EASTERN HEALTH BOARD

PSYCHIATRIC SERVICES

Development Programme into the next Millennium

2000

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NOVEMBER 1995

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Introduction

The Eastern Health Board in partnership with the voluntary sector is moving towards the final stages of completing a ten year major reorganisation of its psychiatric services from an institutional to a community model as provided for in the 1984 Government policy document *Planning for the Future.*

The three main principles on which *Planning for the Future* is based are:

- The development of comprehensive community-based services which would enable many people who, up to then would have required hospitalisation for treatment, to live at home whilst receiving treatment.
- The rehabilitation and resettlement of long-stay patients from institutional care to community living.
- The transfer of acute psychiatric admissions from the major psychiatric institutions to psychiatric units in general hospitals.

These principles were based on the premise that services for psychiatric patients should not be equated with beds, but with achieving optimum treatment results and best possible quality of life.

Development of a Community-based Adult Psychiatric Service

Our Board set out its psychiatric service policy in a report titled *Proposed Development of a Community-Based Adult Psychiatric Service* drawn up in 1986. This report outlined the strategy for the development of community services and the transfer of resources from the major institutions to allow this development to take place. The report established a service ethos whereby the community was seen as the service base whilst accepting the fact that residential facilities were required as an adjunct to a comprehensive range of community services. The key principles set out in that report are as follows:

- Since 1977 our Board had been pursuing a policy of moving from institutional care to community settings and had adequately demonstrated that clients with various degrees of psychiatric impairment could lead a very full life in the community with appropriate support.

- It was recognised that the achievement of a localised comprehensive community service would require close co-operation between all professionals in the statutory agencies in the delivery of a total service to the client and close co-operation between statutory and voluntary agencies. Detailed consultation and planning would be required in each catchment area with the various agencies, statutory and voluntary, to allow services to develop in a co-ordinated manner.

- In line with health service development and, in particular, the concept of primary care, our Board wished to ensure that patients with psychiatric illness would have equal access to the full range of health services and would not be dealt with in isolation.

- Our Board accepted that, as far as possible, in-patient care should be provided in acute units attached to general hospitals where patients presenting with acute psychiatric problems would have access to the full range of diagnostic investigative procedures.

- The concept of service localisation was seen as of paramount importance with each catchment area having the full range of services, including in-patient care, and that a residual service would not be available elsewhere.

- With the development of localised catchment area services, admissions to St. Brendan's and St. Ita's Hospitals would be curtailed and in the longer term discontinued. In this context it was recognised that it would be necessary to keep under close review the management of disturbed patients, vis-a-vis the capacity of each catchment area to deal with these patients.

- It was recognised that the achievement of the community developments as outlined would require the transfer of staff and finance from the institutional services to the community. This resource transfer could only take place on a phased basis and would require continuous consultation with the various staff associations and voluntary agencies and would involve arrangements such as joint appointments of consultant staff, staff secondment and rotation etc.

- The proposals as outlined involved the development of substantial community infrastructure requiring significant capital injection, and could only be proceeded with on a phased basis, particularly as suitable premises came on the market. In this context, it was recognised that our Board would require access to capital funding on an ongoing basis and that as facilities and services developed the parallel rundown and closure of the traditional institutions would generate a land bank to fund further localised developments.

Service Development 1985 -1995

Over the past ten years substantial progress has taken place. Services are delivered from a network of health centres, hostels, day hospitals, day centres, training centres and hospitals (305 facilities overall). In-patient care for four areas are provided in acute units in the following general hospitals: Mater Hospital, St. James's Hospital, James Connolly Memorial Hospital and Naas General Hospital. Plans are progressing for the opening of further units in Beaumont Hospital, St. Vincent's Hospital, Elm Park, James Connolly Memorial Hospital and the new hospital in Tallaght. A new unit has opened in St. Vincent's, Fairview providing excellent facilities.

The continued development and emphasis on rehabilitation (and resettlement) services for continuing care patients "long-stay" and "new long-stay" has been a major feature of service provision in each area. A specialist consultant-led rehabilitation team was established at St. Brendan's Hospital.

The in-patient population in psychiatric hospitals/units has reduced by just over 1,000 in the last ten years whilst 1,300 alternative beds/accommodation are provided in the community.

