehabilitation psychiatry provides specialist care for those with a severe and enduring mental illness. As services move increasingly to the community, the needs of these individuals need special protection. People with enduring mental illness are at risk of falling out of care and the greatest criticism of community psychiatry to date has been the inadequacies of service provision to this vulnerable group. Mental health services in rehabilitation address the needs of such people, through the provision of ongoing active treatment and support with the aim of increasing quality of life and independence. While many people with enduring mental illness live in supported accommodation increasing numbers live with family or other informal carers. The provision of information, advice, support and assistance to carers is an essential component of rehabilitation services to minimise the burden of care.

One specialist rehabilitation team for each 100,000 population is required, with three to four teams for a catchment of 350,000. Within teams, assertive outreach nursing should be available, minimising the need for acute admission beds. The acute beds for this service should be sited with beds for general psychiatry in the regional hospital. A range of community residences is also required in each catchment and should be used jointly by all the rehabilitation teams.

Child and Adolescent Mental Health Services

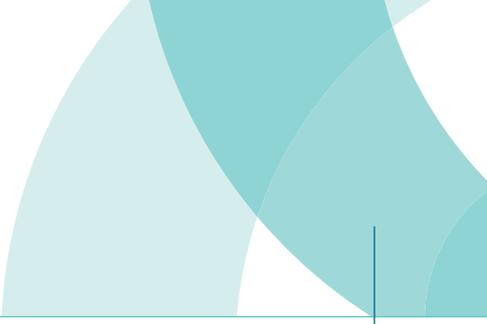
Child and adolescent mental health services require one specialist team for each 100,000 population, with the number of consultants and

therapists per team depending on local factors such as family structure and deprivation levels. Three to four teams would be required in catchments of 350,000. There are unresolved issues regarding the management of the 16-18 year old age group and in the relationship between child and adolescent mental health services and adult services. These problems will best be resolved by having both services under the one catchment management team, and by having well-resourced teams in both specialities so that individual decisions on the most appropriate care to be provided will be based on need rather than chronological age. In general, referrals in this age group should be to the child and adolescent service in the first instance, unless the referral agency believes that the adult services are more appropriate. Child and adolescent mental health services must be available on a 24-hour, seven-day basis and must be in a position to respond to emergency referrals.

Inpatient facilities for children and adolescents are urgently required. The availability of units for the small number of children and adolescents who require inpatient care is wholly inadequate. The bed requirement is quite modest with current estimates suggesting in the region of 120 beds nationally. The location of these units should be planned on a national basis and the number of inpatient places required must be reviewed as the number and staffing of community teams and facilities expand. The urgent provision of these beds must be viewed as a priority.

Mental Health Services for those with Intellectual Disability

As with child and adolescent services, the separation of mental health services for those with intellectual disability from the remainder



of the mental health care programme has not been helpful in the development of comprehensive, coordinated services. The current situation is somewhat disjointed, with services being both under-developed and poorly organised. There are only two designated units for the admission of people with joint problems of intellectual disability and mental health problems. One of these, St. Ita's Hospital in Portrane, has significant numbers of patients who would more appropriately be cared for in community-based residences in the generic intellectual disability programme. On the other hand, on a national level, patients with dual problems of intellectual disability and mental illness are inappropriately admitted to general psychiatric units which are neither staffed nor organised in a way to address their very special needs. There also continues to be significant numbers of people with intellectual disability who are inappropriately placed on long-stay wards in mental hospitals.

Mental health services for those with an intellectual disability must be further developed and organised in such a way that discrete, specialist mental health services are made available for the mental health needs of people with an intellectual disability. The same model of specialist community mental health team applies, with sector populations of 100,000 to 150,000. Catchments of around 350,000 would require three such teams.

The provision of mental health services to people with mild intellectual disability has been problematic. The most appropriate provision of care in an individual case is best decided on an individual needs basis and close relationships between teams providing mental health services for those with an intellectual disability and teams providing general adult mental health services will help to resolve this issue.

