

Adult Mental Health Services



CHILDREN & YOUNG PEOPLE'S SERVICES COMMITTEES
COISTÍ NA SEIRBHÍDÍ DO LEANAÍ & DO DHAOINE ÓGA

Dublin City South
Cathair Bhaile Átha Cliath Theas

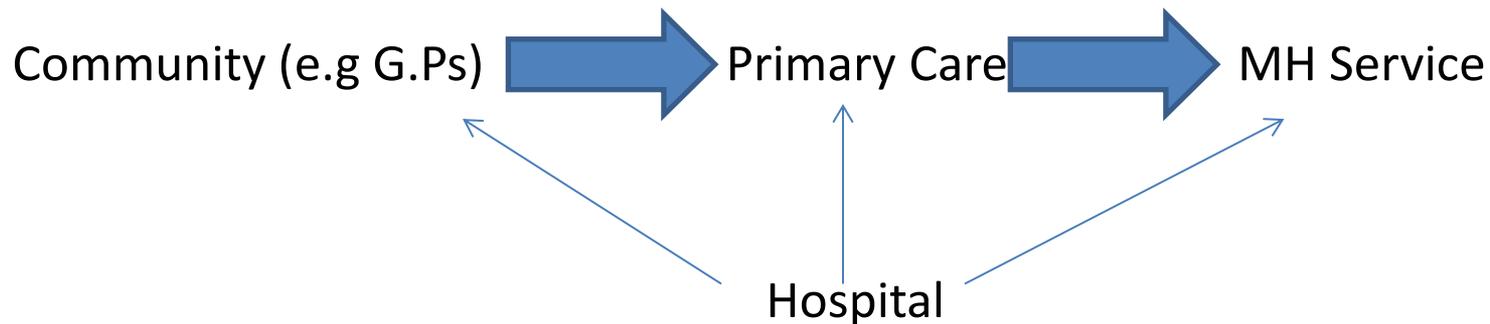


Overview

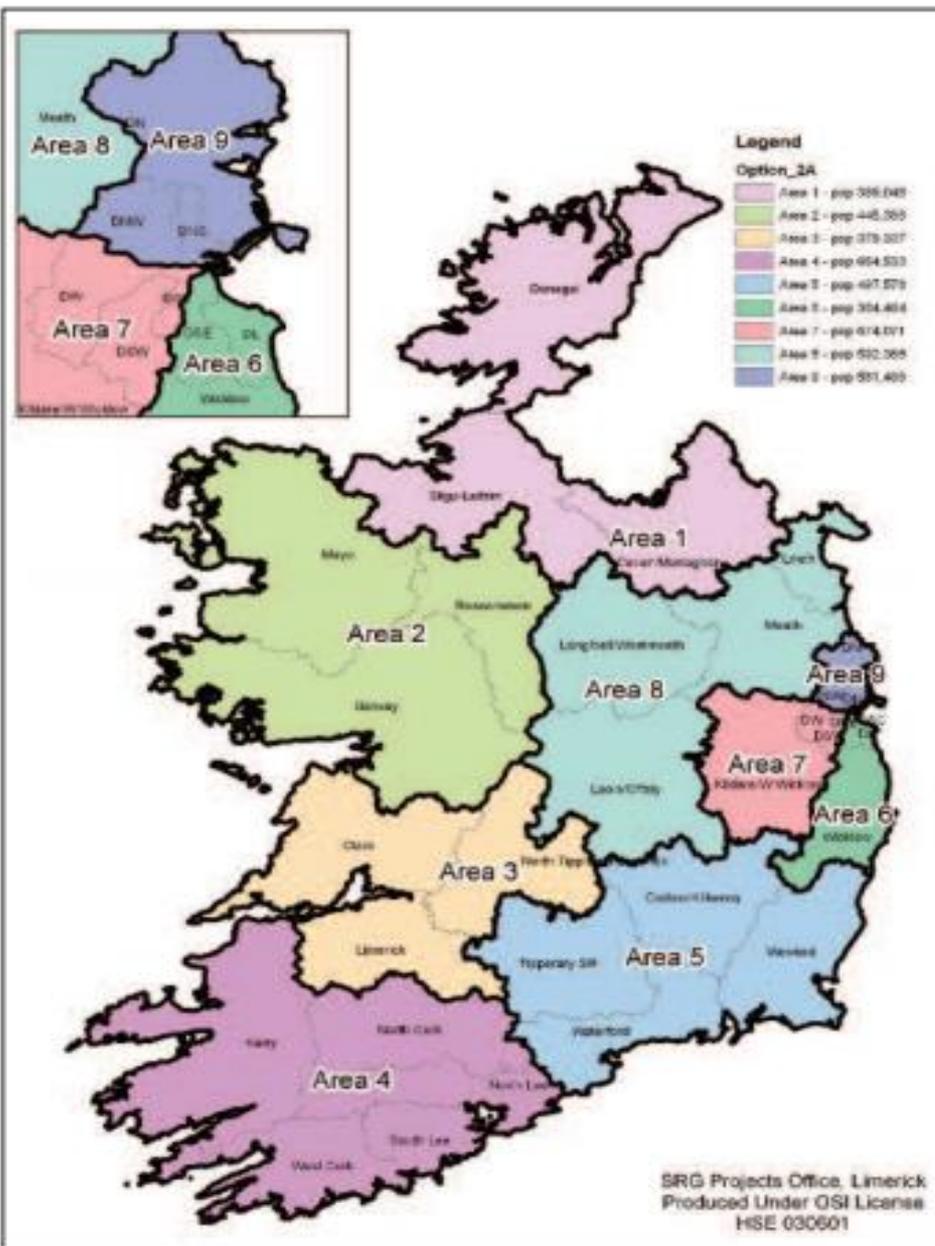
1. National and Local Structure of MH Service
2. Pathways to Care and Referral Process
3. Overview of Types of MH Care
4. Who works in the Service
5. Case Scenarios

