An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Acknowledgements:

The authors of the report wish to acknowledge the contributions made by the Registered Psychiatric Nurses, members of the Psychiatric Nurses Association who gave their time and shared their experience to inform this report.

The authors also wish to acknowledge the Officer Board of the PNA who supported and funded this work.

Finally the authors wish to thank Mr. Des Kavanagh General Secretary and Mr. Peter Hughes General Secretary Designate of the PNA for their vision and support.

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Executive Summary:

The Psychiatric Nurses Association of Ireland (PNA) commissioned the Faculty of Nursing and Midwifery, RCSI to explore the progress of implementation of the " Vision for Change" policy (Government of Ireland, 2006) as experienced by the members of the Psychiatric Nurses Association, (PNA), Registered Psychiatric Nurses (RPNs) who are practitioners within the mental health services in Ireland.

This project was framed theoretically by the Irish Government Policy on Mental Health Services- ("A Vision for Change"). According to the Department of Health *A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.*

This research project is a phased study and this proposal addresses phase 1, which uniquely evaluated the impact of the "Vision for Change" on service provision and resources in relation to the General Adult Mental Health Services. The aim of the study was to comparatively evaluate the intentions of the policy on the realities of practice and service provision.

This project was a descriptive evaluative project which employed mixed (triangulation) methods (quantitative and qualitative). The project utilised an electronic survey questionnaire. The findings from this on line questionnaire subsequently informed the collection of qualitative data through Focus Groups that were conducted regionally across the PNA branch network. Services from every county in Ireland participated in the study.

The findings indicate considerable support for a quality policy framework. However very significant concerns were identified that unambiguously demonstrates a lack of implementation or translation of the national policy into reality. The evidence reported indicates that what was identified as best practice in terms of mental health service development and provision has not

been implemented in any significant, meaningful or cohesive way. The findings indicate that there has been a significant failure to implement national policy; the findings clearly indicate that this failure has very significant impact on the quality of mental health service and care available to the Irish public.

The findings of this report are congruent with those reported elsewhere, including the many reports of the Independent Monitoring Group (IMG). "It is clear to the IMG that the implementation of A Vision for Change (AVFC) to date has been slow and inconsistent" (Independent Monitoring Group, 2012).

This report issues recommendations in relation to the development, staffing and delivery of services as recommended in the Government policy "A Vision for Change".

Ten years following the publication of the VFC policy, the Psychiatric Nurses Association based on this evaluation report calls on all politicians, the Government and the Health Service Executive to fully implement and resource the mental health services nationally based on the Vision for Change.

Chapter 1

Introduction and Background

This chapter provides a preliminary overview of definitions and abstracts from the Irish Mental health policy A Vison for Change, which will give context and focus to the PNA evaluation report on General Adult Mental Health Services following ten years of the implementation of the policy A Vison for Change.

Overview

The Mental Health policy A Vison for Change (AVFC) was developed through a comprehensive and inclusive process, with the policy being hailed as one of international and progressive standing, accepted by politicians of all hues as well as mental health professionals, public servants and user groups. The policy document contains an "implementation "section, which recommended the establishment of an Independent Monitoring group (IMG) to oversee the policy's implementation.

The final report of the IMG was published in June 2012.

Mental health is a distinct policy area, within the broader ambit of health policy. Within this broader spectrum the provision of mental health services is defined and laid out in AVFC.

This report seeks to provide a PNA evaluation of how much of the Vision in the national mental health policy has been fulfilled in the general adult mental health services.

OBSERVATIONS PRE VISION FOR CHANGE

The 2004 Report of the Inspector of Mental Health Services79, revealed a number of issues that need to be addressed "with some urgency". These issues included:

The development of new management systems at expanded catchment and national level are essential to allow the necessary development of specialty services and facilities and to ensure proper planning and funding of services nationally. The development of functioning community mental health teams is necessary to allow the provision of community-based care programmes in all specialties, including home- based and assertive outreach care as alternatives to in-patient care. Increased user input at all levels is necessary to ensure that services are always user- focused. Appropriate clinical governance systems are necessary to ensure safe and effective services and minimise individual practice variations. Service audit systems are necessary to allow ongoing service monitoring and evaluation. Modern information systems are required to support all these activities. (p.125).

Very few mental health services have established home care teams for the treatment of acute mental illness in service users' own homes as an alternative to hospital admission. There is evidence that many day hospitals are not providing the same treatments that are available in an acute in-patient setting and are therefore not offering an alternative to acute in-patient care.

VISION

The vision embodied in this policy is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual. This mental health system should deliver a range of activities to promote positive mental health in the

community; it should intervene early when problems develop; and it should enhance the inclusion and optimal functioning of people who have severe mental health problems. Service providers should work in partnership with service users and their families, and facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.

The mental health service should be organised nationally in catchment areas for populations of between 250,000 and 400,000.

This policy envisions an active, flexible and community- based mental health service where the need for hospital admission will be greatly reduced. It will require substantial funding, but there is considerable equity in buildings and lands within the current mental health system, which could be realised to fund this plan. Therefore, this report recommends that steps be taken to bring about the closure of all mental hospitals and to re-invest the resources released by these closures in the mental health service.

A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.

Key Recommendations of a VISION FOR CHANGE

- Well-trained, fully staffed, community-based, multidisciplinary CMHTs (Community Mental Health Teams) should be put in place for all mental health services. These teams should provide mental health services across the individual's lifespan.
- The mental health services should be organised nationally in catchment areas for populations of between 250,000 and 400,000. In realigning catchment boundaries, consideration should be made of

the current social and demographic composition of the population, and to geographical and other administrative boundaries. Service provision should be prioritised and developed where there is greatest need. This should be done equitably and across all service user groups.

- Services should be evaluated with meaningful performance indicators annually to assess the added value the service is contributing to the mental health of the local catchment area population.
- A multi-professional manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this policy. This plan should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers.
- Substantial extra funding is required to finance this new Mental Health Policy. A programme of capital and non-capital investment in mental health services as recommended in this policy and adjusted in line with inflation should be implemented in a phased way over the next seven to ten years, in parallel with the reorganisation of mental health services.
- *A Vision for Change* should be accepted and implemented as a complete plan.

DEVELOPMENT OF SPECIALISMS

> There is a serious lack of development of the necessary range of specialist mental health servic nationally and no HSE Area has the full complement of services of sufficient quality to provide comprehensive mental health care (Inspector of Mental Health Services p79).

of resources and an insufficient number of multidisciplinary teams in many of the specialist areas. Other specialisms, such as mental health services for those with severe and enduring mental illness (also known as rehabilitation mental health services) have many resources but still remain underdeveloped.

The uneven availability of such services around the country creates an inequitable situation for service users and families. Plans for the development of mental health services across the lifespan are presented in Chapters Ten to Fifteen of AVFC.

FRAMEWORK FOR MENTAL HEALTH SERVICE DELIVERY VFC

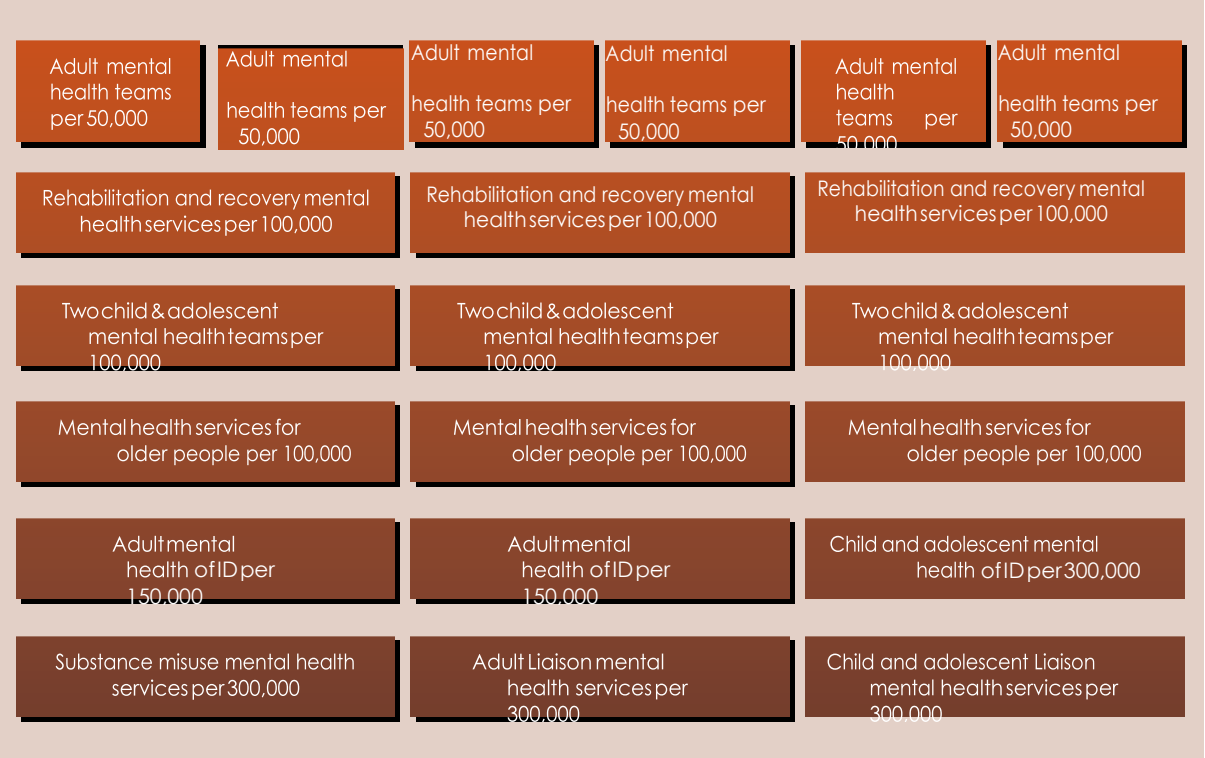
The new catchment areas should have a population of 200,000 to 400,000, depending on local circumstances. The average mental health catchment area should be around 300,000 in population and this is the number that has been used to configure and cost the mental health services in this policy. Larger catchment areas are necessary to ensure the full range of mental health services can be provided to a defined population. Larger catchments allow for the delivery and integration of this wide range of mental health specialties, located together in community mental health centres, and gives more scope for choice to service users while maintaining the advantage of remaining within the service user's local area. Based on these numbers, there will be a total of 12 or 13 Mental Health Catchment Areas in the country. Each Mental Health Catchment Area should contain within it the full range of mental health services, with the exception of those

services that require provision on a regional or national basis.

Catchment areas of this size will cover two or three local health offices, depending on local population and dispersal. It is essential that local health office catchment areas should not be split across different Mental Health Catchment Areas. Boundaries of mental health catchment areas and one or more local health offices must be coterminous.

Preference should be given to providing additional personnel to teams where there is more need but not enough to justify a full team, rather than splitting teams. Services should be organised so that they are located in areas of deprivation, which will ensure easier access, and that local deprivation is taken into account in the provision and staffing of services. Sectors in the new structure will range from 50,000 to 300,000 depending on the specific mental health services. Some services are also provided on the basis of the HSE regions, which have a population of approximately 1,000,000.

Framework for catchment area mental health services 300,000 population approximately



ADULT MENTAL HEALTH SERVICES

The central structure within the adult mental health service should be a specialised CMHT. Each CMHT should serve everybody aged 18–64 years in a population of approximately 50,000. Home-based treatment should be the main method of treatment delivery and all elements of the adult mental health service, such as access to in-patient admission, should be provided as appropriate through the CMHT.

ADULT MENTAL HEALTH SERVICES

- one multidisciplinary CMHT per 50,000 population, with two consultant psychiatrists per team
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care; home-based care; crisis house; day hospital; early intervention etc.
- one acute in-patient unit per 300,000 population with 35 beds*
- one crisis house per 300,000 with ten places
- four intensive care rehabilitation units (ICRU) to be provided – one in each of the four HSE regions, with 30 beds. Each ICRU to be staffed by a multidisciplinary team with

RECOVERY AND REHABILITATION MENTAL HEALTH SERVICES FOR SEVERE AND ENDURING MENTAL ILLNESS

Individuals with severe and enduring mental illness are recognised as an especially vulnerable group of adults, in need of intensive treatment and care in order for the individual to regain their selfhood and their place in society. Mental health services for this group should be provided by multidisciplinary CMHTs, with one team per 100,000 population. These teams should provide intensive treatment and rehabilitation, and should have a number of members delivering assertive outreach care. In-patient beds and other parts of mental health services in the catchment area should be accessed during acute episodes if required.

RECOVERY AND REHABILITATION MENTAL HEALTH SERVICES FOR SEVERE AND ENDURING MENTAL ILLNESS

- one multidisciplinary CMHT per 100,000 population
- based in, and operating from, community mental health centres
- providing intensive multidisciplinary assessment, treatment and care; assertive outreach, etc.
- three community residential units of ten places each to be provided per 100,000 population
- one to two day centres per 300,000 providing a total of 30 places
- one service user-provided support centre/social club per 100,000

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

The mental health needs of older people are recognised as requiring specific skills for assessment, treatment and care. Within each catchment area, mental health services for older people should be provided by three multidisciplinary CMHTs, each serving approximately 100,000 population. All individuals over 65 years can access the mental health services for older people. The needs of the individual will determine which team is best suited to meet those needs (i.e. between adult, older people and the team for severe and enduring mental illness).

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

- one multidisciplinary CMHT per 100,000 total population
- based in, and operating from, community mental health centres
- providing individual multidisciplinary assessment, treatment and care, with an emphasis on home assessment and treatment if possible, and on maintaining the older person in their community
- eight in-patient beds in the general acute in- patient unit
- one day hospital per 300,000 population with 25 places specifically for mental health services

IN-PATIENT CARE

There should be 50 acute in-patient beds per Mental Health Catchment Area, provided in the Regional Hospital. In some areas, these beds may be provided as two units with 25 beds each. The breakdown of these beds is shown below. Flexible use of acute beds is desirable and rigid demarcations are not to be encouraged. However, given the special needs of those in mental health services for older people and those with intellectual disability, it is preferable that 'sub-units' be provided within the overall psychiatric unit to suit the specific requirements of these groups. Similarly, given the therapeutic requirements of adults with eating disorders, it is preferable that these beds be located in one regional unit (i.e. six beds per one million population).

IN-PATIENT CARE

- one acute in-patient unit per catchment area of 300,000 population with 50 beds to be used as follows:
  - 35 beds for general adult mental health services, including six close observation beds
  - eight beds for mental health services of older people (sub-unit)
  - five beds for mental health services for people with intellectual disability (sub-unit)
  - two beds for people with eating disorders (may be amalgamated in one unit per region of six beds)
- this acute in-patient unit should be located in the 'Major' or 'Regional' hospital, while taking into account the location of existing units (can be provided in two units of 25 beds each)
- one crisis house per 300,000 with ten places
- four intensive care rehabilitation units (ICRU)
  – one in each of the four HSE regions, with 30 beds each
- two high support intensive care residences of ten places each, in each HSE region (a total of eight residences with 80 places nationally)
- one unit with 30 beds per 300,000 population for continuing care/challenging behaviour for mental health services for older people
- ten rehabilitation beds in intellectual disability residential centres which have approved centre status
- 100 in-patient beds nationally for 0–18 year olds, in five units of 20 beds each

PHYSICAL RESOURCES REQUIRED

- **OUTPATIENT CLINICS**

  There is a strong clinical consensus in many countries that outpatient clinics, based in community mental health centres or hospitals, offer a relatively efficient way to assess and intervene with a wide range of mental health difficulties, provided that these clinics are easily accessible. Initial appointments and follow- up timed appointments should be provided within the community mental health centre, as they offer a more attractive option for service users. In addition, assessment and treatment planning in the context of the community mental health facility make it easier to draw on the full range of expertise in the CMHT and to avoid protracted delays where users require specialised input from a member of the team. These clinics should be for consultation only and should not be vehicles for the prescribing of medication to repeat attendees. They should be suitably located and be well-designed, well-built and well-maintained.

- **COMMUNITY MENTAL HEALTH CENTRES**

  CMHTs should base their operations in a Community Mental Health Centre. These centres should be located close to other relevant community agencies, and have adequate space and facilities to accommodate the full clinical requirements of the CMHT. They should also present an ethos that is attractive and valued by service users.

- **DAY HOSPITALS**

  The Community Mental Health Centre should include a day hospital. Day hospitals offer an alternative to in-patient admission for a proportion of service users. Social and psychological therapy programmes are offered in addition to medication for people with acute mental disorders whose needs can be met in a day hospital

setting. There is good evidence that acute day hospital facilities are suitable for a quarter to a third of service users who would otherwise be admitted to hospital. It is important that the service user's needs be considered and incorporated in the development of day hospitals. The danger is that many seemingly desirable generic activities and therapy programmes may be offered as a matter of course without the collaboration of service users, whose actual needs should shape the particular range of activities on offer.

CRISIS HOUSES

A crisis house is used for crisis intervention and for acute respite purposes. A crisis period should be brief; usually between 24 and 72 hours. Where it is possible to offer and deliver crisis intervention in the community this should be the preferred treatment option; for example, when the source of the crisis is in the family home a bed in a crisis house may be appropriate. A crisis house is not an intensive treatment option but rather a place of refuge, of understanding, and of support for individuals in crisis. The facility is not restrictive and offers each user an opportunity to deal with issues surrounding their lives by accessing appropriate interventions such as counselling, family therapy, psychology, social work or other available holistic options as required. Service users are encouraged to move on following the resolution of their crisis, with an option for appropriate support and follow-up contact should that be required. Evaluation of crisis houses has found that they are acceptable to service users and that they may offer an alternative to in-patient care for a proportion of those who would otherwise be admitted to hospital.

ACUTE IN-PATIENT UNITS

The provision of a high-quality acute in-patient unit based in a general hospital is an important element of a community-based mental health service. Its purpose is

to provide a range of therapeutic interventions and clinical care options for service users experiencing severe and acute psychological distress, e.g. psychosis, severe depression. Admission is offered when it is established that the individual's acute care needs cannot be treated appropriately at home, or in an alternative, less restrictive, setting. Within the proposed policy framework, 50 beds will be provided for each mental health catchment area of 300,000 population. These beds may be located in a single unit, or may be divided across two units in the catchment area to facilitate easy access for service users and their carers. This provision of in-patient beds proposes a reduction of the number of beds available under current arrangements, but transition to this reduced bed capacity can only occur with the increased provision of community-based alternatives.

COMMUNITY-BASED INTERVENTION PROGRAMMES

In general there are now four main community-based intervention programmes employed in the effective delivery of community-based care:

- home-based care
- crisis intervention
- early intervention
- assertive outreach

HOME-BASED CARE

Home-based care is a treatment modality that responds to acute and severe mental health crises by engaging with the service user in their home setting. This treatment modality is provided through a group of professionals drawn from the general adult CMHT who can respond promptly to crises that occur in the lives of new or existing service users.

A provisional care plan to address immediate needs is drawn up and agreed with service user and carer. The introduction of home-care treatment in a number of Western countries has been found to be greatly appreciated by service users and carers and to dramatically impact on the need for hospital admission. Every effort should be made to provide treatment solutions other than admission to hospital, which should be employed only as a last resort. Short-term living options, which may be available through respite provision in high-density urban settings, or through relatives or voluntary organisations, may also be considered as a way to provide short-term relief in a crisis, where appropriate.

Given the specialist expertise involved in the provision of home-based treatment, a number of dedicated members of the CMHT should form a core sub-team and be responsible for this aspect of the service. Different expertise from within the CMHT can be co-opted to the home-based service, depending on the particular needs of service users. This home-based treatment team should report regularly to weekly CMHT meetings and function as a triage and gatekeeper element. Referrals should be directed to the home-based treatment team via the CMHT. The home-based treatment team assumes responsibility for the care of the individual in crisis and this may involve liaising with other agencies or settings where the crisis occurs, for example Garda stations, third- level educational institutions, and work settings.

Individuals being seen by the home-based treatment team should be reviewed regularly with the full CMHT to ensure coordination of care within the specialist mental health services. Regular discussion within the CMHT should also afford opportunities to review clinical formulation and care plans and consider what additional expertise from within the CMHT or the wider catchment area may be appropriate.

RECOMMENDATION 11.10: Home-based treatment teams should be identified within each CMHT and provide prompt services to known and new service users as appropriate. This sub-team should have a gate- keeping role in respect of all hospital admissions.

CRISIS INTERVENTION

With the provision of a full range of CMHTs and programmes for adults with mental illness, and the closer contact envisaged between service users and their carers, the likelihood of unforeseen and unexpected crises arising should be reduced. However, each adult CMHT will need to agree protocols for ensuring a prompt response to crises that develop within their particular sector. This should be available on a 24/7 basis and should include the capacity to respond in a multidisciplinary way to a It is proposed that there should be a 'crisis house' within each catchment area, offering brief accommodation to service users who need a safe place to recover their bearings and work with the CMHT to evolve a care plan that will address the key factors that have precipitated their crisis. It is proposed that there should be a 'crisis house' within each catchment area, offering brief accommodation to service users who need a safe place to recover their bearings and work with the CMHT to evolve a care plan that will address the key factors that have precipitated their crisis.

RECOMMENDATION 11.11: Arrangements should be evolved and agreed within each CMHT for the provision of 24/7 multidisciplinary crisis intervention. Each catchment area should have the facility of a crisis house to offer temporary low support accommodation if appropriate.

EARLY INTERVENTION

In recent years, there has been an increasing emphasis on prompt identification and intervention with initial or early episodes of psychosis. Emerging evidence indicates that there is a clear relationship between the length of time it takes to respond to an

individual's first experience of psychosis – the 'duration of untreated psychosis' and long-term outcome for that service user. This finding has promoted a movement in many Western countries to establish specialist Early Intervention Services (EIS). EIS consist of specialist multidisciplinary teams dedicated to the care of people with a first episode of psychosis. They differ from standard care in two distinct ways – they focus on early detection of established cases of psychosis and they offer specialised and intensive interventions.

Most EIS are based on populations of 350,000 and care for people in the first three to five years after a first episode. They are recovery-focused and employ innovative and youth-oriented approaches to engage young adults and their families. They provide services predominantly in local community facilities, in environments that are least restrictive, intrusive and stigmatising. Vocational support is also vital to enable young people make a non-stigmatised and seamless transition back toward their goals .There is some evidence to show that EIS reduce the duration of untreated psychosis, reduce the severity of symptoms, reduce suicidal behaviour, reduce the rate of relapse and subsequent hospitalisations and are highly thought of by both those who use such services and their families. From a health economic perspective EIS involvement has been shown to be cost effective.

RECOMMENDATION 11.12: In addition to the existing Early Intervention Services (EIS) pilot project currently underway in the HSE, a second EIS pilot project should be undertaken with a population characterised by a different socio-demographic profile, with a view to establishing the efficacy of EIS for the Irish mental health service.

ASSERTIVE OUTREACH

Assertive outreach, the fourth of the community-based intervention programmes, is employed predominantly in the community rehabilitation of people with enduring illness that has caused substantial impairment and disability.

People with severe and enduring mental illness can experience a range of problems that result in their lives becoming restricted and impoverished. This group of service users is perhaps the most vulnerable in the mental health service, and ultimately, the quality of the service overall can be measured by the quality of care provided to this group. Rehabilitation and recovery CMHTs provide specialised services for people disadvantaged by a range of problems that can develop with severe mental illness, and which cannot be adequately met by the general adult CMHTs.

The central principle is the provision of individualised, focused and proactive care to service users to minimise the risk of disengagement and to maximise involvement in the recovery process. Service users with severe mental illness do not do well in a demand-led health service. As a result, the concept of 'assertive outreach' care has developed. A subgroup within the team, usually psychiatric nurses, should be the main providers of assertive outreach care. Each member of the assertive outreach team will be the key contact for a number of their service users. It is recommended that the optimum number of service users per key contact is 10–12, but this may vary depending on the level of input each service user needs. Underpinning the work of the rehabilitation team is a strong commitment to the principle of recovery.

'Recovery' used here reflects the belief that it is possible for all service users to achieve control over their lives,
to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.

RECOMMENDATION 12.1: A strong commitment to the principle of 'Recovery' should underpin the work of the rehabilitation CMHT - the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.

CORE STAFFING OF A REHABILITATION ADULT MENTAL HEALTH SERVICE

There is an established knowledge base and range of specialised measures which are essential if service users are to be adequately assessed and their needs appropriately addressed.By definition, these people have disabilities which persist in the long term and this, in addition to the associated social supports they require, makes it essential that a range of specialised resources are made available. Dedicated CMHTs are required to coordinate and optimise the use of these resources.

The composition of these teams should include the following:

- one consultant psychiatrist
- 10-15 psychiatric nurses for Assertive Outreach Nursing Team (maximum case load of 12 service users to one nurse)
- mental health support workers – based on numbers of service users who require such support, who can provide peer support and advocacy
- two occupational therapists
- two social workers
- two clinical psychologists
- cognitive behaviour therapist/psychotherapist
- addiction counsellor
- additional staff:
  – domestic skills trainer
  creative/recreational therapists

FACILITIES FOR RECOVERY AND REHABILITATION CMHTS

The following physical resources should be provided for rehabilitation and recovery CMHTs:

TEAM HEADQUARTERS: a community facility large enough to provide a working base for all team members. Such a headquarters should ideally be placed in a community mental health centre and may be shared with other specialist teams, such as general adult community mental health teams.

DAY CENTRE: a facility that provides individualised programmes for service users who are unable to avail of community-based employment or recreational activities. One to two centres per catchment area, depending on population density will likely be required, offering a total of 30 places.

SERVICE USER RUN CENTRES AND PEER-PROVIDED SERVICES: These services are particularly relevant to the users of rehabilitation and recovery mental health services. They offer opportunities for peer support and re-integration and independence in the community. It is recommended that these services be linked to and supported by the CMHT. These support centres offer flexible, broad-based support to all service users both on a drop-in basis and on a planned basis.

ACCESS TO ACUTE IN-PATIENT CARE: the rehabilitation team should have direct access to in-patient care in the catchment in-patient unit if required.

RECOMMENDATION 12.3: The physical infrastructure required to deliver a comprehensive

service should be provided in each sector. Rehabilitation and recovery CMHTs should have responsibility for those physical resources appropriate to the needs of their service users, such as community residences.

DIFFICULT TO MANAGE BEHAVIOURS (DMBS)

Difficult to Manage Behaviours (DMBs) 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.

Service users who present with DMBs are broadly divisible into two clinical types - those with acute short- lived disturbance, typically the consequence of psychotic illness, and those with more enduring mental health problems and associated challenging behaviour. The former require close observation for a relatively short period during the acute phase of illness.

The second group requires longer-term care and rehabilitation in purpose-built accommodation. In addition, outpatients with mental health problems in the context of a borderline personality disorder can pose significant challenges to CMHTs and require explicit treatment protocols in line with current best practice.

It is recommended that four of these intensive care rehabilitation units be provided nationally, one in each HSE region containing 30 beds (a total of 120 nationally). These 30 beds should be in two sub-units of 15 beds each. Intensive care rehabilitation units (ICRUs) should be staffed by a multidisciplinary team with appropriate experience and training, particularly in the area of rehabilitation and recovery. The use of the term 'intensive care rehabilitation' stresses the central importance of rehabilitation and recovery interventions for this group.

The use of the 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. There must also be joint clinical management between catchment area CMHTs and the ICRU team.

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 of ten places and operating in close association with the ICRUs. This will provide a national complement of 80 places.

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.

RECOMMENDATION 11.15: Each of the four HSE regions should provide two high support intensive care residences of ten places each.

PEOPLE WITH BORDERLINE PERSONALITY DISORDER

Borderline personality disorder is one of a number of personality disorders that can pose serious behavioural challenges to services. People with this disorder can present with

histories of abusive relationships, repeated self-harm behaviour, emotional instability and failure to sustain steady employment or housing. Their behaviour on presentation can be quite erratic and they can find it difficult to engage with the standard care options available in community services.

Therapeutic approaches provided by skilled practitioners usually combine a number of core interventions: acceptance and validation, emotional regulation and problem-solving skills, and therapeutic exploration of dysfunctional attachment styles, which reflect destructive early experiences. Medication and social care also have an important role with some individuals.

Dialectic Behaviour Therapy (DBT) is one approach which combines these elements in a very systematic way. Its credibility as an intervention with borderline personality disorder has grown as an increasing number of research trials have shown it to be effective. The HSE has invested in specialised DBT training for clinical teams from different catchment services, and this has produced pockets of specialised programmes in a small number of community-based services.
This service could be in the form of a dedicated DBT team specifically designed for the needs of people with borderline personality disorder. This resource would be available on a catchment basis rather than merely sector basis. Individuals who commit to developing this specialist therapeutic service could be seconded for dedicated weekly sessions from their sector CMHTs.

RECOMMENDATION 15.8.2: Specialised therapeutic expertise should be developed in each catchment area to deal with severe and complex clinical problems that exceed the available resources of generic CMHTs.

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

The critical principle in service provision for older people, including those living in the community, is that – regardless of their mental health history – they should have access to the services most appropriate to their needs. In principle, anybody aged 65 years or over with primary mental health disorders, or with secondary

behavioural and affective problems arising from dementia, should be cared for by a MHSOP team. The preference of the majority of older people with mental health difficulties is that whatever care they require be offered to them in the context of their own home.

RECOMMENDATION 13.1: Any person, aged 65 years or over, with primary mental health disorders or with secondary behavioural and affective problems arising from experience of dementia, has the right to be cared for by mental health services for older people (MHSOP).

SPECIALIST COMMUNITY MENTAL HEALTH SERVICES FOR OLDER ADULTS

MHSOP should operate through specialised CMHTs, with one team per 100,000 population. A total of 39 teams should constitute the MHSOP nationally and each team should include the following personnel:

- one consultant psychiatrist (with specialist expertise in later life psychiatry)
- one doctor in training
- one senior nurse manager
- three psychiatric nurses
- one clinical psychologist
- one social worker

- one occupational therapist
- two mental health support workers/care assistants
- support staff: administrative/secretarial assistance to support the activities of the MHSOP team.

MHSOP should have access to input from physiotherapists and creative and recreational therapists when required by service users.

PHYSICAL RESOURCES REQUIRED

- **COMMUNITY-BASED TEAM HEADQUARTERS**

The MHSOP team should be based in and operate from a community mental health centre. The headquarters may also function as a multi-purpose centre for information and support for the general public, health and social professionals, and carers. It should provide accommodation for meetings, including those of carer groups, and may also provide for a variety of other functions dependent on need and the availability or lack of other community-based resources.

RECOMMENDATION 13.7: Physical resources essential to service delivery, acute beds and continuing care, service headquarters, community-based and day facilities should be provided for MHSOP within each sector.

ACUTE ASSESSMENT AND TREATMENT UNITS

These should be located in a general hospital psychiatric unit, as a separate section of that unit. Each dedicated facility should be entirely self-sufficient with its own facilities, such as day room, garden, courtyard space, etc. It is recommended that there should be eight acute assessment and treatment beds in each regional acute psychiatric unit

for MHSOP.

RECOMMENDATION 13.8: There should be eight acute assessment and treatment beds in each regional acute psychiatric unit for MHSOP

DAY HOSPITALS

Day hospitals are concerned with medical care in the broad sense, in contrast to day centres, which are largely concerned with social care. Day hospitals for MHSOP should be integrated within the campus of a general hospital. The location of the day hospital there is recommended so as to facilitate easy access to diagnostic and other services, given the high level of physical/ mental health co-morbidity in older people.

