

# Fifth Annual Child & Adolescent Mental Health Service Report

2012 - 2013



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



**A Vision for Change**

ADVANCING MENTAL HEALTH  
IN IRELAND

**Fifth Annual Child & Adolescent  
Mental Health Service Report**

**2012 - 2013**

# Foreword

Children represent our future and the importance of their emotional and psychological wellbeing is increasingly recognised. The publication of the Fifth Annual Child and Adolescent Mental Health Service Report shows the commitment of the mental health division (HSE) in providing a comprehensive overview of the development of the service and an ability to monitor trends in service delivery.

The *Vision for Change* policy set out an ambitious programme for the development of comprehensive mental health service for young people up to the age of 18 years. To achieve this goal requires sustained development of services, as it also involves extending the age range of services already in place. Information contained in the report is essential in the process of planning for future development of the service and identifying challenges that need to be addressed.

In the twelve months to October 2013 the number of referrals accepted by community child and adolescent mental health teams increased by 2,086 or 21% to 12,022. There was an increase of 952 or 11% in the number of new cases seen by community to 9,616. Of these children and adolescents 50% were seen within 1 month of referral and 71% within 3 months. Increased demand on the service has had the result of increasing the total waiting list by 491 or 24% to 2,541.

In September 2013 there was a 15% increase in the staffing of community teams compared with the previous year with a resulting improvement in multidisciplinary composition across all teams. As these new staff are embedded in the team and way of working they will allow our services to provide a combination of improved multidisciplinary input to existing service users as well as capacity to see additional referrals. Further posts are due to come on stream by the end of 2013 and in 2014 as we continue to progress development of community child and adolescent mental health services in line with the *Vision for Change* recommendations.

With increased provision of child and adolescent inpatient services the number of children admitted to adult inpatient units continues to fall. In the first 9 months of 2013 78% of child admissions were to child and adolescent inpatient units and of those children admitted to adult units almost one third were subsequently transferred to child and adolescent units. With further capacity coming on stream in 2014 the number of admissions to child and adolescent units should increase further.

The collection of information is integral to service delivery, allowing us to communicate with a clarity and transparency to service users and other stakeholders. We need to extend this capability further, with the provision of information technology, so that we can widen the focus to include information on the quality of the interventions provided and service user outcomes. During 2014 we will develop a feasibility report and implementation plan for a phased improvement in quality metrics in relation to our Child and Adolescent Mental Health Services.



A handwritten signature in black ink, appearing to read 'Stephen Mulvany'.

STEPHEN MULVANY  
National Director  
Mental Health Services (HSE)

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# Executive Summary

Mental health is a prerequisite for normal growth and development. Most children and adolescents have good mental health, but studies have shown that 1 in 10 children and adolescents suffer from mental health disorders severe enough to cause impairment. Mental health disorders in children and young people can damage self-esteem and relationships with their peers, undermine school performance, and reduce quality of life, not only for the child or young person, but also for their parents or carers and families. The majority of illness burden in childhood and more so in adolescence, is caused by mental health disorders. Mental health disorders in childhood are the most powerful predictor of mental health disorders in adulthood.

The development of comprehensive Child and Adolescent Mental Health Services (CAMHS) for young people up to the age of 18 years is described in the Department of Health and Children *A Vision for Change* (2006) policy document. CAMHS had been organised until then for young people up to the age of 16 years. Key to this is the development of 107 multidisciplinary CAMHS teams, based on the 2011 census population, of which 66 are currently in place, 60 community teams (an increase of 2 from 2012), 3 day hospital teams (an increase of 1 from 2012) and 3 paediatric hospital liaison teams. Further recommendations are contained in the policy concerning inpatient services (a total of 106/8 beds), mental health intellectual disability teams, substance misuse, eating disorder and forensic services for young people.

Community child and adolescent mental health teams are the first line of specialist mental health services. In November 2008 the first month long survey of children and young people seen by Community based CAMHS teams was carried out. This was the first fully comprehensive exercise to gather information on the age and gender of children and young people attending the service and the mental health problems they present. The results of the survey, together with information on the admission of young people under the age of 18 years admitted for inpatient assessment and treatment for the year 2008 supplied by The Health Research Board, were published in the First Annual CAMHS Report in 2009.

The Fifth Annual CAMHS Report incorporates the fifth month long survey of the clinical activity of 58 Community CAMHS teams carried out in November 2012. The Report includes information collected monthly through HSE CompStat from each community CAMHS team for the year long period from October 1st 2012 to September 30th 2013, information on inpatient admissions provided by The Health Research Board and The Mental Health Commission. This report also includes a section on young people under the age of 18 years presenting to hospital emergency departments as a result of deliberate self harm in 2012 compiled by the National Registry of Deliberate Self Harm.

For those experiencing mental health problems, good outcomes are most likely if the child or adolescent and their family or carer have access to timely, well coordinated advice, assessment and evidence-based treatment. Specialist CAMHS work directly with children and adolescents to provide treatment and care for those with the most severe and complex problems and with other services engaged with children and young people experiencing mental health problems. Services need to be culturally sensitive, based on the best available evidence, and provided by staff equipped with the relevant up to date knowledge and skills.

To achieve the goals set out in *A Vision for Change* requires the allocation of significant additional resources to CAMHS. Systematic national and regional planning is necessary, working with local networks and structures, to provide the trained personnel and infrastructure. It has been estimated that increasing the age range of CAMHS from 16 to 18 years has the effect of doubling the cost of providing the service.

The Specialist Child and Adolescent Mental Health Service Advisory Group, established in 2009, advises on the data collected from teams and services, and informs the process on setting the key performance indicators linked to these datasets.

For CAMHS teams to work effectively, a range of disciplines, skills and perspectives are required, so that children and adolescents are offered a care and treatment package geared to their individual needs. The total staffing of the 60 existing community teams is 531.76 whole time equivalents (in 2012 this figure was 461.94) an increase of 69.82 whole time equivalents, which is 44.6% of the staffing level as recommended in *A Vision for Change*. The variation in the distribution and disciplinary composition of the workforce across teams and regions has reduced compared with 2012.

All Community CAMHS teams screen referrals received, those deemed to be urgent are seen as a priority, while those deemed to be routine are placed on a waiting list to be seen. In the period October 1st 2012 to September 30th 2013 a total of 12,022 referrals were accepted which is a 21% increase on the previous 12 months. A total of 9,616 new cases

were seen by Community CAMHS teams in the same period October 1st 2012 to September 30th 2013, compared with 8,671 for the previous 12 months, an increase of 11%.

Of the 9,616 new cases seen, 1,551 (16%) were 16 years of age and over an increase of 446 (40%) compared with the previous year. Over this period 50% of new cases were seen within 1 month of referral, 71% within 3 months. 9% of new cases had waited between 3 and 6 months, 5% had waited between 6 and 12 months and 4% had waited more than 1 year to be seen, whilst 11% did not attend their first appointment.

In September 2013 the number of active cases attending Community CAMHS was 17,116 (in 2012 this figure was 16,664) which represents 1.49% of the under 18 year old population.

A total of 2,541 children and adolescents were waiting to be seen at the end of September 2013. This represented an increase of 485 (24%) from the total number waiting at the end of September 2012 (2,056). Forty-one percent of children and adolescents were on the waiting list for less than three months.

Forty-three (72%) community CAMHS teams had a waiting list of less than 50 cases, 11 (18%) had a waiting list of 50 to 99 cases, 4 (6%) had a waiting list of 100 to 149 cases and 2 (4%) had a waiting list of 150 to 200 cases.

In the course of the month of November 2012 a total of 8,577 cases were seen, 7,651 (89.2%) of these cases were returns and 926 (10.8%) were new cases. A total of 15,229 appointments were offered, 12,476 appointments were attended, with a resulting non-attendance rate of 18.08%, decreasing from 18.34% in 2011.

Analysis of the data collected indicated that:

- Children aged 15 years were the most likely to be attending community CAMHS, followed by the 16/17 year old age group and children in the 10 to 14 year age group.
- Adolescents aged 16/17 years constituted 16.9% of the caseload.
- The ADHD / hyperkinetic category (31.6%) again was the most frequently assigned primary presentation followed by the Anxiety category which accounted for 18.3%.
- The ADHD / hyperkinetic category peaked in the 5 to 9 years age group at 43.9% of cases in this age group, dropping to 19% of adolescents in the 15 years and older age group.
- Depressive disorders increased with age, accounting for 21.1% of the 15 years and older age group.
- Deliberate Self Harm, which increased with age, accounted for 9.5% of the primary presentations of the 15 years and older age group, however deliberate self harm / suicidal ideation was recorded as a reason for referral in 25% of the new cases seen.
- Eating disorders increased with age, accounted for 4.5% of the primary presentations of the 15 years and older age group.
- Males constituted the majority of primary presentations apart from Psychotic Disorders (41.6%), Emotional Disorders (47%), Depression (34%), Deliberate Self Harm (22.5%), and Eating Disorders (17.4%).
- 24.3% of cases were in treatment less than 13 weeks, 11.1% from 13 to 26 weeks, 14.1% of cases were in treatment from 26 to 52 weeks and 50.4% greater than 1 year.

In 2012 there were 438 admissions of children and adolescents up to the age of 18 years to inpatient units. Females accounted for 62% of admissions. Thirty-eight percent of all admissions were aged 17 years on admission, 26% were aged 16 years, 19% were aged 15 years, and 18% were aged 14 years or younger. Of the 438 admissions, 329 (75%) were to child and adolescent units and 109 (25%) to adult inpatient units.

The average length of stay was significantly longer in the child and adolescent units, at 52 days (median 40 days), than in adult units at 8 days (median 4.5 days). Thirty-six percent of admissions to adult units were discharged within two days of admission and 65% within one week. Sixty-three percent of admissions to child and adolescent units were for periods longer than 4 weeks.

Depressive disorders accounted for 37% of all admissions in 2012. The next largest diagnostic category was neuroses at 13%, eating disorders at 12%, schizophrenia and delusional disorders at 11%, mania at 7%, and behavioural and emotional disorders of childhood and adolescence, personality and behavioural disorders, and other drug disorders at 3% each.

In the period January to September 2013 there was a total of 306 admissions of children and adolescents under the age of 18 years. 238 (78%) were admitted to child and adolescent units and 68 (22%) to adult units. A total of 21 (31%) of

adolescents admitted to adult inpatient units were subsequently transferred to a child and adolescent units. Seventeen (81%) of those cases transferred were to Health Service Executive funded units and four (19%) to a private unit.

For the period from 1st January to 31st December 2012, the National Registry of Deliberate Self Harm recorded 1,118 deliberate self harm presentations to hospital that were made by 960 children (296 boys and 664 girls) aged from 10 to 17 years which represented 11.8% of all cases.

Of the recorded presentations for all children aged from 10 to 17 years in 2012, 30% were made by boys and 70% were made by girls.



## 1.1 Children in the Population

The total for the population enumerated on the 10th of April 2011 was 4,588,252 persons, compared with 4,239,848 persons in April 2006, an increase of 348,404 persons or 8.2 percent. This translates into an annual average increase of 69,681, or 1.64 percent.

The total for the population under 18 years in the 2011 census was 1,148,687 persons, this compares with 1,036,034 in 2006, an increase of 112,653 or 10.9 percent. The proportion of the population under 18 years increased from 24.43% to 25.04% of the total population.

Figure 1.1 (i) 2011 & 2006 Census by Age

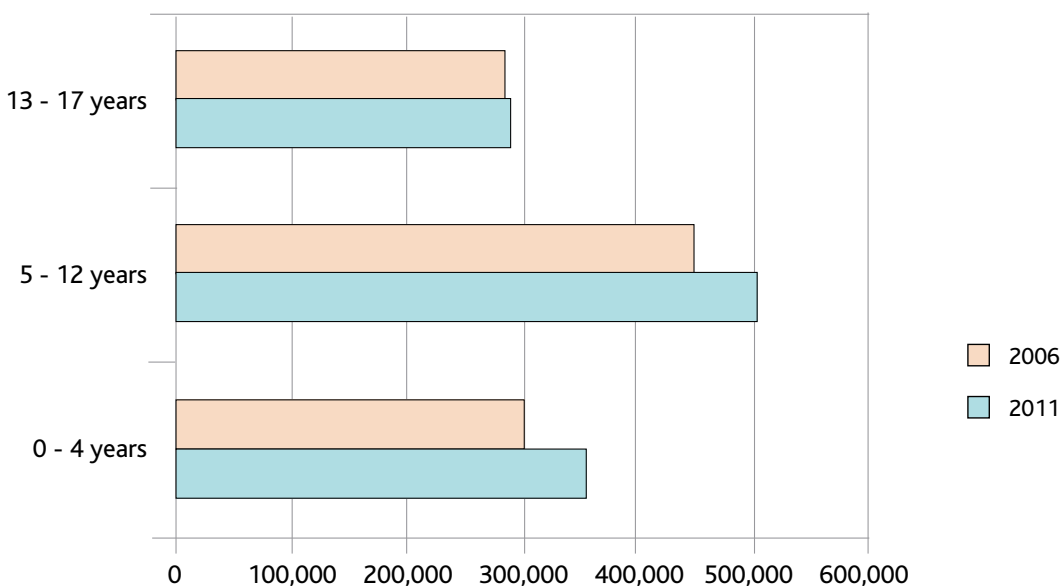


Table 1.1 (a) 2011 & 2006 census by Age

| Age           | Census 2011 | Census 2006 |
|---------------|-------------|-------------|
| 0 - 4 years   | 356,329     | 302,252     |
| 5 - 12 years  | 504,267     | 450,074     |
| 13 - 17 years | 288,091     | 283,708     |
| 0 - 17 years  | 1,148,687   | 1,036,034   |

The population of pre-school children (aged 0-4 years) of 356,329, showed an increase of 54,077 (17.9%) since 2006. The greatest increase in pre-school children was in Laois at 37.1 percent, followed by Cavan (30.2%) and Monaghan (26.8%), while the slowest growth was recorded in Waterford city (5.3%). While almost 30 percent (104,796) were living in one of the 5 cities, they were under-represented in the cities and rural areas compared with the population overall; against this, pre-school children were over-represented in towns of all sizes.

The population of the primary school age group (aged 5-12 years) of 504,267, showed an increase of 54,193 (12%) since 2006 compared to an 8.2 percent increase in the population of the State as a whole. The greatest increase in primary school aged children was in Laois at 28.9 percent, followed by Fingal (28.3%) and Longford (23.5%), while the slowest growth was recorded in Dublin city (0.5%). The primary school aged population decreased in two of the cities with Limerick showing a 9.4 percent fall and Cork city a 7.9 percent fall in numbers.

The population of the secondary school age group (aged 13-17 years) of 288,091, showed an increase of only 4,383 persons, or 1.5 percent since 2006, a consequence of low births in the mid-1990s feeding into today's numbers.

**Table 1.1 (b) 2011 census by Age 0 – 17 years by HSE Region**

| HSE Region          | Total            | 0 – 17 yrs       | %             |
|---------------------|------------------|------------------|---------------|
| Dublin Mid Leinster | 1,320,945        | 324,955          | 24.60%        |
| Dublin North East   | 1,020,891        | 258,569          | 25.33%        |
| South               | 1,162,112        | 292,796          | 25.20%        |
| West                | 1,084,304        | 272,367          | 25.12%        |
| <b>Total</b>        | <b>4,588,252</b> | <b>1,148,687</b> | <b>25.04%</b> |

## 1.2 Prevalence of childhood psychiatric disorders

The majority of illness burden in childhood and more so in adolescence, is caused by mental disorders and the majority of adult mental health disorders have their onset in adolescence. The World Health Organisation (2003) *“Caring for children and adolescents with mental disorders: Setting WHO direction”* states that: “The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive.”

- **1 in 10 children** and adolescents suffer from mental health disorders that are associated with “considerable distress and substantial interference with personal functions” such as family and social relationships, their capacity to cope with day-to-day stresses and life challenges, and their learning.<sup>1,6</sup>
- A study to determine the prevalence rates of psychiatric disorders, suicidal ideation and intent, and parasuicide in population of Irish adolescents aged 12-15 years in a defined geographical area found that 15.6% of the total population met the criteria for a current psychiatric disorder, including 2.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide.<sup>2</sup>
- The prevalence of mental health disorders in young people is increasing over time.<sup>3</sup>
- 74% of 26 year olds with mental illness were found to have experienced mental illness prior to the age of 18 years and 50% prior to the age of 15 years in a large birth cohort study.<sup>4</sup>
- A range of efficacious psychosocial and pharmacological treatments exists for many mental health disorders in children and adolescents.<sup>5,7</sup>
- The long-term consequences of untreated childhood disorders are costly, in both human and fiscal terms (Mental Health: Report of the US Surgeon General, 2001).<sup>8</sup>

## 1.3 Child and adolescent mental health services (CAMHS)

The child and adolescent mental health services were organised, primarily for the 0-15 years’ age group, in each former Health Board area. Within the former Eastern Regional Health Authority there are three separate service providers. Nationally three child and adolescent mental health services are provided by voluntary agencies (Brothers of Charity Cork, The Mater Child and Family Service Dublin and St. John of God Lucena Clinic Dublin), giving a total of 11 CAMH services. The total number of CAMHS teams increased substantially in the period 1996 to 2006.

Mental health disorders increase in frequency and severity over the age of 15 years and it was recognised that existing specialist CAMHS required significant extra resources in order to extend its services up to the age of 18 years.

## 1.4 Department of Health and Children Policy - Vision for Change (2006)

The Vision for Change Policy Document, Department of Health and Children (2006), set out recommendations for a comprehensive mental health service for young people up to the age of 18 years, on a community, regional and national basis.

### Within a Community Mental Health Catchment Area of 300,000 populaion:

- A total of 7 multidisciplinary community mental health teams.
- 2 teams per 100,000 population (1/50,000).
- 1 additional team to provide a hospital liaison service per 300,000.
- 1 day hospital service per 300,000.
- Each multidisciplinary team, under the clinical direction of a consultant child psychiatrist, to have 11 WTE clinical staff and 2 WTE administrative staff.
- **A total of 107 Specialist CAMHS teams** providing community, hospital liaison and day hospital services, based on the 2011 census data.
- A total of 1,391 staff across the country.