Mental Health Service

- Organisational structure change for the delivery of health care services outside of acute hospitals and into the community
- Change from previous health board structure
- Vision for complete and integrated community health care provision
- More coordination of health care service between agencies



The nine Community Healthcare Organisations are outlined below:



Area 1 - Population 389,048

Donegal LHO, Sligo/Leitrim/West Cavan LHO and Cavan/Monaghan LHO.

Area 2 - Population 445,356

Galway, Roscommon and Mayo LHOs

Area 3 - Population 379,327

Clare LHO, Limerick LHO and North Tipperary/East Limerick LHO

Area 4 - Population 664,533

Kerry LHO, North Cork LHO, North Lee LHO, South Lee LHO and West Cork LHO

Area 5 - Population 497,578

South Tipperary LHO, Carlow/Kilkenny LHO, Waterford LHO and Wexford LHO

Area 6 - Population 364,464

Wicklow LHO, Dun Laoghaire LHO and Dublin South East LHO

Area 7 - Population 674,071

Kildare/West Wicklow LHO, Dublin West LHO, Dublin South City LHO and Dublin South West LHO

Area 8 - Population 592,388

Laois/Offaly LHO, Longford/Westmeath LHO, Louth LHO and Meath LHO

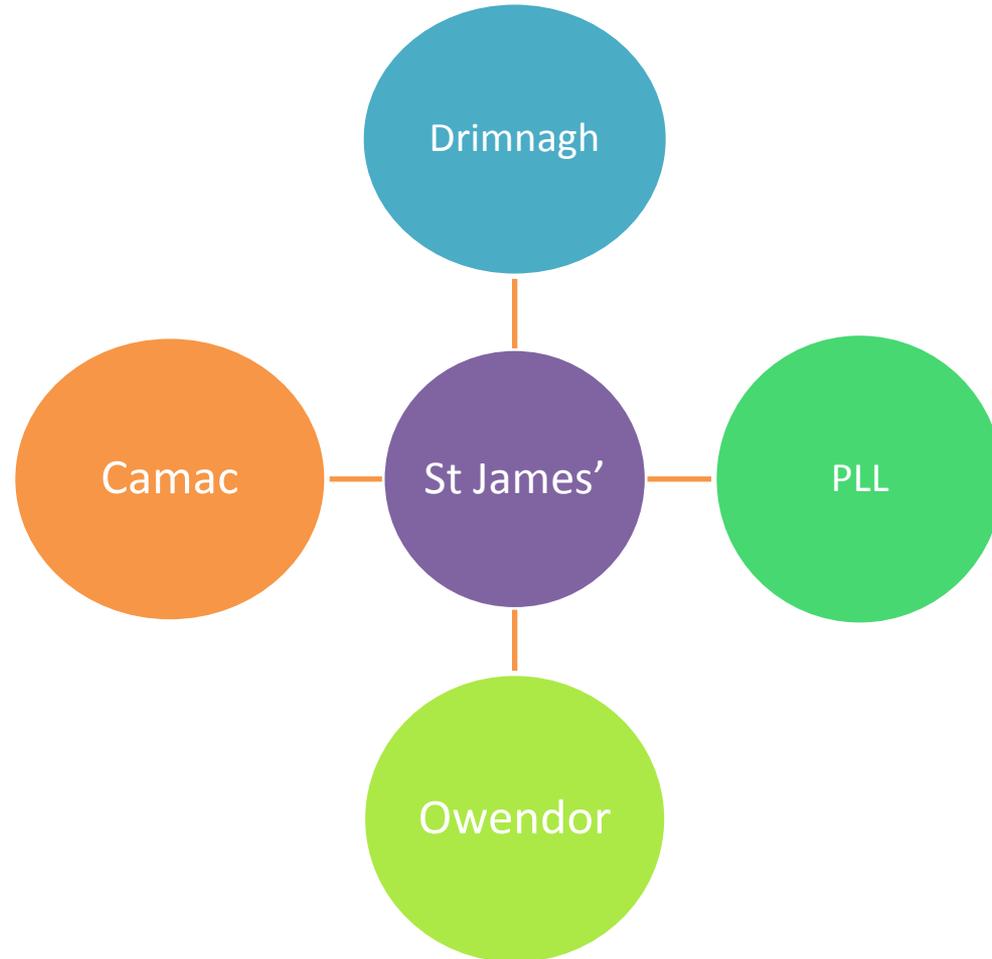
Area 9 - Population 581,486

Dublin North LHO, Dublin North Central LHO and Dublin North West LHO

Area 7

- Community Healthcare Organisation (CHO) 7
- Largest population of all the CHO's (Pop=674,071)
 -  Which presents challenges for service
- Consists of 4 Local Healthcare Organisations
 1. Kildare/West Wicklow → Naas Hospital
 2. Dublin West → Tallaght Hospital
 3. Dublin South West -> Tallaght Hospital
 4. Dublin South Central-→St James Hospital

Dublin South Central Mental Health Local Health Organisation



Areas in Catchment Areas

- Camac

Inchicore, James St, Cork St, The Liberties, Blackpitts, Rathmines

- Drimnagh

Drimnagh, Parts of Crumlin

- Owendor

Rathfarnam, Terenure, Rathmines, Churchtown, Ballyboden

Pathways for MH Care



Referral to Mental Health Service

Referral to a specialised mental health service can happen:

1. From a GP
2. From the emergency department in hospital
3. From another mental health service i.e
CAMHS

How is a referral accepted?

- Referrals are reviewed at a Community Mental Health Team (CMHT) referrals meeting on a weekly basis.
- Referrals are discussed and a decision is made as to whether or not the MH service is an appropriate intervention at that point in time.