It is recommended that one day hospital of 25 places be provided in each mental health catchment area of approximately 300,000. The role of day hospitals in substituting for acute hospital care, for delaying admission to continuing care, and in providing carer respite capacity, should receive evaluation in the Irish context.

In addition to a central day hospital in or adjacent to the catchment general hospital, there is a requirement for peripheral ancillary day hospital provision in association with local community hospitals.

It is not feasible to have people from remote areas attending distant services on a daily basis as may be necessary for extensive diagnostic evaluation or for treatment purposes. It is recommended that proximity to a general or community/district hospital with basic investigative equipment, such as X-ray and phlebotomy facilities, is important to make basic diagnostic procedures possible and to have medical and surgical expertise available on a consultative basis.

It is recommended that a travelling day hospital should be considered, allowing specialist mental health professionals to visit once or twice a week for consultation and advice. Adequate transport for service users is essential to maximise the potential of day hospitals and day centres.

RECOMMENDATION 13.9: There should be one central day hospital per mental health catchment area (300,000 population) providing 25 places, and a number of travelling day hospitals in each mental health catchment area.

DAY CENTRES

Day centres for older people do not come within the remit of mental health services but it is recognised that an inadequate supply of day centres can lead to the misuse of scarce day hospital places. Thirty-one day centres nationwide are currently provided by the Alzheimer's Association. Both paid personnel and volunteers staff them. They are funded through the HSE and by the Alzheimer's Association. A variety of other voluntary organisations also provide day centres. As with day hospitals, the functioning of day centres needs audit and evaluation concerning the needs they meet, the clientele they serve, and their overall contribution to the continuum of service provision for older people.

RECOMMENDATION 13.10: There should be an appropriate provision of day centres in each mental health catchment area, but their provision should not be the responsibility of the MHSOP.

LIAISON MENTAL HEALTH SERVICES

Liaison mental health services (LMHS) provide clinical services and education, teaching and research in general hospital settings. They are concerned with helping patients in hospital to process and cope with the impact of major illness and surgical procedures, and with loss and trauma. They can also identify those patients with severe mental health problems that may have been aggravated by their admission to hospital, or may be manifesting as physical symptomatology.

The main benefits of liaison mental health services are the identification and treatment of mental health problems in the general medical and A&E settings. This leads to reduced morbidity, reduced hospital admission, reduced inappropriate physical investigations, reduced length of stay, reduced outpatient attendances, reduced anxiety and depression and improved quality of life172. Liaison mental health services also have an excellent opportunity to promote mental health through direct intervention with in-patients and through the training of hospital staff.

Every acute admitting hospital in Ireland should have access to liaison mental health services. one liaison mental health team per regional hospital. Existing liaison mental health teams should have the full multidisciplinary team put in place.

The composition of a liaison mental health team should be as follows:

- one consultant liaison psychiatrist
- one doctor in training
- two clinical psychologists
- five clinical nurse specialists to include two specialist nurse behavior therapists or psychotherapists

- two secretaries/administrators.

RECOMMENDATION 15.5.1: The existing provision of nine LMHS teams nationally should be increased to thirteen.

Findings from the reports of the Independent Monitoring Group

AVFC-Vision

AVFC envisaged that there would be fully populated CMHTs in General Adult and Specialist mental health services and the detailed membership of those teams are fully described in AVFC. Year-on-year, the IMG has been told that CMHTs are for the most part incomplete with a paucity of psychology, social work, occupational therapy and other Allied Health Professional posts. Figures supplied by the HSE and MHC support this trend. This situation continues to exist despite the submissions from the HSE proposing that posts can be relocated from institutional services to community based services (IMG, 2012).

Recovery

The Recovery ethos is enshrined as central to AVFC. The development of recovery-oriented practice nationally is evident to the IMG albeit that it appears to have occurred as a result of local/individual interest and endeavour and not as a result of a national strategic implementation plan. Whilst the IMG does not underestimate the scale of the challenge involved in transforming mental health services, it is again disappointing to report that the progress necessary to embed recovery is worryingly slow (IMG, 2012).

Human Resources

All mental health care services by their nature rely heavily on the delivery of comprehensive care and interventions by professionally competent staff. There is little or no reliance on technology in the provision of mental health care. Since the launch of AVFC, there have been significant challenges in providing the type of staffing required due to the implementation of the HSE's Recruitment Embargo and the Public Service Moratorium from 2009 – to date. The HSE Embargo and Public Service Moratorium on staff recruitment have been effective in driving down the overall cost of mental health services but are rather a blunt instrument making it extremely difficult to reshape and reallocate mental health service resources as envisaged in AVFC. Consequently, there has

been very slow progress in fully staffing CMHTs in all areas of mental health services (IMG, 2012). The IMG (2012) reports that the blunt nature of the moratorium means that practically impossible to put in place a proactive and progressive manpower plan.

The unpredictability of retirements and resignations under the various exit schemes has resulted in a haphazard and uneven distribution of remaining staff across the 26 counties. There are manpower shortages in nursing, psychology, occupational therapy, social work, junior hospital doctors (related to supply issue) which make it extremely difficult to populate mental health teams. Additionally, there has been a trend in recent years to depopulate community facilities in favour of preserving staffing levels in residential facilities (Approved Centres). This has resulted in the reduction of staff in day hospitals, day centres, group homes and CMHTs. There has been an overall gross reduction in the availability of professional staff to address the type of service envisaged in AVFC (IMG, 2012). AVFC makes twenty eight recommendations as regards Manpower, Education and Training. It is disappointing to observe that little progress seems to have occurred. Though it is obvious that the economic situation and resource issues will impact on these three areas, little effort seems to have been made to introduce a governance and implementation structure that would make maximum use of the resources available. The IMG (2012) reports that the need for a National Manpower Plan and a body to co-ordinate it would seem even more important in these times.

According to the IMG from submissions received from the HSE, there is a strong focus on the closure of inappropriate institutions and inpatient beds and the transfer of resources to the community. It is clear also that there is a desire to provide services in more appropriate care settings. This policy, however, has been stifled by the HSE embargo and the present Pubic Service Moratorium on recruitment.

Specialist Services

A continual finding from the IMG and the theme consistently repeated in submissions to the IMG is the lack of progress in developing specialist mental health care services. There has been a worrying absence of development of appropriate mental health care services as envisaged in AVFC in the areas of intellectual disability, old age, eating disorders, rehabilitation and recovery, as described earlier, co-morbid severe mental illness and substance abuse problems. This is one of the significant implementation failures of AVFC and continues to be a major obstacle to the provision of responsive specialist mental health care services (IMG, 2012).

Forensic Services

Regarding National Forensic Services the IMG (2012) acknowledges the long awaited policy decisions and planning for the development of a new forensic mental health care service to replace the existing CMH at Dundrum. Despite the protracted delay arising out of disagreements about location, the IMG welcomes the plan to build a facility at Portrane, which will accommodate adult forensic mental health services, children's forensic mental health services and forensic services for people with intellectual disability and in addition, the provision of four regional intensive care rehabilitation units.

Rehabilitation and Recovery Services

Regarding rehabilitation and recovery services the IMG Report (2012) reports there were insufficient rehabilitation and recovery teams to provide a comprehensive service nationally. In existing teams there was a lack of adequate staffing. Where teams existed it was evident that there was strong team working, good service user input, excellent care planning and good service provision within the constraints of poor resourcing. The IMG (2012) is concerned that in reality there is a de-prioritisation of rehabilitation and recovery teams as a direct response to the demands for staffing of acute adult mental health teams. This unwritten policy is a direct contradiction to the stated policy of AVFC. Those areas that have rehabilitation and recovery services have

poorly staffed teams in all disciplines. No area had a fully staffed rehabilitation team as outlined in AVFC (IMG, 2012).

The Inspector of Mental Health Services in the 2008 report noted that from the broader perspective of the quality of care and treatment, little has changed, despite the introduction of A Vision for Change. The findings of this report are congruent with those reported elsewhere, (Mental Health Commission, (2009), Idecon International Consultants (2009) and the reports of the Independent Monitoring Group (IMG 2007 and 2012). "It is clear to the IMG that the implementation of A Vision for Change (AVFC) to date has been slow and inconsistent" (Independent Monitoring Group, 2012).

Chapter 2

Methodology

Project Topic:

This study will explore the progress of implementation of the Vision for Change policy as experienced and reported by the members of the Psychiatric Nurses Association, (PNA), Registered Psychiatric Nurses (RPNs) who are practitioners within the mental health services in Ireland.

Theoretical Framework:

This project will be theoretically framed by the Irish Government Policy on Mental Health Services- ("A Vision for Change). According to the Department of Health *A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.*

The Government has provided ring fenced additional funding to the HSE for mental health in line with the Programme for Government commitment. A new HSE Mental Health Directorate was established in 2013, with full financial and operational responsibility for the delivery of *A Vision for Change.* This project is linked explicitly to the experience of front line staff in those services in relation to the delivery of this policy in practice.

Project Aim:

This research project is a phased study and this proposal addresses phase 1, which will uniquely evaluate the impact of the "Vision for Change" on service provision and resources in relation to the General Adult Mental Health Services. The aim of the study is to comparatively evaluate the intentions of the policy on the realities of practice and service provision. It is envisioned that the subsequent phase of this project will (subject to approval) evaluate the experience from other services such as CAMHs, addictions services and other specialist areas of practice.

Target Population:

The target population for this study is the Registered Psychiatric Nurses, members of the Psychiatric Nurses Association who work in the Mental Health Services in Ireland.

Project Sample and sampling:

The difference between nonprobability and probability sampling is that nonprobability sampling does not involve *random* selection and probability sampling does. Does that mean that nonprobability samples aren't representative of the population? Not necessarily. But it does mean that nonprobability samples cannot depend upon the rationale of probability theory. At least with a probabilistic sample, we know the odds or probability that we have represented the population well. We are able to estimate confidence intervals for the statistic. With nonprobability samples, we may or may not represent the population well, and it will often be hard for us to know how well we've done so. In general, researchers prefer probabilistic or random sampling methods over non-probable ones, and consider them to be more accurate and rigorous. However, in applied social research there may be circumstances where it is not feasible, practical or theoretically sensible to do random sampling.

We can divide nonprobability sampling methods into two broad types: *accidental* or *purposive*. Most sampling methods are purposive in nature because we usually approach the sampling problem with a specific plan in mind. The most important distinctions among these types of sampling methods are the ones between the different types of purposive sampling approaches.

Purposive sampling, also known as judgmental, selective or subjective sampling, is a type of non-probability sampling technique. Non-probability sampling focuses on sampling techniques where the units that are investigated are based on the judgment of the researcher and in this study the commissioner of the

project. The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable you to answer your research questions. The sample being studied is not representative of the population, but for researchers pursuing qualitative or mixed methods research designs, this is not considered to be a weakness. Rather, it is a choice, the purpose of which varies depending on the type of purposing sampling technique that is used. For example, in homogeneous sampling, units are selected based on their having similar characteristics because such characteristics are of particular interested to the researcher.

In purposive sampling, we sample with a *purpose* in mind. We usually would have one or more specific predefined groups we are seeking is verify that the respondent does in fact meet the criteria for being in the sample. Purposive sampling can be very useful for situations where you need to reach a targeted sample quickly and where sampling for proportionality is not the primary concern. With a purposive sample, you are likely to get the opinions of your target population, but you are also likely to overweight subgroups in your population that are more readily accessible.

Purposive sampling will be used in this study to purposively recruit the members of the PNA. Purposive sampling, also referred to as judgment, selective or subjective sampling is a non-probability sampling method that is characterised by a deliberate effort to gain representative samples by including groups or typical areas in a sample. The researcher relies on his/her own judgement to select sample group members. Purposive sampling is mainly popular in qualitative studies.

This study employs Homogeneous sampling , a purposive sampling technique that aims to achieve a homogeneous sample; that is, a sample whose units (e.g., people, cases, etc.) share the same (or very similar) characteristics or traits (e.g., a group of people that are similar in terms of age, gender, background, occupation, etc.); in this case members of the PNA. A homogeneous sample is often chosen when the research question that is being addressed is specific to the characteristics of the particular group of

interest, which is subsequently examined in detail, in this case the experience of members of the PNA of the implementation of Vision for Change in practice.

In purposive sampling researcher and in this case the PNA organisation has sufficient knowledge of topic to select sample of experts and subjects are chosen in this sampling method according to the type of the topic. Therefore, skills and capabilities of the researcher to find appropriate individuals to contribute to the achievement of research objectives play important role on the outcome of studies using this sampling technique.

This sampling technique can prove to be highly effective in following circumstances:

- Data review and data analysis need to be done in a simultaneous manner
- Primary data needs to be obtained from a very specific group of respondents
- Only representatives of certain professions can contribute to the study

This sampling method offers the following advantages:

- Less time consuming compared to many other sampling methods because only suitable candidates are targeted
- Results of purposive sampling are usually more representative of target population compared to other sampling methods
- Purposive sampling can be the only way to recruit the members of rare or much sought after groups

Purposive sampling may be associated with the following disadvantages:

- Very high level of subjectivity by the researcher
- Limited representation of wider population

Data was collected from the 11 Regional Officers and area representatives (n=)

Accessing the Sample:

Access to the Sample occurred through the 11 Regional Officers of the PNA and the area representatives across the PNA Branch Network. An invitation to participate in this research was issued by the PNA to its area representatives and Regional officers.

Project Methodology and Methods

This project is a descriptive evaluative project which will employ mixed (triangulation) methods (quantitative and qualitative). The project will utilise an electronic survey questionnaire. It is proposed to support the completion of the questionnaire through regional meetings. The findings from this on line questionnaire will subsequently inform the collection of qualitative data through Focus Groups. The Focus groups will be organised based on the advice of the PNA Executive and the Regional Officers. The focus groups will also be facilitated on a Regional/geographical basis to support the collection of data from the Branch network. Permission will be sought for participants to audio the recording of the focus groups. This was reviewed with all participants prior to undertaking data collection. Only after reviewing the participation information sheet and addressing any questions in relation to the study were participants then invited to sign a consent form. Permission was also sought to record the interview. In terms of the ground rules adopted for the focus groups there was agreement that no participants would refer to each other by name or refer to their organisation/service.

Project Findings

Data from the survey will be analysed using descriptive statistics on line, data from the Focus Groups will be transcribed in rich text format and analysed using NVivo (Qualitative software analysis package).

Ethical Issues

In terms of meeting the suggested time frame of presenting the data from the project at the 2016 ADC, it is suggested that it is prudent to seek approval from the PNA to undertake this project with its members. Prior to submitting the project proposal to the PNA for approval the proposal will be reviewed by an Expert Ethicist/Philosopher with considerable experience in ethical committees and reviewing proposals. The project will be informed by the following Ethical Principles:

In relation to this project the following principles were used to guide the project:

1. Respect for persons/autonomy
2. Beneficence and non-maleficience
3. Justice
4. Veracity
5. Fidelity
6. Confidentiality (NMBI, 2007 & 2015)

Informed consent was achieved with all participants prior to the commencement of data collection. Individual participants were provided with an on-line information sheet prior to agreeing to take part in the study. This provided the participants with details on the aim and purpose of the research, the methodology and the commitments or requirements for the participants in relation to the research process.

There are a number of ethical principles that should be taken into account when performing research or projects. At the core, these ethical principles stress the need to

(a) Do good (known as beneficence) and

(b) Do no harm (known as non-malfeasance).

In practice, these ethical principles mean that you need to:

(a) Obtain informed consent from potential research participants;

(b) Minimise the risk of harm to participants;

(c) Protect their anonymity and confidentiality;

(d) Avoid using deceptive practices; and

(e) Give participants the right to withdraw from your research.

The purpose of the project, expected duration and procedures was explained to participants or respondents.

Participants' rights to decline to participate and to withdraw from the project once it has started, as well as the anticipated consequences of doing so was made clear to participants.

Reasonably foreseeable factors that may influence their willingness to participate, such as potential risks, discomfort or adverse effects will be explained-there are none expected except the time involved in completing the questionnaire of focus group.

Any prospective research benefits-the impact that the data may have in informing the PNA in order to lobby in relation to resources.

Limits of confidentiality, such as data coding, disposal, sharing and archiving-the confidentiality of all survey and focus group participants will be maintained throughout-individuals will not be identifiable from the data or the report,

Incentives for participation- there will be no incentives provided except the encouragement of the PNA and project lead to invite the practitioner members to make a difference.

Who participants can contact with questions- the participants can contact the project coordinator directly or a nominee from the PNA executive staff.

Advantages of purposive sampling

- There are a wide range of qualitative research designs that researchers can draw on. Achieving the goals of such qualitative research designs requires different types of sampling strategy and sampling technique. One of the major benefits of purposive sampling is the wide range of sampling techniques that can be used across such qualitative research designs; purposive sampling techniques that range from homogeneous sampling through to critical case sampling, expert sampling, and more.
- Whilst the various purposive sampling techniques each have different goals, they can provide researchers with the justification to make generalisations from the sample that is being studied, whether such generalisations are theoretical, analytic and/or logical in nature.
- Qualitative research designs can involve multiple phases, with each phase building on the previous one. In such instances, different types of sampling technique may be required at each phase. Purposive sampling is useful in these instances because it provides a wide range of non-probability sampling techniques for the researcher to draw on. For example, critical case sampling may be used to investigate whether a phenomenon is worth investigating further, before adopting an expert sampling approach to examine specific issues further.

Disadvantages of purposive sampling

- Purposive samples, irrespective of the type of purposive sampling used, can be highly prone to researcher bias. The idea that a purposive sample has been created based on the judgement of the researcher or the commissioner in this study is not a good defence when it comes to alleviating possible researcher biases, especially when compared with probability sampling techniques that are designed to reduce such biases. However, this judgemental, subjective component of purpose sampling is only a major disadvantage when such judgements are ill-

conceived or poorly considered; that is, where judgements have not been based on clear criteria, whether a theoretical framework, expert elicitation, or some other accepted criteria. In this study it is contended that the PNA is justified in ascertaining from its members their experience of the implementation of the National Mental Health Policy A Vision for Change in practice.

- The subjectivity and non-probability based nature of unit selection (i.e., selecting people, cases/organisations, etc.) in purposive sampling means that it can be difficult to defend the representativeness of the sample. In other words, it can be difficult to convince the reader that the judgement you used to select units to study was appropriate. However purposive sampling was the intent of this study to ascertain on purpose the experience of members of the PNA.

Project Governance:

The project was a joint initiative between the PNA and the Faculty of Nursing RCSI and project governance was through the Secretary General of the PNA and the PNA Officer Board. The project lead reported directly to the PNA executive.

Method of collecting data.

On-Line Survey

One of the most widely utilized survey methods, an online survey is the systematic gathering of data from the target audience characterized by the invitation of the respondents and the completion of the questionnaire online. Recently this has been a faster way of collecting data from the respondents as compared to other survey methods such as paper-and-pencil method and interviews. The survey was structured using the "Survey Monkey" platform. The survey was designed and developed using the VFC as a theoretical framework. Item development reflected explicitly on the nature of service development as proposed in the national policy document. The survey was

developed by the project lead and piloted among members of the Officer Board. The survey was forwarded to each PNA Branch, prior to receiving the survey each Branch was provided with correspondence concerning the survey and it detailed a time frame for when the survey would be forwarded and an expected completion date.

Advantages of Online Survey

1.Ease of Data Gathering

The Internet is a vast virtual world that connects all kinds of people from around the globe. For this reason, a survey that requires a hundred or more respondents can be conducted faster via the Internet. The survey questionnaire can be rapidly deployed and completed by the respondents, especially if there's an incentive that is given after their participation. Rapid deployment and return times are possible with online surveys that cannot be attained by traditional methods.

2. Minimal Costs

Traditional survey methods often require you to spend thousands of dollars to achieve the optimal results. On the other hand, studies show that conducting an Internet survey facilitates low-cost and fast data collection from the target population. Sending email questionnaires and other online questionnaires are more affordable than the face-to-face method.

3. Automation in Data Input and Handling

With online surveys, the respondents are able to answer the questionnaire by means of inputting their answers while connected to the Internet. Then, the responses are automatically stored in a survey database, providing hassle-free handling of data and a smaller possibility of data errors.

4. Increase in Response Rates

Online survey provides the highest level of convenience for the respondents because they can answer the questionnaire according to their own pace, chosen time, and preferences. They can answer questions on their schedule, at their pace, and can even start a survey at one time, stop, and complete it later. Respondents may be more willing to share personal information because they're not disclosing it directly to another person. Interviewers can also influence responses in some cases.

5. Flexibility of Design

Complex types of surveys can be easily conducted through the Internet. The questionnaire may include more than one type of response format in such a way that the respondents would not get discouraged from the changes in the manner they answer the questions.

Disadvantages of Online Survey

1. Absence of Interviewer

An online survey is not suitable for surveys which ask open-ended questions because there is no trained interviewer to explore the answers of the respondents.

2. Inability to Reach Challenging Population

This method is not applicable for surveys that require respondents who do not have an access to the Internet. Some examples of these respondents include the elderly and people who reside in remote areas.

3. Survey Fraud

Survey fraud is probably the heaviest disadvantage of an online survey. There are people who answer online surveys for the sake of getting the incentive (usually in the form of money) after they have completed the survey, not with a desire to contribute to the advancement of the study.

The survey was completed from the 22nd of February to the 3rd of March 2016, a total of 69 RPNs representing the PNA branch network completed the survey on line.

Focus Group Interviews:

A focus group interview is defined as a small gathering of individuals who have a common interest or characteristic, assembled by a researcher, who uses the group and its interactions as a way to gain information about a particular issue (Hughes and DuMont, 1993 and Williams and Katz, 2001). Kreuger (1988) defines a focus group as a carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening, comfortable environment. They enable the exploration of the nuances and complexities of participants' attitudes and experiences (Hughes and DuMont, 1993). The purpose of a focus group is data collection through group interaction (Kitzinger, 1995) and they involve the explicit use of group interaction as research data (Merton, 1956 and Kitzinger 1994). Powell (1996 p 499 in Gibbs 1999) defines a focus group as a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research. Within the context of this project they were identified as a method ideal to explore with PNA members their experiences of the impact of VFC in practice based on their own service. The purpose of the focus group interview was to produce qualitative data to provide insights into the attitudes, perceptions and opinions of participants (Krueger, 1994), facilitating and highlighting their views of the VFC in the context of their practice and service experience.

Appropriate recruitment parameters were established and the population was identified. This was to ensure homogeneity within each group to capitalise on shared experiences (Kitzinger, 1995). Regional and service perameters linked to the PNA National Branch network was employed. Purposive sampling was utilised for the focus group, the groups were selected based on the research question so that it was targeting stakeholders who are interested in the phenomena under investigation

The following parameters guided the preparation, facilitation recording and analysis of focus groups conducted within this study among PNA members.

- PNA members as clinicians practicing in the mental health service have a specific experience or opinion about the topic under investigation (VFC)
- An explicit interview guide was used and it was developed following an analysis of the on-line survey
- The subjective experiences of participants were explored in relation to predetermined research questions.

A total of 9 Focus groups were facilitated nationally with a total of 65 participants. Focus group interviews were conducted between the 7th and the 22nd of March 2016.

It was considered important that the focus groups occurred within a comfortable and neutral venue, with an informal atmosphere. While it is doubtful that there is any such thing as a neutral venue it was important to ensure that the decision in relation to the venue choice rested with the participants. The majority were facilitated in hotels while one was facilitated in the Head offices of the PNA. The participants (Branch Officers) in all focus groups selected the venue which in all cases was their own work environment. While this is not a neutral venue per se, it did place the decision of venue selection in the hands of the participants

Recruitment can be difficult and time consuming. It was anticipated that as the study has immediate interest and even benefits for participants that this would hopefully lessen the challenge of recruitment. The social and professional branch networks of the PNA was utilised to great effect to attract participants. The majority of contacts made by the PNA Executive to its members were very positive, welcomed the research and were enthusiastic to participate. Coordinating and takes considerable negotiation and re-negotiation and the

PNA executive and the Branch network are commended for their efficiency and responsiveness in this regard.

The focus group sessions

There were a number of phases to the focus group interviews. The session commenced with an introduction. The researchers introduced themselves, thanked the group for agreeing to participate. By reviewing the correspondence and the project proposal the group was provided with an overview of the study, the methodology, the focus group and its purpose, how data would be verified and analysed and later how participants would have access to the data. Time was provided for questions on the process at this time. The issue of anonymity and confidentiality was clarified and it was clear from the outset that individuals and organisations would not be identifiable. The option of the participant to withdraw from the research at any stage was reiterated. Permission to audio record the interview was sought. It was explained that recording would ensure the provision of a verbatim account. It was also explained that the transcripts and recordings were to be stored by the researcher in a locked cupboard in his office. Computer recorded data was password protected. The recordings would not be made available to anyone else.

Data Collection and Study Sample

Following on their completion of an online survey questionnaire, focus group discussion were conducted with the study participants to explore their perceptions and everyday experiences of working in the mental health system within the context of *A Vision for Change* (2006). The participants were all psychiatric nurses and a total of nine focus group discussions were conducted across a range of geographical areas that included: Galway, Cavan, Monaghan and Louth, Carlow, Kilkenny, Wexford, Waterford, South Tipperary, Cork, Kerry, Limerick, Kildare, Midlands, East Dublin and North Dublin.

Topic Guide for Focus Group Discussions

Based on the findings identified in analysis of the survey data, a topic guide was drawn up whereby focus group participants were invited to discuss the following six topics:

Q1: *Within the context of VFC, outline the bed capacity challenges faced currently within your services*

Q2: *Within the context of VFC, discuss the staffing and team challenges currently experienced*

Q3: *Within the context of VFC, explore the specialist service deficits currently within the system*

Q4: *Within the context of VFC, discuss the key service infrastructure that you believe is required to support the full implementation of VFC*

Q5: *Within the context of VFC, specify the deficits experienced within the system in terms of outreach and crisis services*

Q6: *Within the context of VFC, identify your key priorities for the full implementation of VFC in practice*

Q7: *Any additional comments?*

Methodology

The data analysis methodology adopted by this study is based on the principles of thematic analysis (Braun and Clarke. 2006). Maykut and Morehouse (1994) suggest: "words are the way that most people come to understand their situations; we create our world with words; we explain ourselves with words; we defend and hide ourselves with words"; thus, in qualitative data analysis and presentation: "the task of the researcher is to find patterns within those words and to present those patterns for others to inspect (p18).

Characteristics / Defining Features of Qualitative Research

Qualitative research is based on a phenomenological position. It is a holistic approach, which takes account of contexts within which human experiences occur and is thus concerned with learning from particular instances or cases. Qualitative research seeks to access the inner world of perception and meaning-making in order to understand, describe, and explain social process from the perspective of study participants. This approach does not commence with an *a priori* hypothesis to be tested and proved but with a focus-of-inquiry that takes the researcher on a voyage of discovery as it takes an inductive approach to data analysis. Research outcomes are not broad generalisations but contextual findings; qualitative researchers tend to speak of 'transferability' (from context to context) rather than generalisability.

Thematic Analysis: Overview of Process

While qualitative research is not given to mathematical abstractions, it is nonetheless systematic in its approach to data collection and analysis. Framed by a focus-of-inquiry, whether data is collected through interviews or questionnaires, open-ended questioning allows study participants to articulate their perspectives and experiences freely and spontaneously. In analysing data generated in this format, responses are not grouped according to pre-defined categories, rather salient categories of meaning and relationships between

categories are derived from the data itself through a process of inductive reasoning known as coding. The thematic analysis approach offers the means whereby by the researcher may access and analyse these articulated perspectives so that they may be integrated in a model that seeks to describe and explain the social processes under study.

This method involves breaking down the data into discrete 'incidents' (Glaser and Strauss, 1967) or 'units of meaning' (Maykut and Morehouse, 1994)) and coding them to categories. Categories arising from this method generally take two forms; those that are derived from the participants' customs and language and those that the researcher identifies as significant to the project's focus-of-inquiry. The goal of the former "is to reconstruct the categories used by participants to conceptualise their own experiences and world view". The goal of the latter is to assist the researcher in developing theoretical insights through developing themes that illuminate the social processes operative in the site under study; thus: "the process stimulates thought that leads to both descriptive and explanatory categories" (Lincoln and Guba, 1985, pp 334-341). Categories undergo content and definition changes as units of meaning and incidents are compared and categorised, and as understandings of the properties of categories and the relationships between categories are developed and refined over the course of the analytical process. As Taylor and Bogdan (1984) summarise; "using this method, the researcher simultaneously codes and analyses data in order to develop concepts; the researcher refines these concepts, identifies their properties, explores their relationships to one another, and integrates them into a coherent explanatory model" (p126).

Using Qualitative Data Analysis Software

It must be stressed that in using qualitative data analysis software, the researcher does not capitulate the hermeneutic task to the logic of the computer; rather the computer is used as a tool for efficiency and not as a tool which in and of itself conducts analysis and draws conclusions. As Fielding and Lee (1998) explain, qualitative researchers "want tools which support analysis, but leave the analyst firmly in charge" (p167). Importantly, such software also serves as a tool for transparency. Arguably, the production of an audit trail is the key most

important criteria on which the trustworthiness and plausibility of a study can be established. Qualitative analysis software's logging of data movements and coding patterns, and mapping of conceptual categories and thought progression, render all stages of the analytical process traceable and transparent, facilitating the researcher in producing a more detailed and comprehensive audit trail (codebook) than manual mapping of this complicated process can allow

Phases and Steps Taken in the Analytical Process

Eight discrete cycles of analyses were completed across six stages as defined by Braun & Clarke, 2006. These cycles involved three separate cycles of coding; two cycles of managing codes, one for initial categorisation of open codes and one for data reduction through consolidating codes into a more abstract theoretical framework (themes) and one which uses writing itself as a tool to prompt deeper thinking of the data (Bazeley, 2009) leading to findings from which conclusions may be drawn. These eight cycles are now described and explained:

Phase 1: *Importing and familiarising* involved importing the interview transcripts and related briefing notes into a data management tool known as NVivo (QSR International Pty Ltd. Version 11, 2016); then reading and re-reading the interview data, noting down initial ideas.