### Specialist Mental Health Services organised on a Regional / National basis:

- 1 national specialist eating disorder multidisciplinary team linked with the provision of 6/8 inpatient beds.
- 4 child and adolescent mental health substance misuse teams.
- 2 forensic mental health teams, linked with the secure inpatient facility.
- 15 child and adolescent mental health of intellectual disability teams.

**Table 1.4 (a) Vision for Change Recommendations (2011 census data)**

| Child & Adolescent Mental Health Services        | Recommended |
|--|-------------|
| Community Child & Adolescent Mental Health Teams | 77          |
| Adolescent Day Hospital Teams                    | 15          |
| Hospital Liaison Mental Health Teams             | 15          |
| Eating Disorder Mental Health Team               | 1           |
| Forensic Mental Health Teams                     | 2           |
| Substance Misuse Mental Health Teams             | 4           |
| Intellectual Disability Mental Health Teams      | 15          |
| <b>Total</b>                                     | <b>129</b>  |

### Specialist Inpatient Child and Adolescent Mental Health Services:

- 100 beds (review in progress).
- The building of 4 new 20 bed inpatient facilities.
- 10% of the bed complement to be provided as a secure / forensic facility.
- A 6/8 bed eating disorder unit in the new National Children’s Hospital.

**Table 1.4 (b) Vision for Change Recommendations – inpatient services**

| Inpatient Services (Beds) | Recommended  |
|---------------------------|--------------|
| General                   | 90           |
| Forensic / Secure         | 10           |
| Eating Disorder           | 6/8          |
| <b>Total</b>              | <b>106/8</b> |

## 1.5 Community child and adolescent mental health teams

This is the first line of specialist services. The multidisciplinary team, under the clinical direction of a consultant child and adolescent psychiatrist, is recommended to include junior medical staff, two psychologists, two social workers, two nurses, a speech and language therapist, an occupational therapist and a child care worker. The assessment and intervention provided by such team is determined by the severity and complexity of the presenting problem(s).

To work effectively, a range of disciplines, skills and perspectives are required, so that children and adolescents are offered a care and treatment package geared to their individual needs. A multi-disciplinary composition is therefore required that incorporates the skills necessary to address the clinical management of the varied and complex clinical problems presented. The community team provides:

- Assessment of Emergency, Urgent and Routine referrals from Primary Care Services.
- Treatment of the more severe and complex mental health problems.
- Outreach to identify severe or complex mental health need, especially where families are reluctant to engage with mental health services.
- Assessment of young people who require referral to Inpatient, or Day Services.
- Training and consultation to other professionals and services.
- Participation in research, service evaluation and development.

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## 2.1 Staffing of Child and Adolescent Mental Health Services

A survey of the staffing of Community CAMHS teams, Day service programmes, Hospital Liaison teams, and Inpatient services was carried out in September 2013. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 750.84.

Table 2.1 (a) Vision for Change recommendations – actual staffing (2013)

| Mental Health Services  | Vision For Change (2006) | No. of Recommended Teams | Teams In Place     | Rec. Staff   | Staffing levels at September 2013 |
|-------------------------|--------------------------|--------------------------|--------------------|--------------|-----------------------------------|
| Staff Community MHTs    | 1 : 50,000               | 92                       | 60                 | 1,196        | 531.76                            |
| Adolescent Day Services |                          | (15)                     | 3                  |              | 23.15                             |
| Hospital Liaison MHTs   | 1 : 300,000              | 15                       | 3                  | 195          | 30                                |
| <b>Total</b>            | <b>1 : 42,857</b>        | <b>107</b>               | <b>66</b>          | <b>1,391</b> | <b>584.91</b>                     |
| Inpatient Services      |                          |                          | 4 Units            |              | 165.93                            |
|                         |                          |                          | <b>Total Staff</b> |              | <b>750.84</b>                     |

The total number of staff at the four inpatient units was 165.93 (September 2013).

Table 2.1 (b) Child and Adolescent Inpatient Units

| Inpatient Unit                                      | Linn Dara      | St. Joseph's   | Eist Linn      | Merlin Park    | National       |
|---|----------------|----------------|----------------|----------------|----------------|
| Operational Beds (September 2013)                   | 6              | 8              | 15             | 15             | 44             |
| <b>Discipline</b>                                   | <b>In Post</b> | <b>In Post</b> | <b>In Post</b> | <b>In Post</b> | <b>In Post</b> |
| Consultant Psychiatrist                             | 1.0            | 0.75           | 2.0            | 2.0            | 5.75           |
| Senior Registrar                                    | 1.0            | 1.0            | 1.0            | 1.0            | 4.0            |
| Registrar/SHO                                       | 0.0            | 1.0            | 1.0            | 1.8            | 3.8            |
| Director of Nursing                                 | 1.0            | 0.0            | 1.0            | 0.0            | 2.0            |
| Assistant Director of Nursing/CNM III               | 1.0            | 0.7            | 2.0            | 2.0            | 5.7            |
| CNM II  | 1.0            | 1.0            | 1.9            | 3.0            | 6.9            |
| CNM I   | 2.0            | 3.0            | 0.5            | 3.0            | 8.5            |
| Clinical Nurse Specialist                           | 0.0            | 1.0            | 1.0            | 0.0            | 2.0            |
| Staff Nurse   | 10.5           | 12.0           | 25.58          | 30.0           | 78.08          |
| Clinical Psychologist                               | 1.0            | 0.5            | 1.0            | 2.0            | 4.5            |
| Occupational Therapist                              | 1.0            | 0.5            | 0.4            | 1.0            | 2.9            |
| Speech and Language Therapist                       | 1.0            | 0.3            | 0.7            | 1.0            | 3.0            |
| Social Worker                                       | 1.0            | 0.6            | 2.0            | 0.71           | 4.31           |
| Social Care /Childcare Worker                       | 2.0            | 0.0            | 0.0            | 0.0            | 2.0            |
| Dietician   | 0.0            | 0.0            | 0.8            | 0.0            | 0.8            |
| Physiotherapy                                       | 0.0            | 0.0            | 0.0            | 0.0            | 0.0            |
| Other Therapist                                     | 0.0            | 0.0            | 0.0            | 0.0            | 0.0            |
| Administrative Support staff                        | 1.0            | 1.75           | 1.85           | 3.0            | 7.6            |
| Non Nursing Care Assistant/<br>Multi Task Attendant | 0.0            | 0.0            | 3.0            | 4.5            | 7.5            |
| Non Nursing Chef (Household)                        | 0.0            | 1.0            | 0.0            | 0.0            | 1.0            |
| Non Nursing Catering Assistant                      | 2.5            | 1.69           | 0.0            | 0.0            | 4.19           |
| Non Nursing Driver/Porter                           | 1.0            | 0.0            | 0.0            | 1.0            | 2.0            |
| Teaching Staff                                      | 2.0            | 1.0            | 2.0            | 2.0            | 7.0            |
| Teaching Support Staff                              | 0.0            | 0.0            | 0.0            | 2.0            | 2.0            |
| Other Staff   | 0.0            | 0.4            | 0.0            | 0.0            | 0.4            |
| <b>Total</b>  | <b>30.0</b>    | <b>28.19</b>   | <b>47.73</b>   | <b>60.01</b>   | <b>165.93</b>  |
| Clinical WTE  | 23.5           | 22.35          | 40.88          | 47.51          | 134.24         |

Each of the three Dublin paediatric hospitals has a liaison team and the total number of staff on these teams is 30. There are three adolescent day services in Dublin with a total staff of 23.15. Dunfillan Young Person's Unit is located at the St. John of God Lucena clinic in Rathgar, St. Joseph's Adolescent and Family Service at St. Vincent's Hospital, Fairview and the Linn Dara Adolescent Day Programme at CAMHS facility in Cherry Orchard Hospital, Ballyfermot.

**Table 2.1 (c) Staffing of Day Services and Liaison Teams**

| September 2013               | Day Service                                  |                               |                                    | Paediatric Hospital Liaison               |                             |                                       | Total        |
|------------------------------|--|-------------------------------|------------------------------------|---|-----------------------------|---------------------------------------|--------------|
| Discipline                   | St. Joseph's Adolescent & Family Day Service | Dunfillan Young Person's Unit | Linn Dara Adolescent Day Programme | Children's University Hospital Temple St. | Our Lady's Hospital Crumlin | National Children's Hospital Tallaght |              |
| Consultant Psychiatrist      | 0.65   | 1.00                          | 1.00                               | 2.40                                      | 3.00                        | 1.40                                  | 9.45         |
| Senior Registrar             | 0.80   | 1.00                          | 0.00                               | 0.60                                      | 0.50                        | 0.00                                  | 2.9          |
| Registrar / SHO              | 0.00   | 0.00                          | 0.00                               | 0.00                                      | 1.00                        | 0.00                                  | 1            |
| Social Worker                | 0.00   | 0.40                          | 1.00                               | 3.90                                      | 0.00                        | 0.00                                  | 5.3          |
| Clinical Psychologist        | 0.50   | 0.00                          | 0.60                               | 3.00                                      | 0.00                        | 0.00                                  | 4.1          |
| Occupational Therapist       | 0.00   | 0.30                          | 1.00                               | 1.60                                      | 0.00                        | 0.00                                  | 2.9          |
| Speech & Lang. Therapist     | 0.50   | 0.25                          | 0.45                               | 1.00                                      | 0.00                        | 0.00                                  | 2.2          |
| Social Care Worker/Leader    | 0.00   | 0.00                          | 1.00                               | 0.00                                      | 0.00                        | 0.00                                  | 1            |
| Nurse                        | 6.50   | 3.00                          | 1.70                               | 2.50                                      | 2.00                        | 0.90                                  | 16.6         |
| Administrative Support staff | 1.00   | 0.50                          | 0.00                               | 4.20                                      | 1.00                        | 1.00                                  | 7.7          |
| <b>Total</b>                 | <b>9.95</b>                                  | <b>6.45</b>                   | <b>6.75</b>                        | <b>19.20</b>                              | <b>7.50</b>                 | <b>3.30</b>                           | <b>53.15</b> |

## 2.2 Community Child and Adolescent Mental Health teams

It is possible to compare the staffing of Community CAMHS teams with previous surveys carried out in March 2007, November 2008, and November 2009. The staffing levels in the Community teams increased by 69.82 in the period from September 2012 to September 2013.

**Table 2.2 (a) Community Child & Adolescent Mental Health Teams (2007 to 2013)**

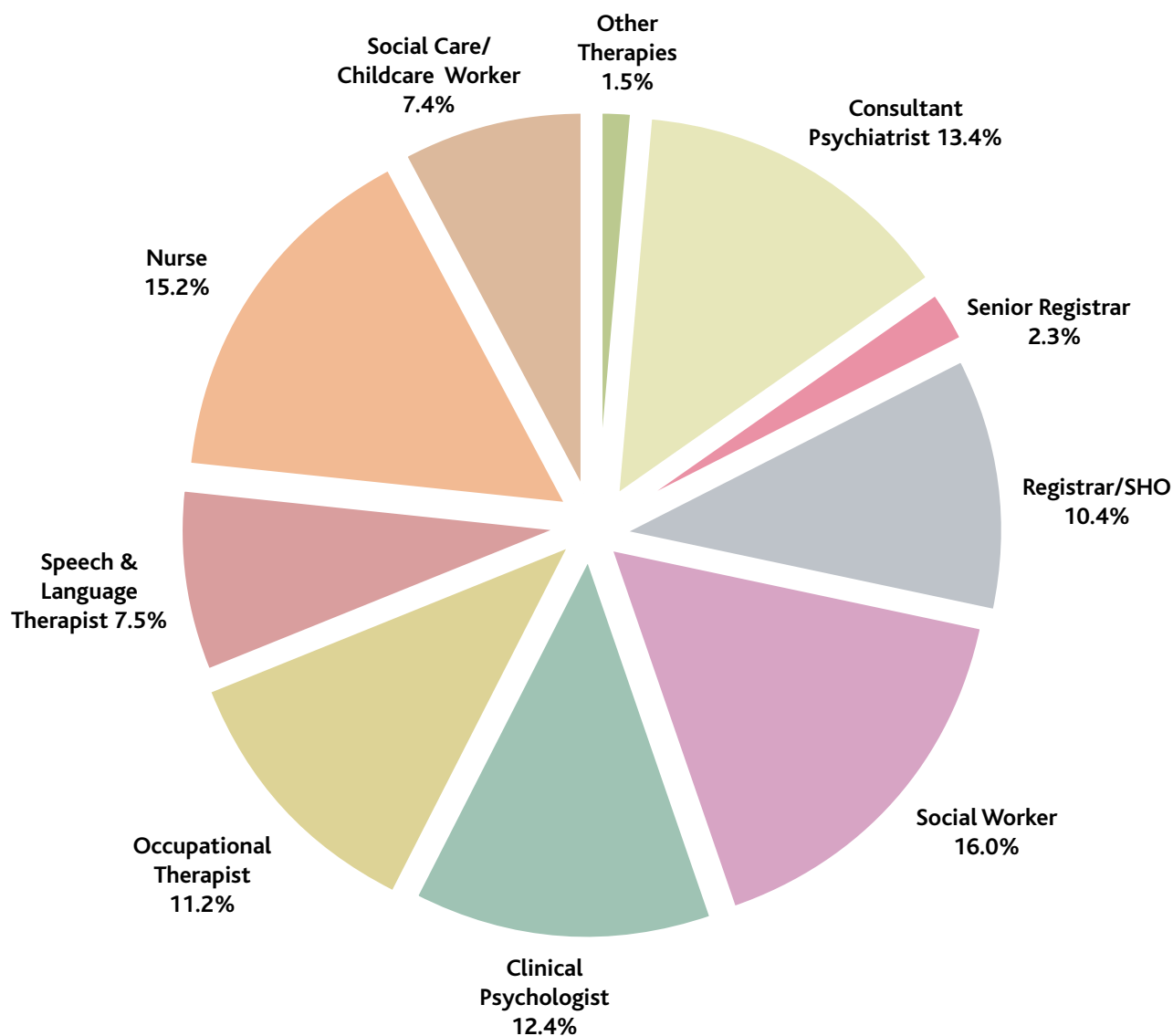
| HSE Region                    | Clinical Staff March 2007 | Clinical Staff Nov 2008 | Clinical Staff Nov 2009 | Clinical Staff Sept 2010 | Clinical Staff Sept 2011 | Clinical Staff Sept 2012 | Clinical Staff Sept 2013 | Change +/-    |
|-------------------------------|---------------------------|-------------------------|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------|
| Dublin Mid-Leinster           | 127.74                    | 128.51                  | 123.77                  | 125.98                   | 130.68                   | 116.55                   | 131.01                   | +14.46        |
| Dublin North East             | 77.05                     | 85.22                   | 89.5                    | 89.76                    | 89.69                    | 86.69                    | 96.05                    | +9.36         |
| South                         | 61.1                      | 60.60                   | 55.35                   | 78.04                    | 74.65                    | 79.85                    | 100.63                   | +20.78        |
| West                          | 74.3                      | 76.90                   | 80.75                   | 86.79                    | 94.24                    | 102.49                   | 123.53                   | +21.04        |
| <b>Total</b>                  | <b>340.19</b>             | <b>351.23</b>           | <b>349.37</b>           | <b>380.57</b>            | <b>389.26</b>            | <b>385.58</b>            | <b>451.22</b>            | <b>+65.64</b> |
| Administrative/ Support staff | 67.8                      | 70.7                    | 71.75                   | 75.54                    | 75.48                    | 76.36                    | 80.54                    | +4.18         |
| <b>Total Staff</b>            | <b>407.99</b>             | <b>421.93</b>           | <b>421.12</b>           | <b>456.11</b>            | <b>464.74</b>            | <b>461.94</b>            | <b>531.76</b>            | <b>+69.82</b> |

In September 2013 there was 531.76 staff (clinical 451.22) working in 60 Community CAMHS teams, with an average of 8.86 staff of which 7.52 were clinical staff per team. The range of team size varies from the smallest team of 4.29 (3.56 clinical) to the largest which comprises of 14.65 (12.2 clinical).

- This translates to a ratio of 1 clinical staff member, working in Community based CAMHS teams, to 2,546 children aged 0 to 17 years.
- The staff complement for a Community CAMHS teams as recommended in *A Vision for Change (2006)* is 13, comprising of 11 clinical and 2 administrative support staff. The recommended for staffing for 60 Community teams is 780 (660 Clinical).

A characteristic of CAMHS teams is that they can draw on their multidisciplinary makeup to undertake comprehensive and complex assessment and treatment approaches as well as provide packages of care where more than one professional or intervention is required in order to meet the needs of young person and their family or carers.

**Figure 2.2 (i) Community CAMHS clinical workforce by profession (2013)**



- The largest professional group was psychiatry making up 26.1% of the workforce (consultant child & adolescent psychiatrists (13.4%), and doctors in training (12.7%).
- The other main professional groups were social work (16%), nursing (15.2%), clinical psychology (12.4%), occupational therapy (11.2%), speech and language therapy (7.5%), social care/childcare (7.4%), and other therapies (1.5%).

Table 2.2 (b) shows the changes in staffing by discipline from 2007 to 2013.



