Psychiatric Bulletin (1991), **15**, 562–564

Letter from . . .

Dublin

Developing community psychiatry in Dublin

AIDAN McGENNIS, Consultant Psychiatrist, Eastern Health Board, Dublin, Ireland

I am a consultant psychiatrist working in one of the Dublin Catchment Area Teams. Over the past few years I have observed the major changes that have taken place in Dublin psychiatry.

These changes had their origin in the Irish Government report *The Psychiatric Services – Planning for the Future* (1984). This was a master plan for the development of psychiatry throughout Ireland. Each Health Board in turn produced a report which detailed how it would implement *Planning for the Future*. In this regard the Eastern Health Board in 1986 adopted *Towards the Development of a Community Psychiatric Service* as its response.

The Eastern Health Board contains a population of approximately 1,250,000 and is overwhelmingly urban in make-up. For the delivery of psychiatric services it is divided into ten catchment areas. Each catchment area is serviced by 3–5 consultants and by a clinical director. The physical facilities are predominantly owned by the Health Board but in two catchment areas the Health Board entered into an arrangement with private hospitals to provide services.

The overall thrust of development, as elsewhere, has been the phasing out of institutional facilities and their replacement by a range of community-based services. Since 1986, this programme has been greatly accelerated.

In the phasing out of institutional facilities, the main attention has focused on St Brendan's Hospital, a time-expired Victorian complex which at one time was the largest psychiatric hospital in Ireland. However, wards have also been closed in other of the Board's psychiatric hospitals.

Paralleling this run-down of institutional facilities there has been a progressive development in community alternatives. These alternatives have been a combination of day care facilities and hostels. To date, the development of day care facilities and hostels has been significant as Tables I and II show.

TABLE I
Day care alternatives to hospital

	Day hospitals	*Day centres*	*Workshops*	*Mental health centres*
1986	5	3	4	2
1990	14	10	8	7

TABLE II
Hostel alternatives to hospital

	Number of hostels	*Number of places*
1986	54	422
1990	103	860

The combination of a large number of day care places with a vigorous hostel programme enabled large sections of our old hospitals to be closed. All these new facilities are run by the health services directly and ex-patients go to hostels that are owned and run by the psychiatric services themselves. This has obvious advantages for follow-up.

These major changes occurred against a background where "double funding" to develop new facilities while continuing to maintain the old ones was not available. That such changes were possible given this difficulty is probably due to four factors.

(a) The severe public expenditure cuts introduced by the Irish government in March 1987 meant that all aspects of the health services had to take their share of cut-backs. For psychiatry this economic imperative paradoxically worked in favour of change: it made everyone more flexible, more conscious of value for money and more open to new ways of delivering psychiatric care.

(b) The programme of voluntary redundancies and early retirements necessitated by (a) meant that mental health personnel who remained were younger and more open to change.

https://doi.org/10.1192/pb.15.9.562 Published online by Cambridge University Press

Court Hall, community residence.

Kilrock House, rehabilitation centre for the homeless.

(c) The use of *de facto* senior registrars to spearhead new programmes. Due to the severe lack of formal SR positions in the Dublin region there were available a number of post-membership registrars of a high calibre. They were employed under consultant cover to initiate new programmes and while so doing received many of the elements of a formal SR training.

(d) Finally, it helped to have a lay administration both in the Department of Health and locally in the Eastern Health Board who were of the same mind. This avoided administrative confusion, and promoted accessibility by health care personnel. For Dublin, small was indeed beautiful.

The number of patients resident in St Brendan's Hospital as of December 1990 is 350 compared with 912 in 1984. To achieve this degree of deinstitutionalisation a special resettlement team (Mohan, 1990) was set up with the aim of resettling the long-stay patients who would benefit from alternative and more appropriate facilities. This team was separate from the catchment area teams and was solely concerned with resettlement. In three years over 400 patients were so resettled from St Brendan's. Patients were transferred with respect to their social networks; friends were moved together. Relatives were consulted and patients were transferred to the facilities nearest to their visiting relatives. The resettlement team attempted to avoid re-admission but in two years had 34 short-term admissions from 17 patients. Six patients had to return to the hospital full-time as their behaviour could not be appropriately managed in the existing community facilities. No one from this programme is missing or homeless as the placements are closely monitored and planned on-going after care is provided by the psychiatric services.

