2010

A MENTAL HEALTH SERVICE IN CRISIS

A Report by the Psychiatric Nurses Association

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Introduction

The Mental Health Services are in free fall due to:

- **The lowest ever spend as a percentage of the Health Budget, currently @ 5.3% compared to the 8.4%recommended under Vision for Change and the 12% spent in the UK.**

- **The huge numbers of Psychiatric Nurses retiring from the service. Nearly 20% of Psychiatric Nurses in the HSE have retired since 2008**

- **<u>596 have retired in 2009.</u>** ***Appendix 1***

According to the HSE's document "HSE Sector (HSE and Voluntary Bodies Employment Control Framework 2010 – 2012), the total number of staff employed by the HSE at January 1st 2009 was 111,800, at the end of 2009 this reduced to 110,353. That represents a cut in numbers of 1447.

Psychiatric Nursing represents less than 5% of the total number of HSE Employees.

In 2009, we know that 596 Psychiatric Nurses retired. In other words our Front Line profession of Psychiatric Nursing contributed more than 40% of the entire job cuts in the HSE in 2009.

It is clearly demonstrable from these figures that the impact of the moratorium is inappropriate and disproportionate.

1) ***Non replacement of Psychiatric Nurses*** who are retiring early has resulted in large numbers of posts remaining vacant.

Government Policy is resulting in:

- Overtime and agency nursing being used to fill the gaps. These are expensive options which are pushing services over budget, leading to further cutbacks.
- In some cases because of shortages of nurses, especially male nurses, and because of the threat posed by some patients, security companies are being employed to provide secure 'care', to those patients.

  Example:
  - Acute Unit, Ennis
  - Admissions, St Ita's
  - Admissions, St Brendans
  - Acute Unit Naas General Hospital

- Some services have invited retired staff to return to work part time to maintain some semblance of service to patients.
- At the same time highly committed, well educated and enthusiastic young graduates are being forced to emigrate.

It is economic madness to be denying employment to these young graduates while incurring excessive costs in using overtime, agency and retired nurses to plug the gaps.

In other cases we have nurses seeking to return from career breaks and/or part time working who are being denied the right to return, and instead the more expensive option of overtime etc being used. Indeed recent reports suggest that Nurses on Career Breaks, unable to get back to their original job, are returning to work via Nursing Agencies.

2) *Suicide and Deliberate Self Harm*

2.1 The increase in the rate of suicide is particularly worrying. In 2008 there were 424 recorded deaths by suicide and intentional self harm and 527 in 2009 on increase on 19.6% **Appendix 2**

2.2 Hospital Presentation for Deliberate Self Harm (D.S.H.) **Appendix 3**

In 2009 there were 11966 attendances at A& E with deliberate self harm. This continued the cycle of increase since 2007 which has seen the number of presentations with D.S.H. progressively increase from:

Number of DSH Presentations	Year
10,688	2006
11,084	2007
11,700	2008
11,966	2009

- Over 2500 of those incidents involved persons attempting D.S.H. for a second or third time or more.
- 14.4% of those attending hospital with D.S.H. leave the hospital without receiving any recommendation re follow up care.
- No figures are available to indicate how many of those who receive follow up care recommendations actually comply with those recommendations.

The preferred methods of self harm are:

Method	%Male	%Female
Overdose	63.8	77.5
Alcohol	45	37
Poisoning	2.1	1.3
Hanging	7.2	3.2
Drowning	3.3	1.6
Cutting	25.2	18.9
Other	5.7	3.3

In many cases the person combines 2 or more D.S.H. methodologies.

The peak hours for admission of persons with D.S.H. are between 11pm and 3am with relatively high numbers of DSH presenting to Hospital Emergency Departments at weekends. However specialist A & E Mental Health Nurses tend to be employed between 9am to 5pm.Indeed the National Suicide Research Foundation in May of this year recommends a review of the adequacy of staff numbers available for self harm management and psychiatric consultations at DSH peak times. The foundation has been recognised by the Department of Health and Children as an official research unit to contribute to the prevention of suicidal behaviour in Ireland. There is little point in "recognising the foundation's comprehensive work and recommendations, if Government fails to respond.

2.3 The Combat Poverty Agency in its document "*Tackling Health Inequalities 2008*" highlights the threat to Mental Health of unemployment and poverty. **Appendix 4**

3) Quality and Risk Management

The HSE's Corporate Safety Statement 2009, outlines the allocation of responsibility and accountability to managers and employees and aspires to "provide appropriate channels of communication to facilitate effective consultation and communication with employees and those who are affected by the activities of the HSE", HSE (2009).

It provides for the organisational responsibility of the CEO, HSE Board, National Directors and Director of Finance, *"The HSE is committed to the protection and well being of its employees, service users and the population which it serves, as well as demonstrating openness and transparency in all matters relating to management and legislative compliance.*

We will ensure the quality and safety of our services. By developing a transparent quality and safety culture and adapting our work practices, we will ensure that continuous quality and safety improvement is integral to all that we do."

The sentiments expressed above are merely aspirational at best. All relevant indicators point to a society in trouble and a Mental Health Service being allowed to disintegrate with no regard for the needs for a quality and safety culture.