Table 2.2 (b) Community CAMHS Teams Staffing Breakdown 2007 to 2013

| Community Teams<br>Discipline | Staffing      |               |               |                |                |                |                |
|-------------------------------|---------------|---------------|---------------|----------------|----------------|----------------|----------------|
|                               | March 2007    | November 2008 | November 2009 | September 2010 | September 2011 | September 2012 | September 2013 |
| Consultant Psychiatrist       | 45.6          | 49.37         | 51.05         | 54.69          | 57.69          | 60.44          | 60.37          |
| Senior Registrar              | 17.8          | 19.5          | 18            | 19             | 19.80          | 20.6           | 10.40          |
| Registrar/SHO                 | 45.2          | 49.85         | 48.5          | 47.49          | 43.49          | 45.2           | 47.03          |
| Social Worker                 | 61.15         | 53.4          | 56.65         | 65.10          | 68.01          | 67.29          | 72.09          |
| Clinical Psychologist         | 48.04         | 50.1          | 47.3          | 53.67          | 57.78          | 57.78          | 55.75          |
| Occupational Therapist        | 13.65         | 15.1          | 16.5          | 24.65          | 26.70          | 25.72          | 50.53          |
| Speech & Language Therapist   | 27.6          | 26.97         | 26.7          | 27.54          | 29.22          | 29.72          | 46.14          |
| Nurse                         | 55.95         | 56.78         | 53.07         | 60.49          | 61.33          | 59.64          | 68.77          |
| Childcare Worker              | 19.9          | 21.8          | 21            | 20.34          | 15.74          | 12.74          | 33.54          |
| Other Therapist               | 5.3           | 8.76          | 10.6          | 7.6            | 9.00           | 6.45           | 6.60           |
| Administrative Staff          | 67.8          | 70.7          | 71.75         | 75.54          | 75.48          | 76.36          | 80.54          |
| <b>Total</b>                  | <b>407.99</b> | <b>422.33</b> | <b>421.12</b> | <b>456.11</b>  | <b>464.24</b>  | <b>461.94</b>  | <b>531.76</b>  |

Table 2.2 (c) Community CAMHS Teams Staffing Breakdown by HSE region 2013 versus 2012

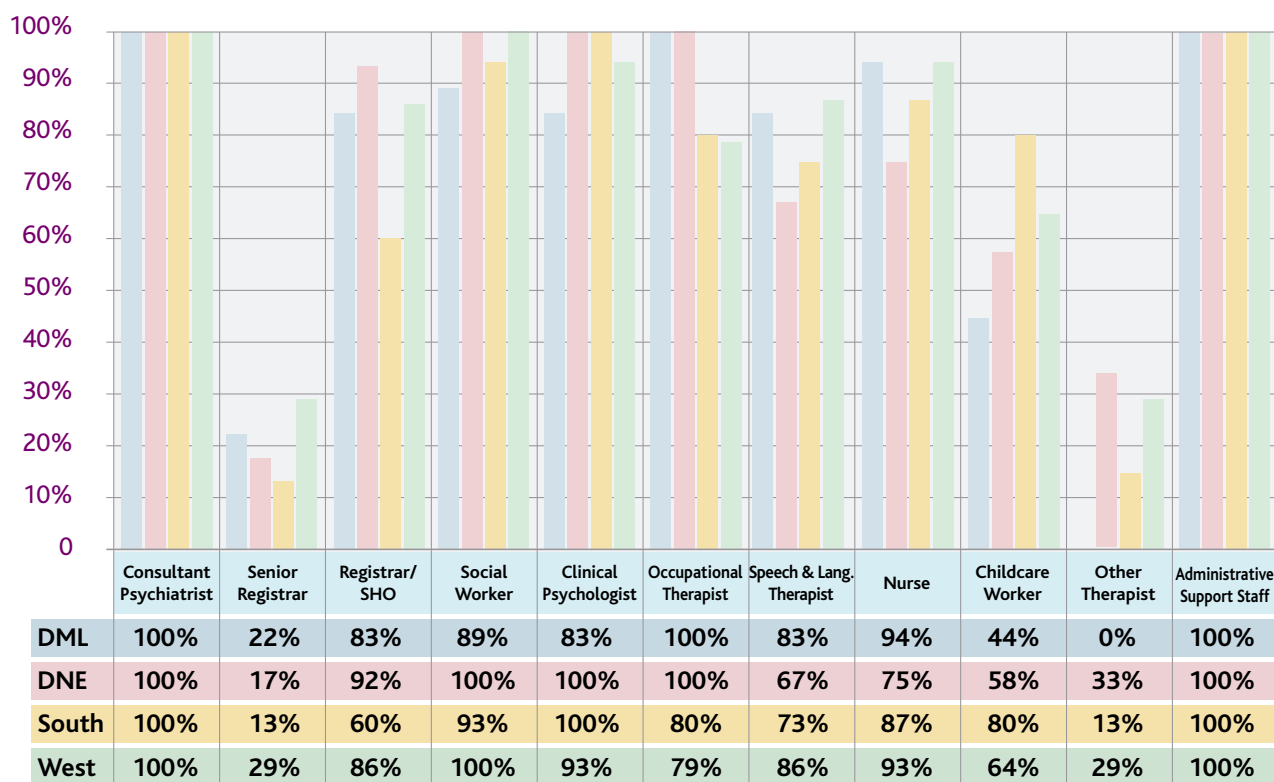
| Region<br>Discipline            | Dublin Mid Leinster |               |              | Dublin North East |              |             | South         |              |              | West          |               |              | Total         |               |              |
|---------------------------------|---------------------|---------------|--------------|-------------------|--------------|-------------|---------------|--------------|--------------|---------------|---------------|--------------|---------------|---------------|--------------|
|                                 | 2013                | 2012          | Var+/-       | 2013              | 2012         | Var+/-      | 2013          | 2012         | Var+/-       | 2013          | 2012          | Var+/-       | 2013          | 2012          | Var+/-       |
| Consultant Psychiatrist         | 18.34               | 17.44         | 0.90         | 12.80             | 13.20        | -0.40       | 14.73         | 15.00        | -0.27        | 14.50         | 14.80         | -0.30        | 60.37         | 60.44         | -0.07        |
| Senior Registrar                | 2.90                | 5.80          | -2.90        | 2.00              | 5.80         | -3.80       | 1.50          | 4.00         | -2.50        | 4.00          | 5.00          | -1.00        | 10.40         | 20.60         | -10.20       |
| Registrar / SHO                 | 16.33               | 16.40         | -0.07        | 9.20              | 10.00        | -0.80       | 7.40          | 8.80         | -1.40        | 14.10         | 10.00         | 4.10         | 47.03         | 45.20         | 1.83         |
| Social Worker                   | 17.81               | 18.87         | -1.06        | 16.30             | 17.22        | -0.92       | 16.68         | 15.30        | 1.38         | 21.30         | 15.90         | 5.40         | 72.09         | 67.29         | 4.80         |
| Clinical Psychologist           | 12.32               | 13.44         | -1.12        | 14.30             | 14.64        | -0.34       | 14.79         | 14.90        | -0.11        | 14.34         | 14.80         | -0.46        | 55.75         | 57.78         | -2.03        |
| Occupational Therapist          | 16.90               | 5.82          | 11.08        | 10.60             | 6.00         | 4.60        | 11.63         | 7.40         | 4.23         | 11.40         | 6.50          | 4.90         | 50.53         | 25.72         | 24.81        |
| Speech & Language Therapist     | 18.08               | 13.70         | 4.38         | 8.90              | 8.92         | -0.02       | 8.36          | 3.00         | 5.36         | 10.80         | 4.10          | 6.70         | 46.14         | 29.72         | 16.42        |
| Nurse                           | 20.73               | 23.08         | -2.35        | 12.05             | 7.46         | 4.59        | 15.44         | 10.55        | 4.89         | 20.55         | 18.55         | 2.00         | 68.77         | 59.64         | 9.13         |
| Social Care / Childcare Workers | 7.60                | 2.00          | 5.60         | 6.50              | 0.00         | 6.50        | 9.00          | 0.00         | 9.00         | 10.44         | 10.74         | -0.30        | 33.54         | 12.74         | 20.80        |
| Other Therapist                 | 0.00                | 0.00          | 0.00         | 3.40              | 3.45         | -0.05       | 1.10          | 0.90         | 0.20         | 2.10          | 2.10          | 0.00         | 6.60          | 6.45          | 0.15         |
| Administrative / Support Staff  | 27.20               | 25.81         | 1.39         | 13.11             | 13.25        | -0.14       | 17.83         | 18.40        | -0.57        | 22.40         | 18.90         | 3.50         | 80.54         | 76.36         | 4.18         |
| <b>Total</b>                    | <b>158.21</b>       | <b>142.36</b> | <b>15.85</b> | <b>109.16</b>     | <b>99.94</b> | <b>9.22</b> | <b>118.46</b> | <b>98.25</b> | <b>20.21</b> | <b>145.93</b> | <b>121.39</b> | <b>24.54</b> | <b>531.76</b> | <b>461.94</b> | <b>69.82</b> |

In 2013 the Community child and adolescent service saw a fifteen percent (69.82) increase in the number of Whole Time Equivalents as part of the new resources it received from the mental health budget. The majority of these Whole Time Equivalents were Occupational Therapist (24.81), Social Care (20.8), Speech & Language Therapist (16.42) and Nursing (9.13) grades, thus strengthening the multidisciplinary facet of the community teams.

## Composition of Community CAMHS teams by professional discipline

- The numbers of each professional discipline employed across the regions shows a decreased variation in 2013 as reflected on their teams Figure 2.2 (ii).

Figure 2.2 (ii) Representation of the professional disciplines on each Community CAMHS team by HSE region (2013)



## 2.3 Community CAMHS staffing compared against Vision for Change recommendations

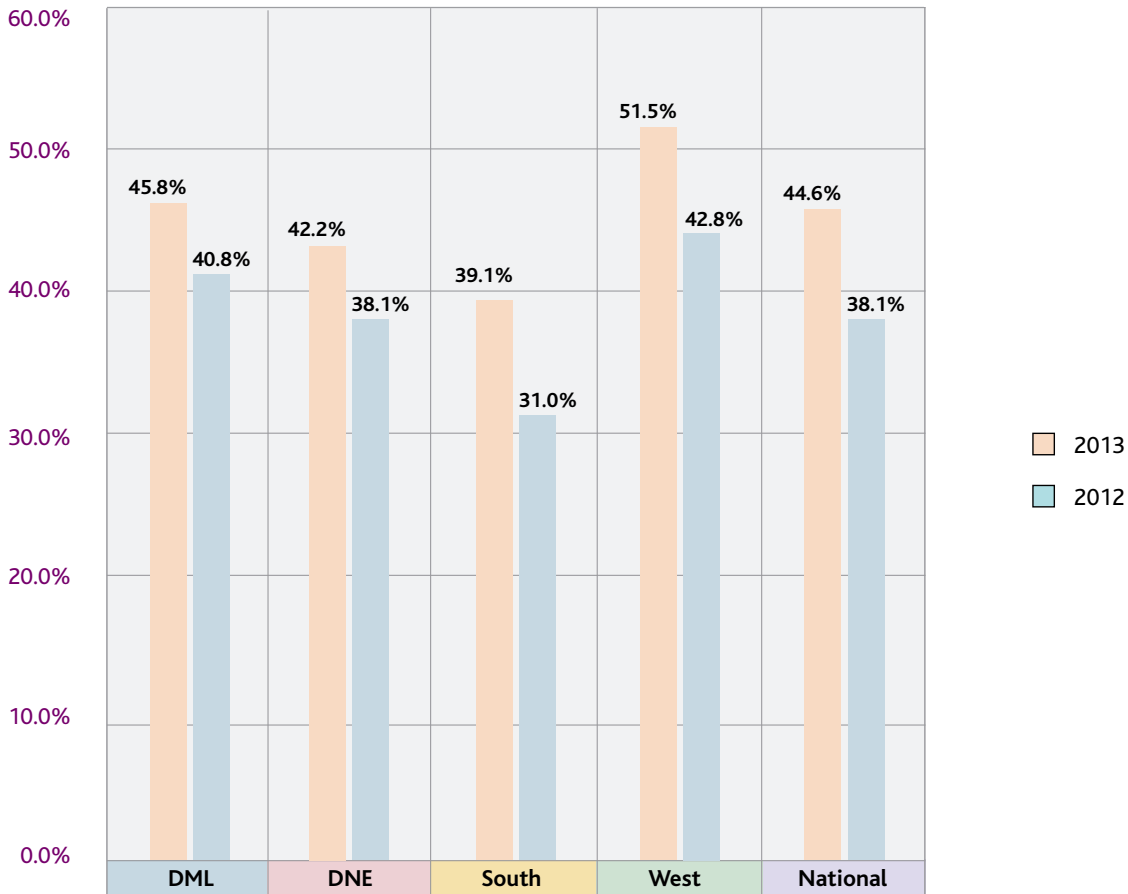
*Vision for Change* (2006) recommends that there should be two child and adolescent community mental health teams for each sector of 100,000 population with individual child and adolescent community mental health teams comprising of the following:

- One consultant psychiatrist.
- One doctor in training.
- Two psychiatric nurses.
- Two clinical psychologists.
- Two social workers.
- One occupational therapist.
- One speech and language therapist.
- One child care worker.
- Two administrative staff.

The composition of each child and adolescent community mental health teams should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions.

In Ireland 25% of the population is under 18 years of age and in September 2013 there was a total of 531.76 staff in situ (451.22 Clinical), this represents 44.6% of the staffing level as recommended in *A Vision for Change*. Figure 2.3 (i) displays the regional comparisons of these staffing levels.

**Figure 2.3 (i) Community CAMHS Teams Staffing vs. VFC recommendation by HSE Region 2013 versus 2012**



In 2013 the staffing level as recommended in *A Vision for Change* had increased by 6.5% nationally on the 2012 position. The largest increase was in the West 8.8% followed by the South 8.1%, Dublin Mid Leinster 5.1%, and Dublin North East 4.1%.

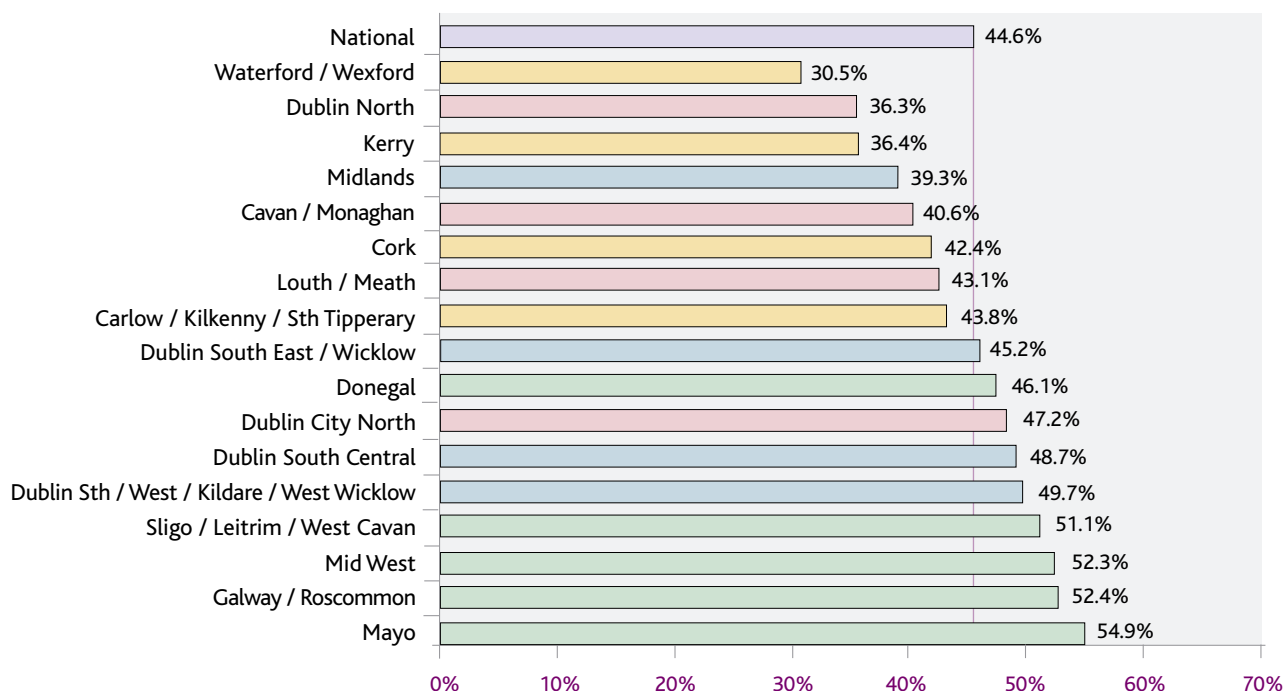
The Health Service Executive (HSE) has mapped the community child and adolescent mental health service by the populations' district electoral division (DED).

