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Report of project team [on] St. Brendan's Hospital / Eastern Health Board

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ST BRENDAN'S HOSPITAL

Report of Project Team

EASTERN HEALTH BOARD

April 1982

Report of Project Team on St Brendan's Hospital

1. CONSTITUTION OF TEAM

The Project Team was established with the agreement of the Minister for Health and held its first meeting on 19 March 1981.

2. The Team consisted of officers of the Department of Health and of the Eastern Health Board. The members of the team were:-

Department of Health: Dr F Campbell, Inspector of Mental Hospitals.

D Devitt, Principal Officer, Mental Health & Services for the Mentally Handicapped Division.

Dr V Dolphin, Asst. Inspector of Mental Hospitals.

R O'Keeffe, Architectural Inspector.

Eastern Health Board: P B Segrave, Chief Executive Officer (*Chairman*).

R Bennett, Chief Nursing Officer.

Professor I W Browne, Chief Psychiatrist.

T Keyes, Programme Manager.

Professor T Lynch, Clinical Director.

J Sadlier, Technical Services Officer.

3. TERMS OF REFERENCE

The terms of reference of the Team were as follows:-

*To examine the whole question of the future of
St Brendan's Hospital and its role in the context
of the continuing development of community services.*

4. EHB POLICY FOR MENTAL HEALTH SERVICES

In considering the future role of St Brendan's in the context of the continuing development of community services, the Team has as one of its main considerations the overall policy objective of the Eastern Health Board to replace the traditional centralised and institution-based mental hospital system by a comprehensive range of alternative facilities in each catchment area. These facilities would include hospital beds for acute, medium and long-stay patients in each area, as well as hostels, group homes, day centres, day hospitals and workshops, as recommended in the March 1978 Report of the Ad hoc Committee on the Development of Community Mental Health Services, which has been adopted by the Board and approved in principle by the Department of Health.

5. In approaching the question of the future role of St Brendan's in this context, the primary consideration of the Team has been the welfare of the present patients in our care and the measures which need to be taken to provide the best possible facilities for them and for future patients.

6. HISTORICAL NOTE

In order to get into perspective the problems of St Brendan's and the programme the Board has adopted for their solution by the development of comprehensive community mental health services, it may be helpful to look briefly at how St Brendan's functioned in the past as the centre of an institution-based district mental hospital system.

7. From its foundation in 1814 as the Richmond Lunatic Asylum - now known as the 'Lower House' - its numbers grew rapidly and in the 1840s and 1850s the older buildings on the west side of the road were constructed to relieve the situation. Numbers continued to grow, and by the 1890s had so outgrown even the capacity of the greatly enlarged institution, that the adjoining prison buildings of the Grangegorman General Penitentiary were taken over to accommodate patients. Temporary buildings were erected at Grangegorman and on a site which had been acquired at Portrane for a new 1,200 bed hospital. On 31 December 1900, a total of 2,254 patients were accommodated throughout this complex. The new hospital at Portrane was completed in 1903; however, the number of patients continued to grow and in 1930 some of the buildings of the former North Dublin Union were taken over to accommodate some 320 patients. Of the Union buildings, only the building housing Units L, M and N remains today.
8. By 30 December 1932, the patient population of the entire complex, including Portrane, was 3,837. The complex, which was known as the Grangegorman Mental Hospital, catered for the city of Dublin and surrounding boroughs, County Dublin, County Wicklow and County Louth. All admissions were made through the central hospital at Grangegorman, with the Portrane hospital serving as an ancillary institution. The opening of a new district mental hospital at Ardee in the 1930s to serve County Louth stopped the inflow of patients from that area to the Grangegorman/Portrane complex.
9. Various plans were put forward over a long period of years to relieve the continuing problems presented by old, unsuitable and overcrowded buildings. The patient population of St Brendan's alone in August 1953 stood at 2,122, and in June 1958 was 1,973.
10. Beds in sanatoria which had become surplus due to the drop in the incidence of tuberculosis, were availed of to relieve the situation in St Brendan's. However, despite the fact that some 500 beds were provided in the former sanatoria at St Brigid's Hospital, Crooksling, St Mary's Hospital and St Loman's Hospital, by December 1965 the population of St Brendan's had dropped by only 345 to 1,628.
11. It was manifest that so long as the traditional centralised district mental hospital remained the only facility for the provision of psychiatric care in the Dublin area with its increasing population and changing demographic structures, this tendency to keep on filling up would continue.

12. DEVELOPMENT OF CATCHMENT AREA SERVICES

A significant development took place when St Loman's Hospital, which had originally served, in the same fashion as St Ita's, Portrane, as an auxiliary hospital to St Brendan's, was defined as a sector service, community-based and serving the population of a defined area of the surrounding city and county. The ultimate objective was to de-centralise the psychiatric services with the setting up of a number of community-based teams, each serving its own catchment area with a comprehensive range of facilities in each area.

13. Following the designation of St Loman's as a sector service, further development included the division of the rest of Dublin city and county into a further six sectors or catchment areas, three of which would be served initially from St Brendan's, viz. Dublin North Central, Dublin South East and Dublin North West. In this way it was intended that St Brendan's would cease to function as the central hospital for the whole of Dublin city and county and, that so far as possible, patients from two of its associated catchment areas (Dublin North Central and Dublin South East) would be admitted to units situated out in those areas (St Vincent's Fairview, and Vergemount Clinic, respectively) with St Brendan's being the acute hospital for patients from the immediate district of Dublin North West until such time as acute facilities were developed at James Connolly Memorial Hospital.

REDUCTION OF IN-PATIENT POPULATION ALTERNATIVE PLACES

Since the implementation of this programme, the in-patient population of St Brendan's dropped from 1,628 at the end of 1965 to 953 at the end of 1981. During the same period, 480 alternative in-patient psychiatric beds have been made available in other locations. These include beds made available at St John of God Hospital, Stillorgan, and St Patrick's Hospital in association with the community psychiatric services which are being provided on an agency basis by St John of God's and St Patrick's in the catchment areas of Dun Laoghaire - South East Dublin County and Dublin South Central respectively. Further in-patient beds have been made available at St Vincent's Hospital, Fairview, St Vincent's Hospital, Elm Park, Bloomfield Hospital, St James's Hospital, St Dymphna's, North Circular Road, Vergemount Hospital, Clonskeagh, James Connolly Memorial Hospital, while the in-patient bed complements at Newcastle Hospital and St Loman's Hospital, Ballyowen, have also been increased.

A number of beds at Cherry Orchard Hospital and at the Weir Home, Cork Street, are also being used temporarily for in-patient care. A further 309 places have been made available in 27 hostels and group homes (*see Appendix 1*). Over the same period approximately 500 day care places have been made available in day programmes at psychiatric hospitals and other centres and workshops listed in Appendix 2.

REDUCTION OF BED COMPLEMENT

Since the commencement of the programme for the development of community-based psychiatric services to date a total of 282 beds have been taken out of use in St Brendan's, made up of 86 in the building which now houses the School of Nursing and Assembly Hall, and 196 in Wards 2, 4, 5, 7 and 8 in the building known as the 'Front Hall' which was demolished recently.