The acute bed requirement for mental health services for those with an intellectual disability is modest. Current estimates would suggest a requirement in the region of 12 beds for catchments of 350,000 with an associated smaller number of beds for individuals with challenging behaviour. As with child and adolescent mental health services and mental health services for later life, the provision of these beds is a priority in the context of the Mental Health Act, 2001. There is also a need for specialist mental health services for children with intellectual disability. This is currently provided either by psychiatrists in intellectual disability or child psychiatrists, depending on availability. There is a need to develop specialist teams staffed by people with joint training in both child psychiatry and intellectual disability.

There is an additional bed requirement for the forensic element of mental health services for intellectual disability. This requirement is quite small, yet is of major importance. Currently, this need has to be met by placements outside the jurisdiction. A comprehensive service, perhaps for the whole island, could best be met by the provision of four residential units with a total of sixty beds.

Forensic Mental Health Services

The forensic mental health services nationally are seriously underdeveloped. While the staffing of the service has expanded somewhat in recent years, services remain inadequate at both hospital and community level. The Central Mental Hospital, a facility providing medium and high security beds, is the only designated forensic unit available nationally, but has long been recognised as providing accommodation that is of a totally unacceptable standard.

Being the only forensic unit, persons from prisons or the courts who require inpatient care will be treated in the Central Mental Hospital even when a lower level of security would be sufficient. Likewise, the lack of low-secure specialist units and the lack of community follow-up of patients outside the city area hinder the discharge of patients from the Central Mental Hospital who no longer require high levels of security. This underdevelopment of services has effects on mental health services nationally.

Local service providers are often reluctant to have patients of their service who offend charged with an offence, because of the lack of any forensic facilities other than admission to the Central Mental Hospital. At other times, pressure on beds in the Central Mental Hospital may result in disturbed patients being forced to remain in services that have neither the specialist staff nor facilities that are required for their appropriate care. Likewise, the pressure on beds adversely affects the level of mental health service available to prisoners, including prisoners with severe mental illness.

As the move to community services progresses and as long-stay wards become a thing of the past, the need to provide appropriate services for people with a mental illness who offend becomes urgent. The provision of such services must be distinguished from the care required by patients who have transiently disturbed behaviour in the context of illness relapse and which can be managed either on an open ward with special nursing, or in more severe cases, in a special observation unit attached to an acute unit. The forensic mental health service should be developed on a national basis with each catchment of 350,000 being served by one multidisciplinary forensic team. Each catchment

team would form part of the national forensic service. This expanded forensic service will require a national network of low secure units. It has been estimated that in the region of 140 such beds is required and this provision would best be met by a regional network of 20 bedded units. Medium and high secure beds would continue to be provided in a single national unit.

The regional forensic teams, with associated low secure units, would provide alternative secure placements for patients no longer needing the level of security provided by the Central Mental Hospital. They would be in a position to provide community-based follow-up to patients, thereby facilitating their ultimate community reintegration. Such services could provide a range of court diversion schemes, so that people with a mental illness who offend would be diverted from entering the prison system and would receive appropriate care at the appropriate level of security in a therapeutic setting.

In addition to providing specialist service to people with a mental illness who offend the specialist forensic teams would provide liaison input at local level to the general mental health services.

Developments in the forensic mental health service are dependent not only on adequate resourcing, but also on developments in the legal framework for mentally disordered offenders. The need for modern legislation that takes account of the developments made internationally in forensic mental health services, including court diversion schemes, is urgent. Appropriate amendments to the proposed new Criminal Law (Insanity) Bill are therefore required. Likewise, the expansion and

development of the forensic mental health service to include regional and community-based services is a matter of urgency.

It has long been recognised that the quality of accommodation available to patients in the Central Mental Hospital is totally unacceptable. The facility has been repeatedly condemned by national and international visiting bodies as contravening patients' basic rights to be protected from inhumane and degrading treatment. The continuation of this situation is unacceptable and the Inspectorate will be recommending that the Commission take whatever steps are necessary to progress developments in this area.