Those of us at the coal face of providing a " mental health service " do so in the knowledge that treatment is not designed just to 'manage' patients, but to bring about their recovery, this is at the heart of modern thinking on mental health services and government policy Vision for Change 2006.

By "recovery "is meant – helping people to live to the highest level of performance and quality of life. Regrettably our services, starved of an adequate nursing resource are being denied the opportunity to be truly responsive and facilitative of growth and recovery.

3.1 **Violence and Aggression** is an unfortunate feature of some mental illness.

It is important to note that the majority of patients are non violent and in fact are often frightened by the sight of:

- Patients assaulting patients
- Patients assaulting nurses
- Patients taking illicit drugs and alcohol
- Patients mainlining in toilets
- Drug pushers seeking to access patients
- Security staff being deployed

- Many of our members have raised the issue of patients suffering from depression, anxiety states, bi-polar disorder etc whose recovery is threatened by their frightening and threatening hospital environment. We are also advised of patients who need to be hospitalised but refuse because of fears arising from previous experience. Indeed, we are aware of nurses who seek alternate assignment to avoid the appalling environment of Acute Psychiatric units.
- The HSE recorded 1314 assaults on staff in 2009. Up from 966 in 2007 and 1104 in 2008. While all of these figures are probably understated they do point to an upward trend in assaults in a time period when staffing numbers are reducing.

Ted Tierney, Deputy CEO of Mental Health Ireland has stated that " *The Moratorium is having a negative impact on the morale of service users and the level of stress on staff is impacting on service delivery"* ***Appendix 5***

Stephen Mc Mahon, Irish Patients Association warned, "*let's not wait until somebody is killed before taking action on this"*

- At the time of writing this report 5 nurses are on Sick Leave following assault and injury in the Admission Unit at St Itas Hospital Acute Unit where there has been 30 assaults on staff between January and end of June 2010.
- In Tallaght Hospital Acute Unit an elderly patient suffered catastrophic injuries when stabbed by another patient.
- In Unit 8a a secure unit for male patients in St Brendan's, the levels of violence and aggression has increased substantially. In the first six months of 2010 there were 39 assaults in this unit while the use of seclusion more than doubled with 1194 hours seclusion from Jan - June 2010 compared with 521 in 2009. On one occasion 8 Gardaí in riot gear had to come to the assistance of nurses trying to manage a highly aggressive patient.
- In Unit O, St Brendan's Hospital, there have been 22 assaults in the first 6 months of 2010, 16 of them on staff. Security men are employed between 7am and 10pm. In times of crisis male nurses from 8a and 8b have responded to alarms. If 8b closes who will respond?
- The absence of Intensive Care Rehabilitation Units ICRU/ Regional Secure facilities is a major problem. Where units exist they hardly function as "Regional Secure". Indeed the HSE is now trying to close one of those Units in St Brendan's (8b)
- An example of the typically dysfunctional decision making of the HSE is their plan to build a 50 bed regional secure unit in St. Brendan's campus but in the meantime halve the available Male secure beds from 24 to 12.
- Gardaí in Riot gear have been called to assist in our Acute Unit and Secure Facilities with increasing frequency in recent years
- Prisons – seek to transfer mentally ill offenders to the National Forensic Service Central Mental Hospital (CMH). The National Forensic Service CMH Dundrum seeks to transfer patients back to their home region but the regions do not have adequate facilities. Indeed Vision for Change states *"Forensic mental health units need to be clearly identified as being intervention and rehabilitation facilities that operate in particular conditions of security rather than facilities offering mainly containment".*
- There is currently a limited consultation role in relation to mental health services in the management of individuals with challenging and aggressive behaviour . Forensic Mental Health Services should be available in all areas where law enforcement agents are likely to encounter individuals with severe mental health problems .
- In some cases personality disordered persons are deemed not appropriate for admission to general mental health services. The person then cuts themselves or demonstrates some form of para-suicide and are admitted. Once admitted they become assaultative and violent. There is no ICRU /secure facility to accommodate them and they are discharged and the pattern later repeats itself all over again.
- In Ennis security personnel are employed to manage one forensic patient 24/7 at a huge cost to the service. This is largely due to the absence of a regional secure unit in the West, and the continuing shortage of adequate staff numbers.

- The need to employ security personnel and the increasing need to call for Garda assistance has only emerged in recent years, why? The PNA is satisfied that these factors are not just related to an increasingly violent society but to:
    - Shortages of nursing staff, including male staff
    - Retirements
    - Reduced recruitment
    - Reduced access to secure facilities

- St Brendan's is now proposing to halve their special care beds and has discontinued the provision of secure services to the rest of the region.
- As a result patients who should be facilitated in Special Care or the proposed ICRU structure are now presenting significant challenges in Acute Services;
    - In St. Ita's, a serial rapist, deemed a serious danger to women is being "secured" by security guards 24/7 while awaiting transfer to Dundrum when the legal procedures are completed.
    - A female patient is receiving treatment in Naas General Hospital Acute Unit who would previously have been treated in the Special Care Unit in St Brendan's.
    - On Sunday night last a patient set fire to part of the Acute Unit in Tallaght Hospital. A number of nurses were injured in the evacuation of patients with burns and smoke inhalation. A week earlier a patient, transferred from Clover Hill Prison, broke his way into the ceiling of the Acute Unit in Tallaght Hospital and accessed electric wiring which he wrapped around himself. When nurses got him down he was threatening and assualtative.

