Galway/Roscommon
Mental Health Services

Final Report of the "Expert Review Group" on Community Mental Health Services in Galway/Roscommon

June 2014

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Chairperson's Foreword

I am pleased to present the Final Report of the "Expert Review Group" on Community Mental Health Services in Galway/Roscommon. Although the primary focus was on Community Hostels/Group Homes, the Review Team extended their remit to include Day Hospital services, Day Centres and Training Centres.

The report was initiated by HSE West (Mr John Hennessy RDO and Ms Catherine Cunningham Area Manager Galway/Roscommon PCCC Services) in March 2013 to determine the level of compliance with the National Strategy "Vision for Change" (2006) and compliance with the Mental Health Commission publication "Happy Living Here" (2007).

It is important to acknowledge and review the significant developments that occurred in Mental Health Services in Ireland from the 1980 onwards after the publication of the national strategy "Planning for the Future 1984"

Planning for the Future 1984 detailed the failures of the institutional model and proposed the phasing out of mental hospitals. It introduced a "model of care in the community" based on sectors of 25,000 population and catchments of 100,000. It promoted the "normalisation" of acute inpatient care by placement of "Acute Units" in General Hospitals. It prioritised the rehabilitation of long term mental hospital patients and their placement in alternative community residences such as hostels and group homes. Those with chronic illness would also have access to day centres and training workshops. Galway/Roscommon were slow in implementing this strategy but there was an accelerated approach in the period from 1999 to 2008 when the number of beds in St. Brigid's Hospital Ballinasloe reduced from 400 beds to 102 beds in 2008. At the time of the Review there were 22 Inpatient beds in Ballinasloe, 22 in Roscommon and 35 Acute Inpatient beds in Galway.

Practically all discharged patients were re-housed in Galway East area, which may explain the high percentage of budget (54%) and WTE (49%). Early 1990s, demonstrated a high level of public and professional dissatisfaction with Mental Health Services in Ireland. The community services for patients with chronic disability, resembled long-stay wards, with the same rigidity, paternalism, lack of optimism and stigma.

In 2006, a new National Strategy "Vision for Change" was introduced. It advocated the introduction of "home based treatment teams", supplemented by a wider range of clinical disciplines e.g. Psychology, Social Workers, Occupational Therapists, CBT etc **for acute illness in crisis,** to be delivered in the "home setting" insofar as is practical. These teams would provide, as required, appropriate interventions to manage the acute illness under the clinical direction of the adult psychiatrist and thereby avoid unnecessary admissions and attendances at outpatients, day hospitals and day centres.

For patients with severe and enduring mental health problems, the Strategy recommended Consultant led Recovery and Rehabilitation Teams, who would have dedicated Multi-disciplinary Teams, who would assume clinical responsibility for community residences.

To date, Galway and Roscommon have operated as three separate catchments – East Galway, West Galway and Roscommon. It would be fair to say that they are "in contention" with each other for resources etc. These catchments have not yet implemented Vision for Change, and the service delivery model very much reflects "Planning for the Future Models of Service"

Research/Analysis

Significant research/analysis was undertaken by the Review Team in the 6 month period of the review (March – August 2013). This process involved

- Interviews with each consultant
- Interviews with members of multi-disciplinary teams
- Interviews with nursing management
- Site visits to Castlerea, Roscommon Town, Boyle, Clifden, Airegal Phoil, Galway City, Ballinasloe, Mountbellew, Portumna, Loughrea, Gort and Tuam
- Met the Mental Health Association in Tuam
- Met the Oireachtas and Forum members for Galway/Roscommon
- Met the staff associations
- Presented the key findings of the Review at a workshop for service managers and considered their feedback
- Review of Mental Health Commission Reports on Community Living

I can state, without exception, that no member of any of the "stakeholder groups" had any difficulty in accepting the proposed "model of care" as outlined in "Vision for Change" and "Happy Living Here".

All would accept that there is "a significant change management project" in moving to the new model and there would be concerns in terms of skill-mix, re-training and having sufficient resources to maintain services and at the same time, set up "home based treatment teams" and "multi-disciplinary rehabilitation teams". However, if the Implementation Team demonstrates strong leadership and commitment in the first year of implementation, I have no doubt it is achievable.

New patients presenting deserve a "modern approach to service" whereby the home-based treatment team, supplemented by the multi-disciplinary team, will deal in the "home setting and local community" and thereby avoid unnecessary hospital admissions and remove the "stigma" of "an illness for life". Community mainstream services in Primary Care should be utilised as much as possible and thereby normalise the intervention. It has to be acknowledged that there is a "legacy" of long-term inpatients who are currently residing in hostels, many of

whom would have severe and enduring mental health problems. However, we have a clear responsibility to maximise their independence and the specialist Rehab Team will have a major impact in achieving these goals.

It should be noted, that there are no statutory regulations governing the care of mental health patients in Community Hostels.

There are no statutory regulations governing the role and function of Day Centres or Training Centres/Workshops.

"The Findings"

We found dedicated, committed group of staff (from all disciplines) who had the patient as their central focus.

We found excellent examples of good practice in place throughout the Region, and the success of those examples is reflected in much lower levels of admission to the Acute Units. Although VFC is not yet implemented, these examples will form a very good foundation for the implementation of VFC, and those sites should be considered as potential "demonstration" sites.

The admission rates, particularly in Roscommon and West Galway are very high. They are double the admission rate of Cavan/Monaghan who have implemented Vision for Change

Vision for Change would recommend a maximum of 9 hostels for Galway/Roscommon catchment. Currently there are 188 residents living in High support (12 hostels) and Medium support (10 hostels). The specialist Rehab teams should have a significant impact in re-assigning clients to more independent settings, which will lead to the closure of some hostels and the redeployment of staff to community teams.

All previous Mental Health Commission reports concluded, staff in community residences are kind, caring, well meaning and have a sense of camaraderie with residents. However, it could be claimed that residents are "over-cared" in a "model of dependency" and denied (not deliberately) any hope of ever reaching their full potential. The skill mix of staff in the hostels, combined with the high numbers of residents who are living there for longer than 3 years, as well as the numbers aged over 65, would warrant an early review.