Phase 2: *Generating Initial Codes (Open Coding)* involved broad participant-driven initial coding of the interviews to deconstruct the data from its original chronology into initial non-hierarchical general codes. These codes were assigned clear definitions and contained the units of meaning which were

coded from the focus group discussions content (Maykut & Morehouse 1994, pp.126-149). (Appendix[1])

Phase 3: *Searching for Themes (Developing Categories)* involved re-ordering codes identified and coded in phase 2 into categories of codes by grouping related codes under these categories and organising them into a framework that made sense to further the analysis of this particular data set and guided by the research question or focus-of-inquiry. This phase also included distilling, re-naming and merging of categories to ensure that their definitions accurately reflected coded content. Categories could be described as a halfway-house between organising initial codes into logical groups and generating themes. (Appendix[2])

Phase 4: *Reviewing Themes (Drilling Down)* involved breaking down the now restructured categories into sub-categories to offer more in-depth understanding of the highly qualitative aspects under scrutiny and to consider divergent views, negative cases, attitudes, beliefs and behaviours coded to these categories and to offer clearer insights into the meanings embedded therein. (Appendix[3])

Phase 5: *Defining and Naming Themes (Data Reduction)* involved consolidating codes from all three cycles into more abstract, philosophical and literature-based themes to create a final framework of eleven themes (Appendix[4])

[1] Appendix 1 – Codebook – Phase 2 – generating initial codes
[2] Appendix 2 – Codebook – Phase 3 – searching for themes
[3] Appendix 3 – Codebook – Phase 4 – reviewing themes
[4] Appendix 4 – Codebook – Phase 5 – defining and naming themes

Phase 6: Involved *writing analytical memos* against the higher-level themes to accurately summarise the content of each category and its codes and propose empirical findings against such categories. These memos considered 5 key areas:

1. The content of the cluster of codes on which it is reporting (what was said)
2. The coding patterns where relevant (levels of coding for example although this could be used to identify exceptional cases as well as shared experiences. (how often was something said)
3. Considering background information recorded against participants and considering any patterns that may exist in relation to participants' profiles (who said it)
4. Situating the code(s) in the storyboard – meaning considering the relatedness of themes to each other, and their importance in addressing the research question and sequencing disparate codes and clusters of codes into a story or narrative which is structured and can be expressed in the form of a coherent and cohesive research report
5. Considering primary sources in the context of relationships with the literature as well as identifying gaps in the literature.

Phase 7: *Validation* involved testing, validating and revising analytical memos so as to self-audit proposed findings by seeking evidence in the data beyond textual quotes to support the stated findings and seeking to expand on deeper meanings embedded in the data. This process involved interrogation of data and forces the consideration of elements beyond the theme itself, drawing on relationships across and between themes and cross tabulation with demographics, observations and literature. This phase resulted in evidence-based findings as each finding had to be validated by being rooted in the data itself and relied on the creation of reports from the data to substantiate findings.

Phase 8: Involved *synthesising analytical memos* into a coherent, cohesive and well-supported outcome statement or findings report offering a descriptive account of the study participants' perceptions and experiences of working within the mental health system in the context of *A Vision for Change* (2006).

Table 1 now links the stages and processes outlined above and conducted in NVivo to the practical guidelines as set out by Braun & Clarke, 2006. Their six-step approach to conducting thematic analysis is displayed in the first column while the second column displays their corresponding application in NVivo. The third column shows the strategic elements of coding as the researcher moved from initial participant-led descriptive coding, to the secondary coding which was more interpretive in nature and as such was both participant- and researcher-led, to the final abstraction to themes which is entirely researcher-led. The fourth column shows the iterative nature of the tasks as the coding, analysis and write-up proceeds towards conclusion:

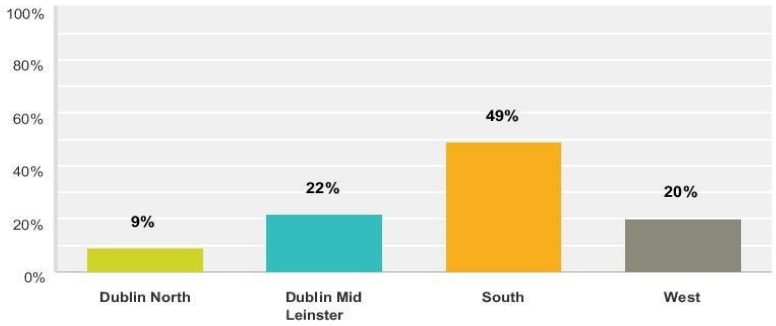
Chapter 3 Findings

Section 1 (Survey Findings)

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q1 Which geographical area best describes where your service is based

Answered: 65 Skipped: 4



Answer Choices	Responses	
Dublin North (1)	9%	6
Dublin Mid Leinster (2)	22%	14
South (3)	49%	32
West (4)	20%	13
Total		65

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	4.00	3.00	2.80	0.86

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q2 Enter the name of your PNA branch here

Answered: 56 Skipped: 13

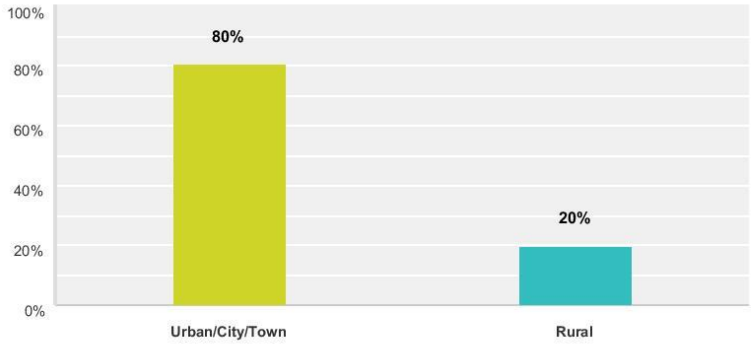
#	Responses	Date
1	limerick	3/13/2016 11:04 PM
2	Kildare	3/2/2016 9:12 PM
3	south lee	3/2/2016 2:35 PM
4	carlow	3/1/2016 9:02 PM
5	St. Brigid's Hosp BAllinasloe	3/1/2016 5:57 PM
6	Louth	3/1/2016 4:22 PM
7	St. Loman's, Dublin	3/1/2016 12:14 PM
8	Kildare/West Wicklow	3/1/2016 9:47 AM
9	Mullingar	3/1/2016 9:30 AM
10	Sligo Leitrim	2/29/2016 5:29 PM
11	Sligo/ Leitrim	2/29/2016 4:55 PM
12	south lee	2/29/2016 3:48 PM
13	St Canice's Kilkenny	2/29/2016 1:45 PM
14	monaghan	2/29/2016 11:04 AM
15	St. James,s Hospital Jonathan Swift Clinic	2/29/2016 10:41 AM
16	Donegal	2/29/2016 9:09 AM
17	Kerry Mental Health Service	2/29/2016 8:44 AM
18	St Senans (Wexford)	2/28/2016 8:14 PM
19	LOUTH	2/28/2016 6:44 PM
20	LIMERICK/NORTH TIPPERARY	2/28/2016 5:14 PM
21	St Iomans, Dublin	2/28/2016 4:04 PM
22	Cork North Lee	2/28/2016 3:44 PM
23	St Fintans portlaoise	2/28/2016 2:25 PM
24	mayo mental health service	2/28/2016 9:26 AM
25	Kerry Mental Health Services	2/27/2016 7:15 PM
26	st otteran's	2/27/2016 2:31 PM
27	St Ita's Hospital DNMH	2/27/2016 12:09 PM
28	West Cork	2/27/2016 12:29 AM
29	Limerick/North Tipperary	2/26/2016 5:56 PM
30	Vergemount, Area2, & St. Vincents	2/26/2016 4:36 PM
31	Dublin North Central	2/26/2016 2:24 PM
32	Newcastle Hospital	2/26/2016 1:45 PM
33	South Tipperary Mental Health	2/26/2016 1:20 PM
34	St Brendans	2/26/2016 11:46 AM
35	St Stephen's	2/26/2016 12:00 AM
36	ROSCOMMON	2/25/2016 8:11 PM
37	St John of God Community Services.	2/25/2016 11:42 AM
38	north kerry	2/24/2016 8:22 PM

39	Waterford	2/24/2016 8:21 PM
40	Waterford	2/24/2016 1:45 PM
41	Waterford branch	2/24/2016 1:42 PM
42	St Otterans	2/24/2016 1:26 PM
43	Waterford	2/24/2016 1:26 PM
44	South Lee	2/24/2016 11:34 AM
45	Kerry	2/24/2016 11:27 AM
46	Killarney	2/24/2016 9:45 AM
47	Kerry	2/24/2016 9:03 AM
48	South Lee, Cork	2/24/2016 2:04 AM
49	carlow	2/23/2016 8:54 PM
50	West Galway	2/23/2016 4:39 PM
51	Donegal	2/23/2016 3:44 PM
52	Kildare	2/23/2016 2:04 PM
53	South Lee	2/23/2016 12:15 PM
54	sjog	2/23/2016 10:07 AM
55	Clare Mental Health Services	2/23/2016 2:46 AM
56	St Canice's Kilkenny	2/22/2016 5:19 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q3 Please enter if you work in an urban or rural setting

Answered: 56 Skipped: 13



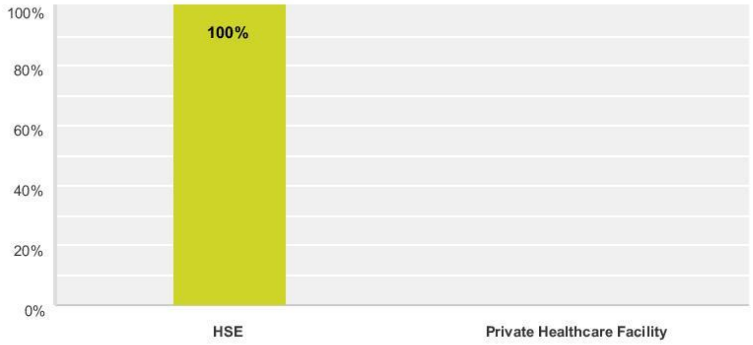
Answer Choices	Responses	
Urban/City/Town (1)	80%	45
Rural (2)	20%	11
Total		56

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.20	0.40

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q4 Do you work in the HSE or a Private Healthcare Facility?

Answered: 55 Skipped: 14



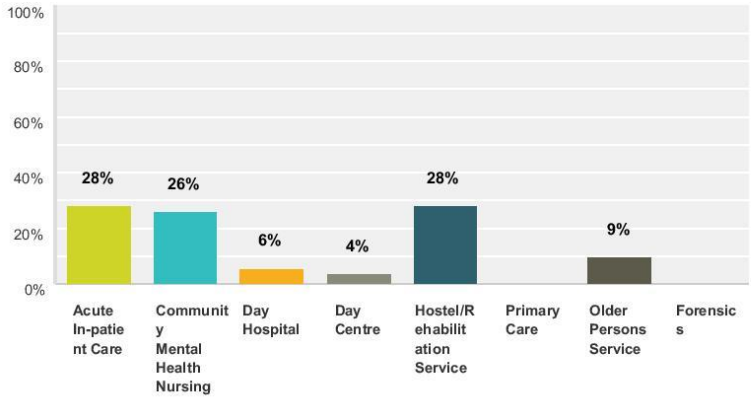
Answer Choices	Responses	
HSE (1)	100%	55
Private Healthcare Facility (2)	0%	0
Total		55

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	1.00	1.00	1.00	0.00

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q5 Which of the following describes your current area of practice within Adult Mental Health Services?

Answered: 54 Skipped: 15



Answer Choices	Responses	
Acute In-patient Care (1)	28%	15
Community Mental Health Nursing (2)	26%	14
Day Hospital (3)	6%	3
Day Centre (4)	4%	2
Hostel/Rehabilitation Service (5)	28%	15
Primary Care (6)	0%	0
Older Persons Service (7)	9%	5
Forensics (8)	0%	0
Total		**54**

Basic Statistics				
Minimum	**Maximum**	**Median**	**Mean**	**Standard Deviation**
1.00	7.00	2.00	3.15	1.99

#	Other (please specify)	Date
1	Home Based Treatment Team	3/1/2016 12:15 PM
2	all of the above except for forensics	2/29/2016 1:45 PM
3	Liaison mental health	2/27/2016 2:32 PM
4	area has acute,community, poa,day centre day hospital	2/26/2016 4:36 PM
5	Based in hostel but constantly being moved to acute unit	2/24/2016 9:07 AM
6	Mental health	2/23/2016 2:05 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q6 Please state the population of your catchment area

Answered: 49 Skipped: 20

#	Responses	Date
1	191165	3/2/2016 2:36 PM
2	58000 approx	3/1/2016 9:03 PM
3	GR 5 is 50,000, my area is 25,000	3/1/2016 5:58 PM
4	144,00	3/1/2016 4:26 PM
5	40,000	3/1/2016 12:16 PM
6	210000	3/1/2016 9:48 AM
7	126000	3/1/2016 9:30 AM
8	75,000	2/29/2016 5:29 PM
9	250,000	2/29/2016 4:56 PM
10	approx 218,747 for CW KK ST. 75,715 for kilkenny	2/29/2016 1:45 PM
11	55000 approx	2/29/2016 11:07 AM
12	45298	2/29/2016 10:45 AM
13	151,000	2/29/2016 9:09 AM
14	50,000	2/29/2016 8:45 AM
15	CSO 2011- county wexford population 145,320	2/28/2016 8:23 PM
16	APPROX 270000	2/28/2016 5:16 PM
17	290,000	2/28/2016 4:05 PM
18	189,000	2/28/2016 3:44 PM
19	180,000 approx	2/28/2016 2:28 PM
20	50,000	2/28/2016 9:27 AM
21	146 approx based on 2011 census	2/27/2016 7:54 PM
22	200000	2/27/2016 2:32 PM
23	250000	2/27/2016 12:11 PM
24	Approx 60,000	2/27/2016 12:29 AM
25	190000 approx	2/26/2016 6:07 PM
26	140000 ? some boundary changes	2/26/2016 4:38 PM
27	154,126	2/26/2016 2:25 PM
28	250,000	2/26/2016 1:45 PM
29	98000	2/26/2016 1:22 PM
30	117,000 Blanchardstown West (Dublin North 400,000)	2/26/2016 11:47 AM
31	60000	2/26/2016 12:01 AM
32	65,000	2/25/2016 8:12 PM
33	18-64	2/25/2016 11:42 AM
34	24,000	2/24/2016 8:23 PM
35	150000?	2/24/2016 8:21 PM
36	191,162	2/24/2016 2:18 PM
37	400,000	2/24/2016 1:46 PM

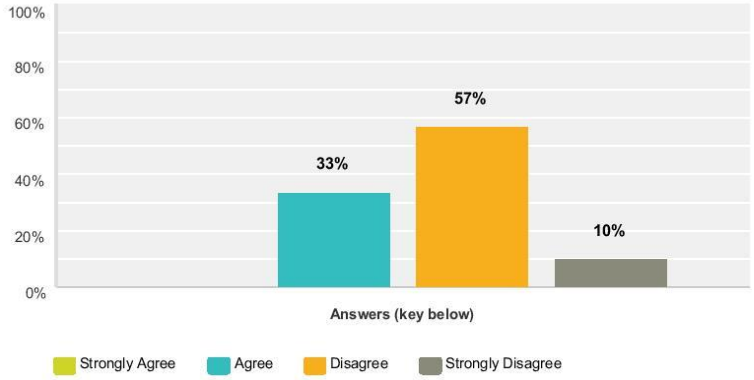
An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

38	278000	2/24/2016 1:44 PM
39	300000	2/24/2016 1:27 PM
40	190,000	2/24/2016 2:08 AM
41	58000	2/23/2016 8:55 PM
42	53400	2/23/2016 4:42 PM
43	75000	2/23/2016 3:45 PM
44	226,000	2/23/2016 2:05 PM
45	30,200	2/23/2016 12:20 PM
46	180,000	2/23/2016 10:09 AM
47	377,000 population	2/23/2016 2:47 AM
48	CW/KK/ST approx 245,000	2/22/2016 9:38 PM
49	jlkj	2/22/2016 11:55 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q7 Please state the extent to which you agree or disagree with the following statementI work within a well-trained, fully staffed; community based multi-disciplinary Community mental health team.

Answered: 51 Skipped: 18



	Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)	Total	Weighted Average
Answers (key below)	0% 0	33% 17	57% 29	10% 5	51	3.43

Basic Statistics				
Minimum 2.00	Maximum 4.00	Median 3.00	Mean 2.76	Standard Deviation 0.61

#	Additional Comments	Date
1	Staff levels at critical low	3/2/2016 9:13 PM
2	there is no full time community mental health centre and no intensive care unit	3/2/2016 3:36 PM
3	OUr team is well trained, not fully staffed	3/1/2016 5:59 PM
4	catchment 75,715	2/29/2016 1:49 PM
5	No crisis house in situ ,limited early intervention teams	2/28/2016 5:18 PM
6	teams short of nursing and allied professionals	2/28/2016 2:29 PM
7	consultant is locum and is based in catchment area 2 days per week for out patient clinic	2/28/2016 9:28 AM
8	No crisis house and no ICRU no proper team bases many vacant posts for different disciplines	2/27/2016 7:55 PM
9	Severe staff shortages	2/27/2016 12:12 PM
10	No ICRU or Crisis house. Limited early intervention teams	2/26/2016 6:09 PM
11	have consultants,no adult icru,have mix of other facilities	2/26/2016 4:42 PM
12	MDT of circu 25,000 population with one consultant no crisis house . we have full MDT members but not full MDT working. Home care is provided from two different bases one team covers two sector areas (9places available) and the other covers four sector areas (7 places available over the 4 sector areas) two day hospitals one covers 2 sectors and provides 12 places over 7 days a week 365 a year Other day hospital has 26 places available again 7 days a weeks 365 days a year. Early interventions not fully rolled out	2/26/2016 2:39 PM
13	No homecare team, Restpite, crisis house.	2/26/2016 11:50 AM
14	Currently alot of rotation of consultants within this area.No team co -ordinator. Social worker not replaced for maternity leave.	2/25/2016 8:17 PM

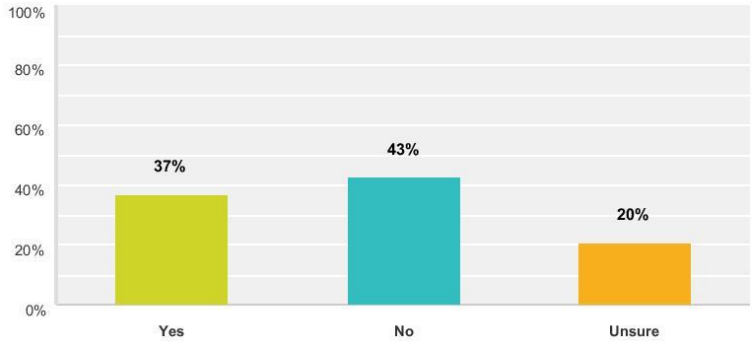
An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

15	we use a large amount of agency and retired staff	2/23/2016 8:56 PM
16	By no means fully staffed	2/23/2016 4:47 PM
17	No crisis house	2/23/2016 10:10 AM
18	In Kilkenny we have a general adult approved centre which caters for admissions for CW/KK/ST. We have 6 CMHNs and 3 consultant psychiatrists which make up the community team. Also a HBTT with 6 WTE of staff nurses in the community. Our crisis house is located in Carlow with 12 beds. We currently have no access to an ICRU.	2/23/2016 8:37 AM
19	gfhgf	2/22/2016 11:56 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q8 Does your catchment area satisfy the VFC specified population of between 250,000 and 400,000?

Answered: 49 Skipped: 20



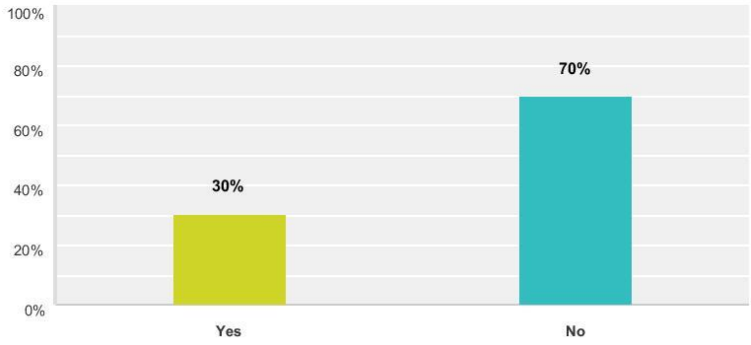
Answer Choices	Responses	
Yes (1)	37%	18
No (2)	43%	21
Unsure (3)	20%	10
Total		49

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.84	0.74

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q9 Are your services evaluated with meaningful performance indicators annually to assess the added value the service is contributing to the mental health of the local catchment area population?

Answered: 46 Skipped: 23



Answer Choices	Responses	
Yes (1)	30%	14
No (2)	70%	32
Total		46

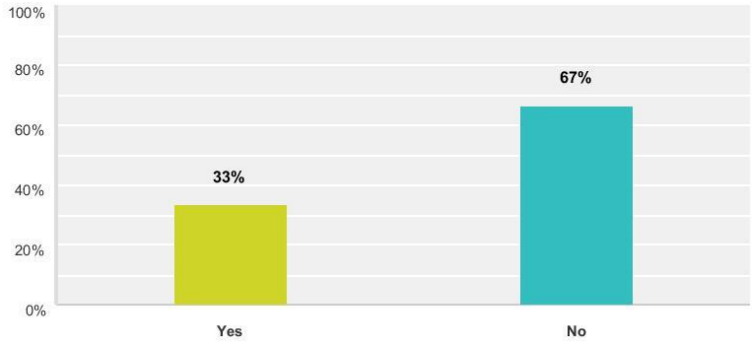
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.70	0.46

#	Additional Comments	Date
1	national perfermonance indicators i.e number of referrals, wait times, admission rates etc. Also local indicators based on the service plan	3/2/2016 3:38 PM
2	Our acute service is audited regarding compliane with MCH MDT care plans.	3/1/2016 4:31 PM
3	I am not sure	2/29/2016 5:36 PM
4	performance indicators are submitted from all areas of service and these stats are considered when developing the operation plan	2/29/2016 1:49 PM
5	Quality care metrics and regulatory risk procedures under the mental health commission framework	2/28/2016 3:51 PM
6	kpi's completed annually	2/28/2016 9:28 AM
7	We have KPIs for the area - these are set by the HSE	2/27/2016 12:34 AM
8	MH commission visits ABA Visits	2/26/2016 4:44 PM
9	Measeurements are quantitative in nature does not reflect complexitvy of work load. It measures waiting lists and did not attends	2/26/2016 2:53 PM
10	no evaluation/no feedback	2/26/2016 1:46 PM
11	Basic stats to hse focusing on quantaty over quality.	2/26/2016 11:50 AM
12	UNSURE.	2/25/2016 11:43 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q10 Has a multi professional manpower plan linked to projected service planning been put in place in your catchment area?

Answered: 42 Skipped: 27



Answer Choices	Responses	
Yes (1)	33%	14
No (2)	67%	28
Total		42

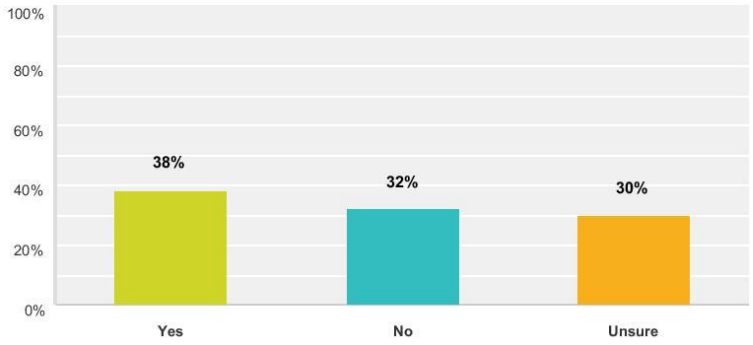
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.67	0.47

#	Additional Comments	Date
1	i believe it is carried out at senior managment	3/2/2016 3:41 PM
2	Unsure	3/1/2016 6:11 PM
3	If there is a manpower paln it ha snot been communicated to our workforce or their union representatives . PNA have asked at meetings . Response :"that is not in the remit of this meeting"	3/1/2016 4:32 PM
4	I assume so	2/29/2016 5:36 PM
5	regular meetings, linked to hse service plan	2/29/2016 1:49 PM
6	In theform of a senior management team	2/28/2016 8:44 PM
7	at present not aware of same	2/28/2016 5:19 PM
8	Unsure	2/27/2016 12:13 PM
9	We have no workforce planning	2/27/2016 12:35 AM
10	area don has manpower planning plan	2/26/2016 4:45 PM
11	Unaware if there is an actual plan but do know that head of disciplines discuss staffing deficient at area meetings and place issues on the riisk register	2/26/2016 3:07 PM
12	not aware of one we are never consulted	2/26/2016 1:46 PM
13	Adhoc planning of services, can barely staff what we have available.	2/26/2016 11:52 AM
14	not that i am aware of	2/25/2016 8:18 PM
15	But...	2/23/2016 2:11 PM
16	A plan was put in place when the catchments were being amalgamated. However the moratorium, retirements and recruitment issues have hampered same.	2/23/2016 8:42 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q11 Within your adult mental health service is there a fully staffed; community based multi-disciplinary Community Mental Health Teams serving a population of 50,000 people aged 18-64 years?

Answered: 47 Skipped: 22



Answer Choices	Responses	
Yes (1)	38%	18
No (2)	32%	15
Unsure (3)	30%	14
Total		47

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.91	0.82

#	If you have answered 'No', please support with additional comments	Date
1	Not fully staffed	3/2/2016 9:14 PM
2	we have a comprehensive mdt but no psychologist allocated to the team	3/2/2016 3:45 PM
3	According to exact guidelines our service is fully staffed, per 50,000 although on the ground the psychology waiting list is 6 -8 months, under our new Consultant in patients are the priority, 6-8 nurses is not sufficient in a pop of 50, 000 esp when crisis team is embedded in this team and not seperate.. Extra staff nurses are needed when home based treatment team and crisis team are embedded within the team and are not separate in my area	3/1/2016 6:11 PM
4	Community Staff Nurses have no defined roll.	2/29/2016 4:59 PM
5	vacant psychologist and family therapist post all other positions filled	2/29/2016 1:50 PM
6	The service areas are inadequately staffed	2/28/2016 8:57 PM
7	teams serve over the 50,000 pop	2/28/2016 4:06 PM
8	Teams not fully staffed	2/28/2016 3:52 PM
9	teams missing allied professionals	2/28/2016 2:31 PM
10	we have 6 RPNs	2/27/2016 12:36 AM
11	have consultantants @ 7cmhns + home care team	2/26/2016 4:50 PM
12	single CMHT of around 25,000 population but does not match the working framework of VFC some vacancies remained unfilled	2/26/2016 3:09 PM
13	9 to 5 team fully staffed, no out of hours service, larger population than 50k	2/26/2016 11:53 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

14	team is missing.... 1.psychologist, 1social worker, 1 ot shared over other areas,3cmhn, 1 addiction cllr. no support staff. no team co-ordinator.	2/25/2016 8:28 PM
15	We have an enlarged team with some additional resources to serve our catchment	2/24/2016 10:08 PM
16	Missing 1xot and 1xsw	2/23/2016 7:41 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q12 If 'Yes', how many?

Variable: 1 Answered: 19 (27.54%)

#	Responses	Date
1	1	3/2/2016 3:46 PM
2	3	2/29/2016 9:13 AM
3	10	2/29/2016 8:47 AM
4	7 in total	2/28/2016 5:21 PM
5	5 teams with only 2 CMHNs	2/28/2016 3:55 PM
6	5 nursing staff - 4rpn's. 1 cmhn .	2/28/2016 9:31 AM
7	Three	2/27/2016 8:03 PM
8	6	2/27/2016 2:36 PM
9	Two	2/27/2016 12:15 PM
10	6 teams working with population of around 25,000 each total catchment area of 154,126	2/26/2016 3:12 PM
11	2 cmhn one consultant one ot one sw one day centre 3 staff nurses one cnm2 daycentre one cnm2 metabolic screening	2/26/2016 1:51 PM
12	3	2/26/2016 1:24 PM
13	4	2/26/2016 11:54 AM
14	1	2/26/2016 12:03 AM
15	?	2/24/2016 8:23 PM
16	5	2/24/2016 9:17 AM
17	5	2/24/2016 2:11 AM
18	4.5	2/23/2016 2:12 PM
19	There are 6 adult teams serving 377,000 population.	2/23/2016 2:58 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q12 If you answered 'No', please support with additional comments

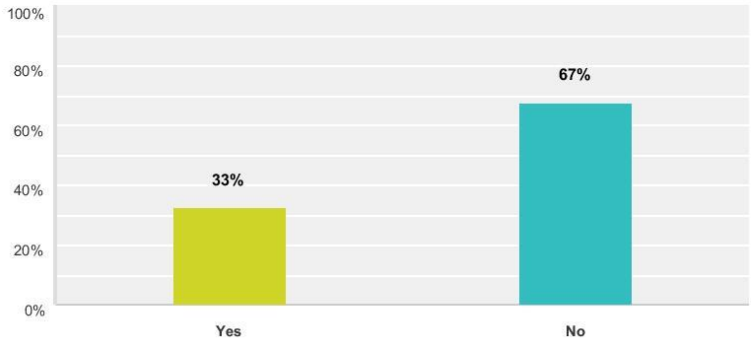
Variable: 2 Answered: 0 (0%)

#	Responses	Date
	There are no responses.	

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q13 Within your adult mental health service is there a fully staffed; community based multi-disciplinary Rehabilitation and recovery mental health service serving a population of 100,000 people?

Answered: 43 Skipped: 26



Answer Choices	Responses	
Yes (1)	33%	14
No (2)	67%	29
Total		43

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.67	0.47

#	If you have answered 'No', please support with additional comments	Date
1	Not fully staffed	3/2/2016 9:14 PM
2	there are staff allocated to rehab and recovery but it is not fully resourced or staffed	3/2/2016 3:46 PM
3	Consultant was just appointed this week.. He is over 65!! Team is being newly formed so I'm unsure of numbers	3/1/2016 6:12 PM
4	There is 1 Assertive Outreach Team which is 1 CNM 2 and 3 staff nurses. THE AOT team services all the sectors. They do not have a social worker, OT, psychologist. PNA have queried lack of a rehab consultant and Social worker , OT. Response from nurse management " taht is out side the remit of this meeting. Each CMHT has an OT and Social worker that the AOT nurses can use".	3/1/2016 4:40 PM
5	Rehab Team in name only	3/1/2016 9:31 AM
6	As befor community staff nurses have no defined roll.	2/29/2016 5:00 PM
7	some allied health professional vacancies. catchment 130,315	2/29/2016 1:51 PM
8	not FULLY staffed	2/29/2016 11:11 AM
9	This service is partially in place and also is under staffed	2/28/2016 9:01 PM
10	One assertive outreach team - nursing,ot, p/t psychology, access to s/w on community teams per total catchment population	2/28/2016 4:07 PM
11	Not full staff compliment	2/28/2016 3:55 PM
12	short allied staff	2/28/2016 2:31 PM
13	referrals only to r&r in castlebar, mayo...does not cover ballina	2/28/2016 9:31 AM
14	Rehab CMHT serves 146,000 poorly staffed.	2/27/2016 8:03 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

15	We have no rehabilitation team	2/27/2016 12:37 AM
16	Have just commenced Rehab With dedicated people	2/26/2016 4:52 PM
17	One CNS -one vacancy for CNS- population of 152,000	2/26/2016 3:12 PM
18	no rehabilitation happeing within the community. all treatment based in the day centre which is institutionalised and innappropriate. staff nurses not permitted to leave the building to visit people at home and integrate them into society. main focus is to increase numbers attending day centre which should be reduced as will be closing when new primary healthcare building occurs	2/26/2016 1:51 PM
19	Not the recovery team	2/26/2016 12:03 AM
20	Currently been developed. Consultant in place for coming year. OT in place. Training in Recovery been rolled out now for all staff.	2/25/2016 8:30 PM
21	we dont have a rehabilitation consultant or SW	2/24/2016 2:21 PM
22	Team dismantled, only 5xcns, 1xadon and 3xca remain	2/23/2016 7:42 PM
23	only 1 newly formed team - not fully staffed	2/23/2016 4:50 PM
24	There is a rehab team but it serves about over 200,000	2/23/2016 2:58 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q14 If yes, how many?