- Appointment times vary among teams usually no longer than 3 months.
- Interventions provided by MDT for as long as required and discharge when appropriate.
- If referral is not accepted, measures are taken to ensure that the referrer is informed of alternative options for the individual- commence on SSRI, Counselling in the community.

Referral Criteria

- referrals for the assessment and treatment of disorders such as;
 - Moderate to severe depression
 - Mood disorders
 - Schizophrenia
 - Psychosis
 - Personality Disorders
 - Anxiety disorders
 - Eating Disorder
 - Suicidal behaviours and ideation with intent

Overview of Adult MH Service

- Serves the mental health needs (High-Severe) of “working age” adults 18-65
- Population of catchment determines number of MH teams
- Three different services within James’s Service:
 1. Inpatient
 2. Outpatient
 3. Day hospital services
- *In other AMHS there are home based treatment teams and assertive outreach teams.

Inpatient Care

2 Phases

Acute Phase: “Crisis Admission” due to acute deterioration in mental well being resulting in immediate risk to the individuals well being. Can be both voluntary or involuntary admission.

Continuing Care Phase: Longer term care, in hospital, for people who require extended inpatient care.

Outpatient/Community Care

- Outpatient/ Community Service

This is a mental health clinic based in the community. Access to service is initiated through GP referral or step down care from an inpatient care unit.

On access, Individual care plans are agreed through bio-psycho-social assessments. These care plans are regularly reviewed and updated with varying MDT input.

The majority of people accessing mental health services are engaged in this capacity.

Attendance and interaction with community service is voluntary.

Number of groups on offer to service users.

Day Hospital

The day hospital is a component of the community service. It is a structured weekly programme that people attend from their home. (“Intensive Care in the Community”)

Referrals are made by MDT.

The structured programme includes psycho-educational groups, wellness groups, relaxation groups, weekend planning, executive functioning skills groups, exercise groups and general 1:1 interaction with MDT on site.