These are current examples, a snapshot of cases, next week, next month; the demands may be even greater, the incident more frightening.

4) Difficult to Manage Behaviours (DMBs)

Difficult to Manage Behaviours can pose the most serious challenges to services and represent serious risk to the service user and to others. Difficult to manage behavioural disturbances require intensive multidisciplinary intervention to produce any significant change. Vision for Change addressees Difficult to Manage Behaviours in Chapter11 and is referred to also in Chapter 15. The overall consensus with regard to service provision for this group of individuals is recommended in Government policy as follows:

RECOMMENDATION 11.14: Each of the four HSE regions should provide a 30-bed ICRU unit – with two sub-units of 15 beds each – to a total of 120 places nationally, staffed with multidisciplinary teams with appropriate training.

The use of the Intensive Care Rehabilitation Units ICRUs should feature as part of a network of regional services and should function smoothly and efficiently in that context. This will require organisational structures and functions and policies that are clearly understood and agreed. Thus the movement and transfer arrangements between the acute unit, close observation area, ICRU and community-based facilities must be smooth and flow easily. In the context of the Criminal Law Insanity Bill there should be good working relations between forensic services and the ICRU.

In association with ICRUs, and as part of continuing rehabilitation, there is a need for community residences of especially high support. These facilities should be specially designed to function as high support intensive care residences. They should be provided on a regional basis with two in each region providing ten places each and operating in close association with the ICRUs. This will provide a national complement of 80 places.

RECOMMENDATION 11.15: Each of the four HSE regions should provide two high support intensive care residences of ten places each (a total of eight residences with 80 places nationally)

While Government and HSE have committed to implementing Vision for Change including its provisions in relation to "Difficult to Mange Behaviours", its failure to provide appropriate services is placing patients and staff at serious risk.

5.0 Where is the "Recovery Approach "within the Irish Mental Health Services?

The principle of the "recovery approach" recognises that recovery is the unique journey people experience in realising and satisfying and fulfilling life with the challenges that can be associated with mental health difficulties.
As a profession Psychiatric / Mental Health Nursing recognises that recovery from mental emotional distress requires approaches from a number of perspectives (not just a bio medical model), and contributions from all stakeholders. The "Recovery" philosophy acknowledges the individual service user as an equal partner in attaining "mental wellness" and that they have access to individualised supports, and the provision of high-quality services. Psychiatric nurses work to ensure the continual enhancement of the quality of life of the people they support.Yet despite countless documents, strategies, presentations and a National Government supported campaign to deal with the reduction of stigma and mental distress (See Change), we have a situation whereby in some cases management are considering making decisions which would have been unconscionable a year ago.

5.1 In Clare we are experiencing serious difficulties in managing the Mental Health Services. Many beds have been closed by transferring patients to Private Nursing Homes. However the Provider now refuses to take any more patients due to their residual disabilities/behavioural problems.

In an attempt to achieve savings and reduce the dependence on overtime the HSE want to amalgamate an Intellectual Disability Unit with a Psychiatric Rehabilitation Unit in the full knowledge that such a strategy is totally wrong, contrary to Government Policy, in breach of Vision for Change and morally offensive! However the Managers say that they have been:

Refused permission to recruit staff
Refused permission to employ agency staff
Even though both strategies would remove the need for overtime.

5.2 Undoubtedly the managers realise that the Mental Health Inspectorate will be highly critical of this decision at their next inspection.

5.3 In Dublin North managers have announced the withdrawal of community based Nurses to augment depleted nursing resources in the Hospital. Staff continue to retire. Yet the HSE refuse to provide replacements, blaming the Government Moratorium. The Government talks about transferring services from hospital to community but on the ground, because of Government Policy, Managers are doing the opposite.

6.0 Staffing Numbers - HSE attempts to minimise the numbers

6.1 In 2009, a total number of 596 Psychiatric Nurses retired and were not replaced. This is on top of the numbers from 2008 who similarly were not replaced.

6.2 In 2010 the indications are that between 200 and 250 will retire.

6.3 The HSE acknowledge that over 700 staff have retired from the Mental Health Services in 2009 but give the figure for Psychiatric Nurses as 420. Does this mean that the number of retirements is 900? Or, are the Psychiatric Nursing retirements being deliberately understated?

6.4 Managers are arbitrarily announcing reduced "approved nursing complements" which bear no resemblance to the numbers actually required to maintain the service or indeed implement Vision for Change.

6.5 In South Tipperary agreement has been reached to close down the hospital which uniquely in the South East has seen little development over the last 20 years. Now we are told by the HSE that we do not have enough nurses to maintain current services nor to develop services planned in accordance with Vision for Change.

6.6 In St Ita's Portrane the needs of the service have been determined through use of internationally respected staff audits. Now we are told that Community Services will have to be cut in order to maintain hospital services due to the dwindling nursing resource.