ALTERNATIVE COMMUNITY BASED FACILITIES NEEDED

The achievement of the ultimate objective of making St Brendan's the district psychiatric hospital for patients from the immediate district of Dublin North West as recommended by the Chief Psychiatrist in his report of November 1977 and bringing about a further reduction in its psychiatric in-patient population as envisaged by the ad hoc committee was and remains dependent on the further development of alternative facilities out in the catchment areas. The Team noted that in their report of March 1978 the ad hoc committee had assessed the needs of each catchment area in terms of in-patient beds for acute, medium and long-stay patients, day hospitals, workshops - day care facilities, hostels and group homes so as to give a full range of facilities and services in each area capable of providing a comprehensive community-based psychiatric service. Their assessment of those needs is set out in Tables I and II of Appendix 3. Lists of the facilities at present available in each catchment area, about to be implemented or being planned currently and the facilities and services which have still to be provided in each catchment area are given in Appendix 4.

In addition to serving as the district psychiatric hospital for the area, St Brendan's would continue to accommodate its present population of disturbed patients numbering approximately 100. To meet both these needs it is envisaged that about 300 psychiatric in-patient beds would have to be maintained at St Brendan's for the foreseeable future.

There are a number of key reasons why this did not happen as planned. First of all, during the period in which this change was being attempted, the population of Dublin increased rapidly. Secondly, with the establishment of the Eastern Health Board the functional area was enlarged to include counties Wicklow and Kildare.

Thirdly, the full range of alternative facilities had not been provided and it had become evident that simply the addition of acute and community facilities alone would not be sufficient and that it would also be necessary to create units for medium and long-stay chronic patients. Fourthly, and perhaps most important, it was not appreciated that unless the flow into the old facility, that in St Brendan's, was controlled the creation of new and alternative services would simply deal with the new population and would not affect the use of the traditional facilities. Fifthly, the parallel services for mental handicap and the elderly remained relatively undeveloped, so that while there was a considerable reduction in the number of psychiatric patients, both by reducing beds and by reducing overcrowding, the number of elderly and mentally handicapped patients remained virtually unchanged. Further, if the age composition of the population of St Brendan's is examined it will be seen that it is dealing with an ageing population.

19. CREATION OF ADDITIONAL CATCHMENT AREAS

In order to resolve the remaining problems in relation to St Brendan's it is necessary then to consider each of these factors mentioned in the previous paragraph. The problem of controlling the inflow into St Brendan's was dealt with by the creation of the Assessment Unit (*Appendix 5*). Since this was set up the catchment areas are now being forced to undertake the work for which they were established even though they do not possess anything like the full range of facilities to enable them to undertake this properly. Secondly, with regard to the question of increased population, this will necessitate the creation of a number of new catchment areas in order to keep these at an average size of 100,000 population. The population of the entire Eastern Health Board is now somewhat in excess of one million people and to deal with this it will be necessary to create three new catchment areas, bringing the total number of psychiatric districts up to twelve. One of these will clearly have to be situated in Dublin North West in the area contiguous to St Brendan's so that the facilities originally envisaged for this area based on James Connolly Memorial Hospital will, in fact, by the time they are created only be able to deal with the new population situated around Blanchardstown. This will leave a further population of approximately 100,000 in the centre city area around St Brendan's, Cabra and Finglas and it has been proposed that these should be served from a 300-bed district psychiatric hospital which the Board proposes will be retained in St Brendan's to provide a psychiatric service for a new catchment area of Cabra/Finglas.

20. CONDITION OF EXISTING BUILDINGS AND THEIR FUTURE USE

The Team considered reports from the Design Team which had been appointed in 1978 for the Capital Works of Maintenance and Fire Alarm Scheme at St Brendan's and which, because of the size of the institution and the expertise necessary, had been requested to assist the Board's Technical Services Department in the task of examining the existing buildings and services and estimating the cost of upgrading and renovation to an acceptable standard for a minimum of 20 years further life.

- 21. The Team noted that the resultant opinions of the Design Team and their estimate of £12.5 million at April 1982 costs, were based on precursory surveys and could only be regarded as general guidelines indicating the magnitude of the work which would be needed.
- 22. Having considered the reports of the Technical Consultants, the Project Team proceeded to examine the future role of St Brendan's, both in the short-term and the long-term, in the context of the major problems arising in relation to ageing buildings and the question of how resources should be allocated having regard to the overall policy of the Board.
- 23. In considering questions relating to the future of individual buildings within the entirety of the St Brendan's campus, the Team took the view that one of the first matters requiring determination was the buildings and units which should be maintained on the site, keeping in mind as its primary consideration the interests of the patients. This necessitated the review of the numbers and classes of patients who would be accommodated on the St Brendan's site, since long-term decisions on the numbers of patients would directly affect short-term measures to be taken and would also influence questions relating to technical and domestic services such as heating, hot water supplies, catering etc.

24. WEST SIDE BUILDINGS

The buildings now in use on the West Side campus of St Brendan's and their approximate bed complements are as follows:-

Unit no.	Bed complement
1A, B, C	107
9	26
10A, B	80
Assessment Unit	8
3A, B	72
23, 23A	58
Block 22, 8, NFA, OR	99
Total	450

The buildings are identified in the attached map of the entire St Brendan's campus.

25. EAST SIDE BUILDINGS

The Team considers that the old buildings on the East Side of the campus (Lower House and Units L, M and N) have no long-term future and should be phased out. These buildings now house 510 patients.

26. EAST SIDE BOILERHOUSE

The Team addressed itself as a matter of urgency to the immediate problem of the boilerhouse on the East Side and agreed with the Board's interim proposals for its solution while retaining flexibility in relation to the future of St Brendan's as a whole. These interim proposals were for the installation of a mechanical turf handling plant and associated building work at a cost of £422,350, being the first phase of a scheme for a centralised boilerhouse.

27. PATIENT STATISTICS

Statistics showing trends in patient population, admissions, discharges, deaths, age-groups and length of stay were submitted to the Team for their guidance. (*Appendices 6, 7, 8, 9 and 10*).

28. CONSULTATIONS

Members of the Team met the St Brendan's Nursing Consultative Council on two occasions to advise the Council of the progress of the work of the Team and to hear and consider the Council's views on the future of St Brendan's. The Team also noted a written submission by the Irish Transport and General Workers' Union in this regard (*Appendix 11*).

29. REPORTS CONSIDERED

The Reports of the Committee on the Care of the Aged, which had been adopted by the Board as its policy for the development of services for the aged, were noted by the Team. The discussion papers submitted by the Chief Psychiatrist on Services for the Disturbed Elderly (*Appendix 12*) and on the Rehabilitation Programme for Long-stay Patients (*Appendix 13*) were also noted.

30. CARE OF DISTURBED ELDERLY

Arising from its consideration of the report of the Chief Psychiatrist, members of the Team had discussions with members of the Working Party set up to consider the general question of services for the elderly in South Dublin. Having considered the problem of the disturbed elderly at length, the Team formed the view that the appropriate setting for the care of these patients is in special units forming part of an integrated geriatric centre and staffed at both medical and nursing levels by psychiatric and general hospital personnel. The views of the Team have been conveyed to the Working Party which has been asked to incorporate them in their recommendations.