Each catchment area has a wide range of community services: out-patient clinics, day hospitals, day centres, hostels, training/employment facilities as profiled in *Appendix I.*

Psychiatry of Old Age

Specialist old age psychiatry services were established in three catchment areas and are currently being established in a further two areas. This specialist service operates on a multi-disciplinary model led by a consultant psychiatrist and is based on the principle of domiciliary assessment and support services. The problem of mental ill health in elderly people is predominantly a community one with 95 per cent of people suffering from such problems living at home. The services are therefore particularly supportive of carers in the community.

Alcoholism Treatment Service

In 1988, our Board adopted a policy on the development of a community-based alcoholism service to be achieved through the rationalisation of existing resources. This programme is now fully operational with four local centres and a residential centre, providing educational and preventive programmes in addition to detoxification and counselling services *(see Appendix II).*

Services for Adult Victims of Sexual Abuse

Three specialist services for adult victims of sexual abuse have also been established and the region is now served through a partnership arrangement with the Rape Crisis Centre. The services work closely with primary care, community care and the formal psychiatric services. In addition to counselling work, the services are involved in education, prevention programmes and research *(see Appendix III).*

Staff Development

These developments have been accompanied by the redeployment of staff from the major institutions to the community and at the beginning of 1995 almost 800 of a total staff of approximately 2,800 are deployed in the community. Redeployments were initially accompanied by in-service training to prepare staff for their new work location.

Nurse Training

The new undergraduate nurse training curriculum was successfully introduced and, as needs became more apparent, more structured and intensive post-graduate training programmes were put in place:

Clondalkin Model Training Programme
Behaviour Nurse Psychotherapy
Postgraduate Mental Handicap Training
Family & Marital Therapy
Challenging Behaviour
Child & Adolescent Psychiatry

Other courses include development in management, counselling skills, rehabilitation course, working with adults who have been sexually abused, legal issues.

Discussions are ongoing at present with the third-level colleges regarding their input to undergraduate and postgraduate nurse training programmes.

Medical Training

At medical level, our Board's psychiatric services are accredited for post-graduate training in psychiatry leading to the MRC Psych. and higher training as senior registrar for consultant appointments. The introduction of sub-specialisation in old age psychiatry and rehabilitation has developed very satisfactorily. Our Board's training programmes are now being integrated with similar programmes based at the Mater Hospital, St.

Patrick's Hospital and St. Vincent's Hospital, Elm Park, and it is anticipated that when fully rationalised there will be four programmes in the eastern region incorporating all the agencies involved in the provision of mental health services together with the three medical schools.

Clinical Psychology

Our Board is involved with the Hospitaller Order of St. John of God and Trinity College, Dublin in a postgraduate training programme in clinical psychology.

Commitment to Training and Development

Our Board's commitment to staff training and development as reflected in the substantial injection of resources to training and training facilities has been acknowledged by the accrediting bodies (An Bord Altranais, the Royal College of Psychiatrists and the Irish College of General Practitioners) and our various training programmes continue to receive approval and commendation.

Legislation

The current legislation governing the provision of mental health services is the Mental Treatment Act 1945 and amending Acts. This legislation is dated and does not conform with the European Convention on Human Rights. A consultative process to devise new mental health legislation commenced in 1992 with the publication of the *Green Paper on Mental Health*. The Green Paper set out options for new legislation and was intended to stimulate discussion and debate in order to reach consensus on the issues to be dealt with by new legislation. The Government has now published a White Paper, *A New Mental Health Act*, which is the basis for legislation which will provide a modern framework for the care and treatment of persons with a mental disorder who refuse or who are incapable of seeking treatment or protection in their own interest or in the interests of others.

Evaluation of Service Development/Outcomes

No one exact model of community care was prescribed in the policy document *Planning for the Future*, therefore development programmes were in effect pioneering ones requiring reorientation of goals in the context of experience gained. Whilst the development of a community model was the overall philosophy, service teams were facilitated in developing their own ethos within the overall policy structure to allow continuous development and comparison of ideas and models of care. Professional staff have been involved in a variety of pilot and research initiatives aimed at evaluating service outcomes and quality of care. The projects listed at *Appendix IV* have been used in support of service developments/restructuring and will continue to support developments in the years ahead.