Conclusions

a) The Government Moratorium and HSE Policy is resulting in the undermining of the Mental Health Services at a time when the demand for Mental Health Professionals especially Nurses was never greater.

b) The HSE's commitment to Mental Health Primary Care Services is abysmal. Despite the success of Pilot Projects in e.g. West Cork, Kerry, Cashel and Ballymun there has been resistance to the mainstreaming of Primary Care Psychiatric Nursing Services.

c) Newly qualified Nursing graduates are being guided to the nearest airport to seek jobs abroad at a time when we need them in our own services. Using overtime, agency and retired nurses as a means of maintaining Mental Health Services is expensive and unsatisfactory and continually forces services over budget and towards further cutbacks.

d) Staff shortages are contributing to unsafe and unsatisfactory experiences for patients. In many cases where overtime and agency staff are used there is a significant lack of continuity of staffing thus undermining care standards.

e) Episodic violence and the use of security personnel are undermining patient confidence in the services.

f) Low morale and threats to Pensions are driving nurses into early retirement making a bad problem worse.

g) The actions of the HSE and indeed the Government Moratorium are completely antagonistic to the stated ambitions and objectives of the same Government, DOHC and HSE.

h) The stated commitment of Minister John Moloney is totally undermined by Government policy and HSE decisions.

i) Those most vulnerable in our society suffering with psychological and emotional distress and their carer's are paying a huge price for Government failure.

j) Psychiatric Nursing must be exempted from the moratorium.

APPENDIX 1

Psychiatric Nursing Retirements 2009

Carlow	13
Kilkenny	6
Clonmel- South Tipperary	1
Waterford	9
Wexford	1
Cork North Lee	28
Cork South Lee	9
West Cork	1
North Cork- St Stephens	9
Kerry	23
Cork ID	4
St Raphael's	2
Limerick	30
Clare	32
West Galway	13
East Galway	52
Mayo	44
Roscommon	28
Sligo/Leitrim	35
Donegal	23
Cavan	11
Monaghan	19
Louth/ Meath	11
Laois/Offaly	26
Longford/ Westmeath	27
St Ita's	ID 34 Psych 20
St Brendan's	29
Area 6	
St Loman's Dublin	13
Vergemount- South Dublin	21
Wicklow	0
Child Psych- Dublin	2
Kildare	6
St Senan's	11
St Loman's Mullingar	1
SJOG	2

2009

Diseases of the Respiratory system	**37**	**J00-J99**	**3,694**	**0**	**2**	**1**	**3**	**9**	**16**	**57**	**177**	**487**	**1,363**	**1,579**
Influenza	38	J10-J11	4	0	0	0	0	1	0	1	0	0	0	2
Pneumonia	39	J12-J19	1,375	0	1	0	0	6	9	16	48	121	404	770
Chronic Lower respiratory disease	40	J40-J47	1,533	0	0	1	3	1	3	17	88	250	669	501
of which: Asthma	*41*	*J45-J46*	*57*	*0*	*0*	*1*	*3*	*1*	*1*	*3*	*5*	*6*	*15*	*22*
Other diseases of the respiratory system			782	0	1	0	0	1	4	23	41	116	290	306
Diseases of the Digestive system	**42**	**K00-K93**	**1,156**	**1**	**0**	**0**	**1**	**15**	**63**	**136**	**167**	**199**	**305**	**269**
Ulcer of stomach, duodenum and jejunum	43	K25-K28	101	0	0	0	0	0	1	12	13	13	33	29
Chronic liver disease	44	K70,K73-K74	299	0	0	0	0	5	44	82	82	51	30	5
Other diseases of the digestive system			756	1	0	0	1	10	18	42	72	135	242	235
Diseases of the skin and subcutaneous tissue	**45**	**L00-L99**	**64**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**6**	**8**	**24**	**25**
Diseases of the musculoskeletal system/connective tissue	**46**	**M00-M99**	**212**	**0**	**0**	**0**	**1**	**1**	**3**	**10**	**11**	**33**	**69**	**84**
Rheumatoid arthritis and osteoarthrosis	47	M05-M06,M15-M19	67	0	0	0	0	0	0	2	2	14	23	26
Diseases of the genitourinary system	**48**	**N00-N99**	**650**	**0**	**0**	**0**	**1**	**1**	**8**	**6**	**15**	**61**	**225**	**333**
Diseases of the kidney and ureter	49	N00-N29	457	0	0	0	1	1	7	5	12	51	160	220
Complications of pregnancy, childbirth and puerperium	**50**	**O00-O99**	**3**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**
Certain conditions originating in the perinatal period[1]	**51**	**P00-P96**	**98**	**96**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Congenital malformations and chromosomal abnomalities	**52**	**Q00-Q99**	**187**	**104**	**12**	**7**	**13**	**7**	**11**	**15**	**11**	**4**	**2**	**1**
Congenital malformations of the:-														
Nervous system	53	Q00-Q07	35	21	6	3	1	2	0	1	0	1	0	0
Circulatory system	54	Q20-Q28	53	27	0	2	8	1	10	2	2	0	0	1
Symptoms, signs, abnormal findings, ill-defined causes	**55**	**R00-R99**	**83**	**22**	**4**	**0**	**1**	**5**	**8**	**6**	**7**	**3**	**8**	**19**
Sudden infant death syndrome	56	R95	22	22	0	0	0	0	0	0	0	0	0	0
Unknown and unspecified causes	57	R96-R99	42	0	4	0	1	5	7	6	5	3	6	5
External causes of injury and poisoning	**58**	**V01-Y89**	**1,894**	**1**	**18**	**25**	**244**	**373**	**304**	**244**	**237**	**149**	**166**	**133**
Accidents	59	V01-X59	1,086	1	16	17	121	166	149	126	138	84	141	127
of which: Transport accidents	*60*	*V01-V99*	*266*	*1*	*10*	*12*	*71*	*45*	*41*	*22*	*19*	*18*	*21*	*6*
Accidental falls	*61*	*W00-W19*	*281*	*0*	*0*	*0*	*2*	*11*	*18*	*24*	*38*	*27*	*85*	*76*
Accidental poisoning	*62*	*X40-X49*	*316*	*0*	*0*	*0*	*32*	*91*	*65*	*55*	*48*	*13*	*11*	*1*
other accidents			*223*	*0*	*6*	*5*	*16*	*19*	*25*	*25*	*33*	*26*	*24*	*44*
Suicide and intentional self harm	63	X60-X84	527	0	0	4	90	139	113	78	61	36	6	0
Homicide/assault	64	X85-Y09	49	0	0	2	9	19	8	5	3	2	1	0
Events of undetermined intent	65	Y10-Y34	195	0	1	2	24	46	34	34	28	17	7	2
All other external causes			37	0	1	0	0	3	0	1	7	10	11	4