It is recognised that the rate of mental illness is significantly higher in the prison population than the population as a whole. The expansion of the forensic service as described would facilitate the development of improved mental health services in prisons and would protect other mentally disordered offenders from inappropriately entering the prison system. The availability of a network of low secure units, in addition to medium and high secure beds, would allow remand and sentenced prisoners who require inpatient treatment to receive it in an environment of appropriate security rather than necessitating automatic transfer to high security beds.

The development of the forensic mental health services should be seen as an urgent priority, given the advent of new legislation relating to criminal law and mental illness and given the unacceptability of the current secure treatment facilities.

Specialty Services for Eating Disorders

There is a requirement for specialist services for those with severe eating disorders.

This service should be developed on a catchment basis with one team for catchment populations of 350,000. These teams would provide specialist care and have a liaison relationship with other mental health teams. These catchment teams would not have a specific allocation of beds, apart from the acute beds in the regional hospitals.

For the most severe eating disorders a regional specialist service with availability of beds is required. Three such teams should be available nationally, with a total bed provision in the region of thirty. These inpatient units need to have close links with departments of gastroenterology and endocrinology, and should be sited in tertiary care hospitals.

Mental Health Services for Substances Misuse

Despite the rise in the abuse of illicit drugs, alcohol remains the major drug of misuse in the State. The significant misuse of alcohol by adolescents and young adults is of particular concern. A national public health response is required and the recommendations of the National Taskforce on Alcohol and the recent Oireachtas Committee should be fully implemented as a matter of priority.

There has been an appropriate movement of services for alcohol related problems away from the mental health services to less formal community-based services based on addiction counsellors. In rural areas, such services should ideally be staffed so that both drug and alcohol misuse can be addressed.

Such community-based services are more easily accessed, have closer links with primary care and community support systems and take on wider roles in education and preventive activity. They are ideally placed to link in with local employers, schools, youth organisations, concerned relatives, community groups and self-help groups. People who abuse alcohol or drugs have a greatly increased risk of developing mental health problems, requiring significant liaison inputs from community mental health teams. Models which allow direct and regular contact between community addiction services and community mental health teams can facilitate this necessary liaison.

Illicit drug abuse is rising nationally, but remains a particular problem in urban areas. In metropolitan areas where there are substantial problems with major drugs of abuse, dedicated drug addiction teams are required. Such teams are available in the Dublin area but additional teams are required and the model needs to extend to other urban areas. This model of care is based on out patient clinics and day hospitals and provides inpatient units for specialised detoxification. One of the many serious consequences of drug abuse is the development of major mental illness in the context of the abuse. Provision of mental health services to this 'dual diagnosis' group will continue to be by the generic mental health services with liaison input from the specialist addiction service.

The association of mental illness, substance abuse and offending behaviour is well recognised and the provision of appropriate links between addiction services and forensic mental health services need to be developed.

Psychotherapy Services

There is a need to substantially increase the availability of psychotherapy resources, in both the primary care and the specialist mental health care settings. Within specialist community mental health teams, this resource can best be of multi-professional origin with psychotherapy provided in the setting of the specialist multidisciplinary teams.

In the training of sufficient numbers of therapists, a particular emphasis should be placed on training in cognitive behavioural therapy and dialectic behaviour therapy.

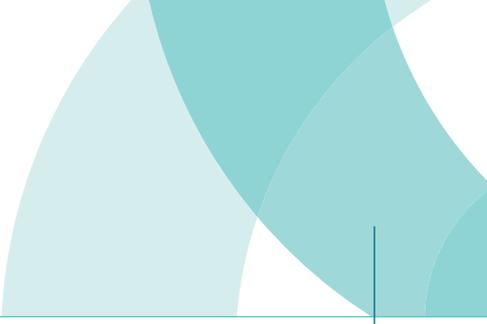
Liaison Mental Health Services

One specialist team for each catchment of 350,000 should be provided for specialist liaison mental health services to the major regional hospitals.

Mental Health Services for People who are Homeless

There continues to be significant numbers of people who are homeless in the Dublin area and, to a lesser extent, in other cities. These people have a range of social, personal and health difficulties. Recent studies in the Dublin area have suggested that this population has high levels of psychiatric morbidity. This morbidity includes mood disorders, psychosis and personality disorder, with many of these conditions being complicated by alcohol and drug abuse. While some sleep on the streets, many have a nomadic existence, moving from shelter to shelter.