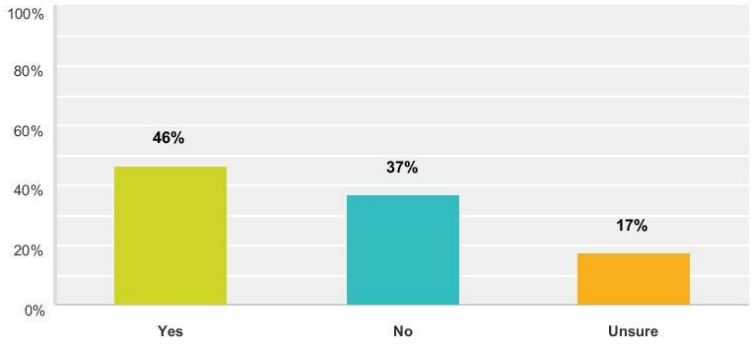
Answered: 20 Skipped: 49

#	Responses	Date
1	1 cns and one consultant	3/2/2016 3:47 PM
2	2 Multidisiplinary Teams	2/29/2016 10:49 AM
3	0	2/29/2016 9:13 AM
4	12	2/29/2016 8:47 AM
5	one	2/28/2016 5:21 PM
6	1	2/28/2016 3:56 PM
7	1	2/27/2016 4:07 PM
8	2	2/27/2016 2:36 PM
9	Two	2/27/2016 12:15 PM
10	2nurses linked with day centre & hostels	2/26/2016 4:54 PM
11	1	2/26/2016 1:24 PM
12	2	2/26/2016 11:54 AM
13	1	2/26/2016 12:03 AM
14	Three teams.	2/25/2016 11:48 AM
15	?	2/24/2016 8:23 PM
16	1	2/24/2016 1:50 PM
17	1	2/24/2016 9:18 AM
18	0	2/24/2016 2:11 AM
19	1	2/23/2016 2:12 PM
20	1 team	2/23/2016 3:00 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q15 Within your adult mental health service is there a fully staffed; community based multi-disciplinary mental health service for older people serving a population of 100,000 people

Answered: 41 Skipped: 28



Answer Choices	Responses	
Yes (1)	46%	19
No (2)	37%	15
Unsure (3)	17%	7
Total		41

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.71	0.74

#	If you answered, 'No, please support with additional comments	Date
1	there is a team in carlow kilkenny for psych of later life but it is not fully staffed	3/2/2016 3:47 PM
2	There is a CNM2 and 1 staff nurse, a psychologist, no OT. There may be a social worker	3/1/2016 4:52 PM
3	No CBT in place.	2/29/2016 5:01 PM
4	catchment is 130,315.	2/29/2016 1:52 PM
5	as joint service with Cavan services	2/29/2016 11:13 AM
6	one PLL team per total catchment population	2/28/2016 4:07 PM
7	Only one consultant and one nurse	2/28/2016 3:57 PM
8	No Consultant previous two resigned	2/27/2016 8:05 PM
9	we have ?o.2 of a consultant only	2/27/2016 12:38 AM
10	Do not have team social worker	2/26/2016 3:20 PM
11	Larger population than 100,000 not fully staffed.	2/26/2016 11:55 AM
12	Not enough staff	2/26/2016 12:04 AM
13	New development,facilitating homevisits only at prsent	2/25/2016 11:22 AM
14	no consultant led team	2/24/2016 8:28 PM
15	Missing 1x consultant and 4xcmhn	2/23/2016 7:42 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q16 If 'yes, how many?

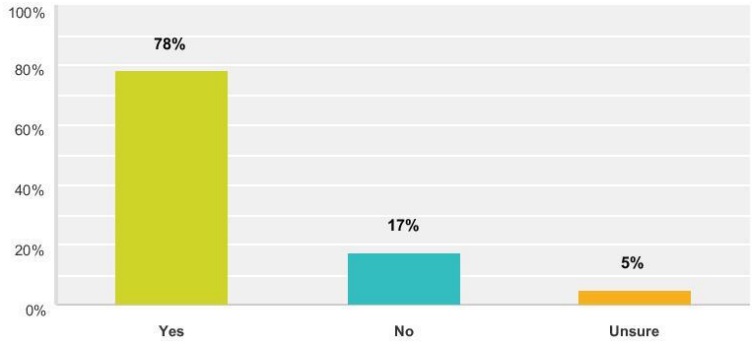
Answered: 18 Skipped: 51

#	Responses	Date
1	2 teams	3/1/2016 9:32 AM
2	1 for the total catchment of CW KK	2/29/2016 1:52 PM
3	1.5	2/29/2016 9:13 AM
4	one at present awaiting for 2nd team for north tipp area	2/28/2016 5:22 PM
5	1	2/28/2016 3:57 PM
6	One	2/28/2016 2:32 PM
7	Full time consultant and 3 CNS	2/28/2016 9:32 AM
8	2	2/27/2016 2:36 PM
9	one	2/27/2016 12:16 PM
10	new team consultant one reg 3 cmhns ot sw psychology but no clinics running as of yet	2/26/2016 1:52 PM
11	1	2/26/2016 1:25 PM
12	1	2/25/2016 8:30 PM
13	One	2/25/2016 11:23 AM
14	?	2/24/2016 8:23 PM
15	1	2/24/2016 1:50 PM
16	1.5	2/24/2016 2:12 AM
17	2	2/23/2016 4:50 PM
18	1 team	2/23/2016 3:01 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q17 Within your adult mental health service is there appropriate access to in-patient admission facilities?

Answered: 41 Skipped: 28



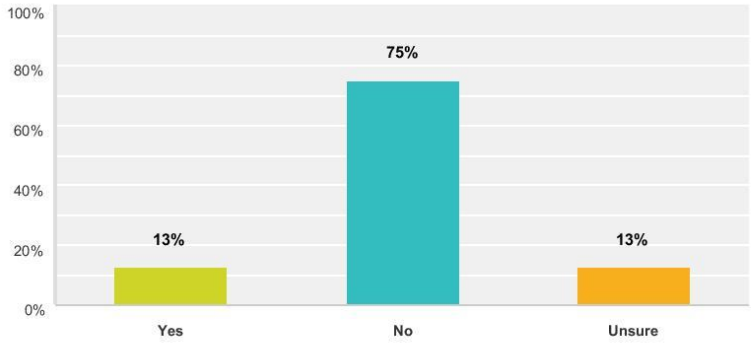
Answer Choices	Responses	
Yes (1)	78%	32
No (2)	17%	7
Unsure (3)	5%	2
Total		41

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.27	0.54

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q18 Within your adult mental health service are you satisfied that is there a fully staffed; community based multi-disciplinary mental health service to ensure home based treatment is the main method of treatment delivery?

Answered: 40 Skipped: 29



Answer Choices	Responses	
Yes (1)	13%	5
No (2)	75%	30
Unsure (3)	13%	5
Total		40

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	2.00	0.50

#	If you answered 'no', please support with additional comments	Date
1	Only one home based team and it does not operate as home are is intended	3/2/2016 9:16 PM
2	there are a team of nurses on a hbtt but no other disciplines	3/2/2016 3:48 PM
3	Because of lack of in pt beds community services are stretched, it is difficult to provide care to anybody else only those in crisis	3/1/2016 6:14 PM
4	There are no teams with 2 consultants. Each consultant has 1 CMHN assigned. There is 1 Home Base Treatemnt team with 4 staff nurses and a CNM2 working 9-5 which services teh enire county of 144,000. Thre is no addcition counsellors assigned . There is 2 alcohol counsellors for the entire 144,000. They do not eal with substance misuse.	3/1/2016 5:13 PM
5	OPD and inpatient care main methods of treatment	3/1/2016 9:32 AM
6	No defined roll for community staff nurses.	2/29/2016 5:02 PM
7	nurses only link with cmht regarding further input from other disciplines	2/29/2016 1:54 PM
8	We have multi purpose CMHTs	2/29/2016 9:15 AM
9	We have no home based treatment teams in place, bar CMHN'S attached to each adult CMHT	2/28/2016 9:11 PM
10	staffing resources an ongoing issue with transfer of staff from community teams to support acute centre occuring on a daily bacis . outreach programme disbanded in north tipp area	2/28/2016 5:24 PM
11	One consultant and five nurses	2/28/2016 3:59 PM

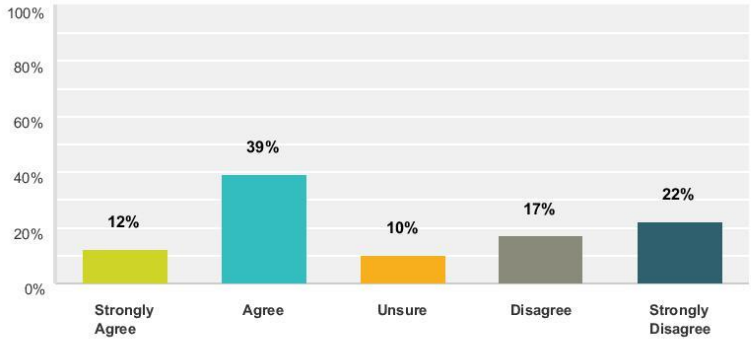
An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

12	1 consultant operates HBT delivery	2/27/2016 8:08 PM
13	no home based treatment teams. no day center in waterford city, no day hsp in west waterford, day hsp in Waterford city not open weekends. no assertive outreach teams	2/27/2016 2:38 PM
14	Not enough teams for population	2/27/2016 12:17 PM
15	We have 1 RPN (employed by NLN) on a home based team	2/27/2016 12:41 AM
16	Vacancies within some of the teams	2/26/2016 3:22 PM
17	no emphasis on community treatment. main focus is on inpatient care. no development, no auditing, no feedback, no cmhns meetings, no cmhn at any management meeting	2/26/2016 1:54 PM
18	Home based Treatment is an option but not the main method of treatment	2/26/2016 1:41 PM
19	caseload numbers of 80 clients makes this impossible, clinic based.	2/26/2016 11:56 AM
20	Not multidisciplinary	2/26/2016 12:05 AM
21	unstructured home based treatment set up last year. 1 cnm2 3 full time and 2 part time staff nurses. referrals from consultants on cmht	2/25/2016 8:33 PM
22	One homecare based team (1cnm2, 4 s/n) not fully functional as cross covering with day hospital	2/25/2016 11:27 AM
23	we had 4 nurses working as a home based service however, they are redeployed	2/24/2016 2:24 PM
24	No hbt	2/24/2016 1:51 PM
25	the service hasbeen cut drasticlly in recent years with reduced staff and closure of staffed hostels	2/23/2016 9:01 PM
26	Too much focus on inpatient in terms of funds, over reliance on in patient treatment	2/23/2016 7:43 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q19 Within your adult mental health service you are based in and operating from a community mental health centre/primary health centre?

Answered: 41 Skipped: 28



Answer Choices	Responses	
Strongly Agree (1)	12%	5
Agree (2)	39%	16
Unsure (3)	10%	4
Disagree (4)	17%	7
Strongly Disagree (5)	22%	9
Total		41

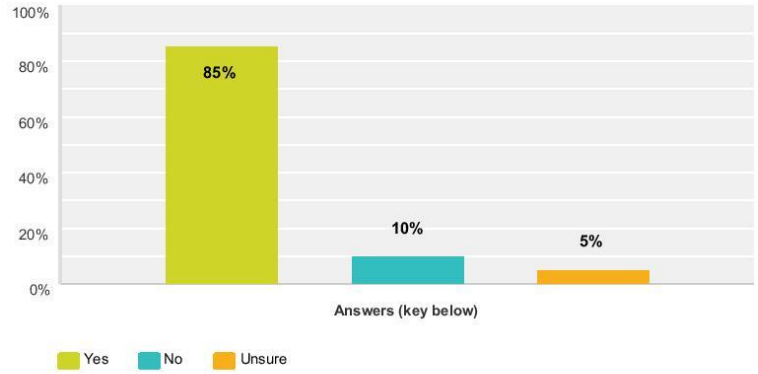
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	2.00	2.98	1.39

#	Additional Comments	Date
1	there is a satellite clinic in tullow and the option to avail of assessment facilities in the carlow primary care centre but this is not currently availed of	3/2/2016 3:49 PM
2	our service is run from one large day hospital in the grounds of St Canice's Hospital	2/29/2016 1:55 PM
3	No identified team base	2/27/2016 8:10 PM
4	Not operated from primary care - any access is secondary	2/27/2016 12:43 AM
5	partley	2/26/2016 4:55 PM
6	Some sector teams based in stand alone buildings	2/26/2016 3:23 PM
7	based in an old hse day care centre that is institutionalised. new build beginning now	2/26/2016 1:55 PM
8	Half of the blancahrdstown team are in a primary care center and the other half in an industrial estate not fit for purpose building.	2/26/2016 11:58 AM
9	our day hospital does not have full time nchd or consultant cover	2/23/2016 9:02 PM
10	Based within a primary care centre with gp and huge primary care centre	2/23/2016 7:44 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q20 Within your adult mental health service do you have access to one acute in-patient unit per 300,000 population with 35 beds?

Answered: 41 Skipped: 28



	Yes (1)	No (2)	Unsure (3)	Total	Weighted Average
Answers (key below)	85% 35	10% 4	5% 2	41	1.20

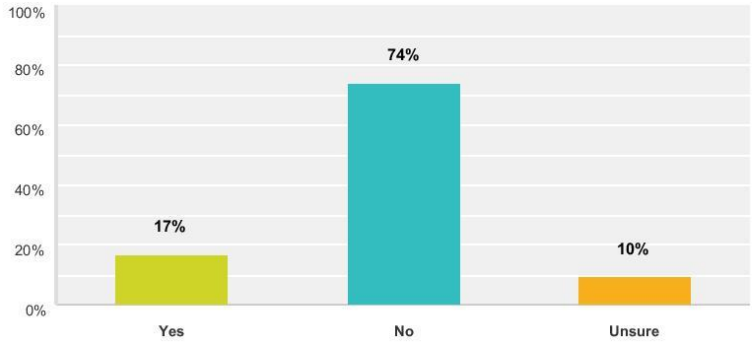
Basic Statistics				
Minimum 1.00	Maximum 3.00	Median 1.00	Mean 1.20	Standard Deviation 0.50

#	Additional Comments	Date
1	Unsure of population but there is a 29 inpatient unit	3/2/2016 9:16 PM
2	there are 44 beds in the dept of psychiatry in st. Lukes hospital kilkenny	3/2/2016 3:50 PM
3	But beds are blocked by long term patients and difficult to get acute care	3/1/2016 6:15 PM
4	44 bedded unit	2/29/2016 1:55 PM
5	awiting of redevelopment completion of acute unit of 50 bedded unit	2/28/2016 5:26 PM
6	32 ACUTE BEDS ONLY	2/28/2016 9:34 AM
7	bed occupancy rates at 100% plus. clients regularly nursed on corridors in acute unit	2/27/2016 2:40 PM
8	we have 18 acute beds - see Higgins report re geographical spread	2/27/2016 12:44 AM
9	Often clients in crisis cannot access these beds due to the ward having no bed available.	2/26/2016 11:59 AM
10	acute unit in Roccommon 22 beds	2/25/2016 8:35 PM
11	29 beds, mixed unit for 226,000.....heavily reliant on other acute units	2/25/2016 11:31 AM
12	one unit closed for refurbishments	2/24/2016 8:31 PM
13	the carlow service has been amalgamated with kilkenny and south tipperery causing a serious lack of access to acute beds	2/23/2016 9:03 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q21 Within your adult mental health service do you have access to one crises house per 300,000 population with 10 places?

Answered: 42 Skipped: 27



Answer Choices	Responses	
Yes (1)	17%	7
No (2)	74%	31
Unsure (3)	10%	4
Total		42

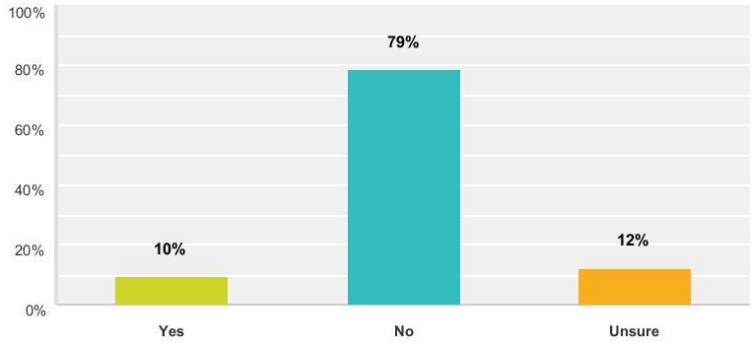
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.93	0.51

#	Additional Comments	Date
1	12 crisis beds in greenbanks house	3/2/2016 3:51 PM
2	CHostel beds are being reduced. Previous residents of hostels are in stand alone accommodation with no access to mental health support after 5 pm. Homelessness is becoming a major feature of discharged persons	3/1/2016 5:16 PM
3	2 houses of 10 beds and 14 beds in Tipperary and carlow. But in Carlow approx half the beds are occupied by long stay patients from other hostels	2/29/2016 1:55 PM
4	Respite support available in High support hostels	2/29/2016 9:16 AM
5	This is not called a crisis house its referred to as a respite unit	2/28/2016 9:14 PM
6	no crisis facility at all in west cork	2/27/2016 12:45 AM
7	2 hs hostels 30 beds overcrowded	2/26/2016 4:56 PM
8	all staff were removed from Ellerslie House which used to house the patients who were in need of admission or close to dc causing increase in admissions	2/26/2016 1:56 PM
9	No crisis house avalable.	2/26/2016 11:59 AM
10	No crisis house	2/25/2016 11:32 AM
11	however it has been used to house long term rehab clients due to a lack of appropriate hostel places	2/23/2016 9:04 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q22 Within your adult mental health service do you have a well-resourced Assertive Outreach team

Answered: 42 Skipped: 27



Answer Choices	Responses	
Yes (1)	10%	4
No (2)	79%	33
Unsure (3)	12%	5
Total		42

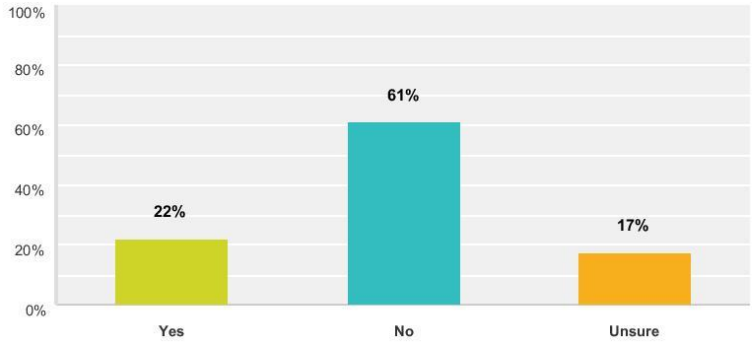
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	2.02	0.46

#	Additional Comments	Date
1	there is one cns allocated part time to aot also the service is attached to general adult but should be attached to rehab and recovery	3/2/2016 3:56 PM
2	There is 1 Assertive oUtreach team with a CNM2 and 3 staff nurses. There is not a multidiscpliniary team. When nurse management have been askedthe response is "this forum is not appropriate for this question. When the Area Services Manager has been asked about AOT, his response is "not for this meeting" Management have recently tried to reduce number of hours that AOT operates from a 10 hour day to an 8 hour day.	3/1/2016 5:21 PM
3	no team	2/29/2016 1:55 PM
4	under resourced	2/28/2016 4:09 PM
5	Understaffed	2/27/2016 12:18 PM
6	Have reimse home care team of 3	2/26/2016 4:56 PM
7	No assertive outreach team	2/26/2016 3:24 PM
8	Has only recently been fully staffed, very few places available and lack of throughput makes it difficult to have a refferal accepted.	2/26/2016 12:01 PM
9	we have an aot but the it is not properly resourced with staff	2/23/2016 9:05 PM
10	No Assertive Outreach team at all	2/23/2016 4:53 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q23 Within your adult mental health service do you have an Early Intervention Service (EIS)

Answered: 41 Skipped: 28



Answer Choices	Responses	
Yes (1)	22%	9
No (2)	61%	25
Unsure (3)	17%	7
Total		41

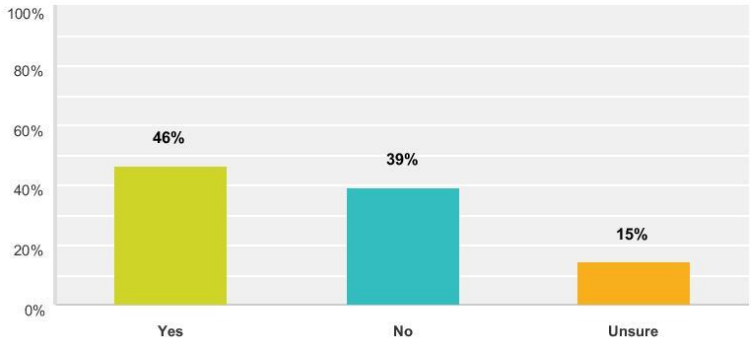
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.95	0.62

#	Additional Comments	Date
1	Small scale	3/2/2016 9:17 PM
2	early intervention of psychosis and eating disorder programe, staff are appropriately trained but are not full time. there is no 'stand alone' early intervention team	3/2/2016 3:57 PM
3	Only commenced in past few weeks.	2/29/2016 5:04 PM
4	service provided by family therapist and is available to all patients who present with a first episode psychosis	2/29/2016 1:57 PM
5	beginnings of with a First Episode Programme which is currently having resource issues	2/28/2016 4:09 PM
6	1 CNS and1 OT	2/28/2016 4:00 PM
7	cmhn teams in adult & POA& Ahome care team with reimse	2/26/2016 4:56 PM
8	EIS is being incorporated within sector teams some training has been given BFT	2/26/2016 3:25 PM
9	Early intervention assesment but no intensive follow up from the same service. This further confuses clients.	2/26/2016 12:02 PM
10	1RPN trained in early intervention service on Home based treatment Team. not recognised as CNS.	2/25/2016 8:36 PM
11	Clinical programme failed.....staff shortages	2/25/2016 11:34 AM
12	Part of clinical care programme but not fully staffed or consistent countywide	2/23/2016 7:46 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q24 Within your recovery and rehabilitation mental health services for severe and enduring mental illness do you have access to three residential units of ten places per 100,000 population?

Answered: 41 Skipped: 28



Answer Choices	Responses	
Yes (1)	46%	19
No (2)	39%	16
Unsure (3)	15%	6
Total		41

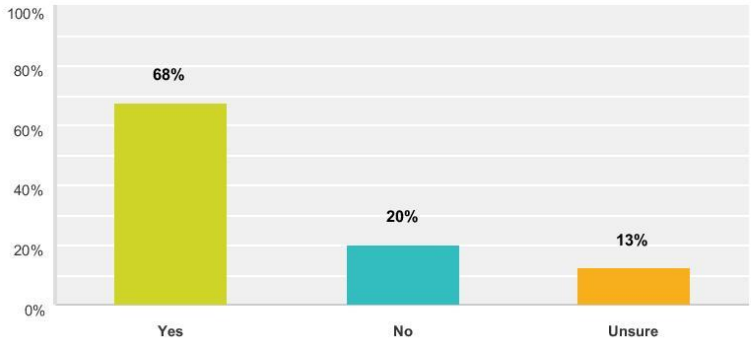
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.68	0.71

#	Additional Comments	Date
1	Unsure of population but there are 2 high support houses of approx 12 beds each	3/2/2016 9:18 PM
2	There are 2 high support hostels for 144,00. 1 has 10 beds, the other 6. Beds have been closed in recent years. Residents have been placed in housing with no OT, Social worker after discharge. They have the services of anurse , but not after 5 p.m.	3/1/2016 5:25 PM
3	2 hostels 30 beds overcrowded	2/26/2016 4:57 PM
4	one team with population of 154,000 with only one nurse one day centre for rehab team with 40 places no service user provided support centre	2/26/2016 3:28 PM
5	one residential unit below 10 beds.	2/26/2016 12:03 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q25 Within your recovery and rehabilitation mental health services for severe and enduring mental illness do you have access to one to two day centres providing a total of 30 places per 300,000 population?

Answered: 40 Skipped: 29



Answer Choices	Responses	
Yes (1)	68%	27
No (2)	20%	8
Unsure (3)	13%	5
Total		40

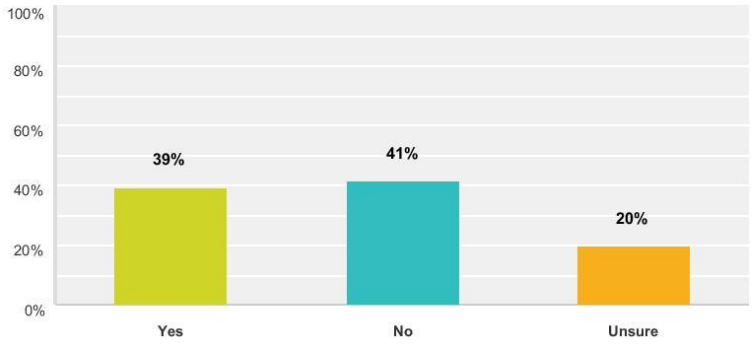
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.45	0.71

#	Additional Comments	Date
1	there is no full time day centre in carlow	3/2/2016 4:02 PM
2	there are day centres in three sectors of the catchment area - a fourth sector has no access to a day centre	2/28/2016 4:11 PM
3	Only one	2/28/2016 4:01 PM
4	1 Day centre &1 Day Hospital	2/26/2016 4:57 PM
5	4 DAY CENTERS SPREAD ACROSS ROSCOMMON, NOT YET UNDER REHAB AND RECOVERY. AWAITING BED REVIEW AND REVIEW OF COMMUNITY SERVICES UNDERTAKED IN 2015	2/25/2016 8:39 PM
6	2 day centers service wide covering 2/5 sectors area, other Been managed in day hospitals.....	2/25/2016 11:38 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q26 Within your recovery and rehabilitation mental health services for severe and enduring mental illness do you have access to one service user-provided support centre/social club per 100,000 population?

Answered: 41 Skipped: 28



Answer Choices	Responses	
Yes (1)	39%	16
No (2)	41%	17
Unsure (3)	20%	8
Total		41

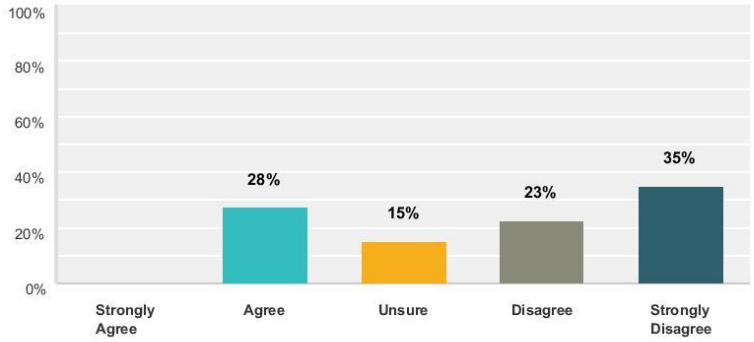
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.80	0.74

#	Additional Comments	Date
1	the 'involvement centre'	3/2/2016 4:04 PM
2	1 in transition	2/29/2016 9:19 AM
3	we have access to service user-provided support /social club but it is not provided by our service	2/28/2016 4:14 PM
4	DAY CENTRE	2/26/2016 4:58 PM
5	clubhouse modle excellent	2/26/2016 1:58 PM
6	Very little peer support, one WRAP service user led group.	2/26/2016 12:07 PM
7	Harvest centre/clubhouse for 132,000 in mid sector	2/25/2016 11:43 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q27 Within your recovery and rehabilitation mental health services for severe and enduring mental illness there is an assertive outreach programme

Answered: 40 Skipped: 29



Answer Choices	Responses	
Strongly Agree (1)	0%	0
Agree (2)	28%	11
Unsure (3)	15%	6
Disagree (4)	23%	9
Strongly Disagree (5)	35%	14
Total		40

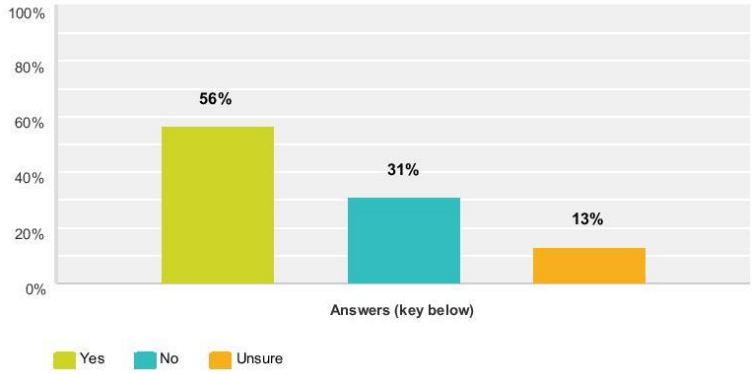
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	5.00	4.00	3.65	1.22

#	Additional Comments	Date
1	the aot is attached to the general adult sevices	3/2/2016 4:04 PM
2	Two CPN on rehab team 7/7	2/28/2016 2:35 PM
3	Reimse Home Care centre	2/26/2016 4:58 PM
4	there is not	2/26/2016 1:58 PM
5	No access to same service due to lack of throughput.	2/26/2016 12:07 PM
6	None available	2/25/2016 11:43 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q28 Within your mental health services for older people do you have one multidisciplinary CMHT per 100,000 total population?