31. PRESENT PATIENT POPULATION

The number of patients at present on the St Brendan's campus is approximately 950, falling broadly into the following categories:-

350	Aged 65 and upwards
100	Aged 60 - 64
400	Psychiatric patients
100	Mentally handicapped

32. ST BRENDAN'S AS HOSPITAL FOR NEW DUBLIN NORTH WEST CATCHMENT AREA

The Team, having examined the buildings available, accepts that the estimated 300 beds needed to enable St Brendan's to function as the district psychiatric hospital for a new catchment area (embracing the contiguous inner city, Cabra and Finglas areas), and to continue to accommodate its

present number of disturbed patients could be accommodated in the better buildings on the West Side of the campus, i.e. Units 3 and 10, 23 and 23A, and the Units 22-22A complex. It was agreed to give priority to a scheme for the renovation and upgrading of Units 23 and 23A for which funds are being made available this year. The estimated cost of this scheme is £130,000. The purpose of this scheme is to adapt those buildings to simulate as closely as possible a normal domestic situation in which patients will be trained intensively preparatory to moving out to live in hostels as described in the Chief Psychiatrist's discussion paper on the Rehabilitation Programme for Long-stay Patients (*Appendix 13*). In addition to the 300 psychiatric beds on the West Side of the St Brendan's campus, the adoption of the recommendation in Paragraph 40(5) *infra*, would increase the total bed complement of the West Side campus to 400. This would be a temporary arrangement pending the provision of special accommodation for the 100 mentally handicapped patients now inappropriately placed in psychiatric wards throughout St Brendan's and who would be accommodated meanwhile in Units 1 A, Band C.

33. ESSENTIAL PREREQUISITES

In order that St Brendan's should function on this basis an essential prerequisite would be the development of:-

- (a) a comprehensive district psychiatric service capable of dealing with all types of patients, in each catchment area, comprising beds for short, medium and long-term treatment, day care and day hospital facilities, workshops and hostels.
- (b) the provision of separate facilities for the disturbed elderly, on a geographical basis,
- (c) making available in-patient accommodation to absorb the 100 mentally handicapped patients who would be housed temporarily in Units 1A, B and C.

34. SEVERELY DISTURBED PATIENTS

While St Brendan's should continue to receive and treat particularly difficult disturbed patients requiring special care that cannot be provided elsewhere in our area, it is recommended that the other main centres should have facilities for the reception and treatment of disturbed patients. A detailed policy in the matter will need to be formulated in consultation with the Clinical Directors of the various catchment areas.

35. The Team accepts that, if these conditions are satisfied, St Brendan's should function in future as a district psychiatric hospital serving its own catchment area.

36. EAST SIDE BUILDING - COST OF ALTERNATIVES

In arriving at this conclusion, the Team had regard to the fact that a compelling factor in considering the future of St Brendan's is the cost of providing appropriate long-term alternative facilities and services in line with modern concepts, as against the prohibitive cost of upgrading and renovating the old and unsuitable buildings now in use on the East Side of the site.

37. ALTERNATIVE ACCOMMODATION NEEDS

The phasing out of the old buildings on the East Side (Lower House and Units L, M and N) and the reduction of the total capacity of St Brendan's to 300 beds (excluding 100 temporary beds for mentally handicapped patients) will involve the provision of alternative accommodation for about 550 patients.

38. NURSES' HOME

The Nurses' Home, which is now used by some of our nursing staff, students and for administrative purposes, may have a limited use for patient services. It is a major asset and should therefore be retained. Other houses owned by the Board and used by staff should be considered for hostel accommodation as they become vacant.

PATIENTS REQUIRING ALTERNATIVE ACCOMMODATION

The 550 patients requiring alternative accommodation are classified broadly, as follows: -

350	Geriatric
100	Aged 60 - 64
100	Suitable for discharge to hostels

RECOMMENDATIONS ON PROVISION OF ALTERNATIVE ACCOMMODATION

- (1) It is recommended that on the opening of the new Beaumont Hospital, those buildings of the present St Laurence's Hospital which are in the best structural condition should be made available to accommodate up to 250 geriatric patients. This would be subject to a detailed examination of those buildings to ascertain their general suitability for this purpose, and the extent and cost of any adaptation and renovation which might be necessary.
- (2) This service could be supplemented by additional beds, as required, for the elderly in new units on the adjoining St Brendan's site.
- (3) The geriatric facility so established should function as a separate entity from the psychiatric facilities on the St Brendan's campus.
- (4) A further 150 - 200 beds should be provided in small units for the disturbed elderly with other geriatric services, the precise size, type and location of such units to be the subject of further study. As in the case of similar units proposed for the East Side of St Brendan's, they should form part of the service for the elderly at these locations and be staffed at both medical and nursing levels by psychiatric and general hospital personnel.
- (5) The 100 long-stay mental handicap patients at present spread throughout the wards of St Brendan's should, ideally, be transferred to specific mental handicap residential centres. Since this cannot be done at present, it is recommended that the three-storey building now housing Units 1A, B and C be adapted to provide mental handicap wards. This building was re-roofed this year and could be retained as patient accommodation for a limited period of 5 to 10 years.
- (6) A programme catering for the special needs of these mentally handicapped patients should be instituted, including the provision of day care facilities and activities distinct from those used by psychiatric patients. This will involve the provision of additional workshop and day-care accommodation.
- (7) Suitable houses should be acquired either by purchase or rental to provide accommodation for the estimated 100 long-stay patients who could live in hostels.

EXISTING COMMUNITY-BASED SERVICES AND FUTURE NEEDS

The lists of facilities and services in Appendix 1 are an indication of the extent to which the various components needed to provide a comprehensive community-based psychiatric service have been established in each catchment area. These facilities and services embrace day hospitals, day care centres, workshops, hostels, group homes and in-patient beds related to specific catchment areas. The number, variety and spread of these community-based services and facilities are, in the opinion of the Team, not sufficiently well known.

While there are gaps in the services in individual catchment areas, it will be seen that, taking an overall view of the area being served either directly by the Board or through the agency of St Patrick's Hospital and St John of God Hospital, at least one example of each of these components has been established.

One aspect of this fundamental change in the pattern of services is clearly seen in its effect on the in-patient population of St Brendan's which has fallen from 1,628 at the end of 1965 to its present total of 950. Significant progress in the development of community-based psychiatric services and facilities has been made during that period. It is in the context of further developments in this direction that the Team has formulated its recommendations on the future role of St Brendan's Hospital.

APPENDICES

1. List of Hostels and Group Homes.
2. Location of Day Hospitals, Day Centres and Workshops.
3. Assessment by ad hoc committee of additional hospital beds, day hospital, day care/workshop and hostel facilities needed (March 1978).
4. list of existing facilities etc. by catchment area.
5. Report on Assessment Centre for 1980.
6. In-patient census, St Brendan's, 1960-1981.
7. Admissions, discharges, deaths of patients 1966-1980.
8. Monthly direct admissions, 1974-1980.
9. Patients by 5-year age groups, April 1981.
10. Age and length of stay of patients at 31 December 1981.
11. Submission by ITGWU.
12. Discussion paper by Chief Psychiatrist on Services for the Disturbed Elderly (22 May 1981).
13. Discussion paper by Chief Psychiatrist on Rehabilitation Programme for Long-stay Patients.
(May 1981)
14. Map of St Brendan's campus.