There is not a culture of "Performance Management in Mental Health Services in Galway/Roscommon. This is reflected by the absence of key performance data on patients, by hostel, by category, by bed numbers, by diagnosis, by age profiles etc. In terms of costing/budget management, e.g. cost of a specific hostel or day centre, or cost of inpatient unit or WTE by business entities, it was not possible to obtain

data with integrity, and accordingly we had to use budgetary and WTE data for 2012, at summary levels.

In addition the National Mental Health Office could not provide "benchmark data" on costing or WTE for comparison purposes.

Comparison of budget and WTE between the areas (West Galway/East Galway and Roscommon) demonstrated significant variations. East Galway, which has 39% of total population for Galway/Roscommon has 54% of budget and 49% of WTE. West Galway has 40% of population of region but has only 24.5% of budget and 25% of WTE, despite the fact it has the largest Inpatient Unit.

There are 11 "Intellectual Disability" residential facilities, totalling 59 clients, under the "umbrella of mental health services". A further 25 clients attend a Day Centre. There is a specific budget allocation of €4.8m and 90 WTE associated with the provision of services, which are primarily based in the Ballinasloe area. I do not think it is in the interests of the ID clients for this arrangement to continue. I would strongly recommend that the "ID" service should be managed by regional ID Service so that opportunities presenting under the "Implementation of Congregated Settings" should be exploited in terms of improving their quality of life.

Statutory regulations are in place in relation to "charges" to be applied in terms of skill mix etc. Although, the subject is not within our remit, there did not appear to be a "consistent interpretation of the legislation throughout the hostels".

Although the Mental Health Commission report "Happy Living Here 2007", strongly recommend that community residences should not be used for respite, crisis care and emergency transfers in place of acute care, these practices appear to be still continuing in the hostels.

Management structures in Galway/Roscommon reflect the policy provided by Planning for the Future, sectors of 25,000 and catchments of 100,000.

Recommendations

Detailed recommendations are included in the Executive Summary. However, it is imperative that the following recommendations are executed to guarantee the "patients of Galway/Roscommon" a quality modern service for the future.

1. Implement "Home Based Treatment Teams" specifically focusing on "Acute Illness in Crisis". The creation of these teams will be a challenge, without the closure of some hostels, but development funding is provided at National level specifically for the development of Mental Health services, and could supplement existing resources in the establishment of the first three home-

based treatment teams. In addition the introduction of "new blood" will bring a new dynamic to service provision.

2. The recruitment of two specialist rehabilitation/recovery teams to assume clinical responsibility for existing hostels/group homes, and for patients in the community with severe and enduring mental health problems.

3. The new catchment management team, including representatives of all clinical disciplines and service users, needs to be effected as soon as possible, as well as the implementation of sectors of 50,000 populations. This multi-disciplinary catchment team must prescribe the role and functions of the sector teams and define the future strategy for mental health services in each catchment. It is fundamental that the catchment management team is in control and successful in the first year of operation.

4. All staff need to be "educated" on the new model of services, as well as recovery specific training in the competencies and principles of recovery. A series of workshops should be undertaken at sector level, to also include presentations from other HSE areas who have successfully implemented Vision for Change.

5. Cleary there is a requirement for the implementation of "basic IT systems" for Patient Management. As this initiative will be managed at National Level, it is fundamental that a minimum dataset (manual) is introduced in 2014 to facilitate the information requirements of the catchment management team in terms of patient management. In relation to Finance and HR systems, management must define "logical business entities" and assign staff to each for reporting purposes from 1st January 2014.

6. Service Plans in 2014 should be prepared in relation to each community entity, outlining

    - purpose of the facility
    - Admission and discharge protocols
    - Annual targets
    - Performance against agreed targets

7. Hostels should be limited in size to 7 beds, and be compliant with the recommendations of "Happy Living Here"

8. 23% of residents (54) are aged 65 years or higher and there is general acceptance, that the physical disability is more pronounced than the mental health disability. It is recommended that priority be given to an early assessment by the Psychiatry of Old Age Team and CSARS Team.

9. Detailed analysis should be undertaken of the needs for "respite facilities" for patients and carers of mental health patients. Consideration should be given to designating one site for "generic respite services" using a social model of care. The same site may be available for provision of respite to disability and older person's service on a scheduled basis.

10. Recruit a "Liaison Psychiatrist and Teams" for University Hospital Galway. The population of Galway City (70,000), large student population and significant numbers of tourists warrant this expertise.

11. Appoint a "dedicated Project Manager" immediately to implement the recommendations. Appoint a Steering Group/Implementation Team who will have overall responsibility for deliverables against a project plan, and report regularly to the Catchment Area Management Team.

12. Voluntary Agencies should be encouraged to take a greater role in supporting residents in low support hostels and in independent living and facilitate the redeployment of nursing staff to community teams.

Acknowledgements and Thanks

I was very fortunate to Chair a small review group who were strongly committed to enhancing the quality of care for current and future mental health service users in Galway and Roscommon. Dr John Owens, Consultant Psychiatrist former Clinical Director Cavan/Monaghan Mental Health Services, former Chair of the Mental Health Commission, joint author of the National Mental Health Policy documents Planning for the Future and Vision for Change, agreed to assist in the review on the clear understanding that the review was "not about cost containment" but about producing recommendations which would be implemented. Dr Mike Reilly, Consultant Psychiatrist in Rehabilitation/Recovery, manages a team in Sligo/Leitrim who assumed clinical responsibility for hostels and provides services in the community to patients with severe and enduring mental health problems. Again, his commitment to work on the review group was conditional on producing recommendations which would be implemented. Their knowledge and experience were invaluable during interviews and site visits, and contributed enormously in reaching conclusions and recommendations of this report. Accordingly, I would like to record my sincere gratitude to both of them for assisting me in delivery of this report.