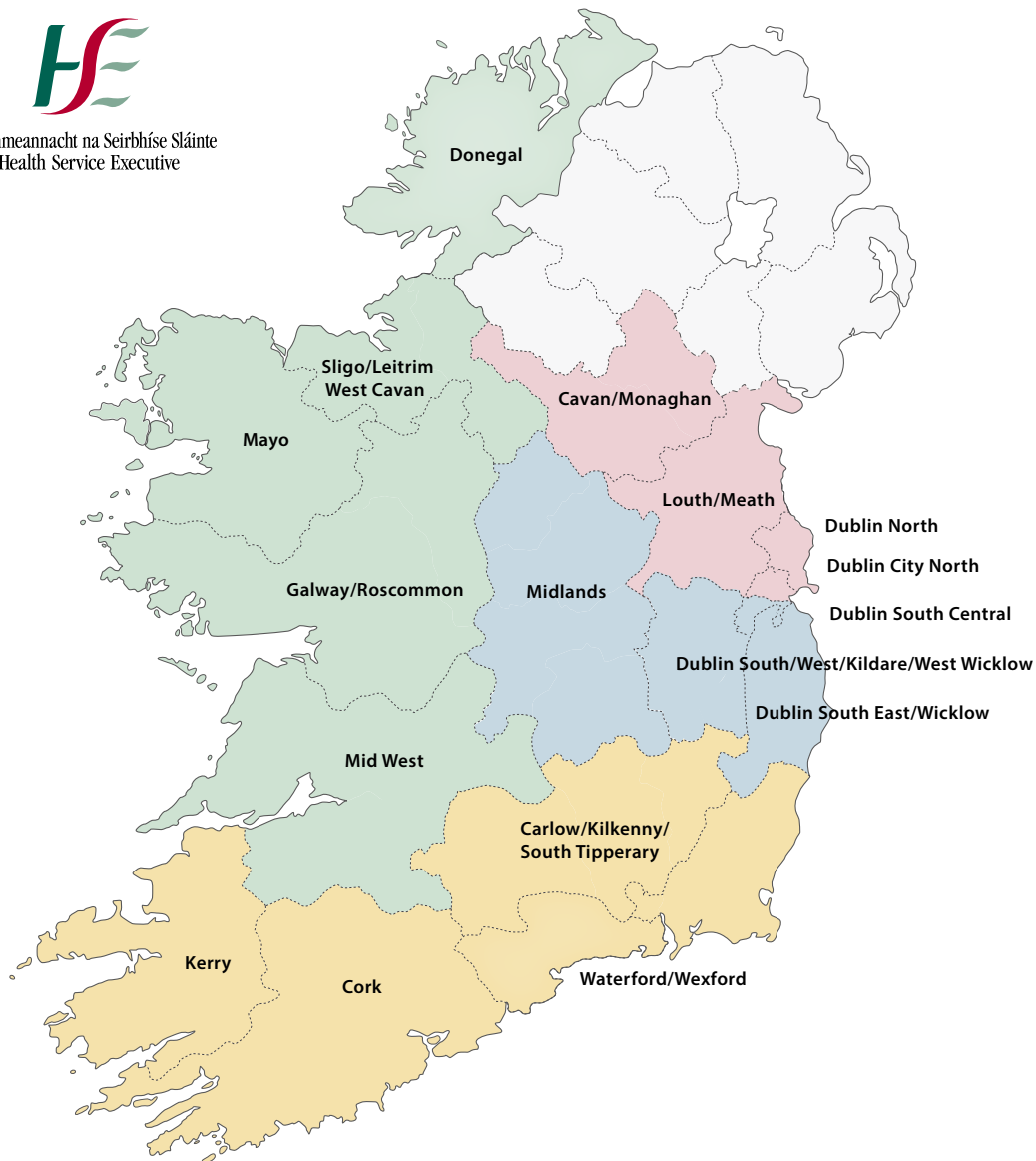
Table 2.3 (a) demonstrates the variances across the HSE Management Area Structures in each region per under 18 years of age population and this ranges from 30.5% (Waterford/Wexford) to 54.9% (Mayo) of the staffing level as recommended in *A Vision for Change*.

Table 2.3 (a) Community CAMHS Teams Clinical Staffing vs. VFC recommendation by HSE Area Structures 2013

| HSE Area Management Structures         | Population     | Clinical     | % of VFC recommendation |
|--|----------------|--------------|-------------------------|
| Dublin South Central                   | 40,483         | 17.36        | 48.7%                   |
| Dublin South/West/Kildare/West Wicklow | 113,552        | 49.69        | 49.7%                   |
| Dublin South East/Wicklow              | 93,194         | 37.06        | 45.2%                   |
| Midlands                               | 77,726         | 26.90        | 39.3%                   |
| <b>Dublin Mid Leinster</b>             | <b>324,955</b> | <b>131.0</b> | <b>45.8%</b>            |
| Dublin North                           | 64,081         | 20.45        | 36.3%                   |
| Dublin City North                      | 71,841         | 29.85        | 47.2%                   |
| Louth/Meath                            | 86,692         | 32.90        | 43.1%                   |
| Cavan/Monaghan                         | 35,955         | 12.85        | 40.6%                   |
| <b>Dublin North East</b>               | <b>258,569</b> | <b>96.1</b>  | <b>42.2%</b>            |
| Carlow/Kilkenny South Tipperary        | 57,800         | 22.30        | 43.8%                   |
| Waterford/Wexford                      | 71,608         | 19.20        | 30.5%                   |
| Cork                                   | 128,448        | 47.93        | 42.4%                   |
| Kerry                                  | 34,940         | 11.20        | 36.4%                   |
| <b>South</b>                           | <b>292,796</b> | <b>100.6</b> | <b>39.1%</b>            |
| Mayo                                   | 32,514         | 15.70        | 54.9%                   |
| Galway/Roscommon                       | 77,270         | 35.60        | 52.4%                   |
| Donegal                                | 43,732         | 17.75        | 46.1%                   |
| Sligo/Leitrim/West Cavan               | 23,862         | 10.74        | 51.1%                   |
| Mid West                               | 94,989         | 43.74        | 52.3%                   |
| <b>West</b>                            | <b>272,367</b> | <b>123.5</b> | <b>51.5%</b>            |

Figure 2.3 (ii) Community CAMHS Teams Staffing vs. VFC recommendation by HSE Area Structures 2013





## Legend

### DUBLIN NORTH EAST

Dublin North 36.3%  
Dublin City North 47.2%  
Louth / Meath 43.1%  
Cavan / Monaghan 40.6%

### WEST

Mayo 54.9%  
Galway / Roscommon 52.4%  
Donegal 46.1%  
Sligo / Leitrim /  
West Cavan 51.1%  
Mid West 52.3%

### SOUTH

Carlow / Kilkenny /  
South Tipperary 43.8%  
Waterford / Wexford 30.5%  
Cork 42.4%  
Kerry 36.4%

### DUBLIN MID LEINSTER

Dublin South Central 48.7%  
Dublin South / West / Kildare /  
West Wicklow 49.7%  
Dublin South East /  
Wicklow 45.2%  
Midlands 39.3%

## 2.4 New Developments 2014

In the Health Budget for 2014 a provision was made for an additional €20m for mental health services in line with the commitment contained in the Programme for Government.

The €20m ring fenced in 2014 will enable the HSE to continue to develop and modernise the mental health services in line with the recommendations of *A Vision for Change* and will allow for the recruitment of additional staff to create new teams as well as further enhancing the existing community child and adolescent mental health teams, ensuring a more complete multidisciplinary composition within these teams and thus enhancing service delivery.

## SECTION 3

# Access to Community CAMHS Teams

### 3.1 Referrals

Community child and adolescent mental health teams are the first line of specialist mental health services with children and young people who are directly referred to the Community CAMHS team from a number of sources, these include General Practitioners, Child Health Services, A&E Departments, Learning Disability Services, Adult Mental Health Services, Primary Care Services and other CAMHS services. Along with these sources, direct referrals from Educational services are also accepted but sometimes may need to be accompanied by a general practitioners referral as well.

Since the 2011/12 to 2012/13 reporting period there has been an increase of 21% nationally in the number of referrals accepted by the Community Child and Adolescent Mental Health service as outlined in Table 3.1 (a).

**Table 3.1 (a) Referrals accepted October 2012 to September 2013 vs. October 2011 to September 2012**

|          | 2012/13 | 2011/12 | +/- Variance |
|----------|---------|---------|--------------|
| DML      | 4,126   | 3,479   | 19%          |
| DNE      | 2,003   | 1,809   | 11%          |
| South    | 2,518   | 1,905   | 32%          |
| West     | 3,375   | 2,780   | 21%          |
| National | 12,022  | 9,973   | 21%          |

### 3.2 Number and length of time waiting to be seen

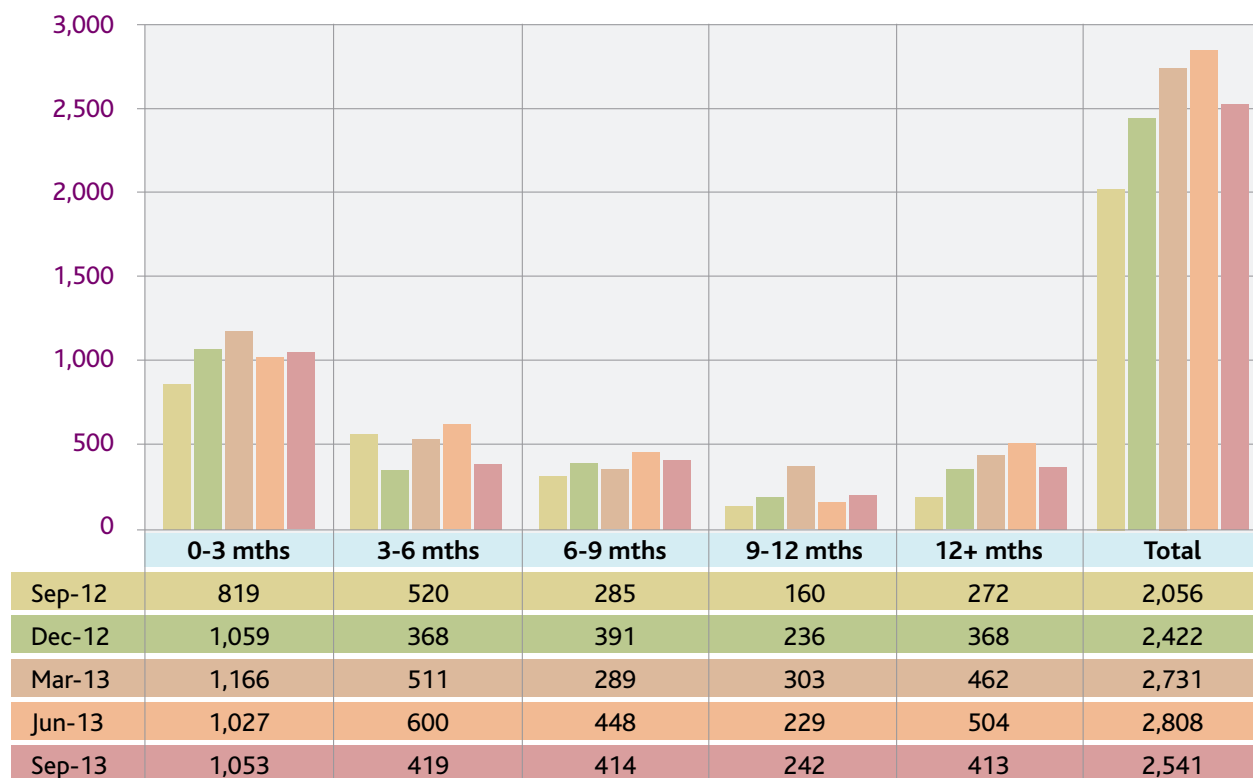
All CAMHS teams screen referrals received, those deemed to be urgent are seen as a priority, while those deemed to be routine are placed on a waiting list to be seen.

Community CAMHS Teams reported a total of 2,541 children and adolescents waiting to be seen at the end of September 2013.

- 1,053 (41%) were waiting less than 3 months.
- 419 (17%) 3 to 6 months.
- 414 (16%) 6 to 9 months.
- 242 (10%) 9 to 12 months.
- 413 (16%) more than 12 months.

This represented an increase of 485 (24%) from the total number of 2,056 waiting at the end of September 2012.

Figure 3.2 (i) Waiting List for Community CAMHS September 2012 to September 2013



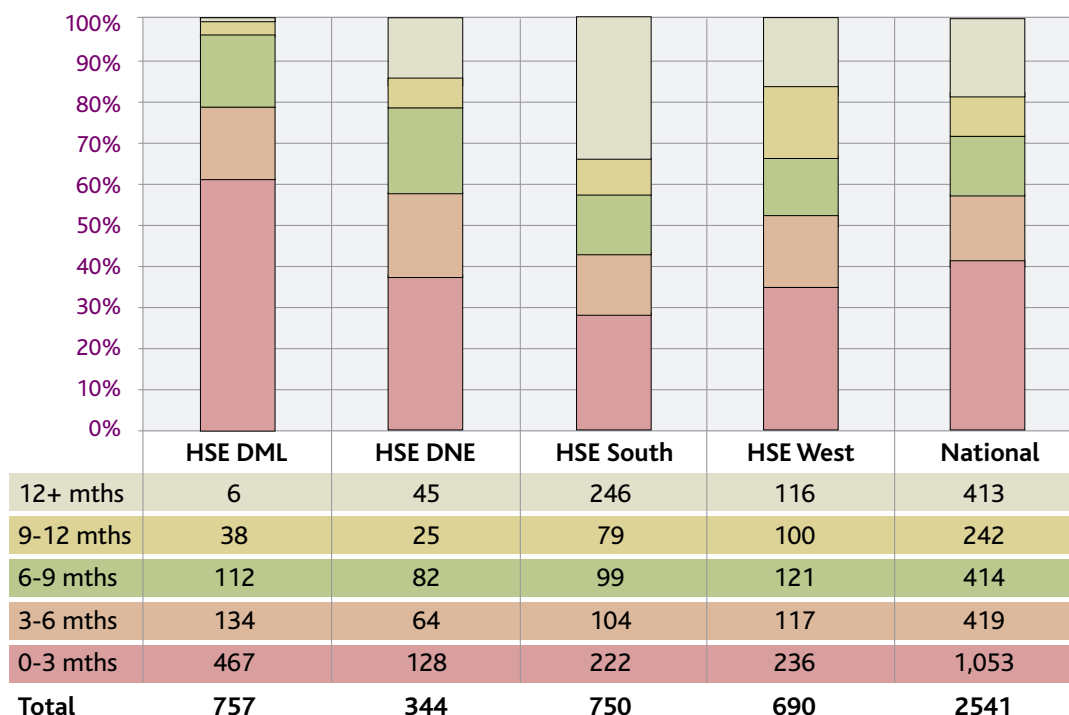
The greatest decrease (-19%) was seen in the group waiting 3 to 6 months from 520 to 419.

Table 3.2 (a) Size of waiting lists by team in each HSE Region (September 2013)

| Total Number Wait List | No. of Teams |           | Dublin Mid Leinster | Dublin North East | South     | West      |
|------------------------|--------------|-----------|---------------------|-------------------|-----------|-----------|
|                        | 2012         | 2013      |                     |                   |           |           |
| 0 - 49                 | 44           | 43        | 13                  | 11                | 10        | 9         |
| 50 - 99                | 10           | 11        | 6                   | 1                 | 2         | 2         |
| 100 - 149              | 3            | 4         | 0                   | 0                 | 2         | 2         |
| 150 - 200              | 1            | 2         | 0                   | 0                 | 1         | 1         |
| <b>Total</b>           | <b>58</b>    | <b>60</b> | <b>19</b>           | <b>12</b>         | <b>15</b> | <b>14</b> |

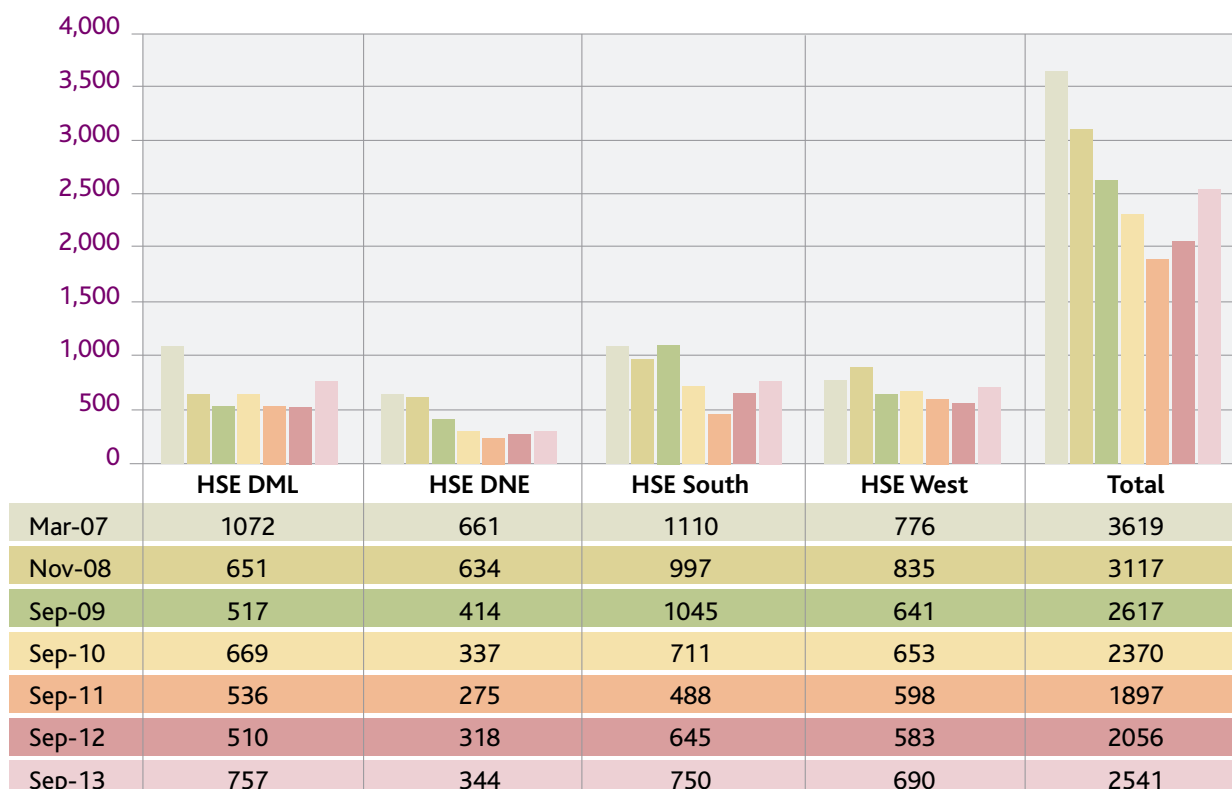
There was variation in the numbers waiting by Community team, with the majority of teams (43) having a total number of less than 50 on the routine waiting list.

Figure 3.2 (ii) Breakdown of Waiting Lists by HSE Region September 2013



The proportion of those on the waiting list more than 12 months was greatest in the South and West regions.