APPENDIX 2

DAY HOSPITALS - DAY CARE CENTRES AND WORKSHOPS

DESCRIPTION AND AVERAGE DAILY ATTENDANCES

St. Francis Raheny. Day Hospital (30)

St. John's, Clontarf. Day Hospital (35) Day Centre (40) •

Vergemount Clinic. Day Centre (40)

31, Mountpleasant Square. Day Hospital (40)

York Road, Dun Laoire. Day Hospital (30)

Cluain Mhuire, Newtownpark Avenue. Day Hospital (50)

Burton Hall. Day Centre (30)

St. Patrick's Hospital. Day Hospital (30) Day Centre (50)

Crumlin Parochial Hall. Day Centre (28)

Usher's Island. Day Centre (28)

230, North Circular Road. Day Centre (18)

St. Dymphna's, North Circular Road. Day Hospital (50)

St. Dymphna's Mews, North Circular Road. Day Centre (10)

Boycetown House, Kilcock, Co. Kildare. Day Centre ((26)

An Lar, Dargle Road, Bray. Day Centre (26)

St. Brendan's Hospital. Day Centre (80)

St. Loman's Hospital. Day Centre (40)

St. Ita's Hospital. Day Centre (20)

Tolco Ltd., Ballyboggan Road, Glasnevin Sheltered Workshop (65)

Hanbury Lane, Dublin 8 (under reconstruction) Sheltered Workshop (70)

Milltown Therapeutic Centre. Sheltered Workshop (20)

Day places are also available in the Community Workshops supervised by the National Rehabilitation Institute at Ballyfermot and Bray. Places are also available in special day programmes at Co lemine Lodge, Clonsilla, Rutland Centre, Clondalkin, Usher's Island and the workshop at Milltown for autistic patients, which are mainly financed by the Eastern Health Board by way of grant.

A P P E N D I X 3

TABLE 1

ADDITIONAL HOSPITAL BEDS NEEDED

Area	Location	Secondary Prevention	Tertiary . Prevention
		Acute	Medium/Long Stay Beds
Wicklow	Newcastle	20	.
Dun Laoghaire & South-East Dublin County	Cluain Mhuire	15	25
Dublin South East	Vergemount	-	40
Dublin South Central		"	50
Dublin West/Kildare North East	St. Loman's	63	.
Kildare Central	Naas	25	25
Tallaght	Tallaght	20	20
Dublin North-West	James Connolly Memorial Hospital	50	30
Dublin North-Central		-	-
Dublin North-East		30	"
Research & Development	Garden Hill	12	
	General Hospital Unit		
Dublin West/Dublin South Central	St. James's Hospital	50	
Dublin North Central Dublin North-East	Beaumont	25	
Tallaght/Kildare	Tallaght	25	

APPENDIX 3

TABLE 11

ADDITIONAL PLACES NEEDED

	Secondary Services		Tertiary Services	
	Day Hospital	Hostel	Day Care/ Workshop	Hostel/ Group Home
Wicklow	25	10	25	30
Dun Laoghaire & South East County Dublin	30	20	50	30
Dublin South-East			50	30
Dublin South-Central	50		20	30
Dublin West) A	30	10	50	40
Kildare North) B	20	10	50	25
Kildare Central	30	10	50	25
Tallaght	30	10	50	25
Dublin North-West	40	10		30
Dublin North-Central	50	10	50	30
Dublin North-East	20	10	50	40
Research & Development	20			

APPENDIX 4

LIST OF FACILITIES, SERVICES ETC. IN EACH CATCHMENT AREA

Dublin North West Population (1979) 122,500,

Existing Facilities:-

In-patient beds: St> Brendan's Hospital

<u>Hostel</u>	Daneswood, Ballymun Road (17)
<u>Group Home</u>	230 _r North Circular Road (9)
<u>Day Care Centre</u>	St. Brendan's, 230 North Circular Road
<u>Sheltered Workshop</u>	Access to Tolco Ltd.

To be provided

In-patient beds	50 acute and 30 medium/long-stay beds at James Connolly Memorial Hospital. Day Hospital (40 places) at Finglas. Hostel/Group Home (at planning stage) 40 places. Sheltered Workshop - 60 places.
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Dublin North Central Population (1979) 135,500.

Existing Facilities

In-patient beds: St. Brendan's and St. Vincent's Hospital, . Fairview-

<u>Group Home</u>	2 and 4 Grange Park, Raheny (14)
Day Hospital/Day Care Centre	St. John's House, Clontarf, (temporary)
<u>Sheltered Workshop</u>	Access to Tolco Ltd.

To be provided

<u>Day Hospital</u>	50 places (at planning stage)
<u>Day Centre</u>	50 places
<u>Hostel/Group Home</u>	40 places.

Dublin South East Population (1979) 76,000.

Existing Facilities

In-patient beds: St. Brendan's and Vergemount Clinic

<u>Hostel</u>	Mountpleasant Square.
<u>Group Home</u>	Kerlogue Road, Ringsend.
<u>Day Hospital</u>	Mountpleasant Square.
<u>Day Centre</u>	Mountpleasant Square and Vergemount Clinic
<u>Sheltered Workshop</u>	Access to Hanbury Lane.

To be provided

<u>In-patient beds</u>	40 medium/long-stay beds at Vergemount.
	Workshop/Day Centre - 50 places.
	Hostel/Group Home - 25 places.

Dublin North East Population (1979) 182,000.

Existing Facilities

In-patient beds: St. Ita's Hospital, Portrane.

<u>Hostel/Group Home</u>	5, Gracepark Gardens, Drumcondra (9)
	Cill Colum, Swords (7)
<u>Day Hospital</u>	St. Francis, Raheny.
<u>Day Care Centre</u>	St. Ita's Hospital

Sheltered Workshop Killester Industrial Estate
(Not yet open).

To be provided

In-patient beds 30 acute in-patient beds

Hostels/Group Homes 40 places

Dublin West (including Tallaght) and Kildare North. Population (1979)
245,500.

Existing Facilities

In-patient beds: St. Loman's Hospital

Hostels/Group Homes St. Mary's, Phoenix Park (II)
40, Upper Ballyfermot Road (7)
Bungalow, St. Loman's (6)
45, Moorefield Ave., Clondalkin (7)

Day Centre Parochial Hall, Crumlin
Usher's Island.
St. Loman's Hospital.
Boycetown House, Kilcock, Co. Kildare.

In development Hostel at Grove House, Cellbridge, Co. Kildare
(15 places).

To be provided

In-patient beds 30 acute and 20 medium/long-stay beds

Day Hospital 80 places

Workshop/Day Centre 125 places

Hostel/Group Home 100 places

Dublin South Central Population (1979) 87,600.

Existing Facilities

In-patient beds: Hospital 6, St. James's, St. Patrick's Hospital

<u>Hostel</u>	St. Martin's, South Circular Road, Islandbridge (17)
<u>Group Home</u>	Captain's Drive, Crumlin (5)
<u>Day Hospital</u>	St. Patrick's Hospital
<u>Workshop/Day Centre</u>	St. Patrick's Hospital
<u>To be provided</u>	
<u>In-patient beds</u>	50 medium/long-stay beds
<u>Hostel/Group Home</u>	30 places

Dun Laoire and South East Dublin County Population (1979) 161,000

In-patient beds: St. John of God Hospital, Stillorgan

<u>Day Hospital</u>	Cluain Mhuire, Newtownpark Avenue
<u>Workshop/Day Centre</u>	Burton Hall, Stillorgan. York Road, Dun Laoire.
<u>In development</u>	Hostel at York Road.
<u>To be provided</u>	
<u>In-patient beds</u>	25 medium/long-stay beds
<u>Hostel/Group Home</u>	30 places.