I was also very fortunate to have administrative and secretarial support from Ms Linda Byrne. She managed all communications with staff and key stakeholders, arranged meetings, interviews, and the production of this report. Again, I wish to record my sincere gratitude to Linda and apologise for all the demands imposed on her.

We were greatly assisted in our work by the Steering Group, comprising of Dr Amanda Burke, Executive Clinical Director, Ms Helen Earley, Director of Nursing, Ms Catherine Cunningham, Area Manager PCCC and Mr Denis Waters, Patient Advocate and I wish to record my sincere thanks.

Finally, I wish to record our sincere thanks to all the staff that attended interviews, facilitated site visits, completed questionnaires and sent comments by email. Your input was invaluable in reaching conclusions and recommendations, and I am confident there is the motivation and capacity within the system to deliver a new and modern mental health service in Galway/Roscommon

Pat Dolan
Chairperson

September 2013

Executive Summary

Introduction

Community Mental Health Services have been the preferred model for the provision of mental health care over the last fifty years. In Ireland, the move from institutional to community care has been directed at policy level by two national policy documents – Planning for the Future (1984) and Vision for Change (2006). Planning for the Future detailed the failures of the institutional model and planned the phase-out of mental hospitals. It stressed the concept of a public health approach towards the planning and provision of mental health care and introduced a model of care provision based on sectors of 25,000 population and catchments of 100,000. Amongst other things it promoted Community Mental Health Teams and prioritised the rehabilitation of long-term Mental Hospital patients and their placement in alternative Community Residences such as hostels and group homes. Clinical assessment was to be carried out in outpatient departments, preferably in Community Mental Health Centres or in General Hospitals. Acute Inpatient care was to be normalised by the placement of acute units in general hospitals. Other Community supports for those with chronic illness, such as day centres and training workshops were also planned. While these recommendations were inadequately financed, they were progressively implemented over the years. It became increasingly evident, however, that the new Community structures for people with chronic disability resembled, in many ways, the former long-stay wards. There was the same rigidity, paternalism, lack of optimism, stigma and separation from the Community at large. Within the Acute Sector clinical activity was characterised by excessive use of admission beds, leading to shortages of bed availability. These units became silted up in the context of a restrictive and over-medicalised service, with the accretion of new long-stay patients much as in the old mental hospital.

In the late 1990s there was increasing public and professional dissatisfaction with the state of Mental Health Services. Particular concerns were expressed about 'the medical model' and the excessive reliance on medication. New ideas about

‘recovery’ and improved awareness and recognition of broader aspects of users’ lives came to the fore, along with views that users should have greater participation in decisions concerning, not just treatment, but how services were organised. It was recognised that a new National Mental Health Policy was required and the current National Policy –Vision for Change- published in 2006.

Vision for Change placed centrality on new, specialised Community Mental Health Teams, normalisation, use of generic Community resources, involvement of a wider range of clinical disciplines and user participation at all levels. The new Community Mental Health Teams, providing care for General Adult Psychiatry were recommended to include a specific Home-Based Treatment Team for acute illness in crisis. Similar teams had been established in other jurisdictions and have variously described as crisis intervention teams and crisis resolution teams. In the Irish context, however, Vision for Change recommended that the Home-Based Treatment Team, though a distinct and separate group, should be embedded in, and form part of the Community Mental Health Team itself.

Specialist Community Mental Health Teams were recommended to care for individuals with severe and enduring mental health problems. These Recovery and Rehabilitation Teams also were planned to have a separate Home-Based Team, in this context called an Assertive Outreach Team, while still maintaining team unity. Other specialist Community Mental Health Teams were recommended to deal with psychiatric services for the elderly. It was also recommended that, as the services evolved, other specialist areas will need to have specialist teams, such as eating disorders, dual diagnosis, resistant mood disorders, forensic services and early intervention. Perinatal specialist services and services for neuropsychiatric disorder as well as adolescent services were also needing specialist provision, albeit at a Regional rather than a Local Level. Specialist Liaison Psychiatric Services were recommended to serve the psychiatric needs of large Regional General Hospitals.

East and West Galway, together with Roscommon, operated as three separate catchment services, throughout the implementation of Planning for the Future. Inpatient services were provided in two large psychiatric hospital, St. Brigid’s

Hospital in Ballinasloe and St. Patrick's Hospital in Roscommon. An Acute Psychiatric Unit in University Hospital Galway provided Inpatient services for West Galway. St. Brigid's Hospital and St. Patrick's Hospital were slow in phasing out long stay beds and providing for alternative residential and other community supports. When the decision was made to do so, the clear impression was of a sudden and precipitated relocation of long stay residents, with limited prior rehabilitation, to community residences, mostly staffed hostels. In the case of St. Patrick's Hospital the final closure was achieved through the purchase of a former small hotel, the transfer of remaining long stay residents to this particular large 'hostel'. The Acute Unit in University Hospital Galway had no accumulated long stay patients, apart from Unit 9A in Merlin Park. The closure of St. Brigid's and St. Patrick's Hospitals resulted in the establishment of a very large number of Community Residences over a period of four to five years.

It is difficult, due to lack of information, to chart the development and variance in hostel-type accommodation over the years. Some information in this regard can be gleaned from the decline in the inpatient population in St. Brigid's Hospital Ballinasloe. In 1998 there were 400 beds in St. Brigid's Hospital this declined to 308 beds in 2001, 207 beds in 2005, 106 beds in 2008 and 38 beds (includes 16 beds for Psychiatry of Old Age) in 2013. The current situation is that there are 58 hostels/group homes in the Galway/Roscommon Region with 343 residents currently in this type of care. The level of staff deployment, both nursing staff and care staff, is difficult to ascertain but is clearly extensive.

A Mental Health Commission report in 2005 highlighted that the living conditions of many people were improved by relocation from long stay wards in hospital to community residences. It stated, however, that without input from a specialist recovery/ rehabilitation team 'such residences become little better than long stay wards in a community setting'.