Answered: 39 Skipped: 30



	Yes (1)	No (2)	Unsure (3)	Total	Weighted Average
Answers (key below)	56% 22	31% 12	13% 5	39	1.56

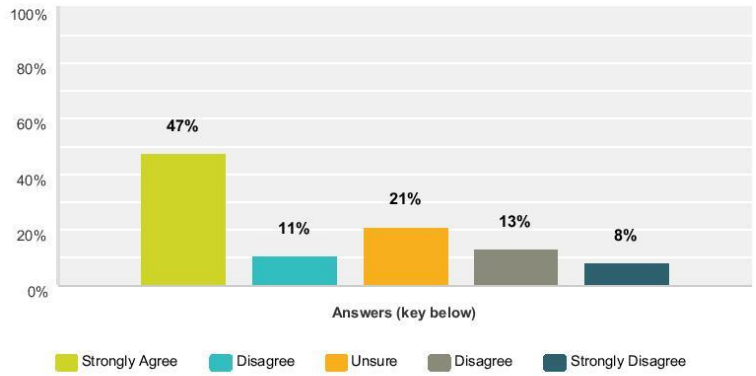
Basic Statistics				
Minimum 1.00	**Maximum** 3.00	**Median** 1.00	**Mean** 1.56	**Standard Deviation** 0.71

#	Additional Comments	Date
1	Unsure of population	3/2/2016 9:18 PM
2	not multi disciplinary	3/2/2016 4:05 PM
3	POLL have admitting rights to our adult admission unit and a separate POLL admission unit. no day hospital services. full MDT	2/29/2016 1:59 PM
4	only 5 beds availible in new unit development for care of the elderly	2/28/2016 5:28 PM
5	one mdt CMHT per total catchement population	2/28/2016 4:14 PM
6	Not fully resourced	2/28/2016 4:04 PM
7	No consultant for existing team	2/27/2016 8:14 PM
8	6 beds in acute	2/26/2016 5:00 PM
9	Service not fully staffed Not located in health centre 6 in pt beds day hospital pop 14,000 8 places available	2/26/2016 3:31 PM
10	Larger population numbers.	2/26/2016 12:08 PM
11	Partly staffed POLL team in place since 2015	2/25/2016 8:41 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q29 Within your mental health services for older people your services provide individual multidisciplinary assessment, treatment and care with an emphasis on home assessment and treatment of possible, and on maintaining the older person in their community

Answered: 38 Skipped: 31



	Strongly Agree (1)	Disagree (2)	Unsure (3)	Disagree (4)	Strongly Disagree (5)	Total	Weighted Average
Answers (key below)	47% 18	11% 4	21% 8	13% 5	8% 3	38	2.16

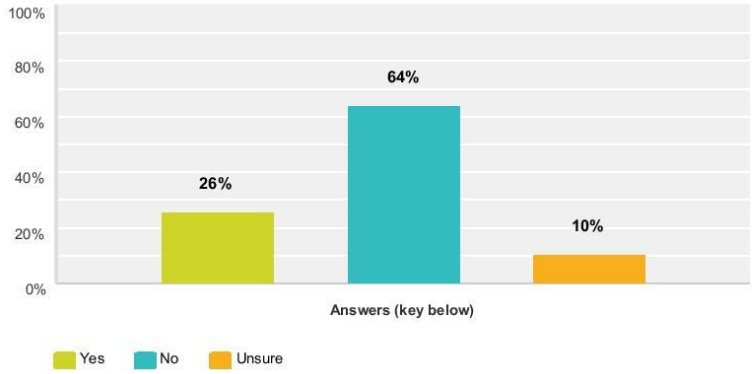
Basic Statistics				
Minimum 1.00	**Maximum** 5.00	**Median** 2.00	**Mean** 2.24	**Standard Deviation** 1.37

#	Additional Comments	Date
1	there is a service but is not fully resourced	3/2/2016 4:06 PM
2	We do not provide service for older people	2/29/2016 10:54 AM
3	want to press agree but error in multi choice?	2/28/2016 4:15 PM
4	have 1 unit providing respite beds linked with cmhn team working withpeople in their homes	2/26/2016 5:00 PM
5	Team is home based only at present.....	2/25/2016 11:44 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q30 Within your mental health services for older people your services provide eight in-patient beds in the general acute in-patent unit?

Answered: 39 Skipped: 30



	Yes (1)	No (2)	Unsure (3)	Total	Weighted Average
Answers (key below)	26% 10	64% 25	10% 4	39	1.85

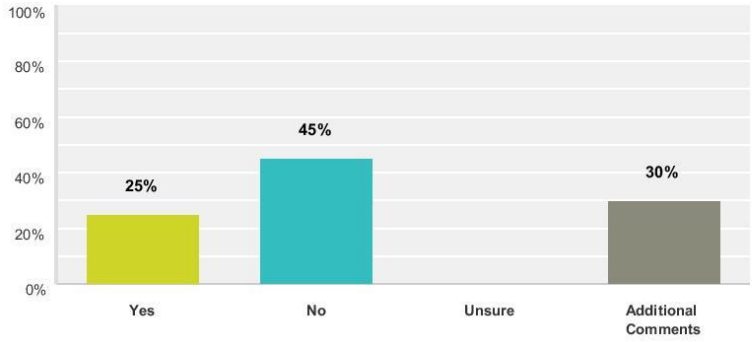
Basic Statistics				
Minimum 1.00	**Maximum** 3.00	**Median** 2.00	**Mean** 1.85	**Standard Deviation** 0.58

#	Additional Comments	Date
1	No beds for old age, put in with adult psych	3/2/2016 9:19 PM
2	there is an approved centre in St Gabriels ward, St Canices Hospital but not in the dept of psychitry	3/2/2016 4:07 PM
3	Specific unit for over 65s, some admit to general acute unit	3/1/2016 9:35 AM
4	our POLL UNIT is a separate approved centre but also has admitting rights to our general adult admission unit in kilkenny	2/29/2016 1:59 PM
5	no specific number of beds	2/29/2016 9:21 AM
6	5 beds awiting opening, nil at present	2/28/2016 5:29 PM
7	access to inpatient bed on the adult units on a needs basis (as per adult pop)	2/28/2016 4:15 PM
8	5 only	2/27/2016 4:06 PM
9	6 acute beds	2/27/2016 12:22 PM
10	we have 6 acute beds for older people 30+beds providing long term care	2/26/2016 5:00 PM
11	6 beds in POA unit attached to adult approved centre	2/26/2016 3:32 PM
12	No allocated beds, acute unit is unsuitable	2/25/2016 11:45 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q31 Within your in-patient adult mental health services are there 50 acute in-patient beds per Mental Health Catchment Area

Answered: 40 Skipped: 29



Answer Choices	Responses	
Yes (1)	25%	10
No (2)	45%	18
Unsure (3)	0%	0
Additional Comments (4)	30%	12
Total		40

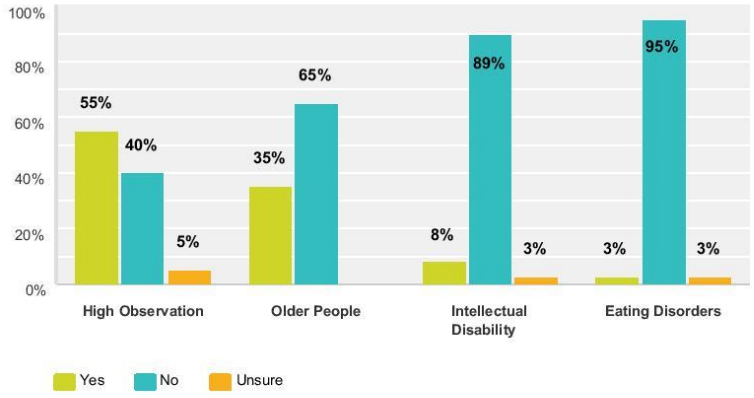
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	4.00	2.00	2.35	1.15

#	Additional Comments	Date
1	there are 44beds	3/2/2016 4:08 PM
2	Proportionally yes	2/29/2016 9:22 AM
3	no intelectual disability beds , 5beded elderly care, 8 bedded high obs,nil camhs beds ,no crisis house beds ,no icru	2/28/2016 5:32 PM
4	44 beds inpatient unit	2/28/2016 2:37 PM
5	We have 18 acute beds but no other service	2/27/2016 12:50 AM
6	area has a mix and part of above	2/26/2016 5:16 PM
7	6 in pt beds for POA no beds for ID/dual dagnosis no beds for clients with eating disorders no crisis house no intensive care rehab unit	2/26/2016 3:37 PM
8	44 acute beds	2/26/2016 1:45 PM
9	There is close to 50 beds but no specific eating disorder beds, no access to mother and baby postnatal beds in the country! lower than 6 high obs beds, no dual diognosis beds and have to accept under 18s from CHAMs due to their lack of resources which is distresssing for the young person.	2/26/2016 12:13 PM
10	Galway Roscommon share acute bed , 44 in GALWAY 22 in Roscommon	2/25/2016 8:43 PM
11	29 per 226,000	2/25/2016 11:46 AM
12	Refurbishments at present, beds shut	2/24/2016 9:41 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q32 Within your in-patient adult mental health services are there sub units for

Answered: 40 Skipped: 29



	Yes (1)	No (2)	Unsure (3)	Total	Weighted Average
High Observation	55% 22	40% 16	5% 2	40	1.50
Older People	35% 14	65% 26	0% 0	40	1.65
Intellectual Disability	8% 3	89% 34	3% 1	38	1.95
Eating Disorders	3% 1	95% 38	3% 1	40	2.00

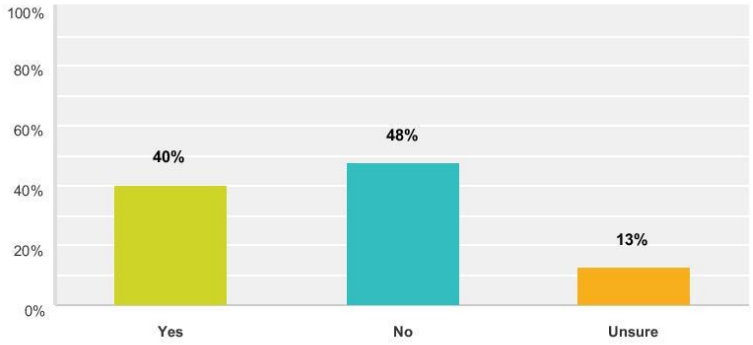
Basic Statistics					
	Minimum	Maximum	Median	Mean	Standard Deviation
High Observation	1.00	3.00	1.00	1.50	0.59
Older People	1.00	2.00	2.00	1.65	0.48
Intellectual Disability	1.00	3.00	2.00	1.95	0.32
Eating Disorders	1.00	3.00	2.00	2.00	0.22

#	Additional Comments	Date
1	separate POLL admission unit in kilkenny	2/29/2016 3:40 PM
2	4 bed High obs built but not opened	2/27/2016 8:19 PM
3	8 bed high obs 5 bed older person	2/27/2016 4:00 PM
4	2 unopened ,high op beds,?not fit for purpose, short staffing	2/26/2016 5:16 PM
5	Eating disorders are not catered for no access to diaticians.	2/26/2016 12:15 PM
6	Not used for high observation	2/24/2016 9:43 AM
7	High Observation is not yet in use	2/24/2016 2:18 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q33 in-patient adult mental health services are there access to crisis facilities?

Answered: 40 Skipped: 29



Answer Choices	Responses	
Yes (1)	40%	16
No (2)	48%	19
Unsure (3)	13%	5
Total		40

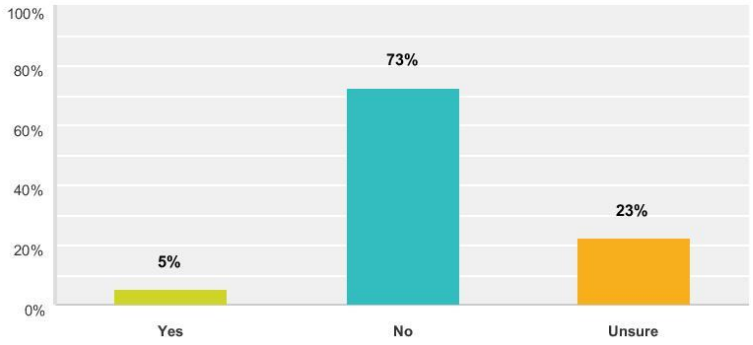
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	1.73	0.67

#	Additional Comments	Date
1	Greenbanks house carlow	3/2/2016 4:08 PM
2	Based in Sligo	2/29/2016 9:23 AM
3	6 crisis nurses covering for 8am to 3am 24/7	2/28/2016 5:33 PM
4	if crisis facility means seclusion rooms and hihj obs then yes	2/28/2016 4:16 PM
5	only if referred to recovery team or admitted to higher secure unit	2/28/2016 9:55 AM
6	Crisis nursing teams in a&e	2/27/2016 3:59 PM
7	Only to acute unit	2/27/2016 12:51 AM
8	Duty Dr assessment out of hours	2/26/2016 3:38 PM
9	hospital assessment with a doctor available 24hrs a day	2/26/2016 2:00 PM
10	Adhoc arrangements for volauntary admisions and involantary admisions in crisis.	2/26/2016 12:16 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q34 Within your in-patient adult mental health services is there access to intensive care rehabilitation units based on a ratio of four nationally and one per region with 30 beds?

Answered: 40 Skipped: 29



Answer Choices	Responses	
Yes (1)	5%	2
No (2)	73%	29
Unsure (3)	23%	9
Total		40

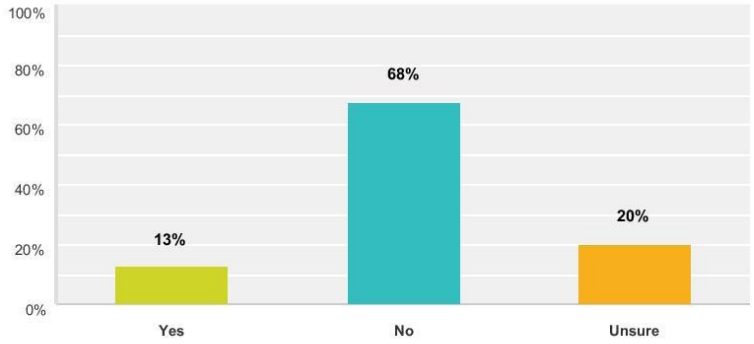
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	2.17	0.49

#	Additional Comments	Date
1	PICU 18 beds	2/28/2016 4:07 PM
2	No access to ICRU beds in Cork	2/27/2016 8:22 PM
3	2 overcrowded hostels now only begining rehab programmes	2/26/2016 5:16 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q35 Within your in-patient adult mental health services is there access to high support intensive care residences on the basis of 2 per HSE region/80 Beds?

Answered: 40 Skipped: 29



Answer Choices	Responses	
Yes (1)	13%	5
No (2)	68%	27
Unsure (3)	20%	8
Total		40

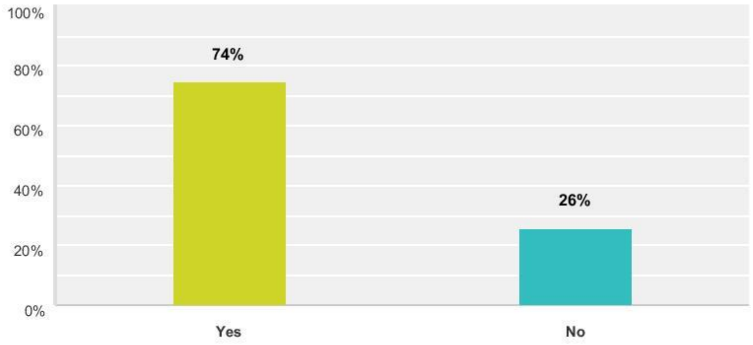
Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	2.00	2.08	0.57

#	Additional Comments	Date
1	have 2 high support hostels 30 beds,houses over crowded	2/26/2016 5:16 PM
2	High support hostel is the most we can access and full at present	2/26/2016 3:40 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q36 Is there a Liaison Mental Health Service within your local acute admitting hospital?

Answered: 39 Skipped: 30



Answer Choices	Responses	
Yes (1)	74%	29
No (2)	26%	10
Total		39

Basic Statistics				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.26	0.44

#	If you answered 'No', please provide additional comments	Date
1	1 nursing post and 1 nchd post for all of the Carlow/kilkenny service	2/29/2016 3:40 PM
2	Currently 6 positions working from 8am to 3am 24/7	2/27/2016 3:57 PM
3	one nurse CNS Mon-Fri 9am-5pm	2/26/2016 3:40 PM
4	liason in wexford but not Wicklow	2/26/2016 2:01 PM
5	No a& e in Roscommon hosp.	2/25/2016 8:44 PM

31	Emphasis on community care and opdcare	2/24/2016 2:19 PM
32	More multidisciplinary teams	2/24/2016 9:47 AM
33	Liaison psychiatry	2/24/2016 2:22 AM
34	Recent opening of in-patient high observation unit	2/23/2016 5:05 PM
#	**2.**	**Date**
1	Staff levels at crisis point	3/2/2016 9:22 PM
2	Cost saving exercise	3/1/2016 6:22 PM
3	There are occupational therapists available	3/1/2016 5:38 PM
4	Beginning to roll out Rehab Team	3/1/2016 9:39 AM
5	Community Mental Teams	2/29/2016 5:11 PM
6	comprehensive development of cmht	2/29/2016 3:40 PM
7	single point of access	2/29/2016 11:23 AM
8	Increase in number of MDTS	2/29/2016 10:59 AM
9	Area management team in situ	2/29/2016 9:26 AM
10	Crisis Intervention	2/29/2016 8:53 AM
11	SCAN	2/28/2016 9:41 PM
12	increased crisis resources	2/28/2016 5:36 PM
13	some increase in AHPs on community teams	2/28/2016 4:17 PM
14	Scan nursing	2/28/2016 2:42 PM
15	extra older adult team	2/28/2016 9:57 AM
16	Home Based treatment team for South Kerry	2/27/2016 8:36 PM
17	all positions in met teams filled	2/27/2016 3:57 PM
18	Increased CNS community nurses	2/27/2016 12:26 PM
19	reimse home care service	2/26/2016 5:16 PM
20	Development of purpose built community mental health centre	2/26/2016 1:51 PM
21	Multidicsiplanary teams.	2/26/2016 12:19 PM
22	Home bbase crisis team started but not fully staffed	2/26/2016 12:10 AM
23	Rehabilitation Beds and centre.	2/25/2016 11:58 AM
24	A&e liaison team	2/24/2016 2:19 PM
25	Home Base treatment	2/24/2016 2:22 AM
26	Recent recruitment of Liaison Consultant	2/23/2016 5:05 PM
#	**3.**	**Date**
1	Top heavy	3/2/2016 9:22 PM
2	More home based treatment care	3/1/2016 6:22 PM
3	CMHTs	3/1/2016 9:39 AM
4	One point referral system	2/29/2016 5:11 PM
5	closure of long stay wards and improved community residences	2/29/2016 3:40 PM
6	2 Hour response to a crisis	2/29/2016 11:23 AM
7	Suicide Prevention Programme	2/29/2016 10:59 AM
8	Acute response to self harm issues	2/29/2016 9:26 AM
9	Suicide Resource Officer	2/29/2016 8:53 AM
10	specific elderly care and rehab teams	2/28/2016 5:36 PM
11	Expansion of POLL service	2/28/2016 2:42 PM
12	redevelopment of acute unit ti vfc standards	2/27/2016 3:57 PM

13	Scan nurses / Crisis team	2/27/2016 12:26 PM
14	6 acute beds for older people	2/26/2016 5:16 PM
15	Development of 10 bedded Crisis House	2/26/2016 1:51 PM
16	Community care improved.	2/26/2016 12:19 PM
17	More emphasis on after care	2/24/2016 2:19 PM
18	Psychiatry of old age admission unit	2/24/2016 2:22 AM
19	Recent establishment of Rehabilitation team	2/23/2016 5:05 PM
#	**4.**	**Date**
1	Primary care the real only change	3/2/2016 9:22 PM
2	Can't think of a 4th!!	3/1/2016 6:22 PM
3	service user representation in policy development and other aspects of service development	2/29/2016 3:40 PM
4	increase in no of specialist posts (nursing)	2/29/2016 11:23 AM
5	Purpose built admission unit	2/29/2016 9:26 AM
6	fully resourced MDT teams	2/28/2016 5:36 PM
7	Expansion of rehab/recovery services	2/28/2016 2:42 PM
8	Psy liason nurses	2/27/2016 12:26 PM
9	new rehab programmes	2/26/2016 5:16 PM
10	Develpment of home based treatment team	2/26/2016 1:51 PM
11	Better provisions foe services and more staff	2/24/2016 2:19 PM
12	Community Services extended to 7 day week	2/24/2016 2:22 AM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

Q38 Please identify the VFC priorities that in your experience have not been achieved

Answered: 29 Skipped: 40

Answer Choices	Responses	
1.	100%	29
2.	90%	26
3.	79%	23
4.	66%	19

#	1.	Date
1	Appropriate beds for high obs and elderly. They should be specific beds.	3/2/2016 9:24 PM
2	We need our Crisis beds..	3/1/2016 6:27 PM
3	Rehabilitation is based on Copelands WRAP, whihc has never been evaluated in the context of severe and enduring mental illness	3/1/2016 5:45 PM
4	Assertive Outreach	3/1/2016 9:41 AM
5	Completion of community mental health teams	2/29/2016 5:11 PM
6	no assertive outreach	2/29/2016 3:42 PM
7	crisis house	2/29/2016 11:25 AM
8	Psychology services not integrated	2/29/2016 9:28 AM
9	Effective CMHTs	2/29/2016 8:54 AM
10	Adequate staffing levels across all desciplines particularly nursing to enable the roll out of VFC	2/28/2016 9:45 PM
11	no ICRU	2/28/2016 5:37 PM
12	staffing resources per population	2/28/2016 4:18 PM
13	ICRU	2/28/2016 4:11 PM
14	Crisis house	2/28/2016 2:44 PM
15	lack specialist services i.e addictions/cbt	2/28/2016 9:59 AM
16	Proper staffing of CMHTs	2/27/2016 8:44 PM
17	No ICRU	2/27/2016 3:57 PM
18	day hospitals/centers	2/27/2016 2:45 PM
19	Recommended MD teams per population	2/27/2016 12:28 PM
20	No community mental health teams	2/27/2016 12:57 AM
21	intensive rehab centres	2/26/2016 5:17 PM
22	Home based teams	2/26/2016 3:43 PM
23	Appropriate access to acute inpatient beds	2/26/2016 1:52 PM
24	No clear planned entrance and exit to service. Lack of beds since transfer to community.	2/26/2016 12:25 PM
25	Primary care teams	2/26/2016 12:12 AM
26	Out reach service.	2/25/2016 11:59 AM
27	All	2/25/2016 11:52 AM
28	High Observation not yet in use.	2/24/2016 2:30 AM
29	No home-based treatment teams	2/23/2016 5:07 PM

#	2.	Date
1	Home based services	3/2/2016 9:24 PM

An Impact Evaluation of "Vision for Change" (Mental Health Policy) on Mental Health Service Provision: A national Descriptive Evaluation project.

2	In my area although we have been divided into areas of 50,000 we are in fact 2 very separate teams working among 25,000.. With no cross cover provided at a practical level	3/1/2016 6:27 PM
3	Community services are limited to 9-5	3/1/2016 5:45 PM
4	Early intervention	3/1/2016 9:41 AM
5	no ICRUs	2/29/2016 3:42 PM
6	forensic services	2/29/2016 11:25 AM
7	Eating disorders not established	2/29/2016 9:28 AM
8	Assertive out reach teams	2/28/2016 9:45 PM
9	No Crisis house	2/28/2016 5:37 PM
10	access to crisis/respite beds	2/28/2016 4:18 PM
11	No assertive outreach team	2/28/2016 4:11 PM
12	intensive care rehab unit	2/28/2016 2:44 PM
13	increased pressure on acute beds due to respite/residential closures	2/28/2016 9:59 AM
14	Proper identified team sector bases	2/27/2016 8:44 PM
15	limited outreach teams	2/27/2016 3:57 PM
16	assertive outreach teams	2/27/2016 2:45 PM
17	Step down units	2/27/2016 12:28 PM
18	No substance misuse team - a factor in increasing numbers of admissions	2/27/2016 12:57 AM
19	no icru for adult psych admissions	2/26/2016 5:17 PM
20	Crisis beds	2/26/2016 3:43 PM
21	Acess to intensive care beds	2/26/2016 1:52 PM
22	No dual diognosis services.	2/26/2016 12:25 PM
23	Multidisciplinary team s fully staffed	2/26/2016 12:12 AM
24	Emergency out patient service.	2/25/2016 11:59 AM
25	No Crisis House	2/24/2016 2:30 AM
26	No Assertive Outreach teams	2/23/2016 5:07 PM
#	**3.**	**Date**
1	Staffing levels recommended never happened	3/2/2016 9:24 PM
2	Home based teams, crisis teams etc are not being develoed fully..no strategy for times ahead, and while everything looks sweet on paper on the ground it is very disjointed and chaotic at times	3/1/2016 6:27 PM
3	Child and adolescent admissions are unplanned, crisis admissions at weekends.. CAMHS operates 9-5 Monday to Friday	3/1/2016 5:45 PM
4	Intensive care residences	3/1/2016 9:41 AM
5	further development of SCAN and Liaison required	2/29/2016 3:42 PM
6	CALMS services underveloped	2/29/2016 11:25 AM
7	No intensive care facilities	2/29/2016 9:28 AM
8	Home based treatment teams	2/28/2016 9:45 PM
9	poor assertive outreach teams	2/28/2016 5:37 PM
10	access to EIS and other clinical programmes	2/28/2016 4:18 PM
11	Under staffing of existing teams	2/28/2016 4:11 PM
12	assertive Outreach	2/28/2016 2:44 PM
13	consistency not following through between sectors	2/28/2016 9:59 AM
14	Setting up of MHSOP	2/27/2016 8:44 PM
15	No crisis house beds	2/27/2016 3:57 PM
16	sufficient bed capacity	2/27/2016 2:45 PM

17	crisis intervention beds	2/27/2016 12:28 PM
18	No home based treatment service	2/27/2016 12:57 AM
19	Assertive outreach teams	2/26/2016 3:43 PM
20	Lack of specialist support for eating disorders until critical then the hse funds the client for private services.	2/26/2016 12:25 PM
21	Crisis beds	2/26/2016 12:12 AM
22	No Assertive Outreach Team	2/24/2016 2:30 AM
23	Many vacancies still exist on MDT teams	2/23/2016 5:07 PM
#	**4.**	**Date**
1	Mdt still consultant and management heavy	3/2/2016 9:24 PM
2	50 bedded unit needs to be built with specialist beds as promised.. and a HDU that can accept patients on need rather than gender!!!!	3/1/2016 6:27 PM
3	The acute unit has become a dumping ground for difficult to place persons such as Forensic service, polysubstance abuse, difficult to manage behaviour, MHSOP. No service in the community operates after 5 pm.	3/1/2016 5:45 PM
4	Day hospitals	3/1/2016 9:41 AM
5	No local acesss to child and adolesent beds	2/29/2016 11:25 AM
6	No home based treatment plan	2/29/2016 9:28 AM
7	poor early intervention programmes	2/28/2016 5:37 PM
8	access to day centres	2/28/2016 4:18 PM
9	home care teams	2/28/2016 2:44 PM
10	lack of crisis/ assertive outreach teams	2/28/2016 9:59 AM
11	Proper provision of crisis services	2/27/2016 8:44 PM
12	fully staffed MDT	2/27/2016 2:45 PM
13	Challenging behaviour specific unit and staff	2/27/2016 12:28 PM
14	Poor access to CAMHS	2/27/2016 12:57 AM
15	Primary care only I CMHN in this service	2/26/2016 3:43 PM
16	Virtually no support for post natal depression/psychosis.	2/26/2016 12:25 PM
17	Rehabilitation	2/26/2016 12:12 AM
18	No Intellectual Disability Service	2/24/2016 2:30 AM
19	No early intervention in psychosis service	2/23/2016 5:07 PM

Section 2 (Findings from Focus Groups)

Qualitative Findings

Introduction

This section presents the qualitative findings of a mixed method study conducted on behalf of the Psychiatric Nurses Association and Royal College of Surgeons in Ireland.

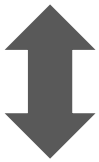
Research Aims / Focus-of-Inquiry

The study set out to explore the extent to which the principles and practices enshrined in *A Vision for Change* (2006) have been realised and implemented nationwide over the past decade.

Data Collection and Study Sample

Following on their completion of an online survey questionnaire, focus group discussion were conducted with the study participants to explore their perceptions and everyday experiences of working in the mental health system within the context of *A Vision for Change* (2006). The participants were all psychiatric nurses and members of the PNA; a total of ten focus group discussions were conducted across a range of geographical areas that included: Galway/ Roscommon/Mayo , Cavan, Monaghan and Louth/Meath, Carlow, Kilkenny, Wexford, Waterford, South Tipperary, Cork, Kerry, Limerick/Clare, Sligo/Donegal, Kildare, Midlands, East Dublin and North Dublin.

Table 1 – Analytical Hierarchy to Data Analysis (Adapted from Braun and Clarke – six stages of analysis)

Analytical Process **(Braun & Clarke, 2006).**	**Braun and Clarke** **Practical Application in NVivo**	**Strategic Objective**	**Iterative process throughout analysis**
1. Familiarizing yourself with the data	**Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas. Import data into the NVivo data management tool**	**Data Management** *(Open and hierarchal coding through NVIVO)*  **Descriptive Accounts** *(Reordering,*	Assigning data to refined concepts to portray meaning  Refining and distilling more abstract concepts 
2. Generating initial codes:	**Phase 2 – Open Coding- Coding interesting features of the data in a systematic fashion across the entire data set, collecting data relevant to each code**		
3. Searching for themes:	**Phase 3 - Categorisation of Codes – Collating codes into potential themes, gathering all data relevant to each potential theme**		
4. Reviewing themes:	**Phase 4 – Coding on - Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis**		
5. Defining and naming themes:	**Phase 5 - Data Reduction - On-going analysis to refine the specifics of each theme, and the overall story [storylines] the analysis tells, generating clear definitions and names for each theme**		

6. Producing the report	**Phase 6 –Generating Analytical Memos - Phase 7 – Testing and Validating, and Phase 8 - Synthesising Analytical Memos. The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis**	*'coding on' and annotating through NVIVO)*  **Explanatory Accounts** *(Extrapolating deeper meaning, drafting summary statements and analytical memos through NVIVO)*	Assigning data to themes/concepts to portray meaning  Assigning meaning  Generating themes and concepts

Format for Presenting the Study Findings

As explained in the methodology section, situating the findings into a storyboard involves identifying the relatedness of themes to each other and their importance in addressing the research question, then sequencing them into a story or narrative which is structured and can be expressed in the form of a coherent and cohesive research report. The findings storyboard comprises eleven interrelated and interdependent themes, issues and concerns identified during data analysis as being of key significance to the research focus-of-inquiry:

Part 1: Recovery Principles Undermined

Part 2: Poor Strategic Planning of Infrastructure for Community-Based Services

Part 3: Missing Linkages and Connections

Part 4: Broken promises

Part 5: Staffing and Team Challenges

Part 6: Bed Capacity Challenges

Part 7: Deficits in Service Provision

Part 8: Regional Inequalities and Geographical Issues

Part 9: Impact on Service Users and their Families

Part 10: Pockets of success

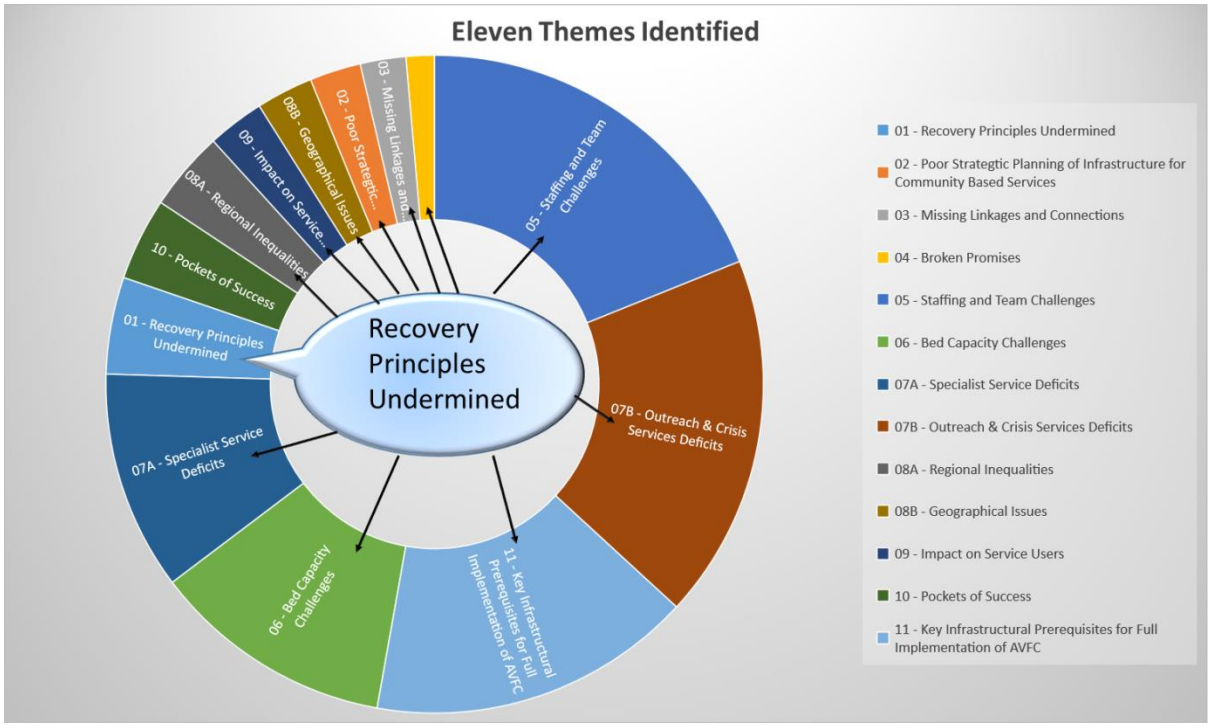
Part 11: Key Infrastructural Prerequisites for Full Implementation of VFC

Note: It must be noted that, over the course of this analysis, charts and matrices do not show absolute numbers as they are designed to show relativity across and between codes, categories of codes and/or themes so as to offer the

reader a true visual representation of participants' collective views, perceptions and experiences of working in the mental health system within the context of *A Vision for Change* (2006)

This section closes with a visual overview of the study findings storyboard:

Chart 1 - The Findings Storyboard



The findings story now opens with the theme 'recovery principles undermined' as recovery principles formed the cornerstone on which the mental health system was to be reconstructed and the failure to adhere to such principles, the data suggests, lies at the heart of all other failures to fully implement systems, structures and practices recommended in *A Vision for Change* (2006).