The general needs of this group are addressed by a range of statutory and voluntary organisations. Because of their nomadic existence it is difficult to provide structured



care programmes of the sort required in dealing with their mental health difficulties and catchment or sector-based service do not easily allow for continuity of care.

Homeless people tend to encounter mental health services in situations of acute social stress and, not infrequently, with acute psychosis. Their mental health needs require special service developments and there are various options in regard to the optimum model of care. Services in the Dublin area are addressing this problem and the Commission might usefully engage with these services in deciding on the most appropriate service solution.

Additional Specialty Services

There will be a need for the development of additional specialist services depending on the needs identified in catchments. There is growing evidence of the importance of early diagnosis of psychotic illness and the value that comes from the provision of a special service response for this category of illness. Other specialist service areas include autistic spectrum disorders, psychosexual disorder, acquired brain injury, mental health services for the deaf and perinatal psychiatry. Refugees are another at risk group. While they do not require a specialist service, they do need special service organisation to ensure the easy availability and accessibility of services.

Structures Necessary for a Community-Based Mental Health Service

Community Structures

There has been substantial capital under-investment in the community structures necessary to support a community-based mental health service. Many of the community structures currently available are substandard and some are frankly unsuitable for their current use. It must be remembered that old mental hospitals not only provided patient accommodation, both acute and long stay, but also provided outpatient facilities, day centre and day hospital facilities, library facilities, continuing education facilities, meeting facilities and headquarters for clinical and administrative staff. Replacement facilities within the community for all these functions are necessary to provide the infrastructure of the new service and all facilities should be of the highest quality and designed for the functions they serve. In the new community-based service, community mental health centres are the hub of service delivery. Such facilities need to be of adequate size and to be designed and located in such a way that they provide the appropriate service base to the newly emerging specialist community mental health teams.

In addition to the required community facilities discussed above, there were 3891 patients in mental hospital beds at the end of 2002, with 2,334 in hospital for more than one year.

A significant number of these, including 460 with intellectual disability, are likely to require alternative community residences. The provision of alternative community residences for these patients must be seen as a priority. Such provision will not only provide long stay patients with more appropriate accommodation, but will enable the freeing up of resources currently still tied to the old

institutions. The recent ministerial announcement of the commitment to retain within the mental health services the finances released from the sale of mental hospital property is most welcome in this regard.

Bridging finance must also be made available where necessary, to allow the development of necessary community facilities to allow the closure of the large mental hospitals.

Bed Requirements for General Adult, Rehabilitation and Later Life Mental Health Services

At the time of publication of 'Planning for the Future' in 1984 there were 12,000 beds within the mental health service. This had dropped to 3,860 in 2003. In the same time frame, 3,200 places in alternative community residences had been developed. Yet, there is a long-recognised lack or absence of specialist inpatient accommodation for particular patient groups. Mental health services for children and adolescents, for those with an intellectual disability, for the elderly and the forensic mental health services all have urgent need for a relatively small number of beds.

As previously discussed, multidisciplinary teams based in community mental health centres would provide the majority of services within all specialty areas, with an integral part of the service being home-based treatment for acute illness in crisis and assertive outreach treatment for those with severe, enduring illness. The implication of this model of care delivery is that acute bed use is likely to be very considerably diminished.

Advanced community care models of treatment provide crisis houses as an alternative to acute hospital beds.

Such facilities are best developed as domestic-sized units of six to eight beds for populations of 50,000 with admissions controlled by community mental health teams. Crisis houses can be used flexibly by a number of specialist teams and the staffing of these units can reflect levels of occupation and patient need.