In January 2007, the Mental Health Commission published a report 'Happy Living Here- a Survey and Evaluation of Community Residential Mental Health Services in Ireland'. The survey focused on three HSE areas, Northwest, Midwest and Northern Areas, comprising eight catchment areas and 102 residences providing 951 places.

The report produced a number of observations and recommendations that will be discussed in detail in subsequent paragraphs.

In 2009, the Mental Health Commission published a report "Overview of 24-hour Nurse – Staffed Community Residences". It is important to note that there are no statutory regulations governing the provision of care and treatment in Community Residences. The Mental Health Commission had undertaken inspections of all 127 residences (24 hour Nurse – Staffed) in 2005, and in 2008, inspected 132 residences with 1,664 places. The aim in 2009 was to inspect the largest residences in each RDO Area, to establish the access service users had to rehabilitation and to assess the quality of care and treatment provided to them. A total of 13, residences were inspected, which represented 257 residents. There were 1,805 places in 24-hour Nurse Staff community residences in 2009. The conclusion of the 2009 inspection reads: - "What is not needed in place of Victorian intuitions is an emergence of "mini – institutions" or "wards in the community" dotted about rural and urban communities. The planners of our mental health services must exercise a vision and identify purposeful housing for residents. "Defenders of the larger community residences point to kind, caring and well meaning staff and a sense of camaraderie among residents and staff". However, such facilities can only deepen individual's sense of detachment from community life, increase attachment to a more paternalistic philosophy of care and smother any hope of ever reaching their full potential as individuals. This care gives rise to caution on the part of residents towards co-operating with moves to more desirable settings. But this concern can only be remedied by the provision and utilisation of fully staffed specialist rehabilitation teams. In the absence of such teams, new residents to the service who are experiencing severe and enduring mental illnesses, as well as long stay residences in medium and low support housing, will not get the specialist care and treatment and essential ongoing interventions to assist them in reaching their maximum potential.

Review Group

The HSE West Mental Health Services Executive in Galway/Roscommon commissioned a review of Community Mental Health Services, in March 2013. The Review was to primarily focus on community residential facilities and resources to ensure compliance with National Policies – Vision for Change and Happy Living Here. A Report with findings and recommendations should be available within a 12 week period. Pat Dolan former Deputy CEO of NWHB and former HSE Area Manager Sligo/Leitrim/West Cavan was appointed Chairperson of the Review. *Mr Dolan*, previously chaired the National Group on Congregated Settings in 2011, which was allocated development funding by the Department of Health in 2013.

Dr John Owens, Consultant Psychiatrist, former Clinical Director Cavan/Monaghan Mental Health Services, former Chair of the Mental Health Commission, joint author of the National Mental Health Policy documents Planning for the Future and Vision for Change.

Dr Mike Reilly Consultant Psychiatrist in Rehabilitation/Recovery has significant experience in over-seeing a multi-disciplinary team which manages all community settings in Sligo/Leitrim/West Cavan.

Ms Linda Byrne acted as secretary to the Group and frequent meetings were held with the Steering Group which comprised of *Dr Amanda Burke* Executive Clinical Director, *Ms Helen Early*, Director of Nursing, *Ms Catherine Cunningham*, Area Manager Galway & Roscommon PCCC Services and *Mr Denis Waters*, Regional Patient Advocate. Because of the timeframe of 12 weeks and resources – 1 part-time Chairperson, and 2 P/T Consultants and a P/T Secretary the review focused on addressing the "Terms of Reference" although information collected during the review, may support more detailed analysis by local management.

Methodology

The approach adopted by the review team was as follows

- Issue of a detailed questionnaire for completion by each residence/hostel

- Analysis of the findings from the questionnaires
- Meeting with each Consultant and catchment teams (at discretion of the Consultants) meeting with multi-disciplinary members and senior Nursing Management
- Site visits to selected sites and detailed discussions with staff and Users. The site visits not only visited community residences, but also day centres, day hospitals, workshops and one in-patient unit
- Meeting with the Tuam Mental Health Association
- Analysis of all the findings and preparation of a "Draft Report for the Steering Group"
- Meeting with Oireachtas/Forum Members
- Presentation and engagement with Mental Health service management
- Meeting with Staff Associations
- Production of a final report

Core Findings of the Review Group

1. The absence of fundamental, key data was a surprise to the review teams. Compilation of a list of hostels by region, by category and by bed numbers, was a significant challenge.

2. Sourcing of budgets and WTE employees by "business entity" was not possible. Accordingly, we had to use budgetary and WTE data for 2012 at a summary level. What became apparent at the early stages of the study were significant variations in resources between the areas (West Galway, East Galway and Roscommon). East Galway has 54% of budget, 49% WTE for 39% population. West Galway has 24.5% of budget, 24.9% of WTE for 40% population. A total budget of €53.8m and 719 WTEs is available for adult psychiatry. Child and Adolescent Mental Health Services have a budget of €10.9m and Intellectual Disability Services (i.e. Intellectual Disability residents managed by Mental Health resources) a budget of €4.8m. We were unable to source National and Catchment financial benchmarks for mental

health services. However, we can confirm that Galway/Roscommon per capita funding in 2012 of €224 is significantly higher than €144 per capita funding in Cavan/Monaghan.

3. An analysis of the community residences confirms the following facts

Level/Type	Hostels	No of Residents
High Support	12	125
Medium Support	10	63
Low Support Hostels *(some daily resource input)*	14	52
Independent Living	11	44
Intellectual Disability Services *(managed by Mental Health)* › High Support	4	20
› Medium Support	7	39
TOTALS	**58**	**343**

Vision for Change recommends a total of 9 x 10 bed Units for the population catchment. Excluding independent living and intellectual disability, there are a total of 240 residents. 130 of those residents (54%) have been in residential care for longer than 36 months and 54 (23%) are aged 65 years or higher. For those residents aged over 65, there is a general consensus among the review group that "the physical disability" is more pronounced than the mental health disability and a significant proportion of patients should be in the care of services for older persons. This measure should be prioritised in the short-term implementation plan and thereby free resources to be used in both the home based care teams and rehabilitation/recovery teams".