County Wicklow Population (1979) 83,950

Existing Facilities

In-patient beds: Newcastle Hospital

<u>Hostel</u>	Newcastle Hospital (former M.O's residence)
<u>Group Home</u>	Curam, Enniskerry.
<u>Workshop/Day Centre</u>	An Lar, Dargle Road, Bray.
<u>In development</u>	Hostel - Ellerslie House, Sidmonton Road, Bray (10 places)
<u>To be provided</u>	
<u>In-patient beds</u>	20 acute beds at Newcastle (at planning stage)
<u>Hostels/Group Homes</u>	30 places
<u>Day Hospital</u>	25 places
<u>Workshop/Day Centre</u>	25 places

In addition to the facilities and services listed above, out-patient clinics are held at various centres throughout each catchment area.

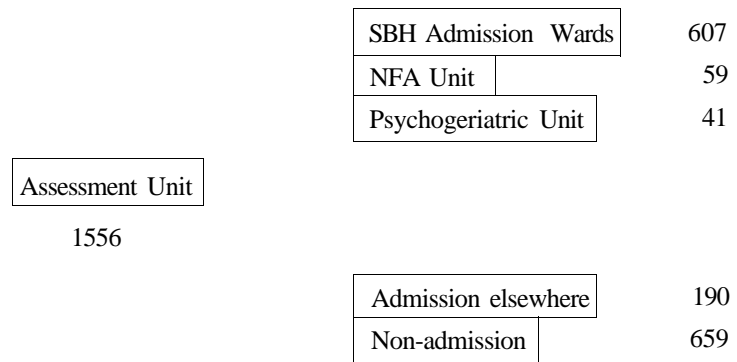
Report on the Assessment Centre at

St Brendan's Hospital for 1980

Introduction

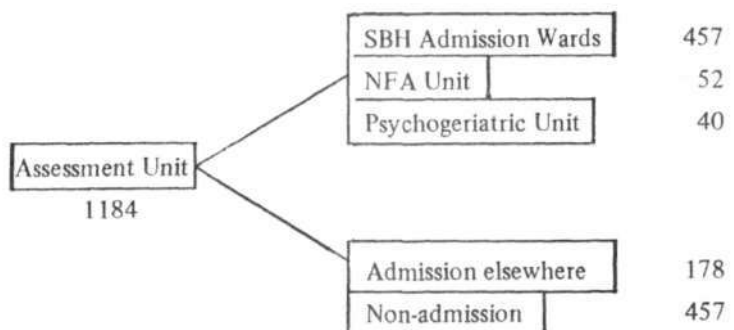
The Assessment Centre was set up on 1 April 1979 to screen all persons seeking admission to St Brendan's whose admission had not already been arranged by the consultants working there. Its brief therefore was to deal with all emergency admissions and to function as a crisis intervention unit. The justification for setting up such a unit was because emergency admissions had constituted such a high proportion (at least 60%) of all admissions to the hospital. Most of these emergency admissions were being dealt with by junior staff. It was felt therefore that while the 'cold' consultant arranged admissions were being adequately screened and catered for, the 'emergency' ones were most definitely not. That St Brendan's Hospital have such a high proportion of emergency admissions should come as no surprise since the hospital still occupied a central position in the psychiatric services of the entire Dublin area. The many and varied services provided for the people of Dublin by St Brendan's has been detailed elsewhere (*McGennis et al, 1980*). With this as the background, it was decided by the Chief Psychiatrist to raise the status of the emergency facilities at St Brendan's to a fully staffed unit headed by a consultant. The results of the operation of this unit in 1980 are given in the following paragraphs.

General results



The above diagram shows that the number of persons who lodged overnight in the assessment unit in 1980 was 1,556. Of these 707 required admission to St Brendan's, 190 were admitted elsewhere and 659 did not receive any psychiatric hospitalisation. Of those admitted to St Brendan's 607 went to the admission wards, 59 to the unit for homeless persons (the NFA Unit) and 41 were admitted to the psychogeriatric section. The above figures represent the total number of persons who lodged overnight in the assessment unit for 1980. They can be subdivided into 3 categories - those assessed by the assessment team, those assessed by the week-end duty consultant, and those who lodged but did not stay to be assessed the next morning. These 3 categories will be dealt with in subsequent paragraphs.

3. *Those assessed by assessment team*



The above diagram shows that those screened by the assessment team (Monday Friday inclusive but excluding weekends) totalled 1,184. Of these 549 require admission to St Brendan's, 178 were admitted to other psychiatric units and 457 did not require psychiatric hospitalisation.

The above graph shows the number of direct admissions per month to St Brendan's for the year before the Assessment Centre, the first year of its operation and the first nine months of its second year. In every month of the first year of the Assessment Centre there was a significant reduction in the number of admissions. This trend has continued in the second year of operation, the only exception being in April when there was a large influx of patients from St Loman's Hospital.

7. Number of admissions to St Brendan's Hospital per month:

1980	No. of admissions	1979	No. of admissions	1978	No. of admissions
April	150	April	138	April	218
May	115	May	184	May	228
June	132	June	172	June	224
July	133	July	165	July	253
August	118	August	156	August	213
September	123	September	130	September	184
October	118	October	158	October	264
November	105	November	132	November	231
December	92	December	98	December	194
Total for 9 months	1,086	Total for 9 months	1,333	Total for 9 months	2,009

The above table shows the total number of admissions to St Brendan's Hospital for the period April - December for the year before the Assessment Centre (1978), the first year of its operation (1979) and the second year of its operation (1980). The first year of the Assessment Centre reduced the nine-month admission figure to 1,333 and the second year reduced it further to 1,086. The Assessment Centre has, therefore, achieved a *reduction* of 46% in the number of admissions to St Brendan's Hospital.

AIDEN MCGENNIS

April 1981

Reference: McGennis A J, Browne I W et al (1980), J. Irish Med. Association 73:9, 351-356.