With the development of home-based and assertive outreach interventions, the availability of crisis houses as alternatives to the use of acute inpatient beds, and the development of specialist beds for particular groups, it is likely that less than half the current planning norms for bed numbers in inpatient units will be required to address the needs of general adult psychiatry, psychiatry of later life and rehabilitation psychiatry. These beds should be sited in the main hospital for each region. The staffing of these acute beds is an important issue. Ideally, nursing staff should rotate through inpatient units and community teams, so that acute inpatient care is seen as an integral part of the care package, and not a separate component. Such an arrangement would also ensure the availability of experienced nursing staff for inpatient units, ensuring high quality care for acutely ill patients.

There has been a progressive development of acute units in general hospitals as recommended in 'Planning for the Future'. In 2002 approximately half of public psychiatric admissions were to such units and it is planned that the use of acute beds in mental hospitals will have ceased by 2006. The location of any additional beds should be reviewed in the light of the proposed health service reforms and the number of additional beds should be reviewed in the context of the likely reduced bed requirement in more advanced community-based models of care.

Specialist Bed Requirements

In addition to general acute beds sited within the regional hospital, there is a well recognised need for inpatient beds for special groups. The following figures relate to current planning estimates of required bed numbers for specialty services. All these estimates will have to be reviewed in the light of developments in community-based services with alternatives to inpatient care. Mental health services for later life may require in the region of 15 beds per 350,000 for those with enduringly disturbed behaviour in association with dementia.

Estimates for forensic mental health service bed requirements suggest that a network of units providing in the region of 140 low secure beds are required for those forensic patients who do not require medium or high security facilities. In addition, the medium and high secure beds in the Central Mental Hospital must be replaced with high quality accommodation as a matter of urgency.

Estimates suggest that child and adolescent mental health services will require in the region of 120 beds nationally. Likewise, estimates for mental health services for those with an intellectual disability suggest a requirement in the region of 220 beds nationally, in addition to forensic beds. Finally, specialist services for eating disorders for those with the most severe illness will require in the region of 30 specialist beds nationally in close association with tertiary level hospitals.

The number and location of all these specialist beds should be the subject of a national planning exercise, to clarify numbers required and to ensure their urgent and rational development.



Approval of Inpatient Centres

Given the lack of specialty beds at the present time, inappropriate admissions occur to general adult inpatient units. This is particularly the case for those with dual problems of intellectual disability and mental illness, for adolescents and for some children. The Inspector will be recommending to the Mental Health Commission that approved centres should be approved in the context of their particular speciality provision, so that each approved centre is approved for the provision of inpatient care for certain groups of patients only. This recommendation highlights the urgent need for national planning of the specialist bed requirements described above.

Other Issues Relevant to a Modern Mental Health Service

A range of additional services and issues need to be addressed in the development of a modern mental health service. The following areas are not exclusive, and are discussed only very briefly.

General Practitioner and Primary Care Services

Most people who have treatment for mental health problems receive it at primary care level from their General Practitioners. The levels of ascertainment of these problems and the quality of treatment vary greatly in relation to practitioner and practice characteristics. By and large, people prefer to seek treatment at primary care level. All these factors emphasise the importance of close links between specialist mental health services and general practitioner services. The development of multidisciplinary primary care teams, as recommended in the Primary Care Strategy, is highly relevant to the development of comprehensive mental health care programmes at both primary and secondary levels. The availability of a range of therapists within primary care will make it possible for a broader range of mental health problems to be dealt with in the primary care environment and will allow the development of new models of shared care for people with more substantial mental health difficulties.

Voluntary and Non-statutory Agencies

Voluntary and Non-statutory services have significant input into the mental health of a community. Mental health services should develop working partnerships with these agencies to encourage the extension of support to people with mental health problems. In this way, people attending the specialist mental

health services can have as much as possible of their needs met in this generic way, fostering a sense of community cohesion and helping to reduce the stigma and exclusion often associated with mental illness. Such agencies can also play a key role in educating the public on issues relating to mental health problems, in advocating locally for individual users and carers and in advocating nationally for increased priority to be given to the development of mental health services.