The first Old Age Psychiatry Service in the Republic of Ireland started in north Dublin in January 1989. This North Dublin Old Age Psychiatry Service (Wrigley, 1990) provides assessment and management of patients who are disturbed as a consequence of dementia or suffering from functional psychiatric disorders. It follows the conventional model of offering a comprehensive community orientated psychiatric service to elderly people within its catchment area. Its catchment population is approximately 27,000 people over the age of 65 years. The service operates as a multidisciplinary team led by a consultant psychiatrist and is based on the principle of domiciliary assessment of all new referrals. Management is community-based where possible and relies heavily on close monitoring of patients by the community psychiatric nurses and on providing emotional and practical support to carers. Most treatment is undertaken in the services' day hospitals. In-patient assessment/treatment facilities are available for those requiring this form of management. Continuing care in the psychiatric service for those no longer able to remain at home is provided for those too disturbed despite treatment to be managed in the usual residential facilities for elderly people.

Dublin, being the largest city of Ireland, has always had a problem of homelessness. To cater for the homeless mentally ill a special programme was established in 1979 and has been developed since then. The inception of this programme was preceded by a year-long in-patient survey, to evaluate the nature and extent of the psychiatric, medical and social problems, believed to be characteristic of this heterogeneous group of individuals (Fernandez, 1984, 1985).

https://doi.org/10.1192/pb.15.9.562 Published online by Cambridge University Press

The present programme deals specifically with destitute male hostel residents, for reasons identified elsewhere (Fernandez, 1985). It currently has the following components: a 16 bed admission unit and a day centre which caters for up to 70 attenders each day, both situated in the grounds of St Brendan's Hospital. In addition, programme facilities include the following community-based components: a rehabilitation programme which caters for 22 residents and ten day attenders, a supervised high-support hostel which caters for ten residents and six day attenders, and a supervised group-house which caters for five residents (Fernandez, 1989). A recent review of the foregoing programme (Kelleher, 1990) concluded with recommendations that "comparable facilities be established by other Health Boards in areas where the needs of the homeless mentally-ill are currently not being met" (p. 25) and that similar specialist facilities be established in the Eastern Health Board area for homeless females.

Many of the programmes implemented since 1986 were of necessity done on a slim budget which precluded a significant research component of a medical audit nature. This, however, has been rectified and several research projects are in being to evaluate and audit the new services. The lack of SR positions and of a properly organised higher training scheme is being attended to. As of January 1991 five general adult SR posts have been filled and an Eastern Regional Higher Training Scheme is being set up.

References

FERNANDEZ, J. (1984) In Dublin's fair city: the mentally ill of no fixed abode. *Bulletin of the Royal College of Psychiatrists*, **8**, 187–190.

—— (1985) On planning a service for the homeless mentally ill in Dublin. *International Journal of Family Psychiatry*, **6**, 149–163.

—— (1989) Homelessness in Ireland: Case Report of the Dublin Project. Paper presented at the Symposium on 'The Vocational Integration of Homeless Persons with Psychiatric Problems'. First European Vocational Rehabilitation Week, Maastricht, The Netherlands.

KELLEHER, P. (1990) *Housing and Settling Homeless People in Dublin City*. The Implementation of the Housing Act 1988. Dublin: Focus Point.

MOHAN, A. (1990) Resettlement Team – St Brendan's Hospital. *Health Service News*, November, 5–6.

The Psychiatric Services – Planning for the Future (1984) Report by a Study Group on the Development of the Psychiatric Services. Dublin: The Stationery Office.

Towards the Development of a Community Psychiatric Service (1986). Dublin: The Eastern Health Board.

WRIGLEY, M. & GANNON, M. (1990) The North Dublin Old Age Psychiatry Service – survey of patients referred in the first six months. *Irish Journal of Psychological Medicine*, **7**, 135–137.

Psychiatric Bulletin (1991), **15**, 564–565

Expert opinion

The molecular biology of Alzheimer's disease

For some years, the pace of progress in clinical neuroscience has progressively quickened but none more so than with molecular biological techniques. Clinical psychiatrists have been promised (some say forewarned) that the systematic application of these techniques will swiftly cut through the multifactorial aetiologies of many mental illnesses and revolutionise diagnosis, treatment and, possibly prevention. Not surprisingly, given the fact that Down's syndrome and Alzheimer's neuropathological changes (senile plaques and neurofibrillary tangles) are so tightly linked, understanding of Alzheimer's disease (AD) was the first mental illness to benefit from these new methods. Once the amyloid β protein component of the senile plaque had been isolated and its 39–43 constituent amino acids sequenced, then it became almost a routine matter to locate the gene and describe comprehensively the much larger (approximately 710 amino acids) amyloid β protein precursor (APP). Almost simultaneously, the gene responsible

https://doi.org/10.1192/pb.15.9.562 Published online by Cambridge University Press