Part 1: Recovery Principles Undermined

> A recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Care plans should reflect the service user's particular needs, goals and potential, and should address community factors that may impede or support recovery.
>
> A Vision for Change (2006)

The following focus group discussion extracts exemplify participants' disappointment at the failure of the national mental health system to translate the principles of recovery into practice, most notably and essentially through its failure to provide the resources vital to the full implementation of AVF:

> *To me one of the biggest things about recovery is choice. It's being able to, you know, control, direct your own care, to have options and to have choice and clearly there is very little choice; and sometimes because the person exercise their choice but because that choice isn't available, they are then deemed to be, what would you call it, non-cooperative or resisting, so they may well end up in an involuntary admission situation because they exercised a choice that wasn't available.*
>
> *Yes, the government, they've released this document and they've released the recovery document and they've released the Manage Risk in Mental Health, they are all lovely, we should all be following them, but they don't provide us with the resources to adopt them and adhere to them.*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

> *I think one of the key things is that the principles of recovery is what is supposed to be underpinning how we deliver the Vision for Change and that is lacking in a lot of areas. People do not understand it, Enda Kenny has ruined the name of recovery. The service that we are supposed to be delivering now is meant to have a meaningful impact on people's lives, not just a one size fits all which is what has happened. People go in, they meet the consultant, they write up a script, they go home, but it is supposed to be more meaningful with a follow up. If we do not get the bottom line of this right, get the heart of it right,*

that the whole ethos of recovery is a different way of thinking entirely … it's a huge challenge for our service and that whole thinking around how we deliver our care.

So what you are saying almost is that a reinvigorating of the recovery principles across services is a fundamental before we start talking about what are our needs in terms of infrastructural redevelopment of the service.

Yes, we cannot do one without the other and that is where we are at now.

FG 1: Galway/Roscommon/Mayo

I think to be honest that Vision for Change has been very like planning for the future. It has been used as a cutting device.

Yes, that's right, it was actually a Vision for Closure.

Planning for the future was actually planning for dissemination of services. Closing hospitals and closing wards that is all that happened, and waiting for people to retire.

FG 4: Cork & Kerry

The data suggests that the failure of the national mental health system to translate the principles of recovery into meaningful practice may best be evidenced in its failure to provide key resources vital to the full implementation of AVF. The subsequent sections of this report consider the study participants' experiences of working in an extremely under-resourced mental health system.

Part 2: Poor Strategic Planning of Infrastructure for Community-Based Services

While good systems and structures could be the outcome of good planning, participants pointed to a lack of strategic planning as accounting for many of the inadequacies they identified in service provision, most notably the absence of adequate infrastructure. Infrastructure refers to facilities / buildings and where they are located and to the deployment of personnel, as typified in the following focus group discussion extracts:

> *Well I suppose the pressure on acute beds is never ending, it is ongoing in the acute units both in Roscommon and Galway. That is basically because there has been no community service developed, there is nothing to alleviate pressure on acute beds, there are no core based treatment teams, there is no crisis house.*
>
> *Closing the bigger hospitals and having people move out to smaller areas, we have people in Roscommon living out in hostels that nobody goes to see, they are involved in nothing, and we are supposed to reintegrate people back into normal society, get on with their lives, go back to work, it is not happening no matter how you dress it up and it looks good and everything but it is not happening, we have mini institutions.*
>
> *I work out of the acute unit simply because the infrastructure is not there and I travel sixty miles out to some of the points. There were plans to move the teams out into community-based facilities in line with primary care areas, as far as I am aware the primary care areas are different than the areas that were re-sectorised when the whole re-sectorisation of Galway and Roscommon came on stream, … we don't have any community-based facility to work out of, hence we are working out of the acute unit, there are nine consultants jockeying for admissions there, it is totally absorbed in admissions but the infrastructure simply is not there. The previous speaker who comes from the old Ballinasloe catchment end of it, they had the big budget back in the day, where we had the small budget, but there was never any planning of infrastructural changes for the other side of the county.*
>
> FG 1: Galway/Roscomon/Mayo

> *So what I am hearing from you is that Kerry both North and South is quite fragmented and disjointed?*
>
> *Yes that is true, you have a bit of everything but nothing is strategic. Nothing is strategic or properly brought together, even supervisory structure and everything, it is completely ad hoc.*
>
> *So often the approach is not strategically linked to the needs of the population.*
>
> FG 4: Cork & Kerry

Indeed, one focus group in particular pointed to an extreme instance of poor strategic planning:

> *What happened in Tipperary was when Clonmel closed, my understanding is that South Tipperary got a load of services, they got crisis houses, they got everything, and North Tipperary got nothing.*
>
> FG 6: Limerick/Clare

This theme, which is related to other themes for discussion over the course of this report, most notably, 'missing linkages and connections', 'regional inequalities and geographical issues' and 'deficits in service provision', runs counter to *A Vision for Change* which recommended that:

> A multi-professional manpower plan should be put in place, linked to projected service plans. This plan should look at the skill mix of teams and the way staff are deployed between teams and geographically, taking into account the service models recommended in this policy. This plan should be prepared by the National Mental Health Service Directorate working closely with the Health Service Executive, the Department of Health and Children and service providers.
>
> A Vision for Change (2006)

Part 3: Missing Linkages and Connections

A Vision for Change recommended that:

> Links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health should be enhanced and formalised.
>
> A Vision for Change (2006)

Yet the following focus group discussion extracts illustrate missing links and disconnects between stakeholders in the provision of mental health care:

> *We have a staff member who comes on duty at 8 o clock in the evening, and she is based in one high support hostel but she visits a low support twelve miles away in Shannon, she visits anybody then who is in independent living around this area. It is hard to understand it, but what happened was there used to be a night supervisor for Limerick and Clare, so management decided this is not cost effective and that they would amalgamate the two. So you used to have one night super for Clare, Limerick, North Tipperary, but what happened then was the Clare night supervisor, there was an issue in Limerick, the house alarms went off one night, and the Clare night supervisor didn't know the Limerick service, and was ringing the acute saying 'what will I do, where will I go?' ... Basically it transpired that the guards were called but if anything had happened, and when the report was done it looked like well you have a night supervisor but they are totally disconnected.*
>
> FG 6: Limerick/Clare

> *Post Natal Diagnosis, there is not one mother and baby bed in the entire country. In fact, the Vision for Change only mentions post-natal twice in the entire document, we have no plan and no joined up link between the maternity hospitals and the mental health services.*
>
> *Yes, there is a failure to integrate these services. Like I don't understand why, if everyone needs to attend an antenatal class, that they don't have a representative from a mental health class saying if you find that your mood has*

> *gone low, that they don't at least tell you how you would access the mental health services, because people don't know.*
>
> FG 7: North Dublin

> *There are extra beds available to us in Portlaoise but the communication between ourselves and Portlaoise is very sketchy.*
>
> FG 8: Kildare, Midlands

Such illustrations of disconnectedness suggest that, in some areas, much more integration of services needs to be established.

Part 4: Broken promises

The study participants talked of unfulfilled promises across a range of infrastructural areas related not just to resources to deliver frontline services but also to administrative and IT support systems, as exemplified in the following focus group discussion extracts:

> *I suppose the problem is Wexford would have more community services than we would have, what we have would be in no way perfect but we have situations where Waterford was promised a lot of community supports when there was an amalgamation but they were never provided.*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

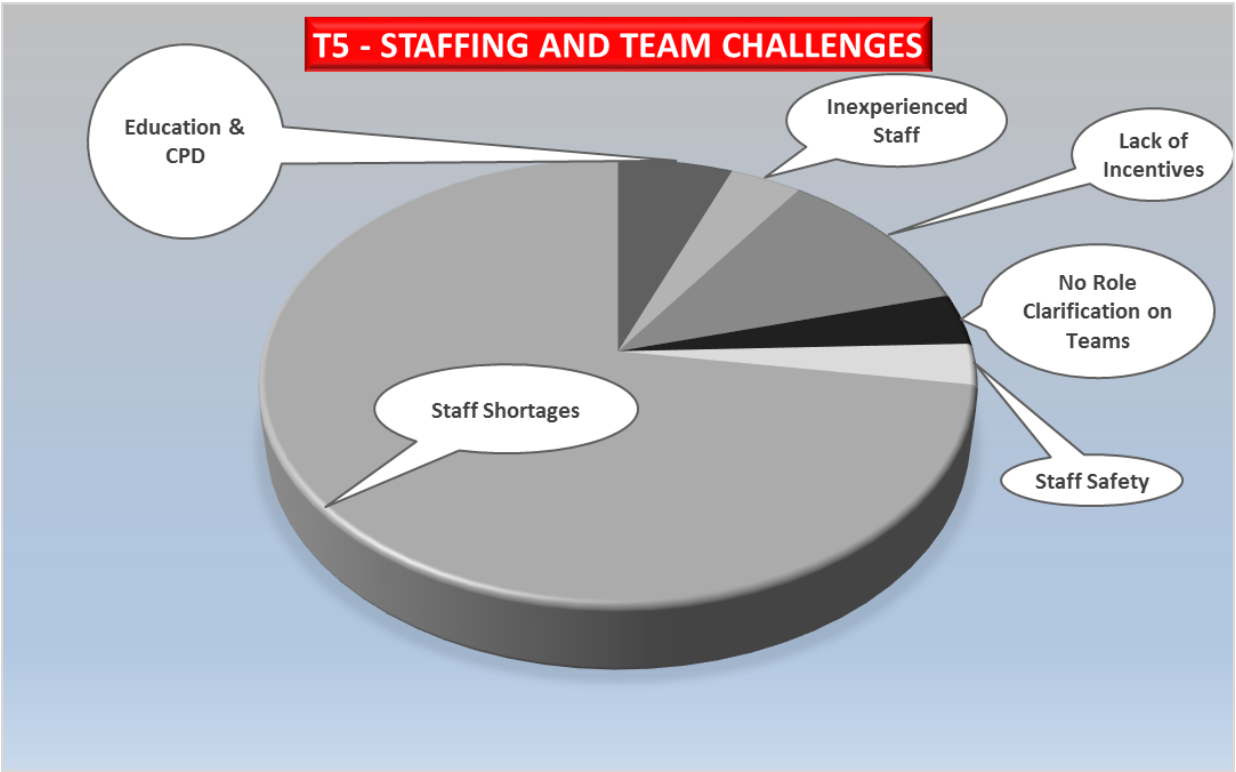
> *We were promised four new computers for the new OPD but we didn't get them. It's not an electronic filing system.*
>
> *Yes, they actually came down and spoke to all of our staff about it and it was going to go ahead but nothing happened then due to funding issues.*
>
> FG 5: East Dublin

> *And in some cases they might say well there are too many beds even. But we don't have the community services that they promised put in, to be able to reduce these numbers.*
>
> FG 7: North Dublin

Part 5: Staffing and Team Challenges

Six themes with regard to staffing and team challenges were identified during the process of data analysis and the weighting of these themes are shown in Chart 2:

Chart 2– Staffing and Team Challenges



Staff Shortages

> *I don't care what anyone says, without the correct staffing you cannot run a service.*
>
> FG 5: East Dublin

As Chart 2 shows, the issue of staff shortages dominated focus group discussions on the topic of staffing and team challenges.

Participants attributed staff shortages to a number of factors, not least the practice of not replacing staff who retire, and not replacing staff who are on maternity leave. This non-replacement of staff emerged as a key source of anxiety for the study participants as large numbers are due to retire in the near future:

> *Day hospitals, with the closure of St. Michaels, the day hospitals were very well resourced from a nursing point of view because we had extra nurses but they were never valued by the multi-disciplinary teams and as people retired in the last four years they were just stripped of the resources.*
>
> *We have ten retirements coming up so we are going to be in serious trouble.*
>
> FG 3: South Tipperary

> *In reality there are a lot of maternity leaves which are not being covered. We have nobody job sharing now we have one or two flexi timers but they are nearly ready to retire. We will have a good few retiring I would say within the next few years so we will have a load of vacancies again.*
>
> *We have a huge amount of retirements over the next three years and then there will be a huge gap, you know?*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

> *Our suicide prevention team members are both on maternity leave and have not been replaced, if they just paid for replacements, it would reduce admissions.*
>
> *That is one thing about maternity leave it is not covered full stop especially in the community.*
>
> FG 7: North Dublin

> *There has been a rotation of consultants, in and out and in and out of the services in the last eighteen months, so it is very unstable and it continues, there is an issue within the team going back to where they didn't replace*

> *cognitive therapists, addiction counsellors, family therapists, social workers, and a social worker gone on maternity leave for a year has not been replaced.*
>
> FG 1: Galway/Roscommon/Mayo

Participants highlighted the huge number and variety of posts currently vacant in the mental health services, as exemplified in the following focus group discussion extracts:

> *Staff shortages. We have currently 19 staff shortages within area 2. It was confirmed to me that there are 40 shortages within the super catchment area.*
>
> FG 5: East Dublin

> *We currently have 8 staff vacancies in the community. In the hospital there are also quite a few vacancies as well as 4 people who are in the middle of retiring, these are all experienced staff – one from a day centre, one from a ward, one from family therapy and one as a specialist.*
>
> FG 7: North Dublin

> *We should have 7 community mental health nurses, we only have 6, one recently became vacant and that's not going to be filled.*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

With so many unfilled posts, the following focus group discussion extracts offer a flavour of the consequent negative impact on service provision:

> *Our service is open seven days but Saturdays and Sundays is just one nurse so nothing can really happen and the nurses really can't do anything with intervention at the weekends or run anything because it's skeleton.*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

> *And it has happened in North Lee that the home based support team has been depleted at weekends because of staff so they then bring them into the acute unit.*
>
> *Yes, the acute unit does take precedence in our mental health services, unfortunately that is due to staffing issues in the community services and this is not right.*

Yes, there are five teams but there are only two mental health nurses on each of those teams to cover the whole population in community mental health nursing. There is the home-based crisis team then on top of it. There are seven nurses on the home-based crisis team but one of those is on the early intervention. Our old age team was set up last year but it didn't really kick into gear until I would say September for the simple reason, there is only one community mental health nurse. And last year there was a team set up for mental health ID but it is not a psychiatric nurse that is on that, it is a RNID.

FG 4: Cork & Kerry

This was an old hospital which has now become a recovery hub, not only that but they are asking community staff to come in and run programmes because they haven't staffed it to a degree that they can run programmes there. Managers are putting pressure on staff from the community to come in to run these programmes.

FG 7: North Dublin

Lack of Incentives

Participants also discussed a lack of incentives for staff to move out into community-based services and to relocate to rural areas:

These rural areas that I mentioned earlier on, there are no incentives for people to go out to these rural areas to work.

Yes, particularly as you cannot access Community Allowance. If a staff member wants to go out of the acute unit they will lose their location allowance, they will inherit nothing. They will not be entitled to unsocial hours payments. They'll really have to fight if they want to get a qualification allowance, if they qualify to attract that. They won't get mileage if they have to be travelling sixty miles in and out every day, unless you actually relocate and that is not on the cards for a lot of people who have families with kids in school, so there is no incentive to go out into these facilities, and they are really rowing against the tide in terms of these incentives. It is a total disincentive. FG 9 Louth Meath/Cavan Monaghan

Yes. Something that the organisation needs to think about is looking at the financial and economic factors around mental health. I think that where they are saving a few quid here and there for staff, and for mileage and allowances and things like that, the actual cost to the health of the community will be one hundred times that.

FG 1: Galway/Roscommon/Mayo

I know there was an advert up there recently for people to cover maternity leave but in community and home-based crisis but none of them will go because they won't get the allowance. The lack of Community Allowance is going to have a desperate impact and there is a very young female nursing staff and most of them are availing of maternity leave, parental leave, et cetera.

And the biggest elephant in the room is the lack of Community Allowance. People just won't go on the teams.

FG 4: Cork & Kerry

Indeed, one participant recounted the personal stark financial repercussions of having moved out to the community:

I took an 8,000 Euro pay cut to come out to the community. Yes this is stopping people.

If the policy is to strengthen community services, how are they going to incentivise people to do that if they are cutting their wages?

FG 7: North Dublin

Yes, the lack of community allowances is a big factor.

FG10: Sligo/Leitrim/Donegal

Inexperienced Staff

In discussing staffing and team challenges, participants expressed concern about the numbers of inexperienced staff operating in a mental health system

that is rapidly becoming depleted of its bank of expertise due to the high numbers of recent and ongoing retirements:

> *Another problem that I see is we have a huge number of newly qualified staff within the inpatient services, no fault of their own, these are young nurses, we value them, we treasure them, but the lack of experience within the services is very stark as well. So even getting these patients in and having a lot of young staff looking after them, without the level of experience in terms of how to access, for example, voluntary services.* FG 1: Galway/Roscommon/Mayo

> *From a nursing point of view, in my own area, two thirds of nurses are now eligible to retire in the next two years, it is horrific to think that a service could be depleted over two years, by two thirds of its nursing experience.*
>
> FG; 9 Louth/Meath/ Cavan/Monaghan

> *I don't know is it just in our area, but I don't know if there are any exit interviews with staff, there is a lot to be learned from this.*
>
> FG 1: Galway/Roscommon/Mayo

Education and Continuous Professional Development

A Vision for Change recommended that:

> Planning and funding of education and training for mental health professionals should be centralised in the new structures to be established by the Health Services Executive.
>
> A Vision for Change (2006)

Yet a number of participants talked of a culture of reluctance to release people from work to avail of training opportunities, a reluctance they attributed to staff shortages:

> *Training opportunities are very sparse on the ground, in terms of staff being able to be released from work, because of the constant pressure that is on, and when they do apply for training they are told no.*
>
> FG 1: Galway/Roscommon/Mayo

> *We applied in Blanchardstown to get a DBT but they wouldn't relieve staff to do the training.*
>
> FG 7: North Dublin

> In Carlow I'd say every third GP referral that comes in requests CBT. We have a psychologist post that can't be filled, we have one nurse trained in CBT but she really can't be released to do it because she is part of the team as well, you know? So training, because what we find is nurses really are going to stay in the service longer than psychologists, you know, so we need more nurses actually trained in CBT, so there is that.
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

One focus group discussion talked about the education of psychiatric nurses in the wider sense of the challenges involved in selecting the 'right candidate' for university courses but also the need for the education system to filter out students who are not showing the skills and attributes requisite for their future roles through adopting more rigorous monitoring and assessment procedures:

> *An assertive outreach team should have ten to fifteen psychiatric nurses with a caseload of twelve clients per nurse.*
>
> *How on earth are you going to fill that when there are only twenty-one nurses in this year's intake in UCC?*
>
> FG 4: Cork & Kerry

No Role Clarification on Teams

In discussing staffing and team challenges, participants' highlighting of a need for roles on community-based teams to be clearly defined resonates with the theme 'poor strategic planning' discussed earlier in this report:

> *There needs to be greater communication between all of the consultants, and between the mental health management, and all of the different teams, and we have heard crisis team and home-based team and assertive outreach team, and*

rehabilitation and recovery team, but these teams seem to differ every county you go to. There is no universal role, there are no actual specific grades or specific roles in any one team and this is what needs to be challenged by the Vision for Change going on into the future because it is not working the way it is. And if we are going to have services, which will please God, be of excellence, going down the road towards 2020 in Ireland, we need to get this right so we know what each team, each role, each person's job is.

FG:10 Sligo/Leitrim/Donegal

Yes standardized. I think if Vision for Change can get that right, it would make the pathway so much easier.

FG 1: Galway/Roscommon/Mayo

We have two home care teams but again they don't meet the criteria because to be a home care team you need a couple of nurses to cover the team, but that has changed, now they are just taking staff off the unit to cover, so it depends when you are on duty, you might be the home care nurse that day. So there is no consistency and it is not person specific.

FG 7: North Dublin

It is about trying to actually define what the teams are. We seem to have got a load of these CNS positions and that was great but it seemed to be like, okay we have applied for these CNS positions but we are CMN's essentially. They were put in there and it looks great on paper but can you really define your role?

We have five or six day hospitals and there seems to be a disconnect between how each of them deliver outreach. There is no structure in place. The roles are too much interchanged.

FG 6: Limerick/Clare

Staff Safety

In discussing staffing issues, some participants voiced concern for the safety of young, newly-qualified and inexperienced staff:

> *We have a lot of young staff in the Mater, newly qualified staff, and a lot of challenging behaviours, and where it is based in the basement of the hospital it can be quite difficult for the staff there to manage.*
>
> FG 7: North Dublin

> *Attached to St. Michael's there are seven liaison nurses but they cover the twenty-four hours and there is one scan nurse. Saying that, they are in a very precarious position because they are based down the corridor miles away from everyone and it is really dangerous for them to be assessing anyone before they are even seen by a doctor. They are in St. Michael's but they regularly go downstairs to the A&E but their designated area is down a long corridor if anybody is sent in from South Doc, for example. At night time to be down in this little cubicle on your own is not right. It is very dangerous, they are all very young nurses, with lots of qualifications but very little ward experience.*
>
> FG 4: Cork & Kerry

Another participant cited staff vulnerability to attack as a deterrent in attracting and retaining personnel in the mental health system.

> *The amount of staff that have been out on sick leave due to being assaulted has led to a huge decreased in our nursing staff numbers in this area and the younger staff who come into Mayo to work do not want to work in this area. Most recently we have had a young girl who was only two years qualified and she is out with the possibility of never returning to work at the moment she was that badly injured. So for this reason you have a complete lack of will from the staff to want to work in this area*
>
> FG 1: Galway/Roscommon/Mayo

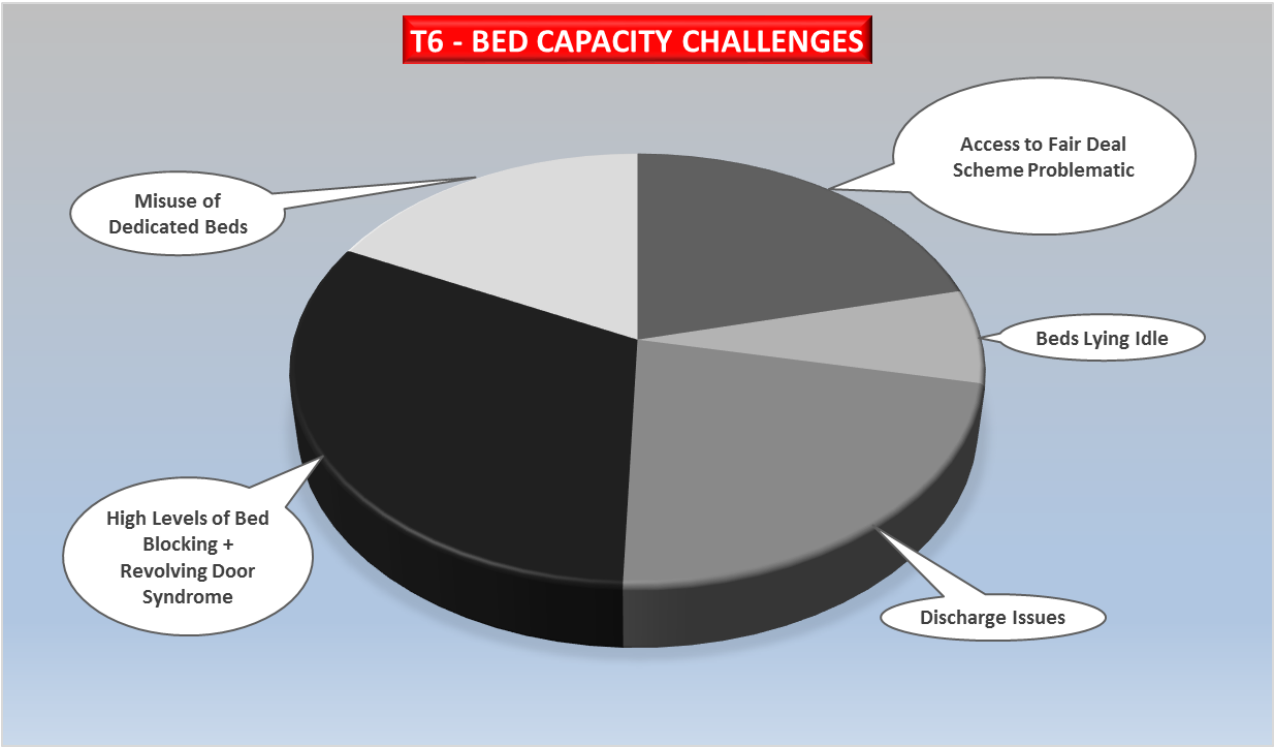
The failure to fully staff community-based services and reluctance to release people to avail of training opportunities discussed in this section runs counter to the recommendation in *A Vision for Change* that:

> Well-trained, fully staffed, community-based, multidisciplinary Community Mental Health Teams should be put in place for all mental health services.
>
> A Vision for Change (2006)

Part 6: Bed Capacity Challenges

Five themes with regard to bed capacity challenges were identified during the process of data analysis and the weighting of these themes are shown in Chart 3:

Chart 3 - Bed Capacity Challenges



High Level of Bed Blocking and Revolving Door Syndrome

The study participants frequently referred to high levels of bed blocking occurring in the system and offered a number of explanations for this phenomenon. One of the key bed blocking factors they identified was a lack of comprehensive community services to which patients could be referred for

ongoing support and such service deficits are discussed in detail in Part 7 of this report:

> *There is nothing meaningful, even if you have the best will in the world regarding comprehensive follow up for people, once you go home to get better and to go back to work and have a normal life, it doesn't always happen because people just get stuck again and end up being readmitted, you know, we can see a good bit of that revolving door.*
>
> FG 9: Louth/Meath/Cavan/Monaghan

> *What we are finding as well is a revolving door policy with a lot of the clients that moved from the locked unit, they are back out in the community a short while but they are back into us again.*
>
> FG 6: Limerick/Clare

> *The Vision is about having in place the right services at the right time to meet the needs of individual people rather than lumping everybody, as currently stands, into an acute inpatient unit, but this is happening because the services infrastructure is weak.*
>
> FG 4: Cork & Kerry

Participants pointed to high numbers of patients over the age of sixty-five occupying beds on a long-term basis, citing several reasons for this blockage.

Some patients were occupying beds long-term as a result of closures and amalgamations of institutional units having taken place but without alternative service provision having been put in place:

> *We have an issue with elderly care, we have a five-bedded unit attached to the acute unit but invariably there are one or two long-term patients there, and last year there could be two to three patients like that, you know, because we don't have a dementia unit.*
>
> FG 6: Limerick/Clare

> *We have a rehabilitation unit that's two four-bedded but there's no throughput, many of the clients that are in there would have been there since it opened.*

> *There would have been a closure, or an amalgamation really between the closure of the intensive psychiatric care unit and the old rehabilitation ward, so many of the patients who are young enough would still be there, others have passed on, you know, have died.*
>
> *And the same in Waterford we do have nurses working in the community houses but, like I said, a lot of the clients would actually be, although they are continuing with their rehabilitation team, they are actually over sixty-five and the aging population ... it's not, by any manner or means, an acute intervention or a crisis, it is long term.*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

Participants, particularly in the Galway/Roscommon/Mayo and Cavan Monaghan/Louth Meath focus group discussion, stressed the need for an intensive care rehabilitation unit in the region as a mechanism for freeing up acute beds and for providing appropriate care for patients in need of continuous and intensive care:

> *We have one patient in who is on a one-to-one special round the clock pushing on two years now. There is no light at the end of the tunnel and no plan for an ICRU that we are aware of and he is not deemed to be a patient that would go to Dundrum.*
>
> *The previous speaker mentioned the one-to-one special for the last two years, I have mentioned the two people who have required three-to-one special, one of these people has had this for the last four years, so this highlights the need for an intensive care unit along the Western seaboard that could facilitate patients like this and free up the beds in our acute units for the lesser acute*
>
> FG 1: Galway/Roscommon/Mayo

Participants also spoke of patients with enduring mental illness occupying acute beds in the long-term:

> *One example of bed blocking would be a man with Huntington's who has been in our acute unit for years now.*
>
> FG 4: Cork & Kerry

For instance, in our thirty-nine-bedded unit, we have five long-term rehab patients, and they have been there for about three years I'd say.

We have the same situation.

FG 6: Limerick/Clare

One participant succinctly summarised the vicious circle arising from deficits in the system whereby patients cannot be moved from acute beds because the services they need are not available in the community and, by default, people in the community who need acute beds cannot access them because they are fully occupied:

In the area that I work in there is a lot of bed blocking and revolving doors as was already said and misplaced service users as well, people that cannot be moved because of the lack of specific services that are required for these people, and this in turn means that there are people in the community who need beds who cannot gain access to the acute admission unit. The admission unit is thirty-two-bedded and in 2016 alone, on 3 separate occasions, has been closed for admissions, due to excess numbers – thirty-five to thirty-six on the books, and we have been informed in the community that we have to contact two out of area acute units if we do need an admission. Otherwise that or manage our patients very well in the community.

FG 1: Galway/Roscommon/Mayo

Discharge Issues

Participants suggested that poor discharge planning is the inevitable outcome of having a weak community-based infrastructure:

There is nothing to discharge people in a proper method. There can be no real discharge plans because there are no services to take up those plans and run them.

Exactly, and people get stuck then in our service. People are admitted into an acute unit where they may not necessarily ever have needed to be at all, and then if they have to be discharged, the resources to discharge them home to are very basic.

Yes, and there is no proper step down or acute management.