Other Services

- **Homebased care Team-** Mental health service provided in SU own environment. Daily or multiple visits per day by keyworker or another MDT member. 7 day service. Used to prevent admission/ quicker discharge/ new treatment regime/ regular support to prevent relapse.
- **Assertive outreach Team-** these teams provide a form of specialised mobile outreach treatment for people with more severe and enduring mental health presentations who have difficulty in maintaining lasting and consenting contact with services.. These teams aim to reduce relapse and readmission rates.
- **Rehab Team-** Individuals currently living in rehabilitative community residences or those that need some longer term extra support to live in their own homes.
- **7/7 Service-** 2 nurses based in local Day Service Sat and Sun. Referrals need to be received by Friday and person needs to be known to the service already.

Rehab Hostels

- **High Support**
- This is a community residence where care staff are on site 24 hours of the day, every day of the week.
- **Medium Support**
- This is a community residence where care staff is on site from 4pm to 10 am on the following day. There is a nurse manager available each morning Mon to Friday.
- **Low Support**
- This is a community residence where staff call in on a regular basis and a support number to nursing staff is provided on a 24hr basis.

Who Works in the Service?

- There are numerous professionals that work in the mental health service
- Every person that is referred and accepted to the service is assigned to a multidisciplinary team or MDT
- The MDT approach was set up to provide an “Holistic Model” of care
- The MDT comprises of different professionals that work with service users on different aspects of their care
- Consultant Psychiatrists are the lead on the team yet in some cases you might see another member more often

The Multi-Disciplinary Team

Consultant Psychiatrist

Doctors/Registrars x 2

Psychologist

Community Nurses x 2

Occupational Therapist

Social Worker

What do they do?

Consultant Psychiatrist

- Clinical Lead of the MDT
- Conduct mental state examinations and assign diagnosis if necessary
- Qualified to prescribe medication and develop treatment plans
- Review service users mental health on an on-going basis
- Discharge people from service

Registrars

- Are trained Doctors who work in the mental health service
- Rotate between teams every 6 months
- Conduct reviews with service users both in the hospital and in outpatients
- Liaise with G.Ps and other medical specialists in hospital and the community

Psychologist

- Are trained to understand human behaviour and the psychological reasons behind certain emotions and behaviours
- Undertake psychological assessments which help pinpoint a certain area that is causing a person emotional distress
- Conducts counselling sessions
- Deliver a range of programmes which help people overcome or manage emotional difficulty e.g CBT or DBT

Community Mental Health Nurses (CMHN's)

- Support when discharged from hospital
- Provide support with medication management
- Home based interventions such as BFT, FEP, Hearing Voices, and practical support
- Advocate between service users and CMHT
- Support managing mental health in the community which prevents admission to hospital

Occupational Therapist

- Assist people to reach optimum levels of independence to have a productive and satisfying life
- Assist in developing leisure interests
- Training in activities for daily living
- Guidance and advice on employment
- Goal setting

Social Worker

- Offer individual, family, and group supports and programmes
- Psycho-Social Assessments
- Facilitating psycho-educational groups
- Liaising between multiple agencies such as housing, child and family, social welfare, and community based programmes
- Case management and care coordination

Case Scenario 1

- Service User X (20 year old female with EUPD traits due to developmental trauma and mild ID) Transferred to James's service from another CMHT service aged 20. Was first referred to CAMHS aged 4 due to aggression directed in particular towards younger sister, behavioural problems in school and support with parenting. Both parents had issues with addiction and SU was placed in foster care aged 9. At age 11 attended St Clare's unit as disclosure of sexual abuse was made. Again attended CAMHS when a teenager with concerns about emotional wellbeing, relationship with foster carer , sexualised behaviour. Residential care at age 17 as foster placement broke down. Referred from CAMHS to adult services and then referred transfer of care to James's service when moved accommodation. Psychology assessment completed and placed on waiting list for DBT Skills. One to one psychology to be offered to do trauma work.

Case scenario 2

- Service user Y (24 year old male) diagnosis of schizoaffective disorder. 21 when presented to the service. Initially presented to the A&E Department and referral was then made to CMHT. Was admitted to hospital shortly afterwards and became homeless while here. Heavily linked with MDT members since coming to the service CPN, OT and Social Work. Currently living in low support hostel provided through the MH service. Has previously attended day hospital and a number of groups within the service. Community Care Plan completed with family involvement. Referral to be made to the newly establish Rehab team and to the job coach.

Contact Details

- Sarah Fitzgerald, Mental Health Social Worker, St James's Hospital.
- Email: Sarah.Fitzgerald@hse.ie
- Phone: 01-4716329