[1] Stillbirths not included.

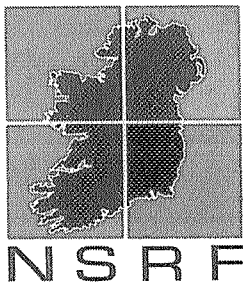
Appendix 2

Diseases of the Respiratory system	**37**	**J00-J99**	**3,436**	**1**	**3**	**3**	**4**	**8**	**11**	**53**	**147**	**479**	**1,253**	**1,474**
Influenza	38	J10-J11	6	0	0	0	0	0	0	2	0	0	2	2
Pneumonia	39	J12-J19	1,303	1	2	0	2	2	7	20	33	111	372	753
Chronic Lower respiratory disease	40	J40-J47	1,346	0	0	2	2	3	2	16	82	231	602	406
of which: Asthma	*41*	*J45-J46*	*56*	*0*	*0*	*2*	*1*	*2*	*1*	*6*	*5*	*9*	*13*	*17*
Other diseases of the respiratory system			781	0	1	1	0	3	2	15	32	137	277	313
Diseases of the Digestive system	**42**	**K00-K93**	**1,101**	**1**	**2**	**1**	**3**	**13**	**52**	**109**	**158**	**213**	**267**	**282**
Ulcer of stomach, duodenum and jejunum	43	K25-K28	110	0	0	0	0	2	3	4	8	22	43	28
Chronic liver disease	44	K70,K73-K74	284	0	0	0	0	7	31	74	87	62	19	4
Other diseases of the digestive system			707	1	2	1	3	4	18	31	63	129	205	250
Diseases of the skin and subcutaneous tissue	**45**	**L00-L99**	**47**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**6**	**17**	**21**
Diseases of the musculoskeletal system/connective tissue	**46**	**M00-M99**	**234**	**0**	**0**	**0**	**0**	**2**	**1**	**4**	**25**	**34**	**81**	**87**
Rheumatoid arthritis and osteoarthrosis	47	M05-M06,M15-M19	84	0	0	0	0	0	0	1	6	20	29	28
Diseases of the genitourinary system	**48**	**N00-N99**	**566**	**0**	**0**	**0**	**0**	**1**	**4**	**7**	**20**	**58**	**202**	**274**
Diseases of the kidney and ureter	49	N00-N29	405	0	0	0	0	0	4	4	18	48	147	184
Complications of pregnancy, childbirth and puerperium	**50**	**O00-O99**	**2**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**
Certain conditions originating in the perinatal period[1]	**51**	**P00-P96**	**120**	**120**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Congenital malformations and chromosomal abnomalities	**52**	**Q00-Q99**	**204**	**128**	**9**	**1**	**12**	**13**	**8**	**8**	**11**	**8**	**4**	**2**
Congenital malformations of the:-														
Nervous system	53	Q00-Q07	32	21	4	0	3	3	0	0	1	0	0	0
Circulatory system	54	Q20-Q28	47	25	2	0	4	8	3	1	0	3	0	1
Symptoms, signs, abnormal findings, ill-defined causes	**55**	**R00-R99**	**90**	**21**	**4**	**1**	**1**	**5**	**4**	**6**	**5**	**3**	**10**	**30**
Sudden infant death syndrome	56	R95	24	20	4	0	0	0	0	0	0	0	0	0
Unknown and unspecified causes	57	R96-R99	28	1	0	1	1	3	3	5	5	2	2	5
External causes of injury and poisoning	**58**	**V01-Y89**	**1,663**	**3**	**9**	**30**	**245**	**296**	**240**	**230**	**181**	**140**	**156**	**133**
Accidents	59	V01-X59	974	2	9	23	117	135	113	128	109	93	117	128
of which: Transport accidents	*60*	*V01-V99*	*290*	*2*	*5*	*14*	*67*	*51*	*38*	*27*	*25*	*24*	*29*	*8*
Accidental falls	*61*	*W00-W19*	*252*	*0*	*1*	*1*	*5*	*8*	*7*	*21*	*40*	*35*	*55*	*79*
Accidental poisoning	*62*	*X40-X49*	*229*	*0*	*0*	*0*	*32*	*61*	*50*	*51*	*22*	*8*	*5*	*0*
other accidents			*203*	*0*	*3*	*8*	*13*	*15*	*18*	*29*	*22*	*26*	*28*	*41*
Suicide and intentional self harm	63	X60-X84	424	0	0	5	95	102	76	75	40	23	7	1
Homicide/assault	64	X85-Y09	39	0	0	1	7	17	10	1	2	1	0	0
Events of undetermined intent	65	Y10-Y34	181	1	0	1	26	42	38	23	27	11	11	1
All other external causes			45	0	0	0	0	0	3	3	3	12	21	3

[1] Stillbirths not included.