Figure 3.2 (iii) Changes in Waiting Lists from March 2007 to September 2013



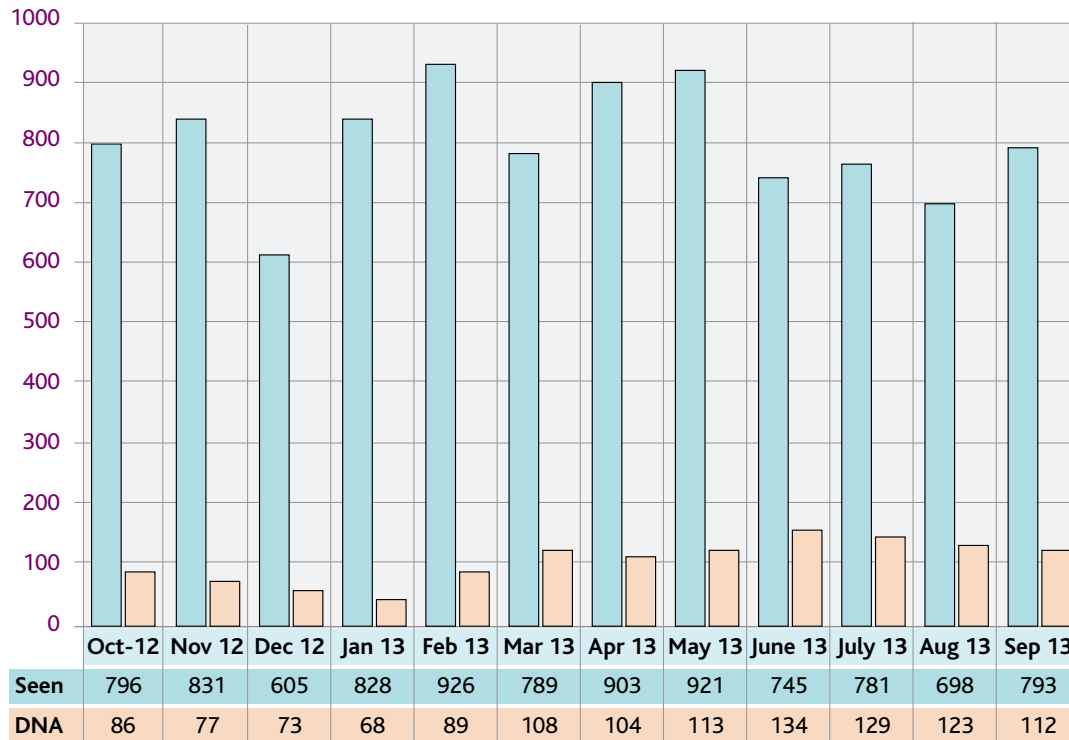
There was a decrease of 1,078 (-30%) in the number on waiting lists for Community CAMHS teams in the period March 2007 to September 2013.



### 3.3 New cases seen by Community CAMHS teams October 2012 to September 2013

From the October 1st 2012 to September 30th 2013 a total number of 10,832 new cases were offered an appointment by Community CAMHS teams. A total of 9,616 were seen and 1,216 did not attend. This gives a non-attendance rate of 11%, ranging from 8% to 15% across the 12 month period.

Figure 3.3 (i) New cases seen and DNAs from October 2012 to September 2013

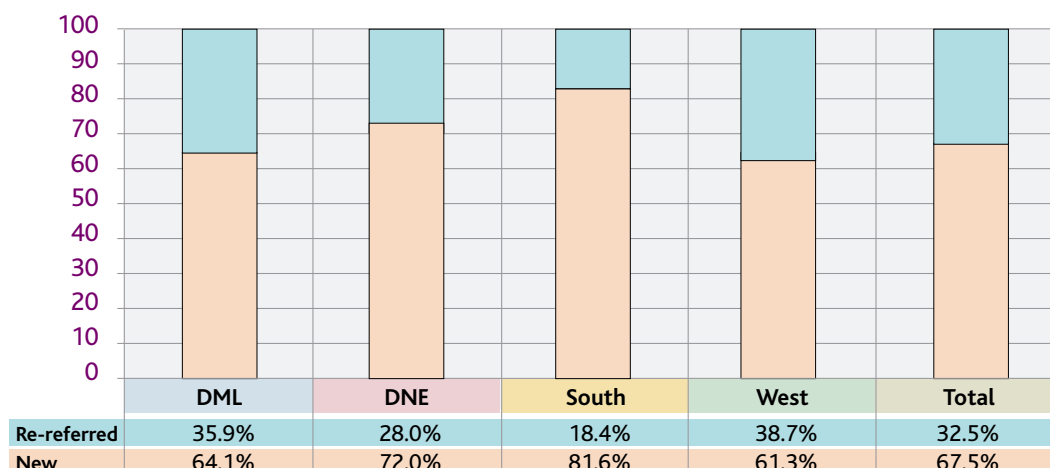


### 3.4 Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen a proportion will have previously attended the service and been discharged. Between October 2012 and September 2013 of the 9,616 cases seen a total of 3,124 had been re-referred to the service. This represents 32% of the new cases seen and can be compared with the national percentages in 2011/12, 2010/11, 2009 and 2008 of 31%, 22%, 21.6% and 20.5% respectively.

The proportion of re-referred cases varied from 18.4% in the South to 38.7% in the West region (Figure 3.4 (i)).

Figure 3.4 (i) Breakdown of new cases (New vs. Re-referred cases) 2012-2013



### 3.5 New Cases including re-referred seen by age profile

For the 12 month period October 2012 to September 2013 a total number of 9,616 new cases were seen by Community CAMHS teams of these new cases (including rereferred) 84% (8,065) were under 16 years of age and 16% (1,551) were over 16 years of age.

55 (95%) of the 60\* teams have seen new cases (including re-referred) adolescents over 16 years of age in 2012/2013.

**Table 3.5 (a) Number of new (including referred) cases seen aged 16 years and over from October 2012 to September 2013**

| HSE Region      | No. of New (including re-referred) cases seen aged 16 years and over | % of teams who have seen new (including re-referred) cases aged 16 years and over |
|-----------------|--|---|
| DML             | 397  | 89%*  |
| DNE             | 119  | 92%   |
| South           | 347  | 100%  |
| West            | 688  | 100%  |
| <b>National</b> | <b>1,551</b>   | <b>95%</b>  |

\* Two teams in the Lucena Clinic service are specifically dedicated to seeing those less than 13 years of age therefore lowering the cohort to 58

### 3.6 Waiting Times for New Cases Seen

For the 12 month period October 2012 to September 2013 a total number of 10,832 were offered an appointment of which 9,616 new cases were seen by Community CAMHS teams. The waiting time to be seen was recorded for each case. Over the 12 month period:

- 50% of new cases were seen within 1 month of referral.
- 71% seen within 3 months.
- 9% of new cases had waited between 3 to 6 months.
- 5% had waited between 6 and 12 months.
- 4% had waited more than 1 year.
- 11% did not attend their appointment.

Figure 3.6 (i) Length of wait to 1st appointment to be seen October 2012 to September 2013

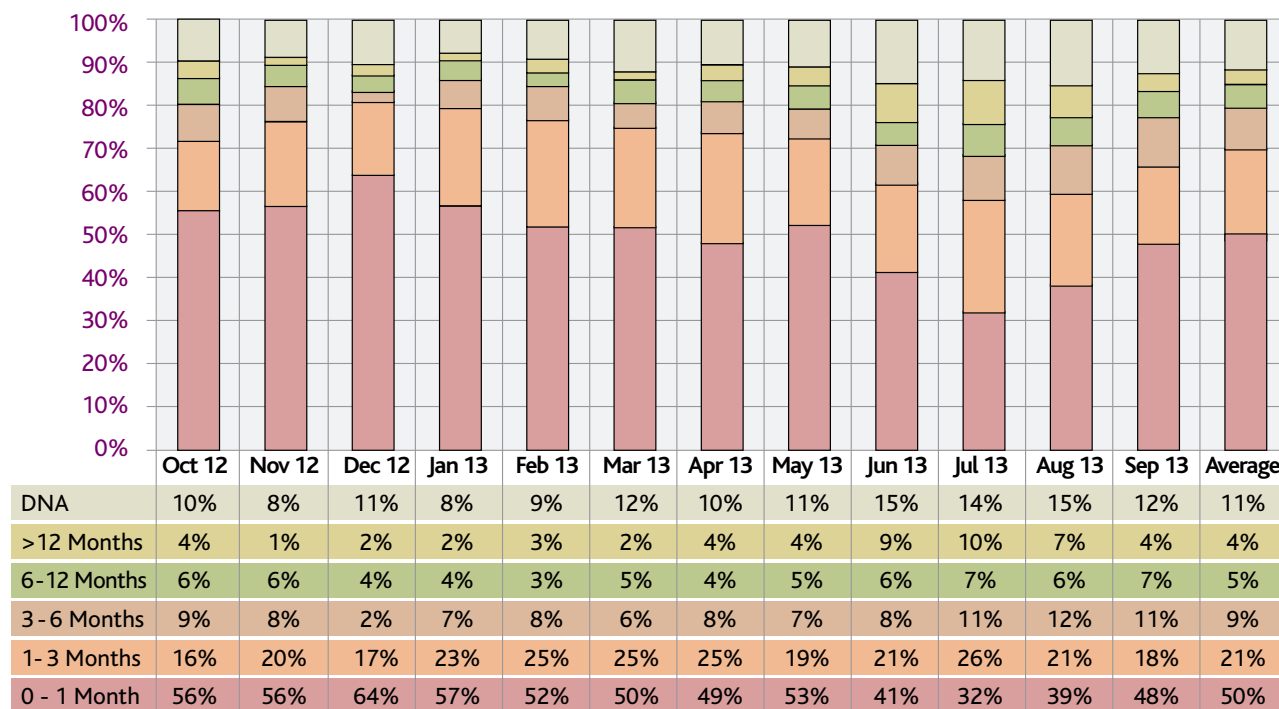
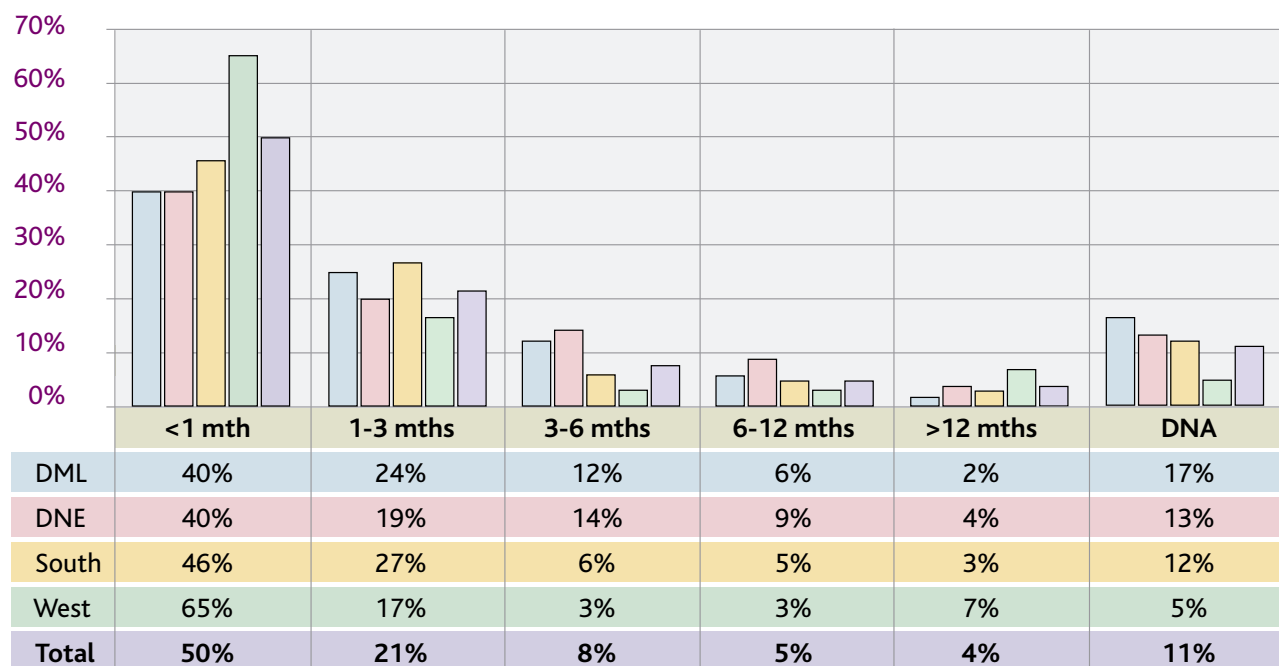


Figure 3.6 (ii) Length of wait to 1st appointment seen October 2012 to September 2013 by HSE Region



In HSE West 65% of new cases were seen within one month of referral with 82% seen within three months of referral.

### 3.7 Community CAMHS Caseload

In September 2013 the number of Active open cases was 17,116; with the number in the West (5,775), Dublin Mid Leinster (5,181), the South (3,475), and Dublin North East (2,685). 1.49% of the under 18 population is currently attending the Community Child and Adolescent Mental Health Service.

Figure 3.7 (i) The number of Active open in cases in September 2013 versus 2012 for the Community CAMHS Service by HSE region

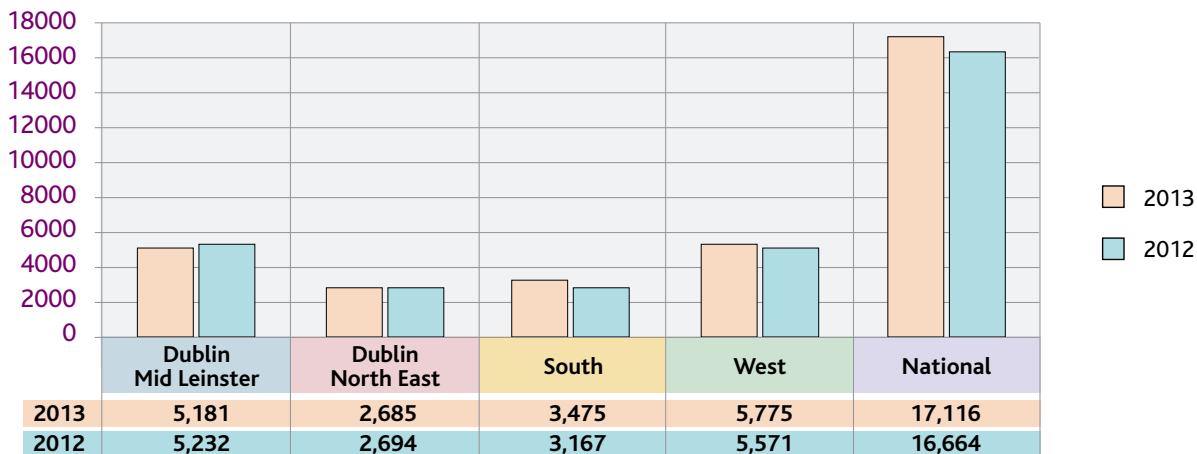


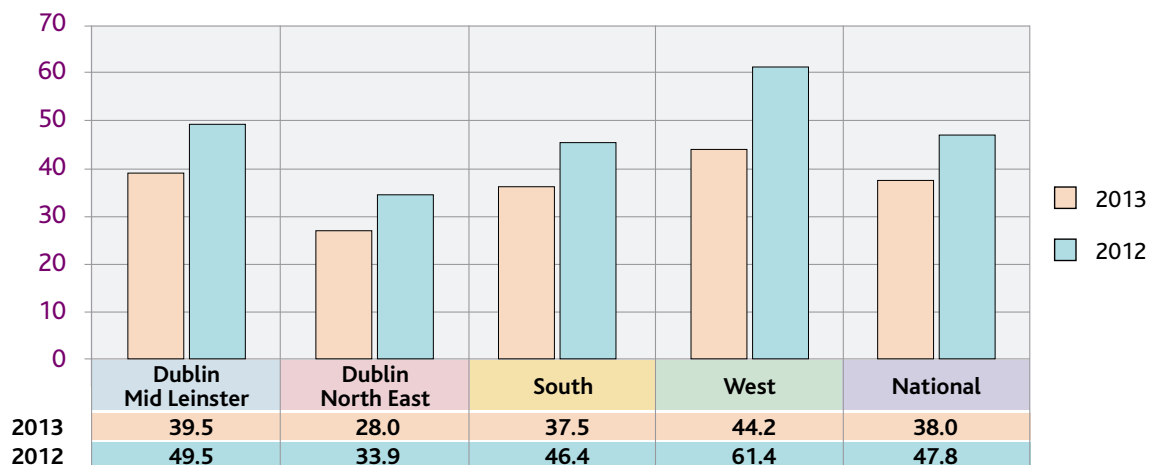
Table 3.7 (a) Percentage of Population under 18 years old attending CAMHS

| HSE Region          | <18 yrs.         | Case-load     | Percentage   |
|---------------------|------------------|---------------|--------------|
| Dublin Mid Leinster | 324,955          | 5,181         | 1.59%        |
| Dublin North East   | 258,569          | 2,685         | 1.04%        |
| South               | 292,796          | 3,475         | 1.19%        |
| West                | 272,367          | 5,775         | 2.12%        |
| <b>Total</b>        | <b>1,148,687</b> | <b>17,116</b> | <b>1.49%</b> |

### 3.8 Community CAMHS Caseload per Clinical Whole Time Equivalent (WTE)

In September 2013 the number of Active open cases per Clinical Whole Time Equivalent was 38. The number of Active open cases per Whole Time Equivalent was in the West (44.2), Dublin Mid Leinster (39.5), South (37.5), and Dublin North East (28.0).

Figure 3.8 (i) The number of Active open in cases for the Community CAMHS Service by Actual Clinical Whole Time Equivalent in September 2013 versus 2012



### 3.9 Cases Closed or Discharged

From October 2012 to September 2013 – 9,445 cases were closed and discharged by Community CAMHS teams.

85.4% of the cases closed were discharged to care of the General Practitioner or Primary Care Team (PCT), 9.1% to a Community Based Service, 3.5% to another CAMHS service, and 2% to an Adult Mental Health Service.