Involvement of Users and Carers

It is at the level of individual care planning and care implementation that users and carers have the most need to be involved with local mental health services. Such involvement has a significant effect on promoting a positive experience of the mental health service for users and those who care for them and has a clear impact on compliance with care. With the ongoing development of community-based services, families and other informal carers are increasingly called upon to be involved in the provision of care and support through both acute and enduring episodes of illness. The need for carers to be involved in the care planning process and to have access to appropriate information and support becomes critical. Users and carers also have legitimate input into service planning, and their role in service evaluation is both relevant and necessary. The inclusion of service users on the Mental Health Commission gives recognition to the rights of users and the Inspectorate will be actively seeking ways of eliciting views of both users and carers during the inspection process.

Mental Health Promotion

Mental health services have a major role in secondary and tertiary prevention. Secondary prevention is best addressed by having high quality, acceptable and easily accessed mental health services at both primary and secondary care level. Community mental health teams, with their close engagement with users, carers, schools, community groups, and voluntary organisations can play a significant role in health promotion. It is particularly important to educate the public on the early recognition of depressive disorders and on the early recognition of signs of relapse. Not only are community mental health teams well placed to be involved in individual and public education, they are in a position to provide flexible services responses that include early intervention, intensive treatment and close follow up for recognised illnesses. By working closely with families and carers, the burden of illness can be reduced. A community-based service configuration is also more acceptable to the public, helping to reduce the stigma associated with attendance at mental health services, thereby increasing accessibility. Community-based addiction services also have a significant role to play, both in educating the public on the risks of heavy or binge drinking or drug use and in providing easily accessible treatment options. Programmes for the early detection and treatment of psychotic disorders have been shown to be effective in minimising long term disability. For established illness, specialist rehabilitation services have a particular role in reducing the long term disability frequently associated with schizophrenia.

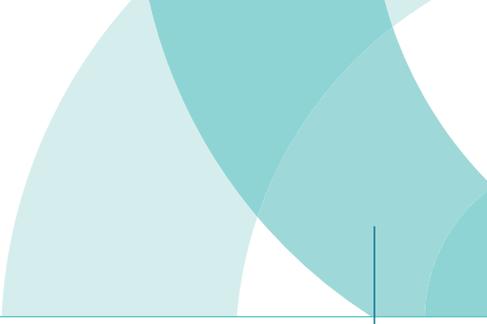
Suicide

There is justified concern at the recent rise in suicide rates, and especially at the marked increase in young male suicides. This concern resulted in the establishment of the National Taskforce on Suicide and the National Suicide Review Group. The reasons for the increase in suicide rates are both varied and complex. Despite this it seems clear that a considerable proportion of those who commit suicide have a mental illness with mood disorders likely to be particularly prominent. Early diagnosis and treatment of depressive illness, therefore, is an important factor in reducing one of the recognised risk factors. This emphasises the importance of the availability of high quality mental health care in the primary care sector and ease of access to specialist mental health care services.

The recommendations of the National Taskforce on Suicide and the National Suicide Review Group should be addressed by management teams and taken into account in service developments. Within clinical services, appropriate risk assessment must form part of clinical evaluation, and appropriate audit structures must be available to investigate service suicides. These audits should permit a review of all factors involved in an individual case. There should be a formal structure set up for the confidential review of these incidents. Such confidential reviews will guide appropriate service responses.

Clinical Governance

Modern mental health services must have quality as their central component. A quality service is one that combines safety and effectiveness. Ensuring these service



characteristics requires the dual approach of clinical risk management and clinical audit. These functions are best managed jointly. The conditions under which clinical risk management and clinical audit could be managed most effectively would be achieved by each catchment service setting up a clinical quality committee, multidisciplinary in membership and having major inputs into service planning, development, implementation and audit.

Constraints on Service Development

There is a range of limiting factors in the overall development of a national mental health service. As already discussed, these include the lack of appropriate structures and staffing mix and the absence of a management system that allows regular on-going review and development of services at a national level. Industrial relations issues, relating to the move away from institutional care, are particularly relevant with regard to the nursing profession. A central body with broad based representation and on-going responsibility at national level is required to address these issues in the long term. A National Service Directorate, as described in the following chapter, and the Mental Health Commission with its Inspectorate could very well take on such a role, having due regard for the statutory responsibilities of those charged with service provision.