The publication of the Health Strategy *Shaping a Healthier Future* in 1994 was timely in terms of a reinforcement of the principles set out in *Planning for the Future* and the *Green Paper on Mental Health Services* published in 1992. The concepts of health gain and social gain which underpin the principles outlined in the Health Strategy of equity, quality and accountability were in effect largely the basis for the restructuring of our Board's psychiatric services.

Equity

It is necessary to direct resources to areas of greatest need and ensure that people can access the services that they require within a reasonable period. This is particularly important for people in acute mental distress who require a safe and protected environment, and for marginalised groups, e.g. homeless people with mental health problems who must have easy access to appropriate services.

Quality of Services

Mental health services have not attracted the same level of health priority and financing as other services. This is partially due to the stigma of

mental illness silencing those affected and their families. The condition of serious mental illness also interferes with effective communication, thus, there have been few complaints from patients themselves. The quality of mental health services should be equal to service for other medical conditions in the range of facilities, staff training, care environments and the allocations for academic research developments.

Accountability

Psychiatric catchment area services are responsible for providing a comprehensive service to the population and to people presenting with a mental illness. Each area must be accountable for the services they provide. This principle is the key to good mental health care. People with serious mental health problems and resulting disability require up to life-time commitments of after-care, monitoring and ongoing engagements by mental health services. Such commitment necessitates assignment of case managers, frequent assessments on health and social aspects, with target setting in these areas and the provision of skills training and support. Lack of accountability may result in destitution and homelessness, unnecessary burden on carers, and distress and poor quality of life for those affected.

Research and Evaluation

As previously stated, our Board developed pilot and research projects on the various components of mental health care to give the measurement tools to provide a consistent and standard way of reviewing service needs, quality outcomes together with measurement of the effectiveness and efficiency of the services (*Appendix IV*).

The pilot/research projects undertaken show:

(i) that the general personal satisfaction of psychiatric patients living in the community, whether at home or in community housing, compares favourably with the general population;

(ii) that a patient's personal satisfaction reduces following one month's hospitalisation and continues to reduce thereafter;

(iii) discharged long-stay patients (following rehabilitation) experience a major improvement in quality of life and personal satisfaction when discharged from long-stay care;

(iv) living in a high support hostel is seen as a very good life outcome for high dependent patients discharged from long-stay care;

(v) an audit of new long-stay patients in the Eastern Health Board in 1992 showed a population of 175; a follow-up audit in 1994 showed a similar population and also showed that those entering the population were cancelled out by those leaving by discharges, death, etc. This gives an attrition rate of 27 patients for the region per year implying that a steady state exists between those becoming new long-stay and those leaving the in-patient services;

(vi) the home support project in Clondalkin showed that a well resourced home support programme gave a highly acceptable service to the patient population, that those patients enjoyed a high level of personal self esteem, and that the programme was highly regarded by the carers and primary care providers. The service showed that not only the patients themselves were happier living in the community but their relatives were happier also. The results of the programme showed a higher level of acute admissions; such admissions were, however, of a very short duration with overall bed days being reduced by 75%;

(vii) the operation of a community day ward (Rose Cottage) is a very effective alternative to in-patient care for selected patients. The service is considered very satisfactory (and more acceptable than in-patient care) for service users, and is highly regarded by primary care staff. The operation of a day ward seven days per week reduces considerably demands on in-patient beds;

(viii) a community-based specialist service in the psychiatry of old age operating a community assessment and home support service,

supported by day hospital, appropriate in-patient and continuing care beds (for elderly patients with disturbed behaviour secondary to dementia), meets the needs of the frail psychiatric elderly and patients with dementia very effectively. It is highly regarded by the users, their carers, and primary care staff. As one carer commented, "Help is only a phone call away".

Acute Psychiatric Units in General Hospitals

The Health Strategy reiterated the policy of transferring the provision of acute psychiatric in-patient care from the traditional psychiatric institutions to acute units in general hospitals.

The first such unit in our Board's area was opened in St. James's Hospital and was in effect a pilot for the further development of such units. The experience of the unit in St. James's demonstrated conclusively that:

- an acute unit in a general hospital could service completely the acute in-patient needs of a given catchment area;
- fears regarding a possible requirement for a parallel service were unfounded;
- the provision of day hospital services within the acute unit was inappropriate and such service should be provided in the community.