Table 3.9 (a) Cases closed and discharged by Community CAMHS teams

| HSE Region          | GP/PCT       | Other Community Service | Other CAMHS Service | Adult Mental Health Service |
|---------------------|--------------|-------------------------|---------------------|-----------------------------|
| Dublin Mid Leinster | 85.9%        | 7.8%                    | 4.8%                | 1.4%                        |
| Dublin North East   | 83.6%        | 12.4%                   | 2.0%                | 2.1%                        |
| South               | 86.4%        | 6.8%                    | 3.6%                | 3.2%                        |
| West                | 85.3%        | 10.2%                   | 2.4%                | 2.1%                        |
| <b>Total</b>        | <b>85.4%</b> | <b>9.1%</b>             | <b>3.5%</b>         | <b>2.0%</b>                 |

# SECTION 4 Audit of Clinical Activity November 2012

## Clinical Audit November 2012

In the month of November 2012 the fifth annual clinical audit was carried out by the 60 Community CAMHS Teams which recorded information on a total of 8,577 cases seen in the course of the month. Results from 2012 were compared with those from 2011.

### 4.1 Source of Referral

As a secondary specialist service children and young people are referred to Community CAMHS teams from a number of sources.

Table 4.1 (a) Source of referral to Community CAMHS teams (2012)

| Source of Referral           | Dublin Mid Leinster | Dublin North East | South         | West          | % 2012        | % 2011      |
|------------------------------|---------------------|-------------------|---------------|---------------|---------------|-------------|
| General Practitioner         | 62.1%               | 68.9%             | 79.9%         | 72.9%         | 70.4%         | 64.6%       |
| Child Health Services        | 6.9%                | 2.2%              | 7.4%          | 7.0%          | 6.2%          | 5.5%        |
| A & E Department             | 2.2%                | 7.8%              | 6.9%          | 4.0%          | 4.8%          | 5.1%        |
| Education                    | 12.4%               | 6.1%              | 1.1%          | 3.7%          | 6.2%          | 9.0%        |
| Primary Care Services        | 2.5%                | 6.1%              | 3.2%          | 5.4%          | 4.2%          | 3.7%        |
| Social Services              | 2.5%                | 3.3%              | 0.5%          | 2.7%          | 2.3%          | 2.7%        |
| Youth Justice                | 0.0%                | 0.0%              | 0.5%          | 0.0%          | 0.1%          | 0.2%        |
| Learning Disability Services | 0.0%                | 0.0%              | 0.0%          | 0.3%          | 0.1%          | 0.7%        |
| Adult Mental Health          | 0.4%                | 1.1%              | 0.0%          | 0.7%          | 0.5%          | 0.3%        |
| Voluntary Agencies           | 0.4%                | 0.0%              | 0.0%          | 0.0%          | 0.1%          | 0.9%        |
| Self referral                | 4.4%                | 0.6%              | 0.0%          | 0.0%          | 1.4%          | 1.2%        |
| Medico legal                 | 0.0%                | 0.0%              | 0.0%          | 0.3%          | 0.1%          | 0.5%        |
| Other                        | 4.0%                | 0.6%              | 0.0%          | 1.0%          | 1.6%          | 2.9%        |
| Other CAMHS                  | 2.2%                | 3.3%              | 0.5%          | 2.0%          | 2.0%          | 2.7%        |
| <b>Total</b>                 | <b>100.0%</b>       | <b>100.0%</b>     | <b>100.0%</b> | <b>100.0%</b> | <b>100.0%</b> | <b>100%</b> |

A total of 70.4% of referrals were received from general practitioners, 6.2% child health services, and 4.8% A & E departments. Educational services were the next largest source of referral with 6.2%, primary care services 4.2% (community psychology, speech and language therapy, occupational therapy), and social services (community social work) accounting for 2.3% of referrals. Self referral accounted for 1.4%. Adult mental health services, other child and adolescent mental health services, learning disability services, voluntary services, medico legal, and other accounted for the remaining 4.5%. As in 2011 referrals from educational services were much higher in the Dublin Mid Leinster and Dublin North East regions. The majority of Community CAMHS Teams have referral protocols in place.

### 4.2 Case Profile

During the period of measurement a total of 8,577 cases were seen by the 60 teams. 7,651 (89.2%) of these cases were returns and 926 (10.8%) were new cases.

### 4.3 Number of Appointments offered

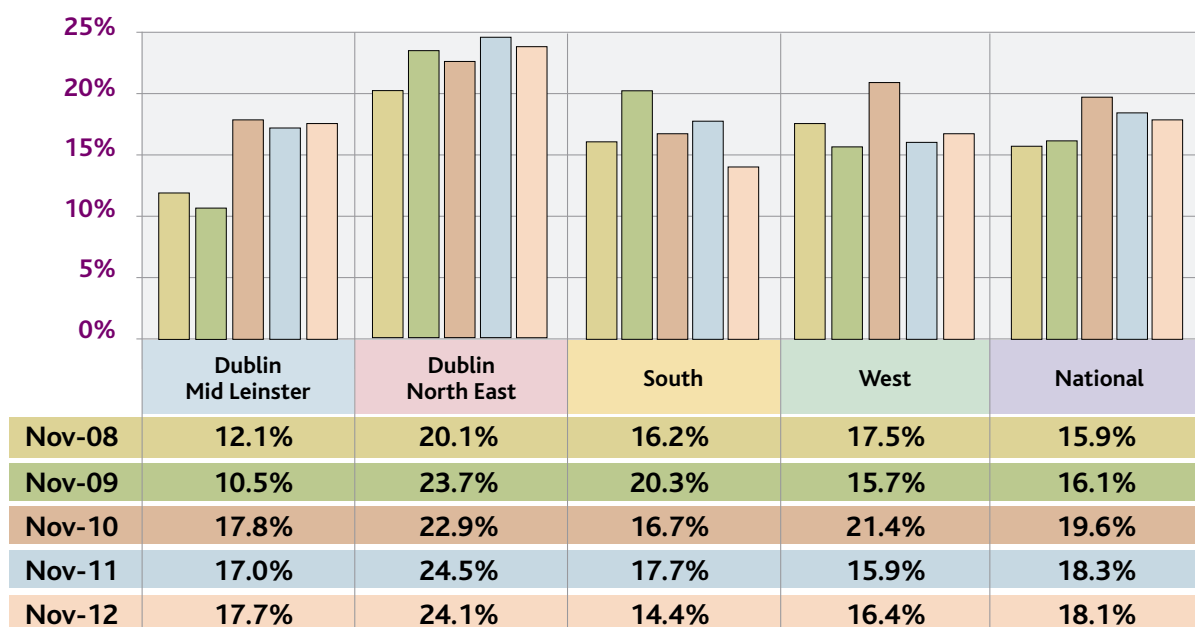
During the period of measurement a total of 15,229 appointments were offered. A total of 12,476 appointments were attended, with a resulting non-attendance rate of 18.1%. In November 2011 the overall non-attendance rate was 18.3%.

Table 4.3 (a) Attendance at appointments

|                       | Dublin Mid Leinster |        | Dublin North East |        | South  |        | West   |        | Total  |        |
|-----------------------|---------------------|--------|-------------------|--------|--------|--------|--------|--------|--------|--------|
|                       | 2011                | 2012   | 2011              | 2012   | 2011   | 2012   | 2011   | 2012   | 2011   | 2012   |
| Appointments          | 2011                | 2012   | 2011              | 2012   | 2011   | 2012   | 2011   | 2012   | 2011   | 2012   |
| Attended              | 4401                | 4692   | 2183              | 2310   | 2312   | 2116   | 3128   | 3358   | 12024  | 12476  |
| Not Attended          | 903                 | 1007   | 707               | 733    | 498    | 355    | 592    | 658    | 2700   | 2753   |
| Total Number          | 5304                | 5699   | 2890              | 3043   | 2810   | 2471   | 3720   | 4016   | 14724  | 15229  |
| Non Attendance Rate % | 17.02%              | 17.67% | 24.46%            | 24.09% | 17.72% | 14.37% | 15.91% | 16.38% | 18.34% | 18.08% |

The non-attendance rate was highest in Dublin North East at 24.1%, decreasing from 24.5% in 2011. Next highest was the Dublin Mid Leinster at 17.7%, increasing from 17% in 2011. The non-attendance rate in the West was 16.4%, increasing from 15.9% recorded in 2011. The lowest rate was in the South at 14.4% which was lower than the 17.7% recorded in 2011.

Figure 4.3 (i) Appointments offered % DNA rate by HSE region



## 4.4 Location of appointments

The majority of appointments took place in the clinic (94 %) with a small percentage taking place in the home (1.4%). A significant number of school visits were recorded (2.7%). The difference in hospital appointments across the regions reflects the presence of dedicated hospital liaison teams in each of the three Dublin paediatric hospitals.

Table 4.4 (a) Location of appointments

| Location of Appointments | Dublin Mid Leinster | Dublin North East | South       | West        | % 2012      | % 2011      |
|--------------------------|---------------------|-------------------|-------------|-------------|-------------|-------------|
| 1. Clinic                | 96.0%               | 96.5%             | 90.7%       | 91.4%       | 94.0%       | 93.9%       |
| 2. Home                  | 1.0%                | 1.1%              | 2.2%        | 1.7%        | 1.4%        | 1.3%        |
| 3. Hospital              | 0.2%                | 0.2%              | 1.6%        | 1.1%        | 0.7%        | 0.7%        |
| 4. School                | 2.5%                | 1.7%              | 3.0%        | 3.6%        | 2.7%        | 3.2%        |
| 5. Other                 | 0.3%                | 0.5%              | 2.5%        | 2.2%        | 1.2%        | 0.9%        |
| <b>Total</b>             | <b>100%</b>         | <b>100%</b>       | <b>100%</b> | <b>100%</b> | <b>100%</b> | <b>100%</b> |

## 4.5 Clinical Inputs

The number of recorded clinical inputs is greater than the number of appointments as members of the multidisciplinary team will frequently work jointly with a child and family as clinically indicated with an average of 1.37 clinical inputs per appointment.

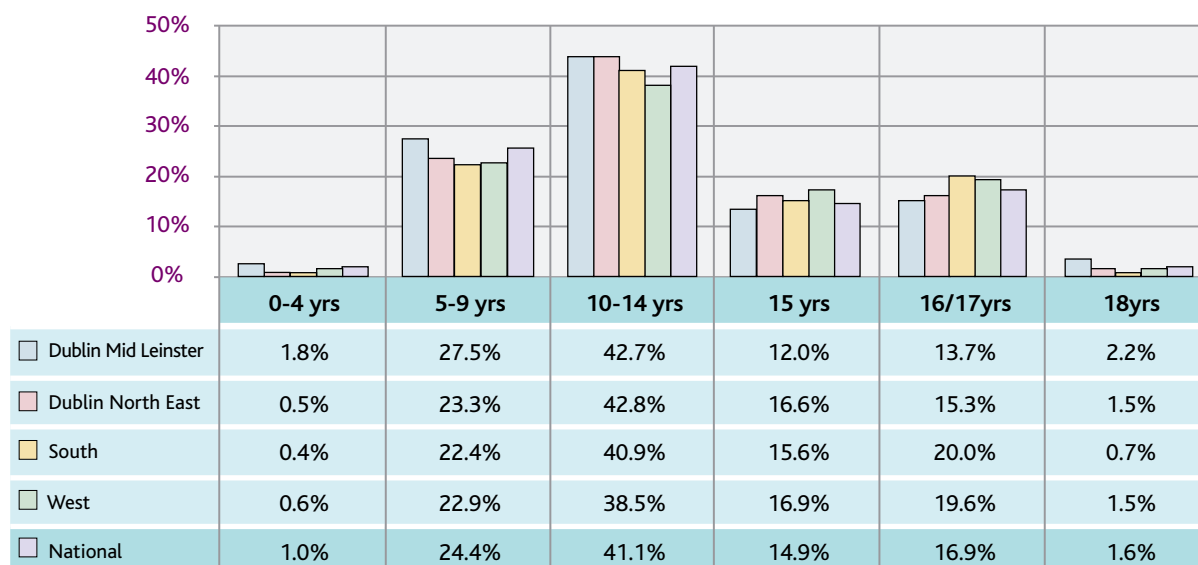
Table 4.5 (a) Clinical Inputs

| Clinical Inputs     | 2012          | %           | 2011          | %           |
|---------------------|---------------|-------------|---------------|-------------|
| Dublin Mid Leinster | 6303          | 36.85%      | 5841          | 35.6%       |
| Dublin North East   | 3295          | 19.26%      | 3114          | 19.0%       |
| South               | 2925          | 17.10%      | 3275          | 19.9%       |
| West                | 4581          | 26.79%      | 4190          | 25.5%       |
| <b>Total</b>        | <b>17,104</b> | <b>100%</b> | <b>16,420</b> | <b>100%</b> |

## 4.6 Age Profile of Cases Seen

Adolescents from the 15 year old age group are most likely to be attending the Community CAMHS teams, followed by children aged 10-14 year olds. Adolescents aged 16/17 years of age constituted 16.9% (an increase from the 2011 figure of 16.5%) of the caseload. One-hundred and thirty seven cases (1.6%) of the total caseload were over 18 years of age.

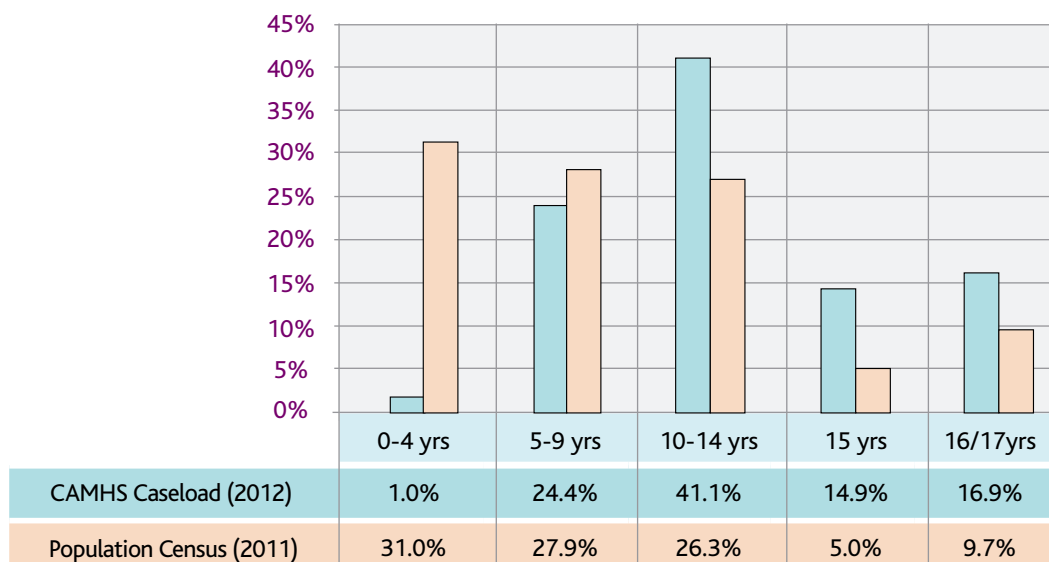
Figure 4.6 (i) Caseload Age Profile by Region



When compared to the age profile of the child population as recorded in the 2011 census, the profile of the CAMHS caseload shows most variance around the 0 to 4 year old and the 16/17 year old age groups (Figure 4.6 (ii)).



Figure 4.6 (ii) Age of caseload compared to age groups in the population (0 to 17 years)



## 4.7 Ethnicity

The ethnic profile of children and adolescents attending the service changed little from 2011 (Table 4.7 (a)).

- 90% of children and adolescents attending were from a white Irish ethnic background. The proportion in the population 0-19 years is 84.4%.
- 3.5% were from a white any other white ethnic background, highest in the South at 4%. The proportion in the population 0-19 years is 6.8%.
- The white Irish Traveller community accounted for 2.8% of cases, highest in the West Region at 5.7%. The proportion in the population 0-19 years is 1.2%.
- Children from a Black ethnic background accounted for a total of 1.8% of all children attending. The proportion in the population 0-19 years is 2.5%.
- Children from an Asian ethnic background accounted for a total of 0.9% of all children attending. The proportion in the population 0-19 years is 2.1%.

Table 4.7 (a) Ethnic Background

| Ethnic Background                               | Dublin Mid Leinster | Dublin North East | South | West  | Total 2012 | Total 2011 | Census <19 yrs 2011 |
|---|---------------------|-------------------|-------|-------|------------|------------|---------------------|
| White: Irish                                    | 89.8%               | 92.0%             | 91.6% | 88.1% | 90.1%      | 90.1%      | 84.4%               |
| White: Irish Traveller                          | 1.5%                | 0.6%              | 2.6%  | 5.7%  | 2.8%       | 3.0%       | 1.2%                |
| White: Roma                                     | 0.3%                | 0.4%              | 0.1%  | 0.3%  | 0.3%       | 0.2%       | *                   |
| White: Any other White background               | 3.7%                | 3.7%              | 4.0%  | 3.0%  | 3.5%       | 3.5%       | 6.8%                |
| Black / Black Irish: African                    | 1.9%                | 2.2%              | 0.6%  | 1.4%  | 1.6%       | 1.6%       | 2.3%                |
| Black / Black Irish: Any other Black background | 0.4%                | 0.0%              | 0.2%  | 0.2%  | 0.2%       | 0.1%       | 0.2%                |
| Asian / Asian Irish: Chinese                    | 0.6%                | 0.3%              | 0.2%  | 0.2%  | 0.3%       | 0.2%       | 0.3%                |
| Asian / Asian Irish: Any other Asian background | 1.0%                | 0.5%              | 0.4%  | 0.5%  | 0.6%       | 0.5%       | 1.8%                |
| Other   | 0.8%                | 0.3%              | 0.3%  | 0.6%  | 0.6%       | 0.8%       | 1.3%                |
| Not Stated                                      |                     |                   |       |       |            |            | 1.7%                |
|   | 100%                | 100%              | 100%  | 100%  | 100%       | 100%       | 100%                |

\*not recorded

## 4.8 Children in the care of the HSE or in contact with social services

Eighteen percent of children (1,553) who attended Community CAMHS teams in November 2012 were in contact with or in the care of social services, a further 5.65% (485) had a history of contact with social services. Of this number 73.2% (1,137) were reported to be in contact only with social services, 5.1% (79) were in relative foster care, 15.3% (238) were in non-relative foster care, and 4.1% (63) were in residential care (Table 4.8 (a)). The figures were largely consistent across the four regions and showed a decrease from the findings of the 2011 survey where 20% of cases seen were in the care of the HSE or in contact with social services.