The high percentage (54%) of residents in high/medium/low supports for periods in excess of 36 month suggests that some residential facilities have become a continuing care facility rather than a rehabilitation centre.

The extent of rehabilitative activity is variable. Most residents have care plans but the overall impression is of a static population with resident's current placement

seen as the end stage of their rehabilitation. Clinical services are operated from mental health centres, based in the sectors, and are mostly day hospitals. Most sectors also have day centres and most operate sheltered workshops. Sector services currently work as independent units. By National standards, they are reasonably well provided for in relevant clinical disciplines.

There are 11 intellectual disability residential facilities. The 59 clients should be incorporated into mainstream disability service and given priority within emerging plans for "congregated settings" development funding.

Interviews and site visits demonstrated significant variations in service delivery between sectors (pop 25,000).

Good examples of innovation/good practice were evidenced e.g. **the hostel in Boyle** is a good example of high patient throughput and integration with the Day Centre and Training/Activity Centre in Boyle. This Hostel is staffed by multi-task attendants.

Clifden Residential Unit (Sycamore House) /Day Centre (Elm Tree) demonstrated that by working closely with other agencies e.g. VEC, Social Housing, an innovative day service and modern residential facility can be provided.

Airegal Phoil, An Tulach: Independent residences, with support outsourced to "Home Instead". Full integration in community and support into home with limited resources.

Loughrea – Analysed the needs of their patients (Service Research/Publication)
- Multi-disciplinary team focus on Recovery – low on admissions
- Innovative approach to day services

Ballinasloe – Multi-disciplinary team, effective day hospital, focus on Recovery, low on admissions.

Bredagh House – Real focus on recovery and placements in mainstream facilities

Clearly Galway/Roscommon has fully implemented the model of care as recommended in Planning for the Future. However, the model of support, although admirable, is a model of dependency rather than independence, and the statistics on number of residents spending more than 36 months in hostels, would suggest that in some cases, as referred to in Mental Health Commission 2009 Report, the service is smothering any hope of ever reaching independency. Rehabilitation and recovery is part of the delivery model in certain sectors but many elements of Vision for Change have yet to be implemented.

Although there are no statutory regulations governing the provision of care and treatment in community residences new regulations were introduced in 2005, which provided for different charging arrangements, dependent on the level of nursing/non nursing input. Although this subject was not within our remit, there appeared 'on face value' to be an inconsistency in the approach by many residences. It is understood that this subject is currently receiving attention by the Finance Department in Merlin Park. Any additional income achieved by this charging process, should be used to 'enhance mental health services' e.g. funding voluntary organisations to take a greater role in the provision of medium/low support residences.

Compliance with National Policy Recommendations

- **'Happy Living Here' 2007 – Study Findings and Recommendations**

The MHC commissioned the Health Research Board to undertake a study to review and evaluate the role of community residences in Ireland and report on how the needs of residents were being met and whether the community residences were fulfilling the original mandate of providing a therapeutic and rehabilitation function. Over 3,000 residents were utilising community residences and utilising considerable personnel and financial resources.

Findings

The rationale was that community residences would fulfil a therapeutic and rehabilitation function such that persons with persistent mental illness would move from higher to lower levels of support and where possible to complete independence. The findings suggest that some residents were over-provided for in terms of the level of accommodation, and some would prefer independent living arrangements. Few residences were providing cognitive behavioural therapies or activities that promoted community integration, mainstream employment or mainstream housing. This is not, surprising giving the lack of specialised multi-disciplinary rehabilitation teams. The climate and culture of the residences reflected more those of a "mini-institution". The philosophy of a "recovery model" was still far from realisation in the community residences that were evaluation. There was evidence of an excess of care, which most likely stemmed from the fact that many staff were trained in the care philosophy of the old psychiatric hospital.

Study Recommendations

- Fully staffed specialised rehabilitation and recovery mental health teams should be established. All team members should be trained in the competencies and principles of recovery. All, current and potential residents should receive a full multi-disciplinary assessment.
- Staff should, by attitude and practice, orient residents to achieve independence.
- Community residences should be used **only** for support and rehabilitation.
- The number of places in high support residences should be reduced to ten.
- Nursing resources, employed in community residences should be evaluated in the context of appropriate skill mix.
- Aims and functions of each community residences should be reviewed and documented.
- Housing needs of those with mental health problems should be part of mainstream housing provided by local authorities.

- Advanced age of residents, most of whom had been relocated from large institutions, suggest the physical problems outweighed the mental health problems, and, were more in need of physical care rather than psychiatric intervention.
- Community residences should **not** be used for purposes other than support and rehabilitation. The use of temporary respite, crisis care or emergency transfers in place of acute care it not in the best interest of those who live in residences.
- The possibility of Voluntary Agencies taking a greater role in the provision of medium and low support residences should be encouraged.
- The methodology used to assign residents to high levels of support needs to be reviewed.

Inpatient Care

At the time of the Review there are three separate inpatient units:

- University Hospital Galway, 35 beds
- St. Brigid's Hospital Ballinasloe, 22 beds
- Roscommon Hospital Psychiatric Unit, 22 beds

Admission rates for Galway/Roscommon are near the top of the national table for admissions, (Appendix D, E, F & H), with substantial variance in admission rates between the former three catchments. In 2011 East Galway had an admission rate of 256 per 100,000 population. The figure for West Galway was 405 per 100,000 population and Roscommon 498 per 100,000. In Cavan/Monaghan, a catchment where the principles recommended in "Vision for Change" have been in operation for over 10 years, the admission rate in 2011 was 182 per 100,000.