FG 10 Sligo/Leitrim/Donegal

While discharge planning may be absent in some areas, participants also talked of areas where "nobody is getting discharged at all", this being the case particularly for elderly patients and patients with enduring mental illness:

> *Can I say that we do have a problem in our service in that we never had proper discharge planning for old age.*
>
> *Yes. the problem that we currently have in our old age service and long-term enduring mental health service is that nobody is getting discharged at all. So we don't have movement. It has blocked up our hostels, it has blocked up everything.*
>
> *Yes, when a patient comes into the unit they just think 'oh they are out of the way now, the nurses will look after them'.*
>
> *Which is really custodial care in a community setting actually.*

FG 5: East Dublin

Some participants talked of consultants' reluctance to discharge patients:

> *There has always been a fight for beds even at the moment, we are always fighting with the consultant to come in to discharge somebody. It is always full, at the moment it could be 105% even.*

FG: 9 Louth/Meath Cavan/Monaghan

And indeed, the absence of appropriate community-based services to which patients can be discharged may be evidenced in an instance cited by a participant based in the Cork and Kerry area:

> *And patients who are being lately discharged, where would they go to? Is the only option enduring mental health high support hostels?*
>
> *Yes, they are the only options, But I know that one gentleman, he was in the acute unit, but they couldn't find a placement for this fifty-six year old gentleman, so he actually has ended up in a nursing home, which is absolutely most inappropriate.*

FG 4: Cork & Kerry

Access to Fair Deal Scheme Problematic

Many participants talked of the slow and complicated processes involved in the Fair Deal Scheme for elderly patients as a significant factor in blocking beds:

> *The whole impetus now is that we are like a holding station for nursing homes, for Fair Deal.*
>
> FG 6: Limerick/Clare

> *We have got some long stay patients out and into nursing homes through the Fair Deal Scheme, so it does happen, but it is a slow and long process. It can take up to two years like.*
>
> FG 4: Cork & Kerry

> *With access to the Fair Deal Scheme it is a huge problem again for beds in the acute services. We have to go through the general hospitals system to access the Fair Deal Scheme for particularly elderly patients who would probably be heading towards a nursing home environment going forward, and that is a major problem, it results in bed blocking. Say on a forty-five-bedded unit you might have seven or eight of those beds blocked on an ongoing and continuous basis.*
>
> FG 1: Galway/Roscommon/Mayo

Misuse of Dedicated Beds

Many of the study participants talked of service users being misplaced in acute beds because the facilities in the community are not adequate to their needs:

> *They might be in a house, and perhaps exhibiting very challenging behaviour, such as agitation or aggression and they cannot be managed there, and because they have nowhere else to go they come into the mental health services and take acute beds.* FG:10 Sligo/Leitrim/Donegal

> *What is happening is those who would have traditionally availed of that service in Ballinasloe are taking up beds in the acute unit in Galway, but they are needing specialist one-to-one on an ongoing, long term basis, it is not fair on the patient themselves as they are not getting the level of care they should be, the rehabilitation or the intensive care that they need.*

FG 1: Galway/Roscommon/Mayo

.

The reality is that if I went to my GP this morning, if I had a crisis, I would be veered towards the acute unit and not toward any day hospital, that is 70% of the time isn't it?

FG 6: Limerick/Clare

And this misplacing of patients, some participants suggested, is not only occurring in acute units but in other pockets of the system where beds are dedicated to a particular service user profile:

We have a POLL team in Roscommon set up now, it has been a full time job to retain the service within the parameters of psychiatry later life, the consultant within that team, has the full backing of other consultants because if they get short with beds in the acute unit in Roscommon, they will parachute someone in on Friday evening who does not fit the criteria for this specialist unit that we have, of twenty-two beds, it will just be someone sent down on a Friday evening at 5 p.m. into an area that is totally wrong. There seems to be a blurring everywhere of lines across all the Vision for Change. If this is a psychiatry for later life unit people should only be coming into it at age sixty-five or over. The Vision for Change, in our service, they have used parts of it for their own end, parts that suited them. The other parts then were totally alienated out of it.

FG 1: Galway/Roscommon/Mayo

We don't have a crisis house, we have a respite unit that is now being called a crisis house/bed unit.

FG 2: Carlow, Kilkenny, Wexford, Waterford

Can I just say as well that we, using twenty-nine beds, we have acute inpatients utilising beds in our high support hostel.

FG 8: Kildare/Midlands

Beds Lying Idle

Given the gravity of bed capacity challenges discussed in this section, it is hardly surprising that, in three of the focus group discussions, participants should lament

the renovated but 'never reopened' mental health units wherein beds are currently lying idle:

> *We had a low support hostel that was renovated about two-and-a-half years ago but never reopened. So the three people that were in it were pooled back into the twenty-six bed high support unit.*
>
> FG 8: Kildare, Midlands

> *We have Grace Park which is part of the rehab team, the rehab team hasn't taken over all the hostels; there was a five bed house renovated four years ago and it has remained empty ever since.*
>
> FG 7: North Dublin

> *We have an acute unit which is being renovated at the moment with thirty-four beds, and four of those beds will be high observation for challenging behaviour, a more secure area with less stimulation. Unfortunately it is not opened yet due to lack of staff. It has been finished for twelve months but it is lying idle.*
>
> FG 4: Cork & Kerry

Arguably, the failure to resource community-based facilities has given way to many of the monumental bed capacity challenges discussed in this section. It has resulted in high levels of bed blocking and revolving door syndrome, and it has led to a situation where many individual mental health service users are being denied the care that is appropriate to their needs. Clearly, this failure to develop a comprehensive community-based infrastructure to accompany closures of traditional mental health institutions is completely at variance with the ethos and recommendations articulated *A Vision for Change*:

A plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources released by these closures should be protected for re- investment in the mental health service.

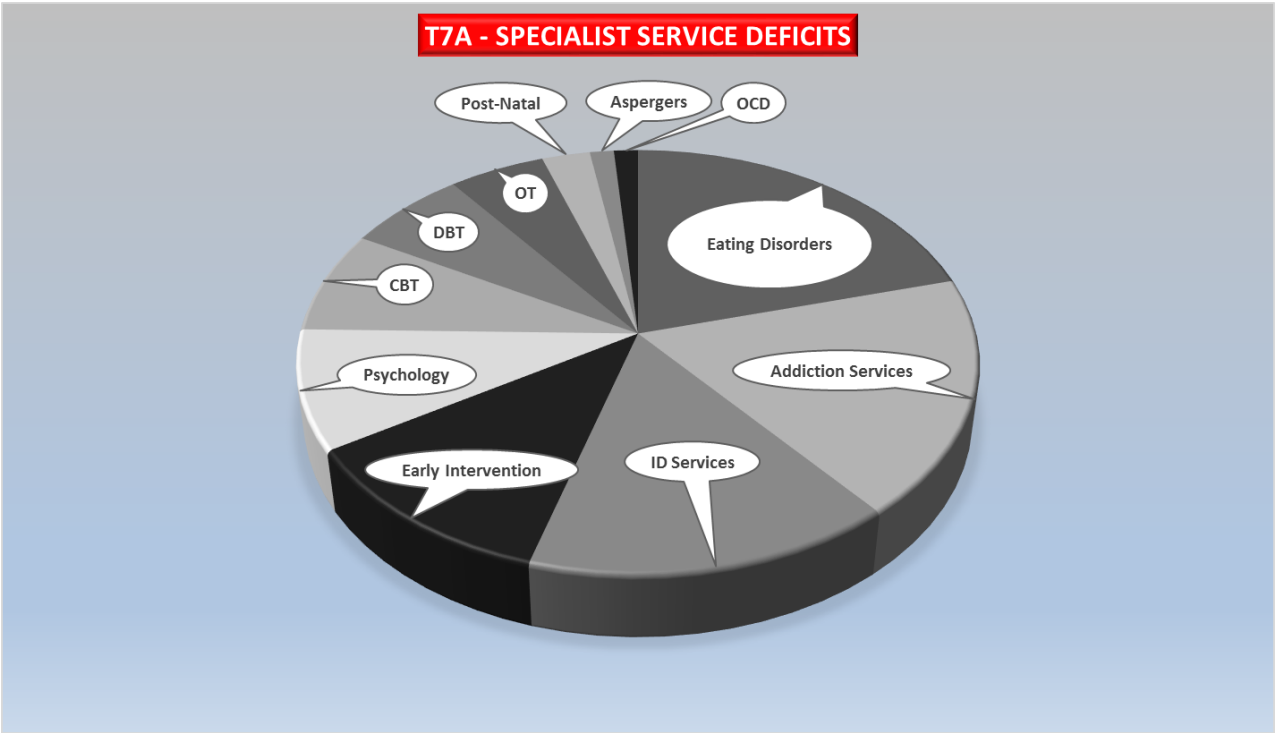
A Vision for Change (2006)

Part 7: Deficits in Service Provision

Deficits in Specialist Services

Participants highlighted a multiplicity of deficits in specialist service provision as shown in Chart 4:

Chart 4– Specialist Service Deficits

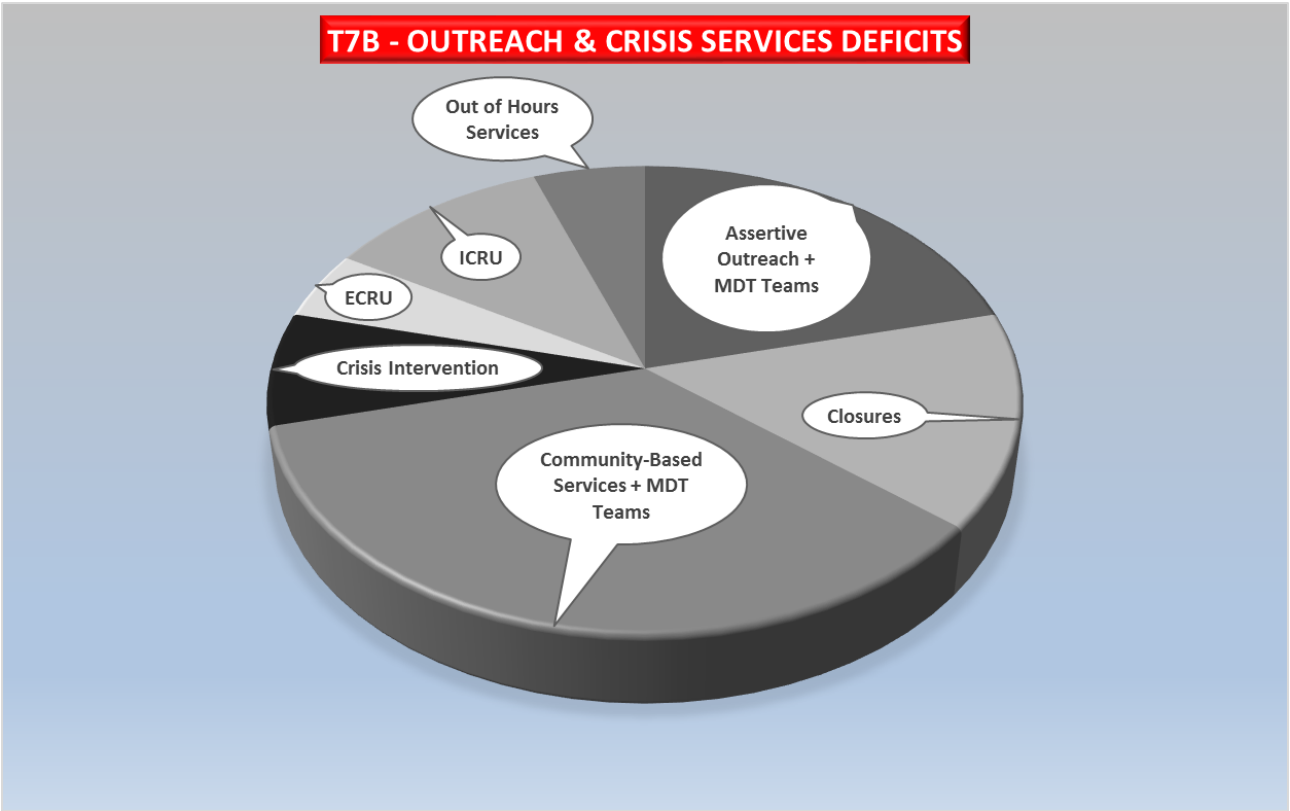


As Chart 4 shows, the top four most frequently cited deficits in special service provision included alcohol and drug addiction services, services for people with eating disorders, early intervention and ID services, and the impact of such deficits on service users in discussed in part 9 of this report.

Deficits in Assertive Outreach and Crisis Services

The key deficits in assertive outreach and crisis services that were identified by the study participants are shown in Chart 5:

Chart 5– Deficits in Assertive Outreach and Crisis Services



Assertive Outreach and Multi-Disciplinary Teams

As the following focus group discussion extracts demonstrate, almost all of the study participants said either that their service had a poorly staffed assertive outreach team or that they had no outreach team at all:

In our area, the deficit would be the lack of teams, teams are non-existent, last year we had one home-based treatment team set up in Roscommon. It is not fully staffed and it only covers a part of an area in Roscommon, spread very thinly on the ground, as Roscommon is a very rural county.

FG 1: Galway/Roscommon/Mayo

There is no assertive outreach team in Kilkenny.

Rehab team, we have one CNS and a part-time consultant. There are two nurses, one is a CNS, and there's the outreach, a CNS as well, but you couldn't call it an assertive outreach service, it has been downgraded.

FG 2: Carlow, Kilkenny, Wexford, Waterford

We have no assertive outreach team. FG 9 Louth/Meath/Cavan/Monaghan

There was an assertive outreach team on paper a long time ago, on paper with one nurse on it, but she either resigned or retired.

Assertive outreach – zero

FG 4: Cork & Kerry

Well with Ferndale, unfortunately it is all ad hoc depending on the service needs elsewhere, and if we are stuck short for a nurse we can pull that nurse to the acute, so then your outreach at night is gone. We are pulling nurses out of day hospitals, day centres, from across the board, we don't have a proper function in outreach. The structures are kind of dodgy, aren't they?

FG 6: Limerick/Clare

Community-Based Services and Multi-Disciplinary Teams

The following focus group discussion extracts demonstrate that almost all of the study participants said that their area lacked comprehensive home-based teams and services, and did not have crisis housing:

There has been no community service developed there is nothing to alleviate pressure on acute beds, there are no core based treatments teams, there is no crisis house FG 9 Louth/Meath/Cavan Monaghan

Yes, that is my issue as currently we do not have home based treatment teams.

There is a huge lack of services within the system, we are totally reliant on inpatient services FG 10 Sligo/Leitrim/Donegal

In Galway we do not have any home based treatment team, there are meetings going on and a mad rush to get them up and running, so we are in consultation at the moment with management in relation to the makeup of those teams. There is no outreach in the plans there is no crisis housing as such, even though we would have one high support hostel in the city, one high support hostel in Carraroe and one high support hostel in Clifden.

FG 1: Galway/Roscommon/Mayo

There's no acute day hospital's in Waterford, there's no home-based treatment team, there's no crisis house

FG 2: Carlow, Kilkenny, Wexford, Waterford

So the reality is that, from a risk perspective, the acute beds are seen to be the priority, however, there are people living in the community who are in crisis – we are not human resourcing the community appropriately.

There are no low support hospitals and there is no crisis house.

There is no crisis house in Kerry.

FG 4: Cork & Kerry

We have no crisis house

FG 5: East Dublin

Crisis Intervention

In similar fashion, a number of the study participants said that crisis intervention services were either inadequate or non-existent in their area. Indeed, a participant in the Cork and Kerry focus group discussion conveyed a palpable sense of exasperation at the failure to develop a crisis intervention model as recommended in *A Vision for Change*:

A lot of the other things are lacking in Kerry. We have no crisis house, crisis intervention is a joke, it is 9 to 5, and it should be at least 8 to 8, as per the model. If staff are off on holidays they put a message in their phone, as if to

say, 'don't have a crisis when I am away', or 'don't have a crisis Sunday morning'. A message on the phone saying 'NURSE NOT AVAILABLE PLEASE CONTACT YOUR GP OR A&E.' This is the carry on which is almost embarrassing. If they did the crisis intervention first and did it right, it would be something. We said to them 'can we do the psycho-social and get it right, at least if nothing else we will get that right?' And it is a model in the context of Vision for Change, a model that will work and a model that is there 24/7. But unfortunately it is like doing your window up for Christmas, people standing outside will get the impression that you have crisis intervention, family therapy, psycho-social intervention, but really you are only skimming the surface.

FG 4: Cork & Kerry

Closures

While the failure to develop a comprehensive community-based infrastructure to accompany closures of traditional mental health institutions has already been discussed, participants returned to the topic of closures in their discussions on outreach and crisis services, this time pointing to closures in the already fragile community-based services sector. Such closures, stemming from staff shortages, are having a profoundly negative impact on patients, families and communities, as reflected in the following focus group discussion extracts:

We have high support hostels and they have crisis beds and they filled a good function but that was all stopped.

In our acute unit, the North Tipperary patients had beds, they were closed, remember? They had a ten-bedded crisis house but that was closed, then they had an outreach team which was disbanded, and now the number for admissions in Clare has gone through the roof from North Tipperary.

We had a lot of high support beds and they closed. One of the big reasons they closed was the moratorium and we didn't have the staff so we couldn't keep them open. That was twenty or thirty beds gone.

The problem we have in Limerick is that we are actually over-subscribed for community beds in Limerick and there is always the danger of that hanging over you, that there will be another closure. We have 100% occupancy in the acute and in the community residence.

FG 6: Limerick/Clare

In the area that I work in two respite units were closed, they were closed on the premise that the staff would go back to support the four new centres in the major Irish town in this county. However a lot of the staff were at retirement age so they just went ahead and retired. The gain in nursing staff from these closures was minimal. The replacement in this community mental team is minimal and less than what would have been there prior to the closure of these respite units, so we are down in staff in these areas.

The day hospital we have in Roscommon, last year they closed the day centre which catered for a lot of elderly and they moved it into the day hospital which is totally unsuitable and goes against everything in the Vision for Change, and it was also unsuitable for the cohort of people attending that, they have to attend a local restaurant for lunch now and they are going to have to be accompanied by somebody. It is humiliating for them

FG 1: Galway/Roscommon/Mayo

We have no Addiction Services, we are lucky though that we had close links with Naas General, there was an addiction substance misuse nurse there, but she retired last year, she was based in the hospital and she won't be replaced and she would have seen a lot of our patients who attended A&E, so they have seen a huge feedback from the nurses in the A&E. We were very reliant on that service.

FG 8: Kildare, Midlands

ICRU

All but one of the study participants said their area had no Intensive Care Rehabilitation Unit / Emergency Care Research Unit to accommodate profoundly mentally ill patients, and the potential repercussions of this lack, for staff and for other patients, was discussed in one of the focus group sessions:

And I suppose one of the issues in terms of access to beds and things, not so much to acute beds but also the intensive kind of ICRU beds, is that, in general, staff feel that people can be quite inappropriately placed in the rehabilitation unit.

You're saying that some people who are in rehabilitation are there inappropriately?

They are not being rehabilitated.

No, but they are not appropriate for it either.

I would say, if we did, by some miracle get the ECRU unit, the regional unit, I would say maybe five could come from the rehabilitation unit right away; five beds could be filled immediately.

FG 2: Carlow, Kilkenny, Wexford, Waterford

Out of Hours Services

Almost all of the study participants said that their area could not offer meaningful out of hours services because of staff shortages:

It is all 9 to 5 and it's all Monday to Friday, there is no 7/7 cover as per the Vision for Change and that seems to be across the board, so everything, outside of service hours, the emergency department is called, which is not exactly good.

FG 7: North Dublin

Our service is open seven days but Saturdays and Sundays is just one nurse so nothing can really happen.

FG 2: Carlow, Kilkenny, Wexford, Waterford

There is one 7-day service in our demographic county of 130,000 population, this is not a 24 hours service, it is a 9 to 5.30 service with one nurse on at any given weekend. Other than that it is West Doc for one particular large town, and it is A& E or the acute unit for the rest of the county.

FG 1: Galway/Roscommon/Mayo

Our crisis team work from 8 a.m. until 3.30 a.m. and that is 24/7. The only problem we would have with that, if you go through the stats, is the increase in admissions after 3 a.m. and a lot of the time you know that if the crisis team were in situ that would be sorted.

FG 6: Limerick/Clare

In view of the profound gaps the participants identified in provision of community-based specialist services, assertive outreach and crisis services, is clear that the mental health service of today falls far short of that envisaged in *A Vision for Change* (2006), not least in its recommendation that:

> To provide an effective community-based service, Community Mental Health Teams should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families.
>
> A Vision for Change (2006)

Part 8: Regional Inequalities and Geographical Issues

A vast array of inequalities in service provision was identified in analysis of the focus group discussions. Such inequalities relate to geographical spread and location of catchment areas, to mental health patients being treated differently to the rest of the patient population, and to bureaucratic issues that lead to people being displaced from their home and hearth in order to receive appropriate care.

In terms of catchment areas, inequalities were identified both within and between regions, with rural areas suffering the most, and predominantly in the Galway, Limerick, Kildare and Midlands areas.

In the Galway region, service provision is spread over a vast geographical expanse that comprises not just large swathes of isolated rural areas but also the off shore islands rendering it difficult for people to access the services and also difficult for staff to outreach to areas that are known to have high levels of mental illness:

> *I would concur with the previous speaker in relation to what she had said also, that there are huge challenges. Demographically, we are a huge widely spread area and access to services for people who really need them are a huge challenge.*
>
> *We incorporate off shore islands here too, and those people are totally forgotten about, their transportation systems are being eroded away, as things stand this has been quite highlighted in the media and the fact of the matter is that the mental health services are very sparse out there. They are an indigenous population who need to be catered for and they have the same rights as everybody else, and we have certain responsibilities to these people. But they are not included on anyone's agenda and access to these islands in the winter is quite difficult, you know, there are dangers attached to travelling to these locations – when we are flying over there we are going on a kite, it's a four seater and it's about 60km above the water. I don't want the islands*

> *forgotten about in all of this as well as they are quite well populated, there is a lot of mental illness out there as well, and traditionally the whole Connemara area has been highlighted as one of the world black spots for illnesses like Schizophrenia.*
>
> FG 1: Galway/Roscommon/Mayo

In terms of mentally ill patients being treated differently to the rest of the patient population, inequalities may be evidenced in disparities between rights accruing to people accommodated in general hospitals and rights accruing to people accommodated in acute units, for example, with regard to step down entitlements and gaining access to the Fair Deal Scheme, as demonstrated in the following extract:

> *You know the way normally if someone presented into a general hospital they are entitled to their two week step down? For example, if you were in Galway Hospital and you were coming back to Roscommon, you would be entitled to respite in Roscommon Hospital for two weeks or a nursing home, but you cannot get that if you are in an acute unit Galway.*
>
> *It is a discriminatory system, it discriminates against people with mental health difficulties and it is a long standing system that is there. I don't know of any mechanism that has been addressed to try and redress that situation but it is a fact of life and it causes huge problems within our system in terms of bed blockers. And once somebody has a bed within a mental health unit in the hospital they are not deemed appropriate for transfer to the general side so they cannot access these services, so it is a total Catch 22 situation that makes absolutely no sense, it bed blocks, it is not cost effective, there is no reasonable rationale for why this should be the case, we are continuously rowing against the tide here, to get these people access to proper services, and going forward, to get them out of the acute system.*
>
> *Again services for the older people, we cannot access, and I want to stress this, we cannot access the Fair Deal Scheme at all. If they come into the general hospital they can access the Fair Deal Scheme, we have to beg, borrow and steal and pull strokes to get them over there.*
>
> *If people are going to be assessed for the Fair Deal Scheme, it has to be the geriatrician from the general hospital. We have a geriatrician in our POLL*

service, and can't access the Fair Deal Scheme. It makes no sense as they both do the same job, dealing with the older population in the country, but one can access the Fair Deal Scheme and one can't. I would call it an Unfair Deal Scheme for people with mental health issues.

FG 1: Galway/Roscommon/Mayo

Focus group participants in the Galway, Mayo, Roscommon, Louth Meath and Kildare Midlands areas pointed to bureaucratic issues that lead to people being displaced from their home in order to receive appropriate care and the impact this has on service users:

I think that Mayo is one of the first places that initiated the rehab and recovery team, and it does cover the county, but the difficulty is that in order for somebody from the sector I work in in Ballina, or the opposite side of the county, Ballinrobe, or Achill Island or somewhere like that to be housed or taken under the care of the rehabilitation team, home-based team, assertive outreach team, it seems to have a different heading all of the time, but in order for somebody to come in under that umbrella they have to be referred, firstly for assessment and secondly to be seen by the consultant, and then if that consultant deems them okay they can be managed under rehabilitation and recovery. That person must then move to the sector, so must move to Castlebar, so we have had instances where service users have had to leave Ballina, have had to leave their own environments, their communities, their GP, everything, to go and live in the Castlebar sector in one of the three group homes which are five to six bed group homes, in which they would then pay rent, or find private rented accommodation.

Yes, I could give an example of a young lad who, due to lack of employment, due to the acuteness of an illness and the fact that he had come through a kidney transplant, he was taken under the umbrella of the rehabilitation and recovery team, but he had to move away from his very elderly father who now lives alone in the home just outside Ballina in a very rural area. He is now renting accommodation in Castlebar with money he had saved in previous employment that is paying his rent, he is not qualifying for disability allowance at the moment, even though that has been pushed through. So we have service

> *users where it is not working on the ground. Yes, it works for people who live or have their ties with the Castlebar area, but for anybody from outside this sector, you must move there or else you suffer the other side of it.*
>
> FG 1: Galway/Roscommon/Mayo

> *It does happen that sometimes an admission is advisable but the person may choose not to take it. Recently an elderly lady admitted to us was offered a bed in Portlaoise and she declined because her elderly sister was still living at home and what happened then was that because this was the psychiatry of later life team there was no follow up at the weekend; but this lady was not going to move to Portlaoise because of the distance from her sister.*
>
> FG 8: Kildare Midlands

Speakers in the Limerick/Clare focus group discussion talked of the implications for individual patients living in areas where the catchment areas differ for medical and psychiatry, necessitating people to drive long distance for medical clearance and admission to psychiatric units:

> *We all know of unfortunate people who have driven to Kilkenny to be medically cleared only to be told to come to Ennis for an admission. Distraught people driving around the country at 3 o'clock in the morning because there is no space for them. This is the catchment area, so the catchment area for them for the medical was Kilkenny but the catchment for Psychiatry is Ennis.*
>
> *We have got patients presenting but they will refuse point blank to go to Limerick for medical clearance, they won't go. There is a decision made then, they are admitted or they are not admitted, and if they are admitted they can admit to having taken some sort of an overdose, but how can they be kept in the acute unit if they are never medically cleared? It is very dangerous, like.*

And one participant offered an example of a particular instance whereby a man had been obliged to drive long distances in order for his wife to be medically cleared and then admitted into the mental health services:

> *A man arrived with his wife about two years ago, at about 2 o'clock in the morning, up to our unit, and he was asking if he could go home and I was*

saying to him will you wait until your wife is seen. He said that he had been on the road all day, his wife had taken an overdose the previous night, he had gone to his GP and she had been referred to Kilkenny, he was from the other side of Thurles, so she was referred to Kilkenny hospital, she went to Kilkenny hospital and was kept there all day until they felt that she was medically clear. Then she was discharged from there but was referred to our services, he then had to drive from Kilkenny to Ennis, now it would have been easier for him to carry on and go to Dublin, and then he had to drive home to Thurles again – that is ridiculous and it drives me mad.

Why was she not sent to Limerick?

Until the redevelopment happens, all of North Tipp are going to Ennis.

The population of North Tipp, they are really being disenfranchised, in a way they are like wandering nomads up there.

The infrastructure, as in the Vision, the infrastructure is not there. This man still had to go to Kilkenny to be medically cleared and there was a decision made to admit this lady into something, in theory she could have been admitted into a crisis house near Tipperary so there would have been no need to go to Clare at all.

FG 6: Limerick/Clare

This section has discussed some of the inequalities inherent in service provision, focussing particularly on inequalities in relation to catchment boundaries which run counter to the recommendation that:

> The mental health services should be organised nationally in catchment areas for populations of between 250,000 and 400,000. In realigning catchment boundaries, consideration should be made of the current social and demographic composition of the population, and to geographical and other administrative boundaries.

A Vision for Change (2006)

Part 9: Impact on Service Users and Their Families

The negative impact on service users of the flaws, failings and shortfalls in the provision of mental healthcare services may be evidenced across preceding sections of this report. In summary, high levels of bed blockage has given way to a situation whereby patients are being denied access to the particular care type that is most appropriate to their specific needs. Patients are badly served in areas that lack outreach teams, home-based services, crisis housing and intensive care rehabilitation units. Patients are being deprived of care in areas where closures of hostels, respite units and day centres have taken place within the already fragile community-based services sector. Inequalities in service provision in relation to geographical spread and location of catchment areas has disenfranchised service users living in remote areas and led to some service users being obliged to travel long distances, and others to relocate, in order to access services. Regarding patient rights and entitlements, particularly in relation to accessing step down support and the Fair Deal Scheme, mental health patients are being treated differently to the rest of the patient population.

Chart 4 in part 6 of this report showed the range of deficits in specialist service provision identified by the study participants. Such specialist service deficits means that particular client groups are being denied access to mental health support in the communities in which they live; and the unserved or badly served client groups the participants cited most frequently were people with addiction problems, people with personality disorders, people with eating disorders and people with intellectual disabilities, as demonstrated in the following extracts from focus group discussions:

> *In the demographic of Limerick we have the highest rates of people presenting with suicidal issues/ self-harm and there is no DBT on an outreach programme or day hospitals and it is correlating that these people have personality disorders. It is correlating that these people have personality disorders, let's call a spade a spade like, and they are blocking beds left, right and centre – it is unbelievable, even at the moment I would say there is ten. If someone came*

into the unit this morning with a personality disorder nobody in the acute unit has DBT training.

FG6: Limerick/Clare

We have one dietician for eating disorders throughout the whole county, a very large demographic area, as I mentioned, of 130,000 people. In the past six months we have had four one-on-one specials in our acute unit alone for eating disorders, so there is a huge lack of knowledge and skills on the ground to deal with that, and the one dietician that we have, there is a waiting list to access her and to be able to facilitate her in the community.

FG 1: Galway/Roscommon/Mayo

There is a mental health and an intellectual disability but because they fit into the mild ID category, one of them has been at home. There are actually no services for them to go to. Services in the region, like Camphill, aren't in a position to take them because they are mild, and Brothers of Charity, when they come to assess them, they don't fit into their admission criteria.

FG 2: Carlow, Kilkenny, Wexford, Waterford

The area that I work in, Ballina, is a more populated area than Castlebar, it has half the population of Mayo, 60,000. We are seen as the youngest population for mental health service users in the whole of Ireland, we have been told that recently, with a lot of eighteen- year-olds and upwards, EUPD's in their early twenties, they cannot access these services due to the bed blocking which is taking place

FG 1: Galway/Roscommon/Mayo

There are a lot of problems with patients dabbling in drugs and there is a big heroin problem in this area and that would be a big problem for the people who would fall into the EUPD diagnosis and maybe if there were crisis houses they would be fine.