Table 4.8 (a) Children in the care of the HSE or in contact with social services

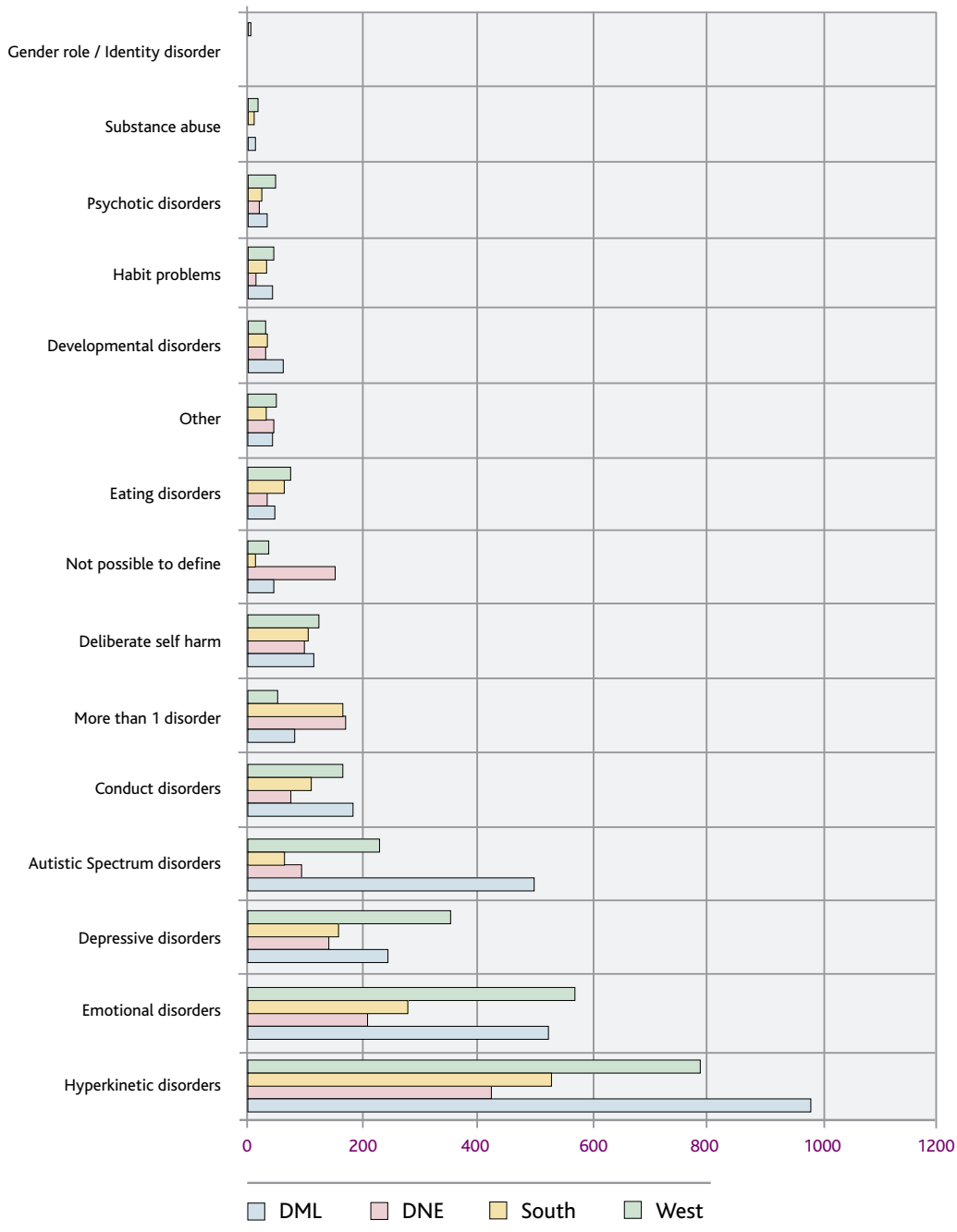
| Social Services            | DML        | %             | DNE        | %             | South      | %             | West       | %             | Total        | %             |
|----------------------------|------------|---------------|------------|---------------|------------|---------------|------------|---------------|--------------|---------------|
| Contact with Service       | 438        | 81.1%         | 229        | 76.3%         | 206        | 66.2%         | 264        | 65.8%         | 1,137        | 73.2%         |
| Foster Care – Relative     | 24         | 4.4%          | 4          | 1.3%          | 24         | 7.7%          | 27         | 6.7%          | 79           | 5.1%          |
| Foster Care – Non Relative | 37         | 6.9%          | 53         | 17.7%         | 60         | 19.3%         | 88         | 21.9%         | 238          | 15.3%         |
| Residential Unit           | 29         | 5.4%          | 11         | 3.7%          | 12         | 3.9%          | 11         | 2.7%          | 63           | 4.1%          |
| High Support Unit          | 6          | 1.1%          | 3          | 1.0%          | 4          | 1.3%          | 5          | 1.2%          | 18           | 1.2%          |
| Special Care Unit          | 6          | 1.1%          | 0          | 0.0%          | 5          | 1.6%          | 7          | 1.7%          | 18           | 1.2%          |
| <b>Total</b>               | <b>540</b> | <b>100.0%</b> | <b>300</b> | <b>100.0%</b> | <b>311</b> | <b>100.0%</b> | <b>402</b> | <b>100.0%</b> | <b>1,553</b> | <b>100.0%</b> |
| All Cases Seen             | 2,895      | 19%           | 1,496      | 20%           | 1,612      | 19%           | 2,574      | 16%           | 8,577        | 18%           |
| History of Contact         | 84         | 2.90%         | 63         | 4.21%         | 114        | 7.07%         | 224        | 8.70%         | 485          | 5.65%         |

## 4.9 Primary Presentation

The primary presentations of 8,577 cases were recorded by gender and age. For the purpose of the audit only one disorder / problem was entered for each case (Figures 4.9 (i – vi)).

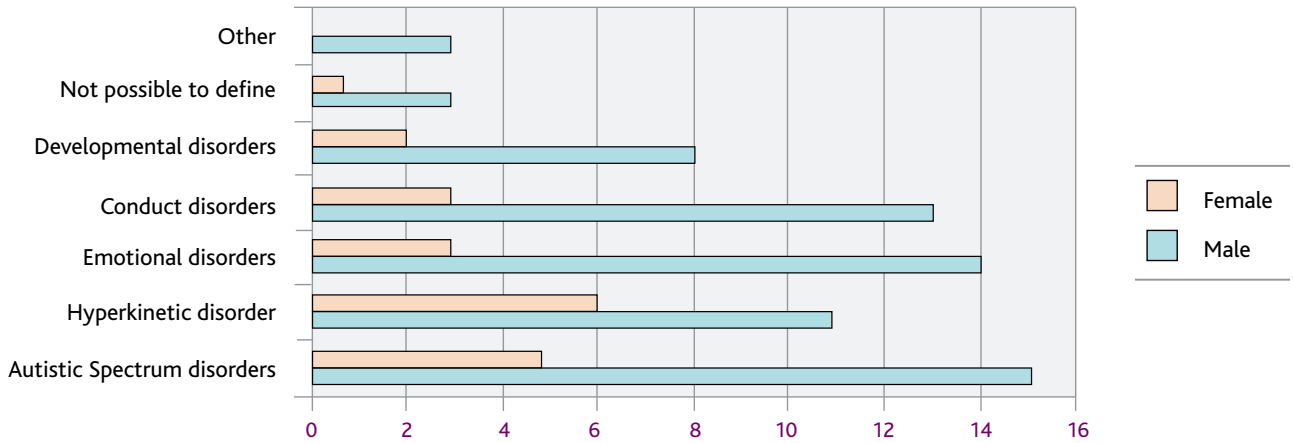
- **Hyperkinetic disorders/problems** included ADHD and other attentional disorders, 2,710 (31.6%) cases.
- **Depressive disorders/problems** included depression, 892 (10.4%) cases.
- **Anxiety disorders/problems** included anxiety, phobias, somatic complaints, obsessional compulsive disorder, post traumatic stress disorder, 1,571 (18.3%) cases.
- **Conduct disorders/problems** included oppositional defiant behaviour, aggression, anti social behaviour, stealing, and fire-setting, 528 (6.2%) cases.
- **Eating disorders/problems** included pre-school eating problems, anorexia nervosa, and bulimic nervosa, 219 (2.6%) cases.
- **Psychotic disorders/problems** included schizophrenia, manic depressive disorder, or drug-induced psychosis, 125 (1.5%) cases.
- **Deliberate self harm** included lacerations, drug/medication and alcohol overdose, 440 (5.1%) cases.
- **Substance abuse** referred to drug and alcohol misuse, 40 (0.5%) cases.
- **Habit disorders/problems** included tics, sleeping problems, and soiling, 131 (1.5%) cases.
- **Autistic Spectrum Disorders/problems** referred to presentations consistent with autistic spectrum disorder, 880 (10.3%) cases.
- **Developmental disorders/problems** referred to delay in acquiring certain skills such as speech, and social abilities, 157 (1.8%) cases.
- **Gender Role / Identity disorder/problems** referred to gender role or identity problems or disorder, 8 (0.1%) cases.
- **Not possible to define** was only to be used if it was impossible to define the prominent disorder, 242 (2.8%) cases.
- **Other** was to be used when Primary presentation was not included in the list, 167 (1.9%) cases.
- **More than 1 disorder/problem** was only to be used if there was more than one prominent disorder, to the extent that it is not possible to identify 'one primary presenting disorder / problems, 467 (5.4%) cases.

Figure 4.9 (i) Primary Presentation by Region (2012)



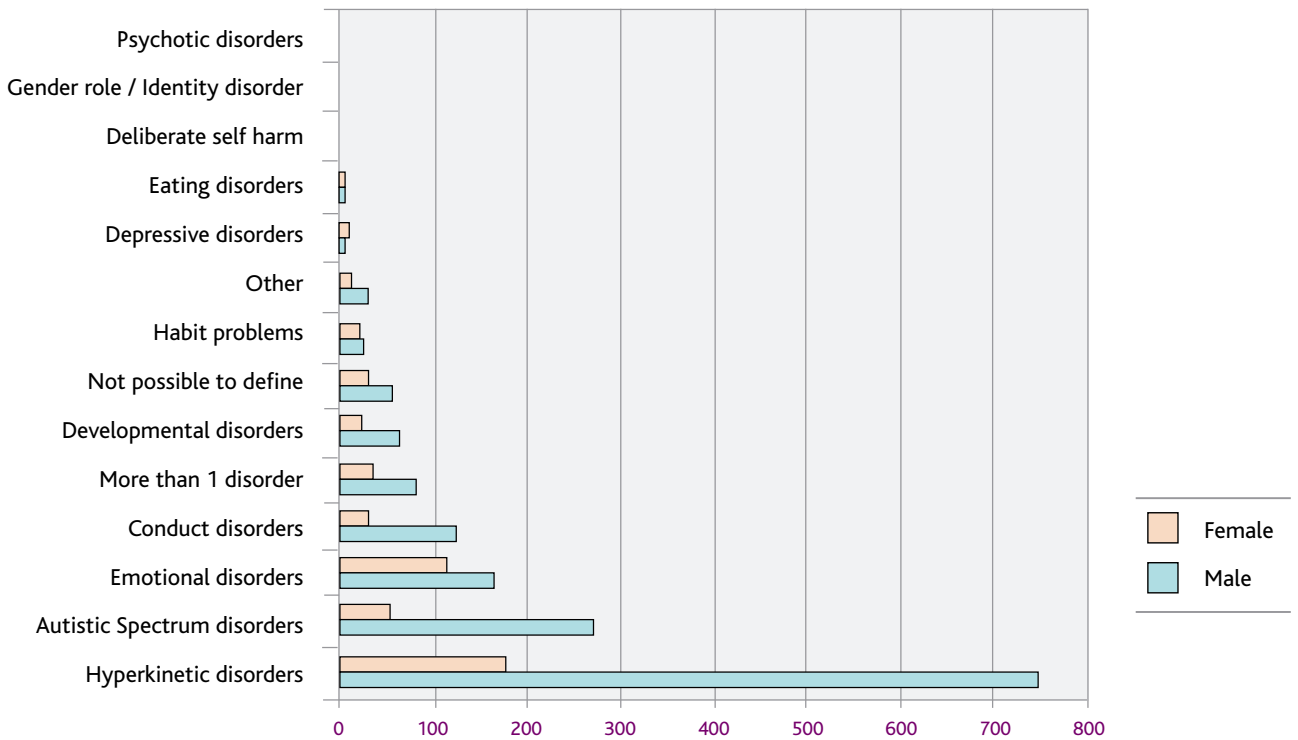
- The ADHD and other attentional disorders (31.6%) was the most frequently assigned primary presentation overall and in each of the regions.
- The Anxiety category the next largest accounting for 18.3% of primary presentations.
- The Autistic Spectrum disorder category was more frequently assigned in Dublin Mid Leinster, accounting for 17.2% of primary presentations.

Figure 4.9 (ii) Primary presentation by gender and age group (0 – 4 years)



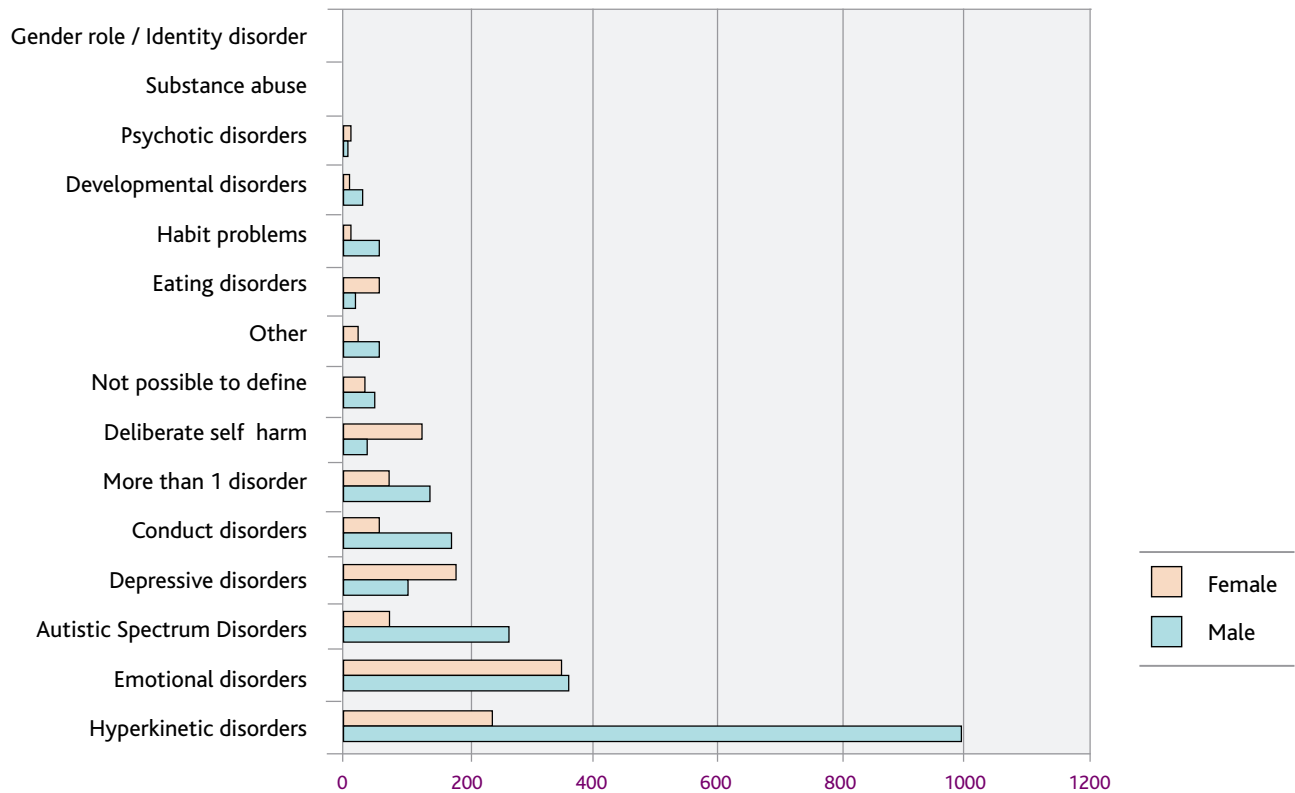
- Boys account for 77% (67) of children seen in the 0 to 4 year old age group.
- 23% seen in the 0 to 4 year old age group had a primary presentation consistent with autistic spectrum disorder.