The high admission rates in Galway/Roscommon are reflective of:

- Lack of home-based treatment teams in acute services
- Lack of assertive outreach services for users with chronic illness
- Over medicalisation of services
- Excessive availability of beds

- Tradition of using inpatient care to deal with acute problems of many sorts
- High percentage of "socially excluded" population particularly in the Tuam area

Currently there are plans to build a new inpatient unit in University Hospital Galway. This will provide a 50 bed unit, and is scheduled to start in 2014. If adequate specialist community mental health teams are available in sectors, this unit could deal with the inpatient needs of the total catchment of Galway/Roscommon. Vision for Change recommends 50 beds for 350,000 population. However, given the geography of the Galway/Roscommon catchment, with the long distances between centres, there are sound reasons for providing an additional 20 bed inpatient unit in the East Galway/Roscommon area.

Vision for Change

The Mental Health Services in Galway and Roscommon are still operating under the policy provided by Planning for the Future. Management structures, in particular, manifest this. While the three Catchments have recently been amalgamated the former separate Catchments still exist in practice in the mindset of providers and users. Separate admission units are clearly central to this thinking. Sector Management has not been reconstructed as recommended in Vision for Change. While some Sectors have coordinators, none has a Practice Manager. The absence of Sector Team Management structures does not permit necessary clinical governance at this level. Sector Management Teams should operate costed Service Plans agreed beforehand in consultation with Catchment Management Teams. The new unified Catchment Management Team still operates as recommended in Planning for the Future, being composed of Executive Clinical Director, Director of Nursing and Area Administrator.

The Galway and Roscommon Catchment Areas did not prepare any written strategy or plan for service change following the publication of Vision for Change in 2006. The new Specialist and Community Mental Health Teams in General Adult Psychiatry, i.e. Community Mental Health Teams with imbedded Home-Based Crisis resolution teams and Rehabilitation/Recovery Teams with inbuilt Assertive

Outreach Teams have not been established. A Specialist Rehabilitation/Recovery Team was set up in East Galway but was not sustained due to the lack of a Specialist Consultant in Rehabilitation and has been allowed to wither.

In General Adult Psychiatry Specialist Community Mental Health Teams with imbedded Home-Based Crisis Resolution Teams have established their value in General Adult Community Mental Health Services (Appendix C). The Home-Based Treatment Teams are predominantly nurses. They operate as a Specialist Service in dealing with acute illness and illness associated with social crisis. The teams can be augmented by any other of the range of Clinical Specialists available on the Community Mental Health Team. They are particularly effective in recognising and dealing with stress factors, educating and supporting carers and families, building therapeutic alliances, implementing recovery practices and enabling users to retain their independent and personal privacy. They allow and facilitate close relationships between Community Mental Health Teams and Primary Care Teams. They enable association with a range of community statutory and voluntary associations of relevance to the normalisation of mental health service user needs. They are particularly effective in reducing admission, particularly crisis admissions. They can potentially obviate the need for crisis houses. As noted earlier, some of the current Community Mental Health Teams facilitate team members in home visiting but this falls far short of the expertise and clinical potential available from a trained home-based nursing team.

Specialist Rehabilitation/Recovery Teams, with Assertive Outreach Teams, are described elsewhere in this report (Appendix P). They are crucial in answering the needs of those with severe and enduring mental illness. They are essential in introducing the principles of recovery so important in the rehabilitation of those with major social handicaps and low self-esteem consequent on their chronic illness. The provision of Specialist Rehabilitation/Recovery Teams in Galway/Roscommon would be administratively easy, considering the large numbers of staff currently implementing largely custodial roles in a service with an astonishingly large number of hostels, day centres, sheltered workshops and other supportive community structures. These structures have, to an excessive extent, become the

focus of treatment. They are inflexible and tie up resources to a prescribed set of functions. Clinical services should focus on user needs and be delivered by Specialist Community Rehabilitation/Recovery Teams at home and in normalised generic community facilities, where they are much more flexible, less stigmatising and user relevant. These new Specialist Rehabilitation Teams will require some initial training. The training needs are, however, relatively modest and can be met by visits and short-term secondments to services in other regions.

Specialist Community Mental Health Teams for the elderly do exist, with two teams, one in East Galway and one in West Galway and have already established their credibility. No Specialist Community Mental Health Team for the elderly is available in Roscommon. In the longer term other Specialist Community Mental Health Teams will be required for eating disorders, dual diagnosis, early intervention and forensic services. There will also be a requirement for patients with difficult-to manage behaviour. Some of these teams, however, will need to operate at a regional rather than a catchment level.

University Hospital Galway operates as a Regional Specialist Hospital and clearly requires a Specialist Liaison Mental Health Team. The absence of such a team is having a significant effect in the West Galway sector services, leading to a regular patter of unnecessary, short-term and mostly weekend admissions to the Psychiatric Unit.

Vision for Change recommends the provision of two Community Mental Health Teams for the provision of psychiatric services for the Intellectually Disabled for a catchment of 350,000. Psychiatric services are already provided for the catchment by a Voluntary Agency based in Galway and, in the immediate term, there appears to be little indication to provide for a second specialist psychiatric team. There is a residual group of 59 clients, mostly former residents of St. Brigid's Hospital, in care in East Galway, mainly in the Ballinasloe area. They are cared for in 4 high support hostels and 7 medium supported houses. There is also a day centre with 25 places. The vast majority of these individuals do not have significant psychiatric problems, their disabilities being predominantly social and educational. They require sheltered care, specialised rehabilitation and ongoing support. Their needs are not psychiatric

and their placement in the psychiatric service is a relic of their inappropriate psychiatric placement in the past. Their care needs are best provided for by Community Care Disability Services. They should be discharged from the Psychiatric Services. Obviously, the current resources provided for their care needs to be transferred with them.