APPENDIX 3

National Registry of Deliberate Self Harm Ireland



ANNUAL REPORT 2009

National Suicide Research Foundation

I. Hospital Presentations

For the period from 1 January to 31 December 2009, the Registry recorded 11,966 deliberate self harm presentations to hospital that were made by 9,493 individuals. Thus, the number of deliberate self harm presentations increased by 2% from 2008 while the number of persons involved increased by 3%. As can be seen in Table 1, which summarises the changes in the number of presentations and persons since the Registry reached near national coverage in 2002, 2009 is the third successive year in which the numbers of self harm presentations and persons presenting have increased.

The age-standardised rate of individuals presenting to hospital in the Republic of Ireland following deliberate self harm in 2009 was 209 (95% Confidence Interval (CI): 205 to 214) per 100,000, a significant 5% increase on the equivalent rate of 200 (95% CI: 196 to 205) per 100,000 in 2008. The incidence of deliberate self harm in Ireland is examined in detail in Part II of this section of the Annual Report.

The numbers of deliberate self harm episodes treated in the Republic of Ireland by HSE region, hospitals group, age and gender are given in Appendix 1. Of the recorded presentations in 2009, 47% were made by men and 53% were made by women. Deliberate self harm episodes were generally confined to the younger age groups. Almost half of all presentations (45%) were by people under 30 years of age and 87% in each year were by people aged less than 50 years.

	Presentations		Persons	
Year	Number	% diff	Number	% diff
2002	10,537	-	8,421	-
2003	11,204	+6%	8,805	+5%
2004	11,092	-1%	8,610	-2%
2005	10,789	-3%	8,594	-<1%
2006	10,688	-1%	8,218	-4%
2007	11,084	+4%	8,598	+5%
2008	11,700	+6%	9,218	+7%
2009	11,966	+2%	9,493	+3%

Table 1: Number of deliberate self harm presentations and persons who presented in the Republic of Ireland in 2002-2009 (2002-2005 figures extrapolated to adjust for hospitals not contributing data).

In most age groups the number of acts by women exceeded the number by men. This was most pronounced in the 10-14 year age group where there were 2.5 times as many female presentations. However, in the 20-34 year age group, the number of self harm presentations made by men was 18% higher than the number made by women.

In 2009, 297 (2.5%) of all deliberate self harm presentations were by residents of homeless hostels and people of no fixed abode and 80 (0.7%) were made by hospital inpatients. The proportion of deliberate self harm presentations made by residents of homeless hostels and people of no fixed abode varied by HSE region, accounting for 5% of all presentations to Dublin/ Mid-Leinster hospitals, 2% in the Dublin/ North East and South Regions and 1% of all presentations in the West.

METHOD OF DELIBERATE SELF HARM

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	Total
Men	3609 (63.8%)	2546 (45.0%)	120 (2.1%)	408 (7.2%)	186 (3.3%)	1426 (25.2%)	324 (5.7%)	5653
Women	4895 (77.5%)	2353 (37.3%)	81 (1.3%)	200 (3.2%)	101 (1.6%)	1192 (18.9%)	206 (3.3%)	6313
Total	8504 (71.1%)	4899 (40.9%)	201 (1.7%)	608 (5.1%)	287 (2.4%)	2618 (21.9%)	530 (4.4%)	11966

Table 4: Method of deliberate self harm by gender, 2009.

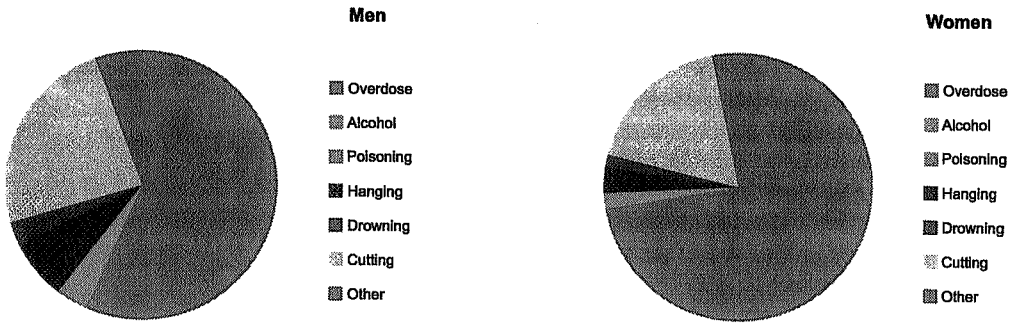


Figure 6: Most lethal method of self harm used by gender, 2009.