The experience gained with the St. James's model underpinned the developments in James Connolly Memorial Hospital, the Mater Hospital and Naas General Hospital.

The service development in Area 7 is particularly interesting in that it involves a partnership arrangement between our Board, St. Vincent's Hospital, Fairview and the Mater Hospital, in the provision of a unitary service to patients in the area. Staff at all levels rotate between the parent organisations and at present 50% of the nursing staff in the psychiatric unit in the Mater Hospital are seconded from the Eastern Health Board.

Our Board is establishing similar arrangements in Area 2 with St. Vincent's Hospital, Elm Park, with the planning of a new acute unit on the general hospital campus. This development will give a major impetus to the restructuring and integration of services in Area 2 in the years ahead.

In-patient services for Area 6 are accommodated at Unit 9, James Connolly Memorial Hospital (Blanchardstown/Clonsilla/Mulhuddart) and at St. Brendan's Hospital (Cabra/Finglas). The overall redevelopment of James Connolly Memorial Hospital will contain a modern psychiatric unit meeting the in-patient needs of the Area overall. In the meantime, Unit 10 at James Connolly Memorial Hospital, when commissioned, will accommodate the in-patient needs of the Cabra/Finglas sectors. This development will effect a reduction in bed numbers at St. Brendan's to 200. The reduction in in-patient numbers from 1986 to 1994 is charted in Table 1. The overall development of the acute in-patient services at James Connolly Memorial Hospital will, in effect, mean that St. Brendan's no longer has a function in the provision of acute in-patient care.

Table 1 IN-PATIENT NUMBERS, ST. BRENDAN'S HOSPITAL

Year	Number of Patients
1986	987
1989	396
1990	385
1992	301
1994	257

The commissioning of the acute unit in Beaumont Hospital for Area 8 is progressing satisfactorily. The unit initially will have 25 beds to service the Coolock/Artane Sectors. The long-term objective is to locate all acute psychiatry in Beaumont Hospital which will require the further commissioning of upwards of 40 beds.

The new Tallaght Hospital with a 50 bed acute psychiatric unit which together with the reorganisation of Area 3, will facilitate the transfer of all acute in-patient services from St. Loman's Hospital which currently services Areas 4 and 5. Approximately 20 continuing care patients will be resettled in community housing thereby facilitating the closure of the main

hospital. The St. Joseph's and Beechaven Units will continue to support the community services in the provision of continuing care services and services for the elderly.

The strong links which already exist within the psychiatric service between our Board, the major teaching hospitals, the private psychiatric hospitals and voluntary organisations will be strengthened and further developed to ensure that services are both readily accessible to the patient and are delivered in an environment which may be perceived as less threatening or stigmatizing.

The in-patient services for East Wicklow are based at Newcastle Hospital. The hospital is strategically located, the buildings are modern, in excellent condition overall and are in line generally with the in-patient needs of the region.

Acute in-patient beds for the Dublin North East Region, Catchment Area 8, are provided in St. Ita's Hospital. The Area is serviced by a range of community services - out-patient clinics, day hospitals, day care centres, hostels and a vocational training/sheltered employment facility. A very successful home care management service was established in the North County Sector in June 1992. The aim of the service is to augment existing services by enhancing the scope and quality of psychiatric social and familial interventions. The service provided is domiciliary based and encompasses a variety of treatment and maintenance strategies which can (i) obviate the need for hospitalisation and (ii) where admission to hospital is unavoidable reduce the length of stay in hospital.

Since 1984 the psychiatric in-patient population in St. Ita's Hospital has reduced as follows:

Year (31st December)	No. of Patients
1984	475
1986	456
1988	395
1990	363
1992	368
1994	283

The commissioning of the acute psychiatric unit in Beaumont Hospital with 25 beds initially has already been referred to. This unit will serve the Coolock/Artane sectors of the catchment area. The long-term objective of the service is to locate all acute psychiatry in Beaumont Hospital. This will require the commissioning of upwards of 40 beds to meet the in-patient requirements of the region (population: 1991 census 188,606).

Of the 283 in-patients at 31st December, 1994, 186 are aged over 65 years. These patients are accommodated within Reilly's Hill, a 96 bed unit, separate from the main hospital and the remainder within long-stay wards throughout the hospital. Reilly's Hill was totally refurbished during 1993/1994 to meet the needs of the elderly and to facilitate the transfer of patients from the long-stay wards within the main hospital which were in a poor state of repair and are now closed.