Implementation Planning

It is the hope of the Review Group that this report will be used to significantly enhance services for patients/clients by implementing a new model of care focused on the patient in their own homes, supported by family and with professional input as and when required. The Cavan/Monaghan catchment has already demonstrated the benefits of implementing Vision for Change. The Review Group is confident that the Galway/Roscommon catchment has the capacity to deliver this new approach to care. The feedback we got from the delivery system, would suggest that there are leaders who have the capacity to project-manage the implementation of service change. In facilitating this process the following recommendations will be important

1. The Galway/Roscommon catchment has now a single tri-partite management structure, Executive Clinical Director, Area Director of Nursing and Area Manager all of whom are relatively new to their posts but who are committed to implementing change. This new catchment management team needs to be substantially enlarged to include representatives of other clinical disciplines as well as a user. The creation of such a catchment management team and the 50,000 population sectors is a major step forward. This multi-disciplinary catchment management team must prescribe the role and functions of the sector teams and define the future strategy for mental health services in each catchment. They must define/agree and implement a minimum dataset of information requirement to be provided on monthly/quarterly/annual basis, and the data returns should form part of the agenda for each catchment management team meeting. Currently

contention between the new 50,000 population sectors and the old, smaller sectors still exists in practice and in the mindsets of care providers and users. Separate admission units may be central in retention of this thinking.

2. It is fundamental that the Catchment Management Team is in control and successful in the first year of operation. It is also very important, that financial reports in 2014 are structured to represent the various business entities and that budget holders are clear on the composition of budgets and understand and take appropriate action on any variations.

3. It is recommended that a series of workshops be set up at an early stage to facilitate the implementation of the new service model. These workshops should address:
   - Model of the Vision of Services so that staff understand the concept
   - Specific training for all staff in the competencies and principles of recovery
   - Workshop on existing best practice in the current system and how these innovations can be incorporated into the new version of services
   - Workshop presentations from areas where Vision for Change is being successfully implemented.

4. Clearly the recruitment of additional consultants and multi-disciplinary teams will take time, but there are adequate resources in the system to commence implementation of home based teams and assertive outreach teams.

5. The Review Group recommends that assessment of hostel residents over the age of 65 should be a short-term priority. This will facilitate the reduction/closure/merger of some residences, which will free resources for re-deployment. In addition, resource utilisation in medium/low facilities

should be reviewed in the context of promoting independent living, whereby voluntary providers could assume a support role.

6. It is necessary for Specialist Rehabilitation/Recovery Teams to assume clinical responsibility for the high support hostels. The Review Group is satisfied that the introduction of such teams will reduce the requirement for residential places by as much as 60%, reduce the need for so many day centres/workshops and significantly reduce admissions. These developments, in addition to the establishment of the new specialist community mental health teams' in general adult psychiatry, should lead to a substantial reduction in the requirement for beds. Some high support facilities e.g. Gort, should close immediately, and serious consideration must be given to reducing bed numbers to a maximum of seven beds per Unit. Accordingly, the Review Group believes there is a significant challenge to meet the goals in Year 1, but are satisfied that there are highly motivated leaders in the system to project-manage the necessary service developments. Given that the recruitment of two Specialist Rehabilitation/Recovery Consultants will take time it is recommended that, in the first year of this Implementation Plan, the Specialist Rehabilitation/Recovery Service should give priority to taking over the management of the following hostels:
    a) Unit 9A Merlin Park
    b) Rosalie Unit Castlerea
    c) Knockroe House Castlerea
    d) Toghermore House Tuam
    e) Gort Hostel

   Given the high percentage of elderly residents in hostels/community houses there is a need for an early assessment of the priority of residents' care needs following a joint review by a rehabilitation/recovery team, the psychiatry of old age team and the CSARS team.

7. Creation of a Specialist Mental Health Team in Liaison Psychiatry, based in University Hospital Galway, is an immediate priority.

8. A third Community Mental Health Team is required for the psychiatry of the elderly.

1. Given the anticipated marked decline in the requirement for inpatient beds, planning should begin for the reduction of a 20 bedded acute psychiatric unit in East Galway/Roscommon.

Implications of Reform Implementation

The modernisation of services, described in this report, should place little financial burden on the service. The Galway/Roscommon Mental Health Services are well endowed financially, with current financial provision being €220 per head of the population. This compares with an estimated National Mental Health expenditure of €174 per head of population. Another useful comparator is the Cavan/Monaghan service, with expenditure of €144 per head of population. The changes recommended in this report will result, not only in the provision of a high quality service, but one in which it is possible to implement modern recovery principles, with maximum normalisation in the delivery of mental health services and reduction in marginalisation and stigma. The move to home-based services will lead to a rapid substantial reduction in admissions and a rapid fall in the requirement for hostel placements. The Cavan/Monaghan analogy, where these programmes have been up and running for some years, gives a good indication of the future profile of the Galway/Roscommon services. Cavan/Monaghan has a population of 132,000. The total admission rate in 2011 was 183/100,000. All admission is provided for by a 25-bedded acute unit in Cavan General Hospital. Galway/Roscommon has a population of 310,000. Admission figures for West Galway in 2011 were 400/100,000, for East Galway 315.7/100,000 and for Roscommon 478.2/100,000. Hostel accommodation in Cavan/Monaghan consists to two high support hostels

providing 26 places. There are no medium or low support hostels. There are four group homes, providing altogether 20 places. High support hostels are defined by having 24-hour nurse staffing. Group homes mostly have daily visits from the specialist rehabilitation team. The high support hostels retain four places for respite admissions. Over 50% of the hostel residents are regarded predominantly as having an age related disability and once these residents are more appropriately placed in the community geriatric service the final long-term hostel requirement for the catchment is estimated to be one 10-place hostel.

The modernisation of the Galway/Roscommon mental health service will result in a dramatic fall in the requirement for acute inpatient beds and long-term community residential structures. With the modernisation of the service it will become increasingly evident that many of the current structures are no longer necessary and this should be helpful in reducing opposition to the their closure.

Summary of Recommendations

1. Completion of the establishment of a broader catchment management team to include the presence of other clinical disciplines and a user.

2. Management structures of Specialist Community Mental Health Teams to be defined enabling the introduction of clinical governance and the implementation of agreed costed Service Plans.

3. Service Plans to include such details as
   a. Purpose of various community structures
   b. Admission and discharge protocols
   c. Annual targets
   d. Comparison of performance against agreed targets

4. The introduction of appropriate health information systems to enable the implementation of agreed service plans. Current financial and HR systems should be optimised. There is a need to implement a basic patient management system.