Almost three quarters (71%) of all deliberate self harm presentations involved an overdose of medication (65% as the most lethal method of self harm employed). Drug overdose was more commonly used as a method of self harm by women than by men. It was involved in 64% of male presentations (57% as the most lethal method) and 78% of female episodes (72% as the most lethal method). While rare as a main method of self harm, alcohol was involved in 41% of all cases. Alcohol was significantly more common in male deliberate self harm episodes (45%) than in female episodes (37%).

Cutting was the only other common method of self harm, involved in 22% of all episodes. Cutting was significantly more common in men (25%) than in women (19%). In 86% of all cases that involved self-cutting, the treatment received was recorded. Almost half (47%) received steristrips or steribonds, 21% did not require any, 28% required sutures while 5% were referred for plastic surgery. Men who cut themselves were twice as often referred for plastic surgery (6% vs. 3%).

Attempted hanging was involved in 5% of all deliberate self harm presentations (7% for men and 3% for women). At 608, the number of presentations involving attempted hanging was 18% higher in 2009 than in 2008 (16% higher for men and 21% higher for women). This is the greatest number of deliberate self harm presentations involving attempted hanging that has been recorded by the Registry.

RECOMMENDED NEXT CARE

In 14% of 2009 cases, the patient left the emergency department before a next care recommendation could be made. Following their treatment in the emergency department, inpatient admission was the next stage of care recommended for almost 41%, irrespective of whether general or psychiatric admission was intended and whether the patient refused or not. Of all deliberate self harm cases, 31% resulted in admission to a ward of the treating hospital whereas 10% were admitted for psychiatric inpatient treatment from the emergency department. This percentage is an underestimate of the percentage of all deliberate self harm cases admitted for psychiatric inpatient care as some of those admitted to a general hospital ward will be subsequently admitted as psychiatric inpatients. In just 1% of cases, the patient refused to allow him/herself to be admitted whether for general or psychiatric care. Most commonly, 44% of cases were discharged following treatment in the emergency department.

Next care recommendations in 2009 were similar for men and women albeit that men more often left the emergency room before a recommendation was made (16% vs. 13%). In previous years, women were more often admitted to a ward of the treating hospital than men.

Recommended next care varied according to the main method of self harm (Table 5). General inpatient care was most common following cases of drug overdose and self-poisoning, less common after attempted hanging and drowning and least common after self-cutting. The latter finding may be a reflection of the superficial nature of the injuries sustained in some cases of self-cutting. Of those cases where the patient used cutting as the main method of self harm, over half (56%) were discharged after receiving treatment in the emergency department. The greater the potential lethality of the method of self harm involved, the higher the proportion of cases admitted for psychiatric inpatient care directly from the emergency department.

	Overdose (n=7764)	Alcohol Poisoning (n=155)	(n=175)	Hanging (n=608)	Drowning (n=253)	Cutting (n=2497)	Other (n=514)	Total (n=11966)
General admission	36.8%	20.0%	41.1%	22.0%	21.7%	14.8%	24.5%	30.5%
Psychiatric admission	7.1%	8.4%	10.9%	26.2%	24.5%	11.3%	16.5%	9.8%
Patient would not allow admission	0.8%	3.9%	2.3%	3.0%	2.4%	0.9%	0.8%	1.0%
Left before recommendation	14.1%	23.2%	11.4%	9.7%	13.8%	17.1%	11.1%	14.4%
Not admitted	41.1%	44.5%	34.3%	39.1%	37.5%	55.9%	47.1%	44.3%

Table 5: Recommended next care in 2009 by main method of deliberate self harm.

Next care varied significantly by HSE hospitals group (Table 6). The proportion of deliberate self harm patients who left before a recommendation was made varied from 8% in the South Eastern Hospitals Group to 22% in the Dublin North East Hospitals Group. Across the hospitals groups, inpatient care (irrespective of type and whether patient refused) was recommended for 18% of the patients treated in the Dublin North East, 29% in the North Eastern, 35% in the Dublin South, 42% in the Southern, 44% in the Dublin/ Midlands, half (50%) in the West/ North Western, 58% in the Mid-Western and two thirds (67%) in the South Eastern. As a corollary to this, the proportion of cases discharged following emergency treatment ranged from 25% in the South Eastern Hospitals Groups to 60% in the Dublin North East. The balance of general and psychiatric admissions directly after treatment in the emergency department differed significantly by hospitals group. Overall, direct psychiatric and general admission were almost equally common in the Dublin South Hospitals Group. In contrast, direct general admissions were eight and ten times more common than direct psychiatric admissions in the South Eastern and North Eastern Hospitals Groups, respectively.

Appendix 2 details the recommended next care for deliberate self harm patients treated at every hospital. For each hospitals group, there were significant differences between the hospitals in their pattern of next care recommendations.