Planning and Management within the Mental Health Service

A New National Mental Health Service Policy

The lack of a modern national mental health service policy is being addressed by the expert group. This plan should be guided by recommendations from the Mental Health Commission and in turn, the Commission's work will be informed by the new strategy.

Management of the Mental Health Service

The new health reforms describe two programmes for the management of the national health service, a national hospital programme and a primary, community and continuing care programme. Many services, including the mental health services, do not fit easily into such a division. What is of major importance for the mental health services, however, is that they maintain their integrity and cohesion and that this is reflected in management structures and funding. Unlike the current situation, where mental health services for children and adolescent and for those with an intellectual disability are frequently separated from the rest of the mental health services, all mental health services should be under unitary management to allow appropriate streamlining of service development and delivery.

Many of the current problems within the Irish mental health services have arisen from problems within the management of the service. There has been no management structure to facilitate regional and national developments with the result that there has been no forum for the planning and development of specialist services. The management of the resource shift from the institution to community has been slow and

incomplete. Catchment management teams have been a traditional tripartite structure of hospital administrator, director of nursing and clinical director. This arrangement has had only limited success and has suffered from a lack of management expertise in some team members. The role of clinical director, which evolved from the role of resident medical superintendent, has not been clearly identified as having as its major responsibility the planning, implementation and evaluation of service developments.

A combination of interest, aptitude, qualifications and experience, together with appropriately structured posts is necessary in the appointment of suitable directors.

There is a need to evolve a new management structure suitable for the proposed larger catchment areas of 350,000. Such a management structure will allow for appropriate specialty development and more rational resource management. The ideal management team for a catchment population of 350,000 would consist of five to seven people forming a Service Directorate and representing administration, medicine, nursing, and allied professionals. All clinical members should have at least half-time commitment to the Directorate, and all members should be appointed on the basis of proven proficiency in service planning and evaluation. A rolling membership for periods of seven years would provide continuity. Each Service Directorate should be represented on the regional health management structures likely to result from the health reforms. Representatives from all Service Directorates nationally should meet regularly to decide on national service objectives and the presence of the Mental Health Commission at these meetings would ensure that all agencies with responsibility for quality in services would



have agreed priorities. In any reorganisation of management in the manner described above, current clinical directors will continue to be required to fulfil the role assigned to them under the Mental Health Act, 2001.

The new health reforms emphasise the devolution of management responsibility to the direct providers of care. In line with this principle, management of clinical services is ideally devolved to the maximum extent to the community mental health teams. These teams in turn, must be willing and have the ability to take on these management responsibilities and accept the accountability which comes from

such management authority. Community mental health teams would then be facilitated in deciding on their own service priorities, negotiating their own budgets, and setting up appropriate structures of clinical governance to allow service evaluation and accountability.

Funding of the Mental Health Service

It is generally agreed that mental health disability contributes in the region of 20% to total health-related disability. Extrapolating from a recent Sainsbury Centre study on the economic cost of mental illness in Northern, the cost of mental illness annually in the republic is likely to be in excess of €10 billion. Such costs relate to the cost of services and the economic and personal costs of illness. Current funding for the mental health services is €680 million, amounting to 6.8% of the total health budget. It is clear that mental health services are seriously under-funded, both in terms of percentage of total health spending and in terms of the costs of mental illness related disability. This under funding is reflective of the low priority given to the provision of mental health services, the lack of public awareness of the prevalence of mental disorder and the generally negative and stigmatised attitudes toward mental illness. With the low priority given to mental health services generally, health planners and managers require to establish a minimum funding baseline, as a percentage of total health spending, to ensure adequate resourcing. This has been achieved in some other jurisdictions, and has resulted in policies of allocating a minimum portion of health funding to mental health. In England and Wales a figure of 12.5% has been adopted. A similar national strategy should be adopted in Ireland and would ultimately reduce the costs to the exchequer of mental illness related disability.