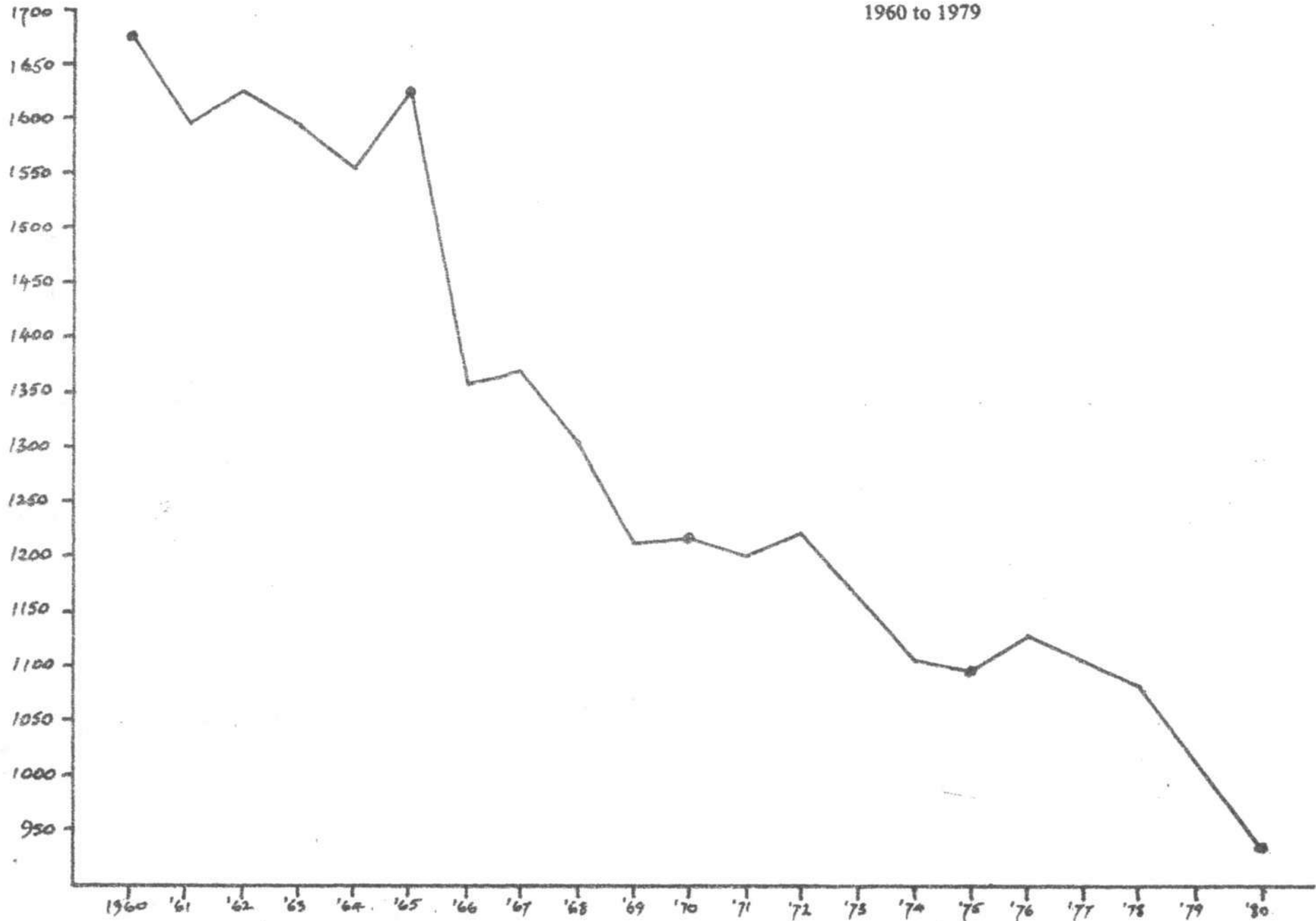
IN-PATIENT CENSUS: ST, BRENDAN'S

1960 to 1981

1960	1677
1961	1595
1962	1627
1963	1595
1964	1557
1965	1628
1966	1364
1967	1377
1968	1310
1969	1219
1970	1223
1971	1209
1972	1230
1973	1172
1974	1113
1975	1105
1976	1139
1977	1118
1978	1093
1979	1024
1980	942
1981	953

NO. OF PATIENTS

IN-PATIENT CENSUS: ST BRENDAN'S HOSPITAL
1960 to 1979



Appendix 6/2

A P P E N D I X 7

ST. BRENDAN'S HOSPITAL

STATISTICAL DATA

1966 - 1980

Year	Direct Admissions	Discharges	Deaths	In Hospital
1966	2158	2086	166	1364
1967	2257	2134	130	1377
1968	2419	2471	110	1310
1969	2551	2623	108	1219
1970	2594	2684	131	1223
1971	2443	2422	93	1209
1972	2465	2259	88	1230
1973	2463	2291	117	1172
1974	2506	2313	129	1113
1975	2682	2367	117	1105
1976	2465	2362	99	1139
1977	2447	2358	92	1118
1978	2676	2576	88	1093
1979	1902	2000	87	1024
1980	1558	1529	100	942

APPENDIX 8

DIRECT ADMISSION TO ST. BRENDAN'S HOSPITAL

	1974		1975		1976		1977		1978		1979		1980	
	M.	F.	M.	F.	M,	F.	M.	F.	M.	F.	M.	F.	M.	F.
January	128	92	158	99	138	119	148	102	143	113	140	88	96	67
February	102	89	120	73	124	80	111	102	108	89	126	80	83	76
March	124	101	149	85	109	107	133	92	116	100	137	94	82	78
April	121	77	118	99	108	100	115	78	124	94	88	50	85	65
Hay	149	113	136	92	109	92	110	102	128	100	96	88	59	56
June	118	75	132	97	127	100	140	101	134	90	- 96	76	77	55
July	128	93	120	83	124	82	132	98	149	104	88	77	72	61
August	110	73	137	93	159	105	120	98	138	75	93	63	61.	51
September	112	87	136	114	119	91	ng	78	110	74	86	44	72	50
October	112	94	135	85	94	91	109	82	151	111	85	73	65	53
November	103	83	118	88	124	76	110	75	134	97	68	64	59	43
December	135	87	125	90	101	75	117	85	109	85	57	41	46	46
	! 1442	1064	1584	1098	1438	1027	i 1464	983	1544	1132	1064	838	857	701
	2506		2682		2465		2447		2676		1902		1558	

ST. BRENDANS HOSPITAL

Ages in five year groups - Male Patients - 5 April, 1981

Units	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	
1A	-	-	1	1	-	-	2	5	4	7	6	8	4	1	-	39
IB	1	-	-	2	4	4	3	5	8	10		2	2	1	-	43
9	-	-	-	1	2	7	1	4	4	4		-	-	1	-	25
2 & 2A	1	2	3	1	1	6	3	3	2	1		1	1	-	-	26
8A & 8B	-	-	3	6	2	8	4	2	-	-		-	1	-	-	27
NFA	1	-	-	2	-	4	2	-	-	1		-	-	-	-	11
23	-	-	1	1	2	3	2	7	4	3	4	-	-	-	-	27
3A	1	3	5	3	2	5	3	7	5	3	2	1	-	-	-	40
10B	~	4	4	-	6	1	6	2	4	6	-	1	-	1	-	35
I	-	2	1	5	5	2	7	3	7	5	5	3	-	-	-	45
J	-	-	-	-	1	2	2	2	4	4	5	6	2	1	-	29
K	-	-	-	1	3	4	7	8	4	8	4	4	2	1	1	47
P	-	1	-	-	1	-	2	2	2	1	-	-	-	1	-	10
5C	-	-	-	-	1	-	1	-	-	2	1	5	6	2	-	18
A	-	-	-	-	-	-	-	-	-	1	4	3	7	2	2	19
TOTALS	4	12	18	23	30	46	45	50	48	56	36	34	25	11	3	441

A P P E N D I X 1 0

In-Patients on 31 December, 1981

St. Brendan's Hospital

(A) Number of patients in the hospital on 31 December, 1981

<u>Male</u>	<u>Female</u>	<u>Total</u>
450	503	953

(8) Age and length of stay of patients at (A)

Length of Stay \ Age	Under 16	16-19	20-44	45-64	65-74	75 and Over	All Ages
Under 3 months		3	41	27	32		103
3-12 months		2	28	31	39		100
1-5 years		1	42	72	NO		225
Over 5 years			94	268	163		525
All lengths of stay		6	205	398	344		953

(C)	(i)	Number of admissions during 1981	<u>1553</u>
	(ii)	Number of discharges during 1981 (This figure should include deaths)	<u>1651</u>

IRISH TRANSPORT & GENERAL WORKERS' UNION

The I.T.G.W.U. has as its main function the protection of its members' conditions of employment. However, in the psychiatric service we have never taken such a narrow view and believe that the union must act as a channel for its members¹ views on a wide variety of issues affecting the service itself and its development.