Reilly's Hill now functions as the admission unit for the elderly services with a number of respite beds and will, in the longer term, provide continuing care and respite facilities for the elderly with functional psychiatric illness and dementia.

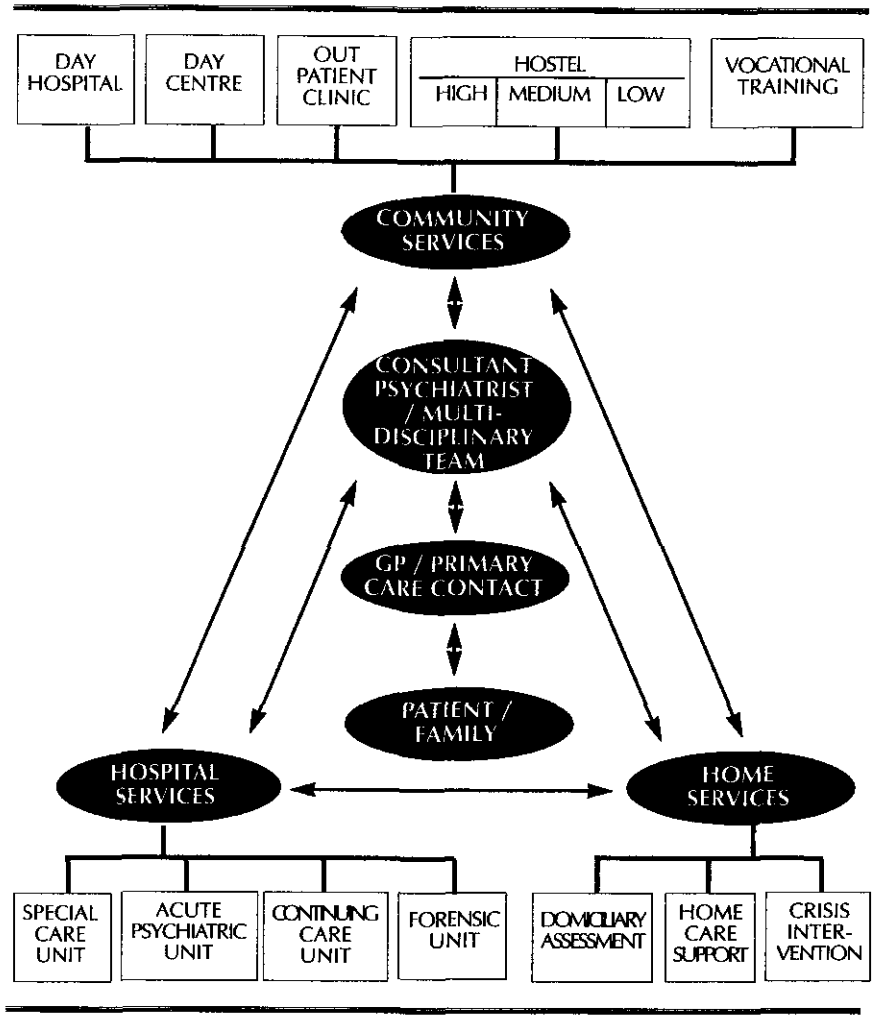
Patients are no longer being admitted to the main hospital building at St. Ita's - old wards are being taken out of commission in line with reduction in patient numbers and in the immediate future the main hospital building will be fully closed. A similar situation is developing in the units in the main hospital building associated with the Mental Handicap Service. Our Board's current development plan will effect the closure of all hospital wards in the main building over the next four - five years. St. Ita's campus will then consist of the new buildings:

Mental Handicap Service	Units 11, 12 & 13
	Units R and S
	Housing Units on Campus
Psychiatric Service	Admission and Assessment Unit
Elderly Service	Reilly's Hill
	Hostels on Campus

Service Development - The Next Five Years

The services, as developed over the last ten years, means in effect that the majority of treatment outcomes are dealt with in the community or with a combination of community and in-patient care, on a catchment area basis. The various treatment options are listed in Table 2 below:

Table 2 Paradigm of Mental Health Treatment



Experience has shown that a catchment area with a full range of facilities leads to a more efficient and effective service to patients in terms of health gain and social gain. To achieve self-sufficiency for all catchment areas a further development programme must be embarked upon in the following service components:

- extended care/rehabilitation services;
- services for the homeless mentally ill;
- services for persons with disturbed/challenging behaviour.