Many of the problems within Irish mental health services are attributed to inadequate funding. While funding is certainly a factor, particularly in some services, the lack of appropriate use of resources is more a factor in others. There are remarkable funding

differences between mental health catchments. These differences reflect the historical nature of funding distribution and do not reflect modern population needs and levels of deprivation. There has been no attempt over the years to rationalise funding provision, or to make it more reflective of catchment morbidity levels.

The stage has been reached where the catchment mental health funding varies from €300 to €56 per head of the population per year. This inequitable funding has made it impossible to prioritise service needs in under-funded services.

Funding levels do not necessarily relate directly to quality of care and some areas with high funding retain high levels of institutional care and minimal development of community teams. There are catchment areas which are already funded to such a degree that they have the potential to have modern, high quality mental health services. Likewise, there are catchments, particularly in the Eastern region, which are seriously under-funded despite having high levels of social deprivation with associated high levels of psychiatric morbidity. It must be accepted, however, that there should be no transfer of resources between traditional catchment areas unless it is clear that some catchments have resources in excess of what is required to provide a modern, high quality service. Existing funding inequities must be addressed through the provision of additional funds and there must be clear accountability by management teams on the use of existing resources in all services, to allow comparisons of the cost-effectiveness of services nationally.

Priorities in Service Development

The report thus far has outlined the Inspector's views on what constitutes a modern mental health service, and has briefly described the issues that need to be addressed within the Irish mental health services to put such a service in place. Mental health services nationally must be community based to the maximum degree, be delivered by multidisciplinary teams and provide a range of specialist services to address areas of special need. Services must be of high quality, be evidenced-based, allow genuine user input and reflect the needs of carers. The services must be governed by principles of equity and proportionality and must allow visibility in terms of performance and use of resources. They must be adequately funded and well-staffed with a range of highly trained professionals. It is the Inspector's view that, in moving towards a modern service, a number of areas should be prioritised nationally for development.

Expanded Catchment Size for Service Planning and Delivery

The Inspector is of the opinion that increased catchment populations of 350,000 are required to facilitate the planning and delivery of the range of specialist services that are required.

New Management Structure for Expanded Catchments

All mental health services should be under the one management structure to facilitate the development of specialty services. Management structures will have to be altered to reflect the larger catchment size and the increased range of professionals delivering such a service. The primary qualification for all those involved in service management should be proven proficiency in the area.

Priorities in Supporting Service Development

Community Mental Health Teams: It is the Inspector's view that the development of Community Mental Health Teams should begin immediately so that the emphasis in service delivery can be moved from inpatient care to community-based care. The further professional development of psychiatric nursing is of major importance. In particular, clinical nurse specialists in home-based nursing and assertive outreach nursing are required. Rectifying identified staffing deficiencies must be given high priority at both national and local level. Appropriate community facilities are required for teams.

Community Residential Units: The discharge of remaining long stay patients from mental hospitals should be prioritised to allow the closure of mental hospitals to be completed.

Specialist Bed Provision: The provision of specialist beds is urgent. This is particularly the case in the forensic mental health service and in mental health services for children and adolescents and for those with an intellectual disability.

Specialty Service Development

It is the Inspector's view that the service areas in most urgent need of development are mental health services for those with enduring mental illness (rehabilitation psychiatry), mental health services for those with a learning disability and forensic mental health services. The development of these services should be prioritised nationally. An appropriate, modern legislative framework is required to support the development of forensic services.



Information Technology

Significant expansion of the information management capabilities of mental health services must take place to allow rational service planning. It is likely that a national initiative will be required to achieve this aim.

Clinical Governance

An environment must be fostered that allows clinical risk management and clinical audit to develop to ensure ongoing quality improvement in service delivery.

Appropriate Funding

The priorities outlined in this chapter require additional revenue and capital funding. This cost must be accepted as necessary and measured against the high overall cost of disability associated with mental illness.

The Mental Health Commission has statutory responsibility relating to the provision of high quality mental health care. It is appreciated that a new national policy is being developed and major health service reforms are on the horizon, but whatever happens in these areas, the principles described in this report that underpin a quality mental health service will remain. The Mental Health Commission has a unique opportunity to lead the transformation of Irish mental health services and the Inspector looks forward to working with the Commission to achieve this goal.