5. The establishment of two specialist rehabilitation/recovery mental health teams with embedded assertive outreach teams.

6. All hostels should be under the management of rehabilitation/recovery teams. Priority should be given to the specialist management of Gort Hostel, Unit 9A Merlin Park, Rosalie Unit Castlerea, Knockroe House Castlerea and Toghermore House Tuam. Consideration should be given to the creation of a second Hostel in West Galway with a specific *Recovery Agenda.*

7. Hostels should be limited in size (7 beds) to maintain a domestic ambience.

8. Skill mix in community residences should be re-evaluated to prevent inappropriate use of nursing resources.

9. Voluntary Agencies should be encouraged to take a greater role in supporting residents in hostels and community homes.

10. Existing Community Mental Health Teams in General Adult Psychiatry should have embedded home based treatment teams.

11. The establishment of a Specialist Liaison Psychiatric Team based in University Hospital Galway.

12. The establishment of a further Specialist Psychiatric Team for the Elderly.

13. De-designation of the learning disability service to Community Disability Services including re-deployment of existing resources. Priority should be given to this core group in implementing the recommendation of the Congregated Settings Report.

14. The current plan to develop a new 50 bedded Inpatient Psychiatric Unit at University Hospital Galway must be actively followed up and provided as currently intended by 2015.

15. In the light of the anticipated marked decline in the requirement for inpatient beds, planning should begin for the reduction of a 20 bedded acute psychiatric unit in East Galway/Roscommon.

16. A detailed implementation plan should be drafted to execute these recommendations.

17. A series of workshops detailing this new vision of service and how it will operate should be made available to all staff. All staff should be educated on the philosophy of the *Recovery Model*. All members of the Rehab and Recovery Teams should be trained in the competencies and principles of recovery.

18. Consideration should be given to designate one site for *"generic respite services"* using a social model of care. The facility should also focus on providing supports and respite to carers. Consideration could also be given to extending the respite services to disability and older person's service on a scheduled basis.

Implementation Plan

Context

The "Terms of Reference" of the Review required that we would phase the implementation of the recommendations into short-term, medium-tern and long-term. The following is our proposal:-

A) Short-term (within 12 months of commencement of the Implementation Plan)	
1a	Recruit a "Specialist Rehab Consultant" to focus initially on "identified sites" listed in the recommendations
2a	Establish/empower the "Catchment Management Team" and establish "Sector Management Teams" across all the specialised community mental health teams.
3a	Agree and implement a "minimum dataset" of key performance indicators for both "Patient Management", "Financial Management", and HR Management. Should be executed from *1st January 2014*
4a	Clinical assessment of all residents aged over 65 and relocate in an appropriate care setting
5a	Commence the re-configuration of hostels – separate "Rehab/Recover" facilities, from long stay facilities
6a	Identify one single site for the provision of respite for patients and for carers
7a	All staff should be educated on the philosophy of "recovery model". All members of the Specialist Rehab Team should be trained in the "competencies" and "principles of recovery"
8a	As part of the reconfiguration of services which will result in the closure/merging of hostels, implement a strategy to reduce bed numbers to 7 in hostels
9a	Commence implementation of "Home based" Teams by redeployment of resources from both the Acute Units and Hostels
10a	Recruit a "Liaison Psychiatrist and Team" for University Hospital Galway
11a	Hold Workshops to educate staff on "New Vision" of staff and retention of

	current innovative practices
12a	Engage with Voluntary Organisations to establish the interest/capacity to assume responsibility for medium/low support hostels
13a	De-designate Intellectual Disability Service to Community Disability Services
14a	All service areas prepare a Service Plan and Annual Report
15a	Agree a minimum *specification of requirements* for a patient management system and commence procurement of an IT system
Medium-term (within 12 months – 18 months)	
1b	Recruit 2nd "Rehab" Consultant
2b	Review performance in Year I and prioritise any outstanding recommendations
3b	The reconfiguration of hostels will result in closure of some facilities. If in ownership of HSE, consideration should be given to disposal of same, whereby capital monies would be utilised to enhance mental health care settings
4b	Implement a "social care model" of respite on one site, for patients, carers and for other care groups e.g. disability and older persons
5b	Implement an I.T. system (basic) that supports "Patient Management"
6b	Evaluate skill mix with an objective of more emphasis on "social model" and less on nursing model
Long-term (within 18 months – 24 months)	
1c	Hostel provision to meet V.F.C recommendations i.e. 9 hostels
2c	Acute Admissions to match Cavan/Monaghan
3c	Have "best service" in Ireland

APPENDICES to the Report

A. Bed Numbers 1998 – 2013 St Brigid's Hospital Ballinasloe

B. Ballinasloe/Mountbellow – Dr O'Grady Admissions/Re-Admissions 2006-2012

C. East Galway – Admissions/Re-Admissions 2002-2012

D. 2012 Admissions/Re-Admissions – Acute Unit Galway (plus Admission Rate per 100,000)

E. 2012 Admissions/Re-Admissions – Ballinasloe Acute Unit (plus Admission Rate per 100,000)

F. 2012 Admissions/Re-Admissions – Acute Unit Roscommon (plus Admission Rate per 100,000)

G. Budget/WTE/Population Comparison by Sector (Roscommon, West Galway, East Galway)

H. Admission Rates (2012) 1st & Re-Admissions Comparison data

I. Final "Terms of Reference" of Mental Health Review

J. Final Questionnaire for completion in respect of Community Residences in Mental Health

K. List of Hostels in Roscommon by bed capacity, age analysis and residency > 36 months

L. List of Hostels in West/South Galway by bed capacity, age analysis and residency > 36 months

M. List of Hostels in East Galway by bed capacity, age analysis and residency > 36 months

N. List of Hostels in Roscommon/East Galway and West Galway (Independent Living) by bed capacity, age analysis and residency > 36 months

O. List of Hostels in Roscommon/East Galway and West Galway (Intellectual Disability) by bed capacity, age analysis and residency > 36 months

P. Rehabilitation and Recovery Services