It is our Boards's policy, as previously outlined (ref. *Towards the Development of a Community-Based Adult Psychiatric Service*) to resource the development of comprehensive community-based catchment area services through redeployment of existing capital and revenue resources assisted by central funding from the Department of Health.

Rehabilitation Services/Extended Care

The aims of Rehabilitation/Extended Care Services are as follows:

- to maintain a high level of expertise in the assessment, rehabilitation and placement of people with high levels of social and psychiatric disability;
- to provide a resource of expert opinions and consultations to other patients in the community on request;
- to develop a multi-disciplinary training course on rehabilitation to diploma level in conjunction with a third-level institution;

REHABILITATION

- to meet the needs of patients whose level of need is such that any reduction in care or support would result in significant risk to themselves or others on an ongoing basis. (The research would suggest that about 6 - 10 beds per 100,000 of the population would be required.);
- to provide and develop a multi-disciplinary, individual care approach to the patients' requirements for extended care.

EXTENDED CARE

As already indicated, following the commissioning of Unit 10, James Connolly Memorial Hospital, 200 beds will remain in use at St. Brendan's Hospital. Approximately 150 of those beds are a resource to the catchment areas providing continuing care and rehabilitation services for new and old long-stay patients. The design and layout of the units is totally unsatisfactory for modern practices in the provision of a therapeutic rehabilitation milieu and there is a further problem in their being detached from the catchment areas with a resultant break of the link in the overall care process.

It is now opportune to further our Board's policy of developing comprehensive community-based services in the provision of rehabilitation/extended care facilities in each catchment area. This development will enable each catchment area to provide for the rehabilitation and extended care needs of their existing population together with the anticipated number of new long-stay patients presenting. As demonstrated by research carried out in 1992 and 1994, previously referred to (Ref. *New Long-stay Patients* - Gannon et al 1992, and *1994 Follow-up*) a steady state exists between those becoming new long-stay and those leaving the in-patient services.

Rehabilitation/extended care services should be provided in purpose-built domestic style units (25 beds) designed in such a way as to allow the flexible use of the facility in treating a wide variety of patient needs. These units should be available in each of our Board's catchment areas. In some areas facilities exist which, in the near future, will be vacated through the development of other services. It may be possible to adapt some of these facilities for this new role.

The developments proposed for each catchment area are as follows:

Area	Rehabilitation/Extended Care Proposal	Possible Location(s)
1	Purpose Built Unit	Cluain Mhuire Burton Hall
2	Adapt Vergemount Clinic	
3	Purpose Built Unit	To be identified
4	Purpose Built Unit	Glenabbey, Belgard Rd
5	Adapt St. Joseph's Unit St. Loman's Hospital	
6	Purpose Built Unit	To be identified
*7	St. Vincent's Hospital, Fairview	
8	Purpose Built Unit	To be identified
9	Purpose Built Unit	Tus Nua, Kildare
10	Adapt existing unit, Newcastle Hosp.	

** In relation to Area 7, it is considered that St. Vincent's Hospital may wish to consider modernising facilities within the hospital. Such a development would further enhance the overall role of St. Vincent' s Hospital in the provision of a comprehensive service in Area 7.*

In summary, it is proposed to develop six new purpose built units, and to adapt existing facilities in the remaining catchment areas.

Services for Homeless Mentally Ill

Ideally, no person with a high level of disability from mental illness should be homeless. However, there are great variations and reasons why, even in near ideal circumstances, there are groups who remain symptomatic and homeless.

- ➢ There are people who are intermittently ill and who have lived in the inner city direct access hostels for considerable periods of time and who consider these their home - (it is questionable whether they are truly homeless). Some do not find any other offered accommodation acceptable.
- ➢ Despite there being a comprehensive range of services in the catchment areas, some patients drift to the anonymous urban areas. Unless they are continuously certifiable as involuntary patients requiring hospital care, they may leave hospital once their symptoms are contained and they may decline offers of aftercare only to surface when their behaviour brings them to the notice of others and the cycle is repeated.
- ➢ Many people with substance abuse problems drift down the social scale, become homeless and occasionally suffer mental disturbance for which they seek help in the short term but do not find aftercare services acceptable and are not prepared or able to lead a more settled lifestyle.