It was in this context that a recent general meeting of the St. Brendan's Branch considered the proposals of the project team and agreed the following proposals.

That the hospital should be modernised and be the hub of the organisation of Psychiatric Services for the St. Brendan's catchment area.

We would agree that 150 beds in Units 3 and 10 would be sufficient for acute admissions but feel that long stay patients should not be retained in these Units as is the case at present.

Regarding the disturbed patients we feel 100 beds are adequate for the catchment area but there is a problem as regards overcrowding and facilities, i.e. single rooms are not secure enough; rest and recreation area too small resulting in tension and aggression.

A resolution was passed that 23 and 23A be demolished as they are structurally unsuitable and that a modern Unit for Med Longstay patients be built for the £130,000 that is proposed to be spent on these Units. Regarding the Psychogeriatric patients in the lower house it is felt that a small fraction of these patients are confined to *bed* and that the majority are ambulant patients with psychiatric disorders, i.e. confusion, disorientation *etc.* and would be highly at risk if placed in hospitals such as named in the Report. It was also felt that St. Laurence's would be totally unsuitable and any money spent on that would be a waste and expensive to maintain as it is practically as old as the lower house.

{'Proposals to deal with the Psychogeriatric patients were as follows:

That the services of other catchment areas be made responsible for patients from these areas and that modern Units be built in St. Brendan's to house the remainder of the Psychogeriatric in-patients from the catchment area and to

provide a proper service for future psychogeriatrics from the St. Brendan's catchment areas.

As regards the mentally handicap patients in I.A.B.C. it was felt the present situation is intolerable and that dividing the wards is not the solution; in fact it will confine space more and make conditions worse for patients and staff. As a large number of those patients are suffering from an underlying psychosis their suitability for Programmes at present in operation is limited. It was felt that suitable patients be placed in those programmes immediately. The remainder should be housed in proper conditions and a serious look taken at the admission of Mentally Handicapped patients in the future.

Having said this, there may emerge final proposals which will have industrial relations implications, especially for staffing levels, movement of staff etc. Needless to say, we expect to be fully consulted about any such changes before they are made and given whatever opportunity is required to conclude negotiations on them should that be necessary.

APPENDIX 12

APPENDIX 12 SERVICES FOR THE DISTURBED ELDERLY

The lack of effective services for geriatric patients constitute the greatest problem facing the Eastern Health Board at the present time. Relative to all other services they remain the least developed, and with the increasing number of elderly people in a community exceeding 13% on the South side of Dublin, if appropriate services are not developed as a matter of urgency both the psychiatric and general hospital facilities will become unworkable within the next ten years.

The fact that geriatric services are still in an embryonic stage of development does at least provide us with an opportunity to ask afresh what way should these services now develop. Unfortunately our tendency is usually to follow the lines along which services are already developed in Britain. Indeed it often appears that we adopt a line of development at the *very* point where Britain having found that such a direction is not workable is about to give it up. In this instance the general approach to the development of geriatric services in Britain and probably in most western countries has been to divide them into two groups - the ordinary geriatric patient who is said to be mentally clear and is not disturbed and the psycho-geriatric. The latter *are* those who *at* the point of admission are too disturbed to be admitted to an ordinary geriatric ward, and therefore have to be passed on to a psychiatric or psycho-geriatric facility within the psychiatric service. In practice a considerable proportion of these are not even disturbed on admission, but are sent to a psychiatric institution simply because *there* is no other bed available, and because traditionally psychiatric hospitals have always felt obliged to accept patients who are committed to them.

The difficulty is, that once admitted these patients, for whatever reason they come, are labelled psycho-geriatric from that point onwards and classed as a separate group for whom the geriatric service proper has no responsibility. This is true, even though the vast majority, are no longer disturbed within a few days of admission and are indistinguishable from many partially or wholly demented patients who are being cared for in ordinary geriatric wards.

The essential characteristic of illness in the elderly which differentiates it from that occurring in younger people is that, due to the ageing process and the weakening of the immune defences of the body, the person is likely to

be affected by multiple complaints, both somatic and psychological and to manifest a mixed pathological picture. The typical old person requiring geriatric care is likely to have a variety of problems - dietary, difficulty in getting about, confusional states, social or housing complications, and somatic symptomatology. At the time of presentation the old person may be confused, uncooperative and disturbed, and this may be due to an underlying dietary deficiency or acute physical illness, or to an advancing process of dementia etc. Satisfactory assessment *and* treatment therefore is likely in any given case to involve a number of medical disciplines and this fact alone makes nonsense of the notion that there are two discrete separate groups of *elderly* people.

What is clearly required then, is a comprehensive integrated geriatric service in which a full multi-disciplinary assessment and treatment can be applied as required to all elderly persons. If this is so then we have to ask what is the appropriate role of the psychiatrist within a geriatric service? At the present time of nearly four thousand elderly patients who are admitted to geriatric facilities each year, approximately 400 are admitted to psychiatric services, 300 of these to St. Brendan's Hospital alone. But the number who are confused and disturbed at the point of admission and present a difficult management problem is probably far higher than this. I would guess that somewhere between 25 and 50% show some degree of disturbance and psychiatric symptomatology when they present, ranging from mild to severe. Any many of these would benefit from psychiatric intervention. It is also true that any of the large pool of elderly people in hospital, requiring extended care, may at a given time become disturbed and require psychiatric intervention and management.

In the light of these facts it seems inescapable that the correct role for psychiatry and for the psychiatrist in the care of *the elderly*, is the management and treatment of disturbed behaviour wherever and whenever this makes its appearance. For this reason what I would now recommend is *the* development of a sub-speciality of gero-psychiatry separating itself off from the rest of psychiatry along the same lines as child and forensic psychiatry have done. What this will mean in practical terms is that within an integrated comprehensive geriatric service there will be psychiatric units for the care and management of disturbed elderly, staffed by psychiatric nurses and under the control of consultant psychiatrists who will specialise in this form of psychiatric care these psychiatrists will then of course also be immediately available to intervene and give consultation to the ordinary geriatric wards. To take a specific example, if Vergemount Hospital is now to be developed mainly as

a geriatric centre, I would recommend that one unit of say 50 beds should be built within that complex as a unit for the disturbed elderly, staffed by psychiatric nurses and under the control of a consultant gero-psychiatrist.

It may be objected that if all elderly patients are to be treated together in one comprehensive geriatric complex in this way, does this mean that mentally clear and confused demented patients will be all jumbled up together in the same ward; that where this has been allowed to happen in the past, it has been unworkable. But of course this does not follow from what I have been saying, for clearly it would be a simple matter to separate the mentally clear and the demented into separate wards or sections of wards for management purposes within a comprehensive geriatric complex. The essential point is that within such an integrated geriatric centre, all patients would have available to them multi-disciplinary assessment, management and treatment, including psychiatric intervention where necessary.