	HSE Dublin / Mid-Leinster		HSE Dublin / North East		HSE South		HSE West		Republic of Ireland
	Dublin/ Midlands	Dublin South	Dublin North East	North Eastern	South Eastern	Southern	Mid-Western	West/North Western	
	(n=1486)	(n=1783)	(n=2027)	(n=964)	(n=1234)	(n=1433)	(n=1076)	(n=1963)	(n=11966)
General admission	35.8%	18.9%	11.4%	26.3%	58.5%	27.8%	45.4%	34.9%	30.5%
Psychiatric admission	8.0%	15.8%	5.8%	2.2%	7.5%	13.1%	8.5%	13.3%	9.8%
Patient would not allow admission	0.5%	0.2%	1.0%	0%	0.6%	0.6%	3.8%	1.7%	1.0%
Left before recommendation	11.9%	15.4%	21.6%	13.4%	7.9%	11.2%	13.5%	15.6%	14.4%
Not admitted	43.7%	49.6%	60.2%	58.1%	25.4%	47.2%	28.9%	34.5%	44.3%

Table 6: Recommended next care in 2009 by HSE hospitals group.

RESEARCH

Tackling Health Inequalities

An All-Ireland Approach to Social Determinants

Compiled by Clare Farrell, Helen McAvoy, Jane Wilde, and Combat Poverty Agency

IPH

Combat Poverty Agency *working for a poverty-free Ireland*

APPENDIX 4

A study of disability and social inclusion in Ireland found that people with disabilities were twice as likely to be in poverty as others in society (Gannon and Nolan 2006). In Northern Ireland over half (56%) of households that contained one or more disabled person were in poverty compared to 29% of 'non-disabled' householders living in poverty (DHSSPS 2004).

Families with children with disabilities are also at risk of poverty. Many parents opt out of the labour force to care for their disabled children and their employment opportunities can be compounded by a shortage of appropriate care and education facilities.

Mental health

Living in poor material circumstances or being faced with discrimination or exclusion is a stressful experience. People living in poverty tend to experience poorer mental health and have a higher dependency on mental health services than people in higher socioeconomic groups (Burke 2007 cited in Combat Poverty 2007a). In Northern Ireland research has shown that people who were unemployed were almost twice as likely to show signs of a possible mental health problem as those in employment (DHSSPS 2002).

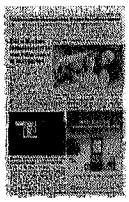
Sexual orientation

It is widely acknowledged that lesbian, gay or bisexual groups are at risk of discrimination and exclusion. This exclusion can also result in stress and mental health difficulties.

Policy issues to consider

- Addressing social exclusion, promoting social inclusion and respecting diversity need to be key public policy priorities.
- Data collection strategies need to ensure that adequate information about the social and spatial patterning of population health is made routinely available.
- Public service delivery should be equitable, culturally sensitive and appropriate to diverse needs and accessible to people with disabilities and other vulnerable groups and communities. Information about health and welfare entitlements and public services should be made available in a broad range of formats and languages, including Irish Sign Language.

APPENDIX 5



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Headline: Psychiatric units suffer rise in assaults amid staff shortages

Psychiatric units suffer rise in assaults amid staff shortages

Patricia McDonagh

PHYSICAL assaults in mental hospitals and psychiatric units have increased by 36pc in the space of three years, as the sector struggles to cope with a crisis in staff levels.

More than 1,314 assaults were recorded in psychiatric services run by the Health Service Executive (HSE) last year – compared with 966 in 2007.

The disturbing figures are contained in a database compiled by the Clinical Indemnity Scheme (CIS), obtained by the *Irish Independent*.

It brings the total number of assaults involving staff and patients during the three-year period to 3,384.

More than 700 staff – including 400 psychiatric nurses – left the sector last year, and have not been replaced due to the recruitment freeze.

In a bid to ease pressure, the HSE secured an exemption from the embargo to hire an additional 100 staff, but this promise has yet to be fulfilled.

According to mental health groups, this exodus is to blame for the increase in assaults because the skeleton staff cannot cope.

As well as assaults, the new figures on the mental health sector also show a 65pc increase in bullying and intimidation in units, over the three-year period – with 63 incidents last year, compared to 38 in 2007. Incidents of attempted self-harm rose by 29pc during that period, while the number absconding from institutions increased by 41pc.

There was also a minor increase in the level of sexual harassment, with 31 recorded incidents last year, compared to 30 in 2007.

John Saunders, director of the mental-health organisation Shine, insisted the Government had to take action on the staffing situation.

He was joined by Ted Tierney of Mental Health Ireland, who said: "The moratorium is having a negative impact on the morale of service users and the level of stress on staff is impacting on service delivery."

Stephen McMahon, of the Irish Patient's Organisation added: "Let's not wait until somebody is killed before action is taken."

Irish hospitals, and other health care organisations operating here, have been legally obliged to report any "adverse clinical incidents" to the CIS since 2000.

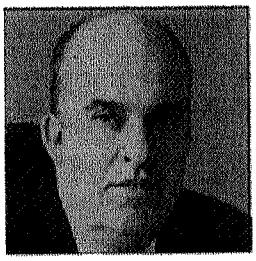
A new HSE guidance document on Risk Management in Mental Health Services had been implemented in 2009, a spokeswoman said.

"The increase in the number of reported incidents, within mental health, reflects the implementation of these serious incident reporting protocols and where such a system is introduced, (the result is) an increase in the number of incidents reported," she said.

"This should not be read as an increase in severity or in the number of incidents. It is as a result of the new reporting protocols."

However, she admitted that while safety was central to mental health services, adverse events did occur.

"This is sometimes with tragic personal circumstances," she added.



John Saunders: criticism