The aims of the services for the homeless mentally ill are as follows:

- to provide a comprehensive mental health service to people with mental illness and homelessness, both male and female;
- to provide an outreach, support, consultation and liaison service to the inner city hostels and other services who are in contact with homeless people;
- to have clearly described access procedures for emergency psychiatric assessment and treatment of homeless people.

St. Brendan's provides limited services for people who have mental illness and are homeless. The latter homeless group referred to overleaf provide the biggest challenge to the current assessment services at St. Brendan's.

Whilst the homeless have very special needs, our Board must endeavour to prevent homeless persons being marginalised in psychiatry. Our Board, together with Dublin Corporation, and in association with the Departments of Health and Environment have developed a strategy for the provision of an integrated service for persons who present as homeless. The specialist psychiatric service component, together with the range of primary health care services, will be provided in two dedicated city centre clinics.

The management of homeless mentally ill requiring in-patient care will be co-ordinated and reviewed through a small cross catchment area multi-disciplinary committee. This committee will also review the needs of persons moving from catchment area to catchment area making it difficult for the service to provide continuity of care.

Over the next twelve months, ongoing review of the service should indicate whether the psychiatric in-patient care needs of the homeless mentally ill can be provided in the acute units in the catchment areas or whether a specialist in-patient facility is required. The latter perpetuates exclusion of patients and is the least satisfactory option.

Services for Disturbed Mentally Ill

It is recognised that a number of patients are so disturbed by their illness that they require a highly staffed, specially designed area that can contain and manage difficult and dangerous behaviours safely and quickly.

The aims of a special care unit are as follows:

- to provide special care facilities for patients from the Eastern Health Board whose level of disturbance is such that they cannot be contained or managed in acute wards;
- to make available about 14 such male beds and up to 10 female beds for new acute patients in an environment suitable for their needs;
- to provide a secure facility for Eastern Health Board patients referred from the Central Mental Hospital.

The special care units at St. Brendan's Hospital provide a very valuable service for persons whose level of disturbance is such that they cannot be contained or managed in acute wards, to all catchment areas with the exception of Area 8. A Department of Health Review Group is currently examining the requirements for such services on a regional basis. Recommendations in relation to the development of service facilities will be forthcoming from this Review Group in the near future. Whilst *Planning for the Future* recommended the provision of regional secure units, experience to date in the Eastern Health Board area would suggest that this concept is dated and that services for this group should be an integral component of the catchment area service. Given the numbers in this category presenting in our Board's region and the intensive staff requirements necessary to operate such specialised units it would appear more appropriate that needs would be met by the provision of three small units based north, south and west. Such units would require cross catchment area management with appropriate operational policies to ensure the effective and efficient use of the resources as an integral part of the catchment areas being served.

A final policy decision on this service must await the outcome of the deliberations of the Department of Health Working Group.

Conclusion

On balance, our Board is quite satisfied that over the last decade we have succeeded in changing the whole orientation of our psychiatric services from an institutional to a community-based service. These developments have been achieved with community support and goodwill at all stages and have had the full support of all staff. The range of new facilities provided are modern, bright and comfortable. When the final stages of development are in place in two to three years time, we will have a range of services and facilities responding to the diverse needs of the mentally ill and their carers and one which will fulfil the career aspirations of all staff associated with the service.

The concentration of developments over the last decade has of necessity been in community settings and in acute general hospitals; we are however conscious of a growing sense of isolation among many of our staff who have of necessity had to remain in the institutional setting; thes proposed new developments present a very exciting and challenging opportunity for all staff to be part of a fully integrated service, to work in modern purpose built facilities designed to meet patient need in its wides context, with the capacity to rotate through the various specialist areas.

The commitment of our Board's staff to the overall reorganisation programme achieved to date is fully recognised and appreciated and we are looking forward to their continued commitment and support in achieving the final stages of reorganisation and development.