To come now to the question of how this new comprehensive geriatric service could be made to take shape in practice. Inevitably we have to come to the position in St. Brendan's. There are approximately 400 elderly persons in St. Brendan's and a further 100 will be over 65 years in the next four years. These patients are mainly concentrated on the East side of the road in St. Brendan's in two buildings - the Units L, M and N over by the Broadstone (120 patients) and the lower House which was the original Richmond Asylum (approximately 300 patients). I think it is quite clear to everybody now that these buildings are no longer serviceable, and are a serious fire hazard, are quite unsuited to modern therapeutic care and will have to be demolished. On a more positive note it is also clear that the nursing staff and psychiatrists who are caring for the elderly people in these buildings are quite contented, indeed are keen, to go on working with geriatric patients, and if alternative facilities are made available are quite willing to move entire units, both patients and staff, to new locations as appropriate. Thus, it becomes possible to see a practical way of achieving two purposes in one bold manoeuvre if we only have the courage to grasp the opportunity.

It is not possible to say at this stage exactly where these units for the disturbed elderly should be placed; what the optimal size of such units should be or exactly how they should be staffed, and how these staff would integrate and work with the doctors and nurses in the geriatric service proper. These questions will ultimately have to be worked out on the ground in the light of practical circumstances. Nevertheless to illustrate the sort of lines along which this could be achieved, let me suggest the following scenario

REHABILITATION PROGRAMME FOR LONG-STAY PATIENTS IN ST. BRENDAN'S HOSPITAL

This is a preliminary report indicating *the* essential elements which must be present if a programme for rehabilitation for long-stay patients is to succeed. The provision of these should be agreed by the Project Team before the programme begins.

i A full assessment as to the potential for rehabilitation of the long-stay population of St. Brendan's. This will involve mainly Wards 1 ABC, 23A the upper floor of the lower house, Units M and N, Ward 9 and those long-stay patients who are resident in the acute wards 3A and B, Ward 10 and the disturbed wards. It is predicted that approximately 100 patients who are capable of rehabilitation to the point of living outside in hostels will emerge from a comprehensive survey of this long-stay population.

2. The development of a professional rehabilitation team, this has yet to be worked out in detail but is likely to consist of approximately the following;

One psychologist

A team of volunteer male and female nurses

Two community nurses

Two nurse attendants

One occupational therapist

Vocational teachers on a sessional basis

The composition of this Team is tentative as yet and may *need* to be altered or added to from time to time. The necessary training, visits and exposure to appropriate experiences will have to be provided for the members of this team as indicated.

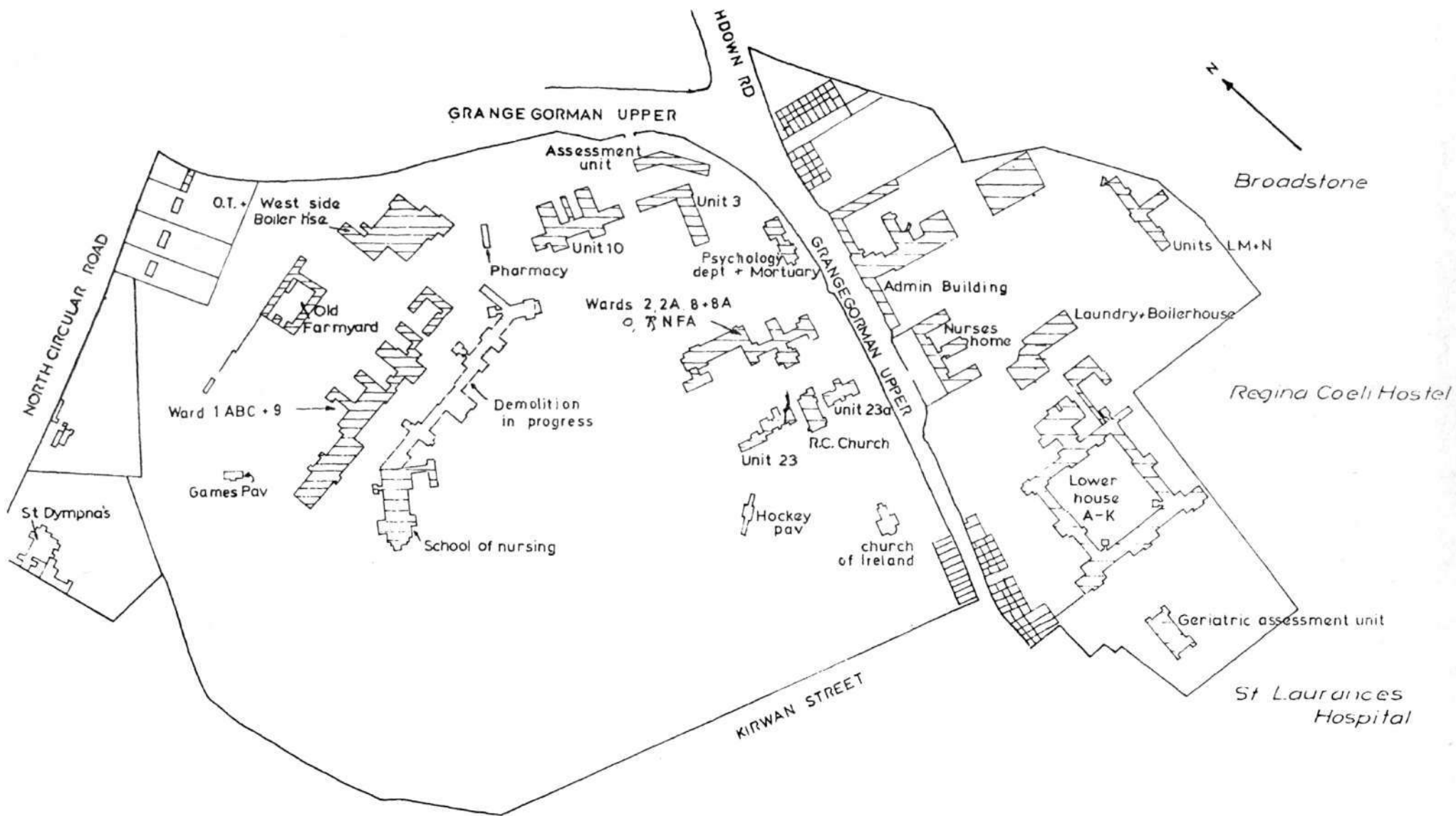
3. Having assessed the population in Ward 1 ABC as to the different categories of patient it is proposed to reorganise the utilisation of that entire building. Given the failure of the Eastern Health Board to provide an adequate geriatric service St. Brendan's is *under* continuous pressure to provide beds for the elderly. At the moment we are just barely managing in terms of female beds but have insufficient male beds to deal even with emergency cases that simply have to be taken in for humanitarian reasons.

of the Nurses Home currently used as a doctors residence which has its own separate entrance and can be cut off from the rest of the building, for this purpose. To undertake this intensive work it will be necessary to develop a small team of nurses and others skilled in behavioural psychotherapy who hopefully will volunteer to undertake this work.

Lastly, it is essential right at the commencement of the project that an active and sustained effort be undertaken to find rented houses so that these are ready and available as groups of patients are trained and develop the daily living skills necessary for life outside. Any delay in providing the necessary living space for patients who are trained and ready to leave hospital would destroy morale and bring the whole project into disrepute. It is necessary therefore that some one person should be made responsible for finding these houses and that the finance to rent them should be available right from the beginning of the project.

Ivor Browne
Chief Psychiatrist

May 1981



EASTERN HEALTH BOARD
ST BRENDANS HOSPITAL
BLOCK PLAN