FG 4: Cork & Kerry

The study participants also spoke about the negative impact on service users of placing patients in accommodation that is not appropriate to their specific

needs. For example, placing very unwell patients in community residences can sometimes discommode patients already living there:

> *We would have a 24-hour supervised hostel, I would say that the facilities aren't great, but you adapt to what you have, so it is probably a bit unfair, you know, that their lives are turned upside down when somebody who is very unwell comes in, so on that side of it it's not great, but in terms in keeping people out of hospitals, it is to balance that out, to do good versus to do better.*
>
> *The other thing that we have to take account of is that the people in these houses have to pay rent, so if you have someone parachuting in, putting it simply they are using the electricity, they are eating my food and stuff like that, it adds to the mix and it discommodes, it upsets the atmosphere in the house.*
>
> *In Clifden, we use a respite bed to prevent admissions because of the demographics of the place, it's fifty miles out, it works quite well but it is not enough. It is a high support hostel with a respite bed in it which we utilise because of its distance away from the hospital but obviously you cannot put every patient in there, as one of the previous speakers said, because you discommode the patients that live there.*
>
> FG 1: Galway/Roscommon/Mayo

> *So we have one guy who's there nearly a year I'd say at this stage. He's in the sub-acute but to be honest our sub-acute is locked almost all of the time so we have become a fully locked unit whereas our sub-acute would have been open for a number of years. But what will happen is the consultant will document in the chart: for this reason we need to have the doors closed; you know, it affects the rest of the service users as well.*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

One of the speakers recalled an instance whereby a seriously mentally ill patient was placed in a residence and the presence of this patient had a very disturbing effect on the residents:

> *Two years ago I was working in a hostel where they have long term residents of all ages and on a Friday evening a consultant referred in an man with huge social problems, very risky, and I couldn't get a risk assessment done. I rang my DON because I knew this was all wrong, my DON got a two page letter of*

complaint about me trying to hinder the admission of a vulnerable adult into the services, even though this person was parachuted into a room to share a room with a young man who was extremely vulnerable, and it was wrong on all ends. We won't go into the details but suffice to say that over the next couple of months he had to be changed around to the acute unit, he had to be moved by the Guards eventually, and he is now in jail for seriously assaulting an elderly gentleman in the town. We had staff on their own on night duty in that unit, and the knock on for the rest of the residents was horrific. That happens all the time and at the minute now they are taking down beds in that unit to stop this nonsense going on on a Thursday or Friday, landing someone totally unsuitable.

FG 1: Galway/Roscommon/Mayo

Focus group participant talked of overcrowded conditions and the impact of this on the dignity of service users:

There are forty-four beds but inside the acute unit there's high support. Recently there have been five extra patients so there are five beds on the floor in corridors which is horrendous, in terms of dignity.

And considering that there are people who are very acutely unwell, potentially more volatile, more distressed, services are piling five in a room, 50% above capacity.

I should mention that there are five people with visitors and things and if you have five beds on the floor and they have only two visitors each that's a huge amount of people in a busy area.

FG 2: Carlow, Kilkenny, Wexford, Waterford

I will just say I am in a high support hostel with one step down bed. It was initially envisaged that that hostel would be five beds. It was deemed that one of the rooms wasn't sizeable enough for a bed so it was made into a nurses' office. It is envisaged, due to an individual in the hospital in the inpatient unit needing a high support hostel, that somebody from that high support hostel will move into that bedroom that was deemed not fit for purpose to accommodate somebody new.

FG 8: Kildare, Midlands

In contrast to discussing the impact of overcrowded conditions on service users, other participants talked of the impact on patients of living in residences where they are completely isolated and bereft of supervision:

> *The rehabilitation team is catering for all of Limerick. And they are so stretched because they are dealing with the acute, with the community, they are so stretched that they might not get anyone visiting them at all in houses.*
>
> FG 6: Limerick/Clare

Having considered the negative impact on service users of the flaws, failings and shortfalls in the provision of mental healthcare, the next section considers areas where successes in meeting the recommendation of *A Vision for Change* (2006) have been achieved.

Part 10: Pockets of Success

Some focus group discussion participants talked of successes in their area of meeting some of the recommendations put forth in *A Vision for Change* (2006):

> *There have been some small success we have a group led by service users themselves, which is good, but compared to Vision for Change, Recovery Ireland Services seem to be trying to implement them but not fully supporting them or resourcing them.*
>
> FG 7: North Dublin

> *I would say that we have a home-based treatment team set up in Roscommon, it is not a full team though by any means and there are three nurses, the other people that should have been on the team are in the community mental health team. But as a resource, I had a call recently on a Sunday from a family that needed someone to come in, and it was the first time in twenty years that they were able to say 'I need somebody out here now'. It changed the whole dynamic of how the family were able to cope and made a huge difference. Ultimately they had to bring the person into hospital but it wasn't as dramatic as it would have been previously, it stopped at having to have assisted admission but it involved a shorter admission for this person, but if there had been a crisis house there in that situation that person could have been brought to a crisis house and home again in a day or two, so that is where the gap is.*
>
> FG: 1 Galway/Roscommon/Mayo

> *Just to say we have DBT programme for those with borderline personality disorder in Waterford*
>
> *Yeah, we have that in Wexford too*
>
> *We have it in Kilkenny*
>
> *We have it in Carlow*
>
> FG 2: Carlow, Kilkenny, Wexford, Waterford

> *We have one nurse for early intervention psychosis attached to the home-based crisis team. She is a CNS actually. And it is a very new service, there are*

actually two consultants doing research on early intervention psychosis at the moment in South Lee.

We just have the self-harm nurses and they are 8 to 8. That is a good service that was brought in.

FG 4: Cork & Kerry

We actually have an ICRU

FG 7: North Dublin

All of our sectors are 7/7, apart from psychiatry of later life and the rehab team, so all the other sectors. The community mental health team provides cover for weekends, and each sector base usually leaves one CNS on with somebody from the day hospital.

FG 8: Kildare, Midlands

Over the course of the focus group discussion in South Tipperary, it was established that a number of elements of service provision were functioning in accord with the ethos and recommendations articulated in *A Vision for Change* (2006). Such elements included: three fully staffed and operational adult mental health teams; an assertive outreach team providing a 7 day service; a single point of entry for referrals to be triaged operating 24/7; a single healthcare record that follows the service user, albeit in hard copy rather than electronic format; and adherence to the principle that patient stays should not exceed seventy-two hours, although, in reality, bed blockages are hindering putting that principle into practice. However, if these process and practices in South Tipperary could be considered praiseworthy, the stark contrast with the dearth of services available to service users in North Tipperary serves as a reminder of stark inequalities embedded in the mental healthcare landscape.

In a similar vein, service users in the catchment area for Cluain Mhuire in Dublin are well served in comparison to other catchment areas and participators in the East Dublin focus group discussions attributed the success of the service to the dogged determination of personnel involved is developing community-based services:

There is a phenomenal and huge community service, there was no stoppage to them appointing staff, throughout the embargo they were able to get staff, but they used to steal them from the hospital, they are actually very proactive in keeping community teams going.

So you are saying that because of the investment in community services you are actually reducing your admissions?

Yes, they try and keep patients out at all costs. They have heavily invested in the teams. They have a very proactive service.

Do you have a rehab and recovery mental health team?

DETECT is on the go there now for around ten years, it's an early intervention team.

That is a sub team of rehab and recovery which all services are supposed to have, it is interesting that you are the first we have come across.

FG 5: East Dublin

This section has highlighted areas where successes in meeting some of the recommendation of *A Vision for Change* (2006) have been achieved, with South Tipperary and East Dublin regions identified as reaching a high standard of care in some of their community-based services. It may be concluded that successes are patchy and that availability of services and standards of provision vary greatly within and across the twenty-six counties. And the final section of this report offers a regional analysis of the issues and concerns raised by the study participants, followed by an outline of the key infrastructural prerequisites they identified for full implementation of *A Vision for Change*.

Part 11: Key Infrastructural Prerequisites for Full Implementation of VFC

Table 2 shows the themes, issues and concerns identified in data analysis and discussed in preceding sections broken down by regions:

Themes, Issues and Concerns by Region

The cross regional analysis of the eleven inductively coded themes shows similarities and differences across regions. The themes recovery principles undermined, poor strategic planning of infrastructure for community-based services, staffing and team challenges, bed capacity challenges, specialist service deficits, outreach and crisis services deficits and key infrastructural prerequisites for full implementation of AVC were common to all focus groups.

The theme missing linkages and connections was talked about in Cork and Kerry, Limerick, North Dublin, Kildare Midlands, Sligo, Leitrim, Donegal and Louth/Meath/Cavan Monaghan focus groups.

Broken promises were talked about in Carlow, Kilkenny, Wexford, Waterford, Cork and Kerry, East Dublin, North Dublin and Kildare, Midlands, Louth, Meath, Cavan and Monaghan.

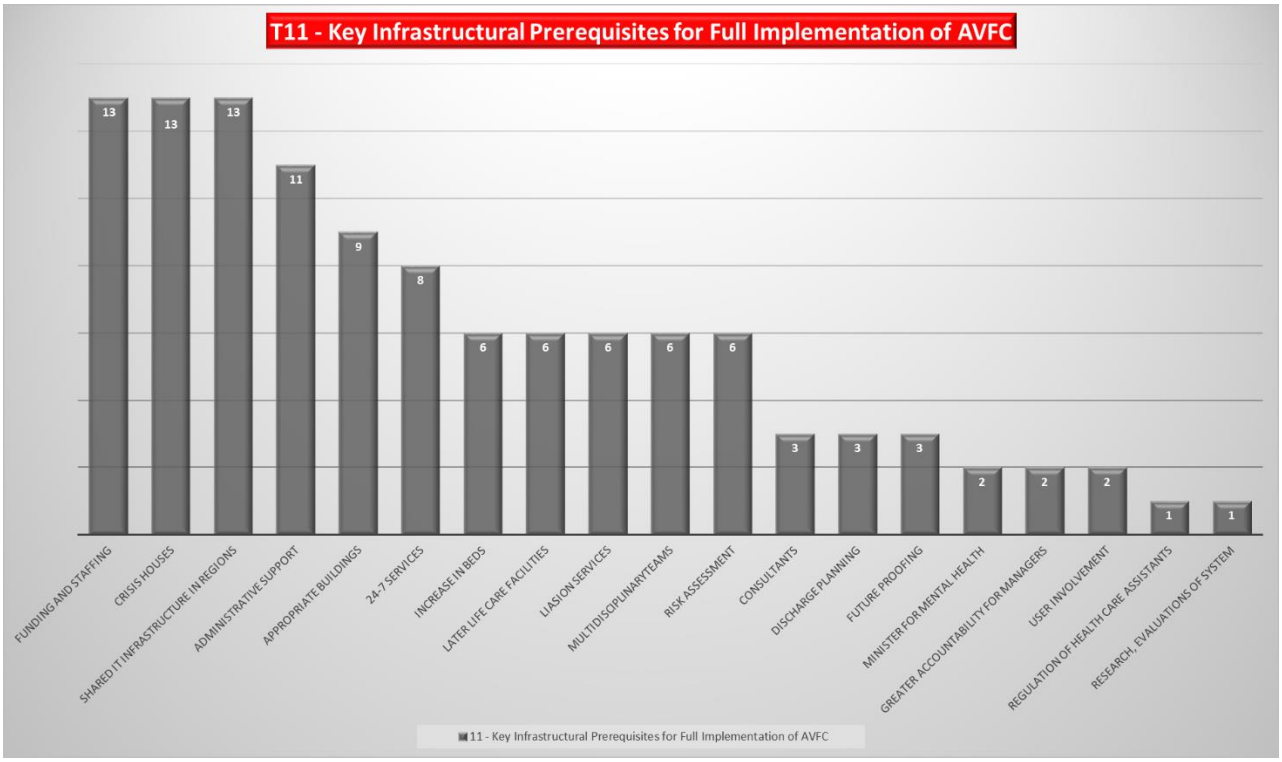
Regional inequalities were talked about in Louth/Meath/Cavan/Monaghan, Galway/Roscommon and Limerick/Clare/North Tipperary; and geographical issues were raised in Sligo/Leitrim/Donegal, Galway, South Tipperary, Limerick/Roscommon, and Kildare, Midlands.

Impacts on service users were talked about in Louth Meath, Cavan/Monaghan Galway/Roscommon, Carlow, Kilkenny, Wexford, Waterford, Cork & Kerry, Limerick, Clare/North Tipperary and Kildare, Midlands.

And pockets of success were talked about in Carlow, Kilkenny, Wexford, Waterford, South Tipperary, Cork and Kerry, and East Dublin.

Having outlined the themes, issues and concerns as voiced by each region, Chart 6 now shows the key infrastructural prerequisites for full implementation of *A Vision for Change* identified by the study participants.

Chart 6- Key Infrastructural Prerequisites for Full Implementation of AVFC



As chart 6 shows, when asked to identify their key priorities for the full implementation of *A Vision for Change* (2006) in practice, the study participants named a multiplicity of priorities, the top three being comprehensive staffing and resourcing of community-based services, increased crisis housing facilities,

and local services to be underpinned and cohered through the development of a shared IT infrastructure.

While all of the priorities shown in Chart 6 are necessary to the full implementation of VFC, based on the perceptions and experiences of the study participants and the themes, issues and concerns discussed in this report, there can be no doubt that unless the community-based mental health service is fully staffed and resourced the system will continue to malfunction and fail to comprehensively meet the needs of its users, the mentally ill, an already vulnerable cohort in Irish society.

Staff shortages were identified as a key issue impacting on the community-based mental health service at all levels. Staff shortages were identified as the cause of the deficits in specialist, outreach and crisis services identified in this report. Staff shortages were identified as the cause of the closure of hostels, respite units and day centres that have taken place within the already fragile community-based services sector. Staff shortages were identified as the cause of renovated units not being re-opened. It is therefore vital that the huge amount of vacant posts identified by the study participants be filled, that staff who retire be replaced, and that staff on maternity and / or long-term sick leave be replaced.

A Vision for Change recommended that "service provision should be prioritised and developed where there is greatest need and this should be done equitably and across all service user groups" (*A Vision for Change*, 2006). This recommendation requires that catchment areas develop and fully staff their services in accordance with the particular needs of the service users, so that the many deficits identified in service provision can be redressed.

Finally, the study participants identified the priority that local services be underpinned and cohered through the development of a shared IT infrastructure, as a prerequisite to full implementation of *A Vision for Change*, demonstrating that, a decade after publication, its recommendation that "mental health information systems should be developed locally and these

systems should provide the national minimum mental health data set to a central mental health information system" has not yet been implemented. (*A Vision for Change*, 2006).

The data below outlines in stark contrast the challenges associated with the implementation of VFC. The necessary and agreed closure of in-patient beds has not coincided with a well-funded and resourced community based alternative in line with national policy.

	1984	**2004**	**2015**
Mental Health Service In Patient Beds	12,484	4,173	1,656

Drop in Percentage between 1984 and 2015 = 85%

Drop in Percentage between 2004 and 2015 = 60%

Community Residential Beds

2004	942
2015	285

Percentage drop between 2004 and 2015 = 90%

Mental Health Budget as a % of Health Budget

1984	2004	2015
14%	= 7.34%	6%

UK/Australia = 12-14% of Health Budget devoted to Mental Health (Source PNA, June, 2016)

Discussion

This report presents the quantitative and qualitative finding of a mixed method study that aimed to explore the extent to which the principles and practices enshrined in *A Vision for Change* (2006) have been realised and implemented nationwide over the past decade. A series of ten focus groups discussion were conducted nationwide with psychiatric nurses all members of the PNA; to explore their perceptions and everyday experiences of working in the mental health system within the context of *A Vision for Change* (2006).

The findings indicate considerable support for a quality policy framework. However very significant concerns were identified that unambiguously demonstrates a lack of implementation or translation of the national policy into reality. The evidence reported indicates that what was identified as best practice in terms of mental health service development and provision has not been implemented in any significant, meaningful or cohesive way. The findings indicate that there has been a significant failure to implement national policy; the findings clearly indicate that this failure has very significant impact on the quality of mental health service and care available to the Irish public.

The findings of this report are congruent with those reported elsewhere, (Mental Health Commission, (2008 and 2009), Idecon International Consultants (2009) and the reports of the Independent Monitoring Group (IMG 2007 and 2012). "It is clear to the IMG that the implementation of A Vision for Change (AVFC) to date has been slow and inconsistent" (Independent Monitoring Group, 2012).

This report issues recommendations in relation to the development, staffing and delivery of services as recommended in the Government policy "A Vision for Change".

Ten years following the publication of the VFC policy, the Psychiatric Nurses Association based on this evaluation report calls on all politicians, the Government and the Health Service Executive to fully implement and resource the mental health services nationally based on the Vision for Change.

The study found that, in a number of areas in the community-based mental health services, the recommendations put forth in *A Vision for Change* (2006)

have been poorly implemented, or indeed, not implemented at all, leading to many gaps in service provision.

The study found that the failure of the national mental health system to translate the principles of recovery into meaningful practice stemmed from its failure to provide key resources vital to the full implementation of *A Vision for Change* (2006). Severe staff shortages emerged as the most striking deficiency in the functioning of the mental health services, impacting on all levels of service provision.

The study found that, while *A Vision for Change* (2006) recommended that the closure of traditional mental health institutions be accompanied by the provision of services in the community to which patients may be transferred, the failure to adequately resource the community-based infrastructure has led to a deficit in patient-appropriate options. This failure has led to a blockage of beds in acute units and hostels and the placing of patients almost to wherever there is a bed rather than to a unit that best serves their particular needs.

The report identifies deficits in specialist, outreach and crises service provision stemming from the failure to adequately resource the community-based infrastructure, as well as inequalities in service provision within and between regions, and discusses the impact of these systemic shortfalls on patients, families and communities.

Significantly the findings of this study correlate with the findings of the various reports of the independent monitoring committee. While there is significant support for the VFC Policy, the concern is that as the national policy for mental health service provision it has not been implemented on a consistent basis throughout the country. The report highlights some areas where successes in meeting some of the recommendation of *A Vision for Change* (2006) have been achieved, with Cavan Monaghan, South Tipperary and East Dublin regions identified as reaching a high standard of care in some of their community-based services and concluding that availability of services and standards of provision vary greatly within and across the twenty-six counties.

The report closes with a regional analysis of the issues and concerns raised by the study participants, followed by an outline of the key infrastructural prerequisites they identified for full implementation of *A Vision for Change* (2006).

Findings provide clear and unambiguous evidence that suggests from the perspective of PNA members, clinicians, clinical managers and clinical nurse specialists working at the front line of the Irish mental health services that Vision for Change-while welcome-the evidence when it is used as a framework against which to measure service operationalization reveals that the dire need to develop and implement a needs and rights based service for people with mental health needs remains.

Vision for Change is far from being implemented 10 years after launch. The lack of progress continues the findings of this study correlate positively with report after report from the Independent Monitoring Group (2010, 2011 and 2012) and the findings reported by Mental Health Reform (2015).

The findings clearly demonstrate that service provision when benchmarked against Vision for Change paints a picture of Irish Mental Health services that are incomplete locally and inconsistent nationally.

The evidence reveals that the specialist services identified in need of urgent development by the Independent Monitoring Group in 2012 remain in 2016. The one small ray of light here in some regions is the developments in older persons services which are very welcome.

Conclusion

The Psychiatric Nurses Association of Ireland (PNA) commissioned the Faculty of Nursing and Midwifery, RCSI to explore the progress of implementation of the " Vision for Change" policy (Government of Ireland, 2006) as experienced by the members of the Psychiatric Nurses Association, (PNA), Registered Psychiatric Nurses (RPNs) who are practitioners within the mental health services in Ireland.

This project was framed theoretically by the Irish Government Policy on Mental Health Services- ("A Vision for Change"). According to the Department of Health *A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.*

This project was a descriptive evaluative project which employed mixed (triangulation) methods (quantitative and qualitative). The project utilised an electronic survey questionnaire. The findings from this on line questionnaire subsequently informed the collection of qualitative data through Focus Groups that were conducted regionally across the PNA branch network. Services from every county in Ireland participated in the study.

This research project is a phased study and this proposal addresses phase 1, which uniquely evaluated the impact of the "Vision for Change" on service provision and resources in relation to the General Adult Mental Health Services. The aim of the study was to comparatively evaluate the intentions of the policy on the realities of practice and service provision. Data collection took place between January and March, 2016.

While the study participants identified a multiplicity of prerequisites for the full implementation of *A Vision for Change*, their top three priorities were identified as:

- comprehensive staffing and resourcing of community-based services,
- increased crisis housing facilities, and
- local services to be underpinned and cohered through the development of a shared IT infrastructure.

The report concludes that unless the community-based mental health service is fully staffed and resourced the system will continue to malfunction and fail to meet the needs of its users, people with mental health needs and mental illness, an already vulnerable cohort in Irish society.

Recommendations

1. Services must have meaningful performance indicators and must be evaluated against them

2. A manpower plan must be put in place to ensure that the services recommended based on VFC can be delivered locally and nationally

3. CMHTs as described in VFC must be staffed in order to provide comprehensive, community based programmes of care and treatment for the Irish population.

4. These Services and the interdisciplinary teams needed to staff these services must be resourced now as a matter of urgency

5. Crises houses must be opened, resourced and staffed now as a matter of urgency

6. Assertive outreach teams must be established nationally now as a matter of urgency

7. Regional ICRUs must be built, resourced and staffed now as a matter of urgency

8. The over-reliance on admission and re-admission to the acute in-patient units are in contradiction to what VFC advocated, this will continue in the absence of resourced CMHTs and community and home based services.

9. Mental health problems and illness do not only occur during office hours, there is an urgent need to ensure that comprehensive out of hours community services are provided nationally.

10. Specialist services within the adult mental health services such as eating disorders, addiction services and services for people with intellectual disability must be implemented immediately based on VFC.

11. The key resources are our clinicians-they continue to haemorrhage from the service and the mental health service faces very significant additional challenges based on the age profile. A wide range of strategies must be employed nationally to strengthen the RPN workforce in light of these findings-including re-introducing and expanding pre 2010 undergraduate BSc RPN places introduce Graduate entry RPN programme nationally in 2016, introduce post graduate RPN programme in 2016

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APPENDICES

Appendix 1 – Codebook – Phase 2 – generating initial codes

Phase 2 - Generating Initial Codes (36 initial codes generated)	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
Access to Fair Deal Scheme	References to the need to go through general hospitals to access the FD scheme	24	8
Aging Demographic of Nurses Needs to be Planned	References to the high level of nurses becoming eligible for retirement in the coming years will mean a dearth of experience in mental health services and this will need to be planned for in the context of full implementation of the VFC	2	1
Closing Community Services Compounds Acute Capacity Issues	Lack of community based services places additional pressure on acute services. This is where the kernel of the issue	18	3
Demographic & Regional Spread & Inequalities	References to geography and demographics impacting on admission to acute bed decisions and other regionally and demographically related challenges	24	3
Diminution of Budgets		1	1
Greater Accountability for Managers	References to a need for greater accountability for managers in the HSE	2	1
Home Based Services Required	References to the need for greater home based services	23	7
Impact of Inappropriate Mix of Patients	References to inappropriate placement of patients in crisis and the knock on effect on other patients	24	7
Inability to Access Training Opportunities	References to the inability of nurses to access training opportunities mainly because of staff shortages rendering it	1	1

Phase 2 - Generating Initial Codes (36 initial codes generated)	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
	very difficult to get time off to attend		
Inability to Discharge	References to the inability to discharge patients because of poor community based services	9	3
Inappropriate use of Acute Beds	References to staff dealing with ID cases when they are not trained as ID Health Care Professionals	32	8
Inexperienced Staff	References to a large number of inexperienced staff in the system resulting in additional pressures on quality of services	2	1
Infrastructure Without Services - Pointless	References to infrastructure being pointless without skilled teams inside buildings to deliver services	15	6
Intensive Care Facilities Needed at Regional Level	References to the need for intensive care facilities at regional level as a current infrastructural deficit	1	1
Lack of Administrative Support	References to a lack of administrative backup or admin staff leaving and not being replaced forcing the health professional to do more paper work taking them away from their primary role	2	1
Lack of Community Services Compounds Acute Capacity Issues	Lack of community based services places additional pressure on acute services. This is where the kernel of the issue	24	4
Lack of Incentives for Rural Deployment	References to a lack of incentives in the system to encourage skilled staff to deploy in rural areas	9	3

Phase 2 - Generating Initial Codes (36 initial codes generated)	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
Lack of Multi-Disciplinary Teams	References to the lack of MDTs in specialist services	18	1
Minister for Mental Health Required	References for the need to have a Minister for Mental Health to ensure full implementation of VFC	2	1
Mistrust of Management	References where participants demonstrate a mistrust of management	20	5
New Centres Need 24hr Crisis Management Facilities	References to new community and MDT based services missing a 24hr Crisis Management Facility	35	8
New Distribution of Power Required	References to the need to shift the power base to be more equitable amongst health professionals	3	1
No Data Analysis at Regional Level	References to participants' perceptions that there is no data analysis by management at regional level as promised in VFC	1	1
No Out of Hours Services	References to lack of out of hours' services as a contributory factor in addressing bed capacity issues	18	5
Political Agendas Superseding Good Operational Management Decisions	References to political agenda superseding good operational management decisions	2	1
Poor IT Infrastructure in Regions	References to poor or no IT infrastructure in regions and particularly rural areas	1	1
Poor Leadership	This code contains perceptions that lack of leadership is in evidence as there appears to be no vision for	3	1

Phase 2 - Generating Initial Codes (36 initial codes generated)	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
	change at management level		
Poor Leadership (3)	This code contains perceptions that lack of leadership is in evidence as there appears to be no vision for change at management level	3	1
Poor Management Communication with Front Line Services	References to poor communication between management and front line services in relation to closure of services	9	3
Poor Strategic Planning of Infrastructure for Community Based Services	References to a disconnect between infrastructural planning and strategic decisions already made such as shifting emphasis to community based care	11	5
Recovery Model - Gaps in Health Professionals' Buy in	References to gaps between nurses' willingness to develop recovery modes and other health professionals such as consultants	17	8
Regulation of Health Care Assistants	References to the need for regulation of the growing number of HCA's in the system	1	1
Requirement for Better Shared Services	References to a need to share services through shared infrastructure	17	8
Staff Shortages	References to staff shortages due to staff not being replaced and no additional numbers being added to the system	32	7
X - Closing Community Services Compounds Acute Capacity Issues	Lack of community based services places additional pressure on acute services. This is where the kernel of	18	3

Phase 2 - Generating Initial Codes (36 initial codes generated)	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
	the issue		
X - Lack of Community Services Compounds Acute Capacity Issues	Lack of community based services places additional pressure on acute services. This is where the kernel of the issue	38	8

Appendix 2 – Codebook – Phase 3 – developing categories

Phase 3 - Searching for Themes (developing categories)	Units of Meaning Coded	Focus Groups Coded
1 - Bed Capacity Challenges	79	8
Access to Fair Deal Scheme Problematic	18	6
Bed Blocking Factors	25	6
Discharge Issues	19	7
Makeshift Beds	1	1
Misuse of Acute Beds	8	3
Non-Existent Beds	6	5
Socio-Economic Status of Catchment Area	2	2
2 - Staffing and Team Challenges	176	8
Community Allowance Issues	14	7
Education & CPD	8	5
Inexperienced Staff	5	3
IR Issues	20	4
No Role Clarification on Teams	5	3
Recovery & Rehab Principles Undermined	22	6
Staff Safety	4	3
Staffing Issues	98	8
3 - Specialist Service Deficits	77	8
Addiction Services	14	5
Asperger's	1	1
CBT	6	1

Phase 3 - Searching for Themes (developing categories)	Units of Meaning Coded	Focus Groups Coded
DBT	5	3
Early Intervention	9	5
Eating Disorders	16	8
ID Services	12	7
OCD	1	1
OT	4	3
Post-Natal	2	1
Psychology	7	4
4 - Service Infrastructure Required	88	8
24-7 Services	8	4
Administrative Support	11	7
Appropriate Buildings	6	2
Consultants	2	1
Crisis Houses	13	5
Discharge Planning	3	2
Future Proofing	1	1
Increase in Beds	6	2
Later Life Care Facilities	6	3
Liaison Service	6	4
Multidisciplinary Teams	6	5
Research, Evaluations of System	1	1
Risk Assessment & Management Practices	6	3

Phase 3 - Searching for Themes (developing categories)	Units of Meaning Coded	Focus Groups Coded
Shared IT Infrastructure in Regions	13	6
5 - Deficits in Outreach and Crisis Services,	120	8
24-7 Services	5	4
Assertive Outreach	26	7
Closures	19	7
Crisis Intervention	10	6
ECRU	6	1
Home-Based Services	40	7
ICRU	14	6
6 - Key Priorities for the Full Implementation of AVFC	11	5
Funding and Staffing	4	4
Greater Accountability for Managers	2	1
Minister for Mental Health Required	2	1
Regulation of Health Care Assistants	1	1
User Involvement in Team Meetings	2	2

Appendix 3 – Codebook – Phase 4 – Reviewing Themes

Phase 4 - Reviewing Themes	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
Broken Promises	References to unfulfilled promises of resources	10	5
Geographical Issues	References to geographical issues	20	4
Missing Linkages and Connections	References to a disconnect between services	16	4
Negative Impact on Service Users	References to negative impact on service users and their families / carers of inadequacies in the system	16	5
Pockets of Success	References to some praiseworthy achievements but only in pockets	29	6
Poor Strategic Planning of Infrastructure for Community Based Services	References to a disconnect between infrastructural planning and strategic decisions already made such as shifting emphasis to community-based care	18	4
Recovery Principles Undermined	References to undermining of principles underpinning AVFC	22	6
Regional Inequalities	References to discriminative practices across catchment areas (availability of services, displacement of people in order to avail) + against mental health patients. This is across and within regions and the urban - rural divide.	28	4
Stats, Facts, Configurations	References to statistics concerning bed capacity / occupancy; and to facts and configurations of service provision at operational level. This date is not given to qualitative analysis.	79	7

Appendix 4 – Codebook – Defining & Naming Themes

Phase 5 - Defining & Naming Themes	Code Definitions for Coding Consistency (rules for inclusion)	Units of Meaning Coded	Focus Groups Coded
01 - Recovery Principles Undermined	References to undermining of principles underpinning AVFC	34	8
02 - Poor Strategic Planning of Infrastructure for Community Based Services	References to a disconnect between infrastructural planning and strategic decisions already made such as shifting emphasis to community-based care	18	4
03 - Missing Linkages and Connections	References to a disconnect between services	16	4
04 - Broken Promises	References to unfulfilled promises of resources	10	5
05 - Staffing and Team Challenges	References to staffing and team challenges	135	8
06 - Bed Capacity Challenges	References to bed capacity challenges	87	8
07A - Specialist Service Deficits	References to specialist service deficits	77	8
07B - Outreach & Crisis Services Deficits	References to outreach and crisis service deficits	128	8
08A - Regional Inequalities	References to discriminative practices across catchment areas (availability of services, displacement of people in order to avail) + against mental health patients. This is across and within regions and the urban - rural divide.	28	4
08B - Geographical Issues	References to geographical issues for service providers and for service users. Displaced people.	19	4

09 - Impact on Service Users	References to negative impact on service users and their families / carers of inadequacies in the system	21	5
10 - Pockets of Success	References to some praiseworthy achievements but only in pockets	29	6
11 - Key Infrastructural Prerequisites for Full Implementation of AVFC	Those named and those arising from analysis of the deficits in services and staffing	116	8