Michael Walsh
Programme Manager

APPENDIX I

Profile of Community Services as at 31 December 1994

Out-Patient Clinics

No. Locations : 51
No. Clinics Held : 5,137
Total Yearly Attendance : 103,423

Day Hospitals

No. Locations : 18
Total Yearly Attendance : 48,442

Day Centres

No. Locations : 15
Average Daily Attendance : 26

Hostels

No. Locations : 88
No. Places : 800

Training/
Employment Facilities

No. Locations : 21
No. Places : 825

APPENDIX II

Alcoholism Services

AREA	NO. OF ATTENDANCES 1994	BASE
1, 2 & 3	2,153	Baggot St. Hospital
4, 5 & 9	2,023	Tallaght Alcohol Treatment Unit
6, 7 & 8	11,576	Stanhope St. Centre
10	114	Lincara Centre, Bray

RESIDENTIAL SERVICES

No. of Places : 10 Base : Barrymore House

APPENDIX III

Adult Victims of Sexual Abuse Service

Services commenced January 1994

Clontarf
North Circular Road
Tallaght

- Counselling for people who have been sexually abused in childhood.
- Information on the effects of sexual abuse.
- Liaison with agencies providing sexual abuse services.
- Information and support to other professionals.
- Training resources for health workers.
- Research on effectiveness of service.

APPENDIX IV

Pilot/Research Initiatives

Services to Psychiatric Patients: Epidemiological and Cost Effectiveness Issues, St. Loman's Hospital
(Dr. R. Williams)

An evaluation of the quality of life to patients with schizophrenia in the St. Loman's community service and the cost effectiveness of service provision.

Outcomes of 95 Discharged Patients from a Long-stay Psychiatric Ward
(Drs. O'Neill and Mohan)

This research involved a cross sectional study of 95 patients discharged from a long-stay psychiatric hospital ward. The research dealt with the outcomes for the discharged group studied.

New Long-stay Patients
(Drs. Gannon, Johnson, Meagher, Hussen and Farren, 1992).
1994 Follow-up
(Drs. Gannon, Meagher & Watters)

Research carried out on new long-stay patients 1992, and a follow-up study by Drs. Gannon, Meagher and Watters in 1994 gives a clear indication on their overall rehabilitation needs. The study is a very useful backdrop for our Board and clinicians in planning services for the future.

HIGH SUPPORT HOSTEL CARE

(a) *High Support Hostels Meeting High Dependency Patients' Needs*
(Dr. A. Mohan)

An evaluation of high support hostels as a service component with particular emphasis on meeting high dependency patient needs and evaluating health gain and social gain.

(b) *Is Community Care what the Patient really wants - High Support Hostel accommodation*
(E. Cusack)

A review of discharged patients in hostel accommodation.

Clondalkin Project

An investigation on the running of a community psychiatric service and the effectiveness of the service as measured by a variety of outcomes - clinical outcomes, family burden, patient and carer satisfaction to services, G.P. satisfaction to services, economic outcome and change in hospital in-patient care usage.

Rose Cottage - an Acute Community Day Service

Rose Cottage Day Ward was opened in 1993 as an adjunct to the in-patient service provided by St. Vincent's Hospital, Fairview. With the opening of the day ward, usage of acute beds has reduced significantly. The development offers a comprehensive seven days a week community service.

OLD AGE PSYCHIATRY

(a) *The North Dublin Old Age Psychiatry Service - Survey of Patients Referred in the First Six Months*
(Wrigley, Gannon, 1990)

This study audited all referrals in the first six months of operation and confirmed the need for the service reflected in its high appropriate referral rate, and highlighted the requirements for further service development.

(b) *Consultation - Liaison Referrals to the North Dublin Old Age Psychiatry Service*
(Wrigley & Loane, 1991)

This study provides information on elderly acute hospital in-patients referred to the North Dublin Old Age Psychiatry Service during the period January 1989 - June 1990. The study confirmed the need for immediate and close liaison between acute hospital and community personnel in the appropriate placement of patients.

(c) *The Day Hospital in Psychiatry of Old Age - What difference does it make?*
(Corcoran, Guerandel & Wrigley, 1994)

The study assessed how the service day hospitals were meeting clients' needs. The study found that a day hospital provides a satisfactory process of care for patients, with a low usage of in-patient beds.

(d) *Sitting Service - a Model of Voluntary Home Care Service for Elderly People*
(Shasby & Freyne, 1994)

This service arose from an identified need for additional support services for both elderly dementia patients and their carers and produced significant beneficial outcomes for both groups.