Figure 4.9 (iii) Primary presentation by gender and age group (5 - 9 years)



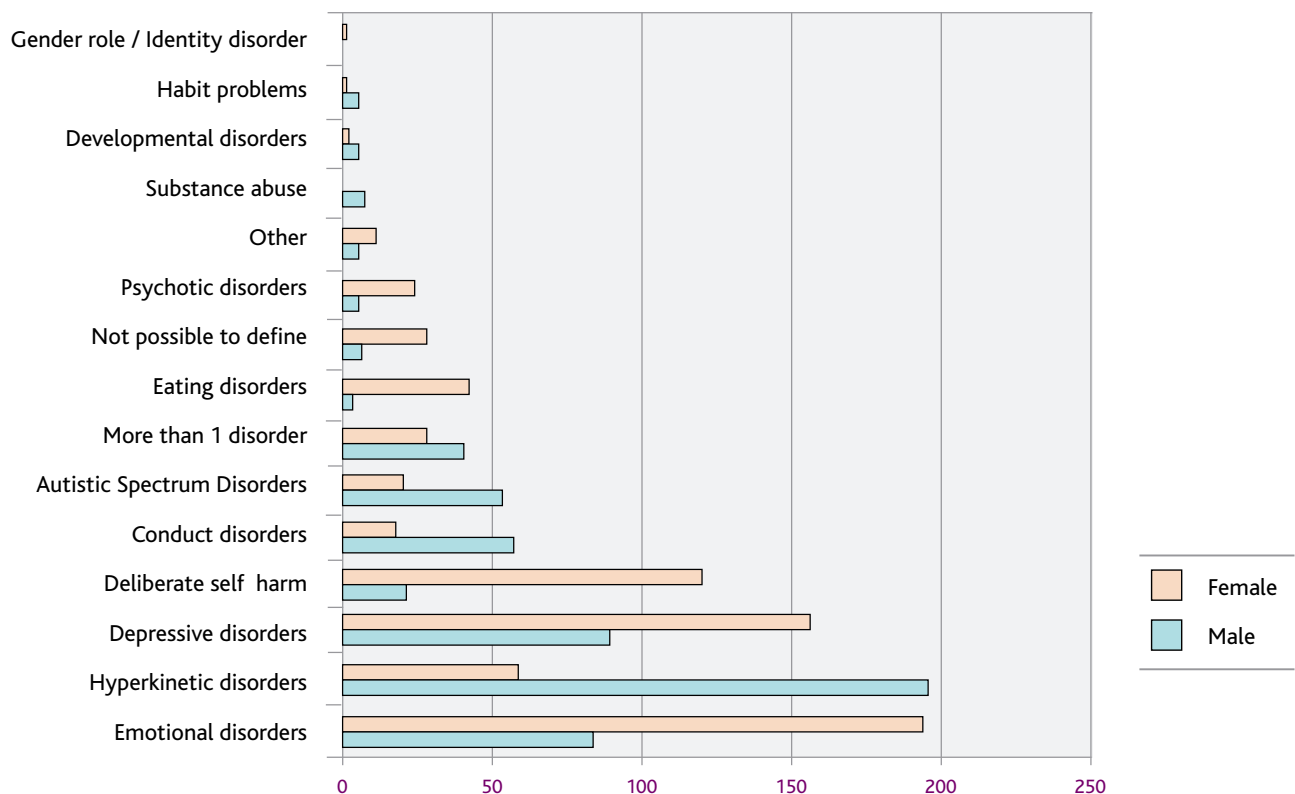
- Boys account for 75.3% (1,583) of children seen in the 5 to 9 year old age group. ADHD and other attentional disorders account for 44% of primary presentations in boys of this age group.
- 17.2% (272) of boys seen in the 5 to 9 year old age group had a primary presentation consistent with autistic spectrum disorder.
- Girls account for 24.8% (521) of children seen in the 5 to 9 year old age group. ADHD and other attentional disorders account for 34% of primary presentations in girls of this age group.
- The male to female ratio for ADHD or other attentional disorders is 4:1.

Figure 4.9 (iv) Primary presentation by gender age group (10 - 14 years)



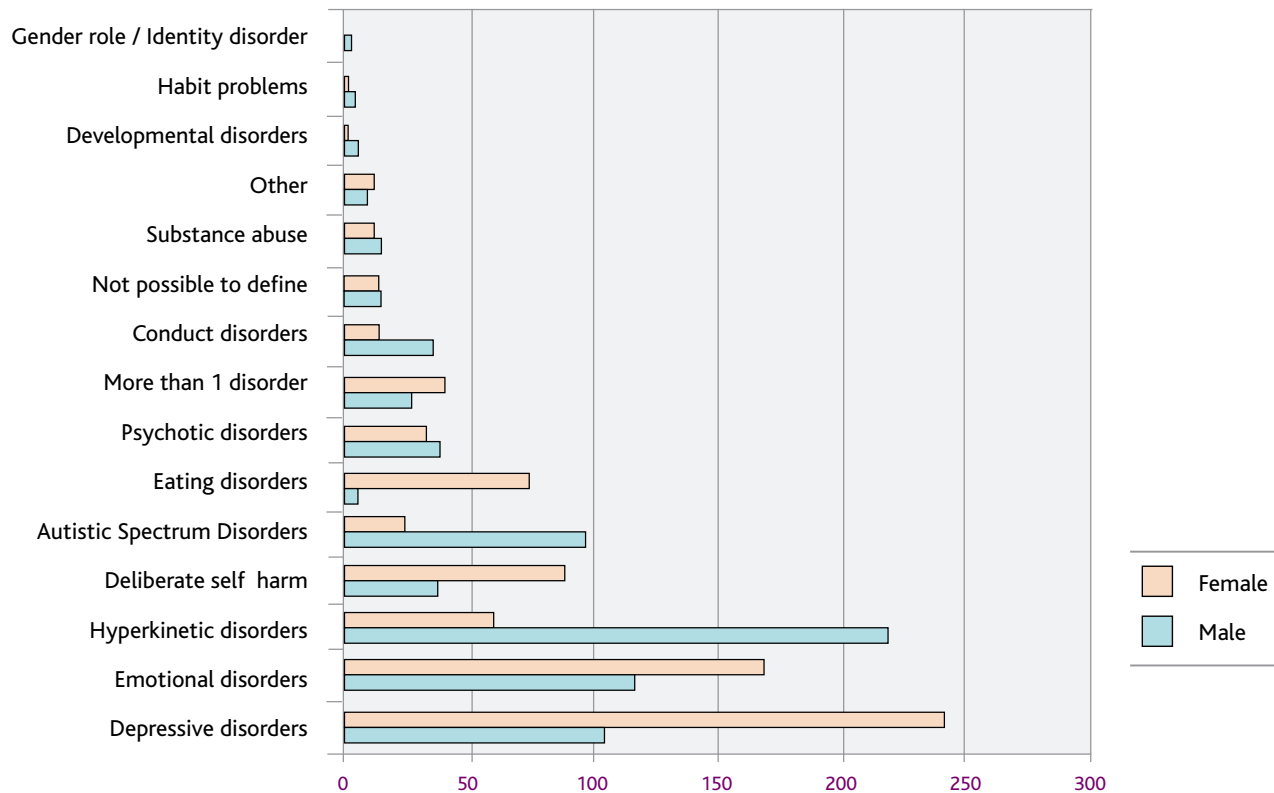
- Boys account for 64.6% (2,305) of children seen in 10 to 14 year old age group. ADHD and other attentional disorders is by far the most frequent presentation, depression and anxiety disorders were increasing in frequency.
- Girls account for 35.4% (1,263) of children seen in this age group. Anxiety and depressive disorders (41.9%) occur with the greatest frequency, the frequency of ADHD and other attentional disorders decreased to 18.9% from 22.3% in 2011.

Figure 4.9 (v) Primary presentation by gender and age group (15 years)



- Boys account for 45.1% (583) of children seen in the 15 year old age group. ADHD and other attentional disorders continue to predominate but the rates of emotional disorders including depressive and anxiety disorders was increased.
- Girls account for 54.9% (709) of children in this age group. Emotional disorders were the most frequent primary presentation, followed by depressive disorders, self harm and eating disorders.

Figure 4.9 (vi) Primary presentation by gender age group (16 years and over)

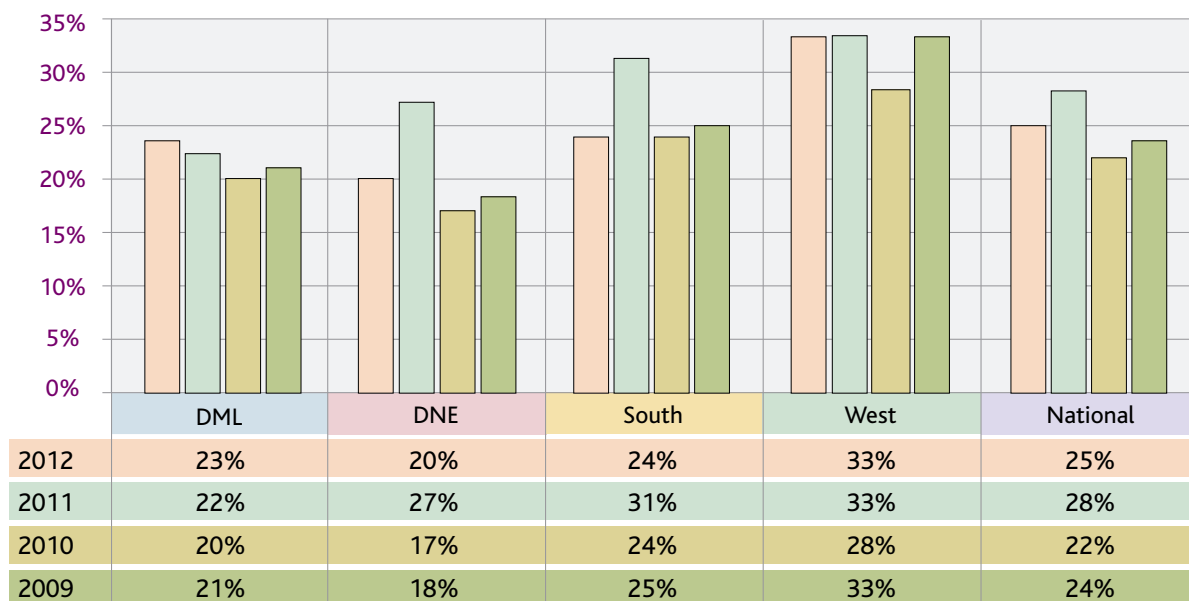


- Boys account for 48.4% (738) of children seen in the 16 and over age group. ADHD and other attentional disorders continue to predominate but the rates of emotional disorders including depressive and anxiety disorders was increased.
- Girls account for 51.6% (788) of children in this age group. Depression was the most frequent primary presentation, followed by anxiety disorders, self harm and eating disorders.

## 4.10 Suicidal Ideation / Deliberate Self Harm

As deliberate self harm or suicidal ideation may be present in a number of different primary presentations the CAMHS teams were asked to record the number of new cases including re-referred cases seen in November where the reason for referral to CAMHS included a history of suicidal ideation or deliberate self harm (Figure 4.10 (i)).

Figure 4.10 (i) Suicidal ideation / deliberate self harm as part of reason for referral

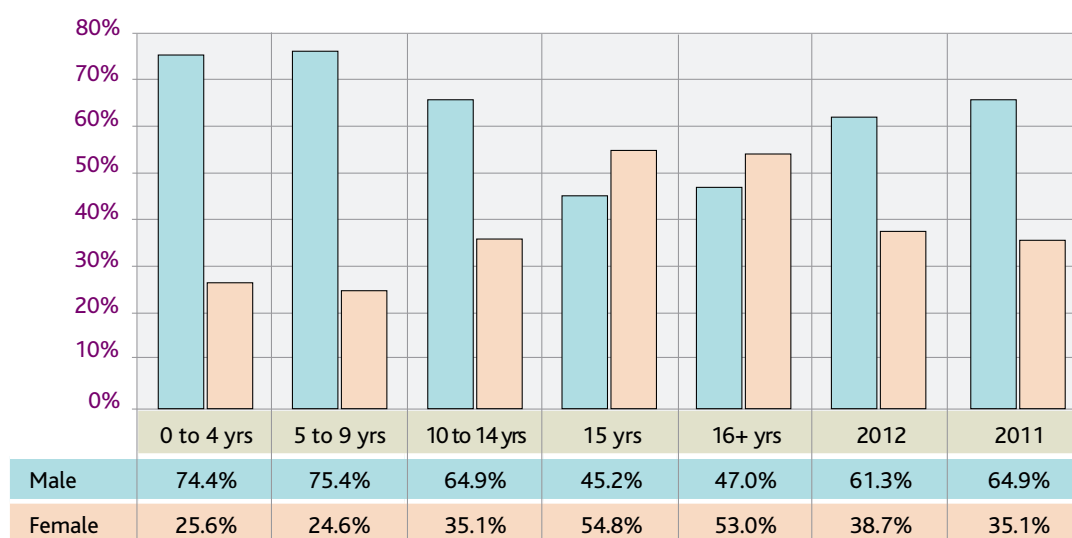


In 25% of the new cases the reason for referral to CAMHS included suicidal ideation or deliberate self harm.

## 4.11 Gender profile of cases and primary presentations

Males accounted for 61.3% of all children seen and were in the majority in each of the age groups (Figure 4.11 (i)).

Figure 4.11 (i) Gender by Age group 2012



Males constituted the majority of primary presentations apart from Psychotic Disorders (41.6%), Emotional Disorders (47%), Depression (34%), Deliberate Self Harm (22.5%), and Eating Disorders (17.4%), (see Figure 4.11 (ii) and Table 4.11 (a)).

Figure 4.11 (ii) Primary presentation by gender

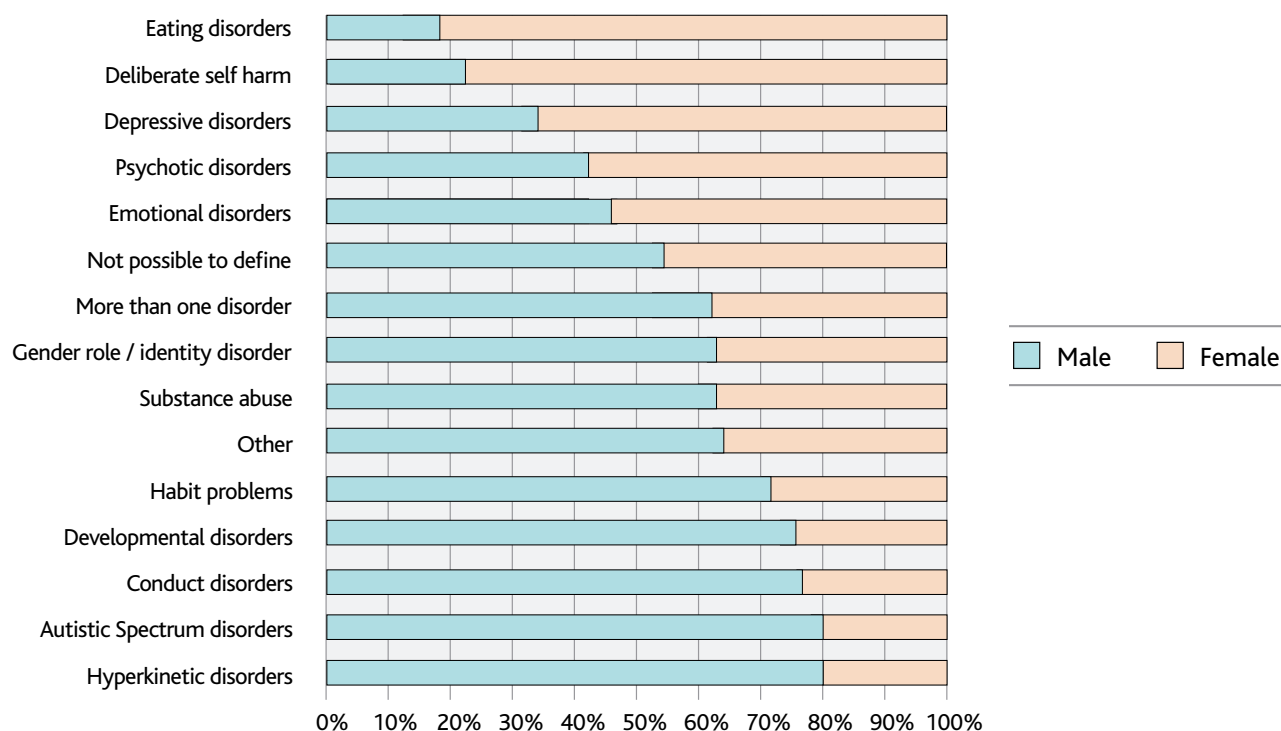


Table 4.11 (a) Primary Presentation by Gender 2012

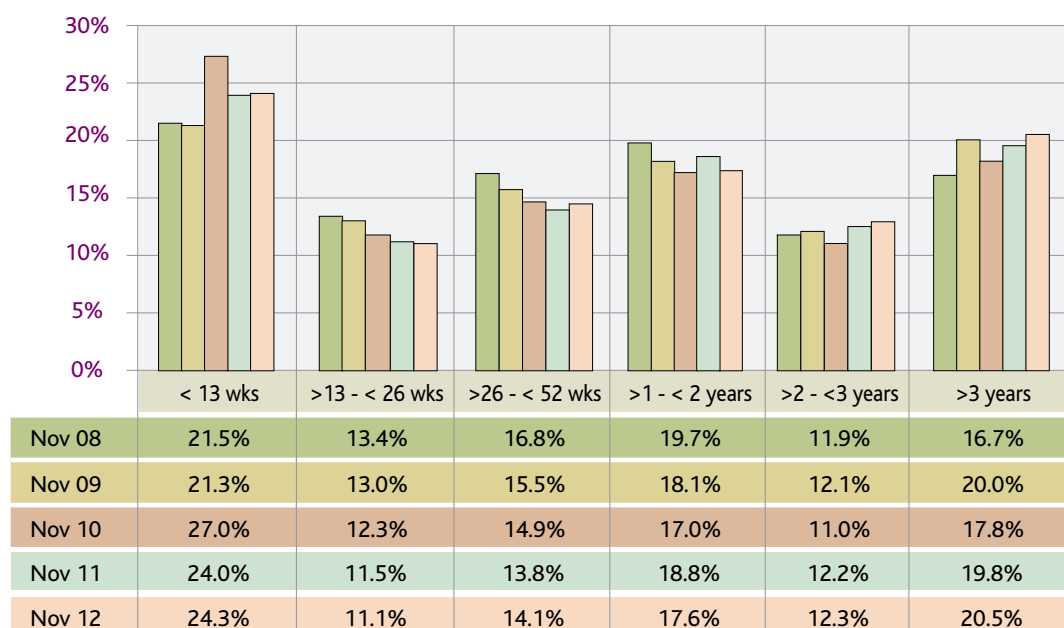
| Primary Presentation  | Male % | Female % |
|---|--------|----------|
| Hyperkinetic disorders / problems: Includes ADHD and other attentional disorders.   | 80.0%  | 20.0%    |
| Autistic Spectrum Disorders / problems: Refers to presentation consistent with autistic spectrum disorder.                                    | 79.9%  | 20.1%    |
| Conduct disorders / problems: Includes oppositional defiant behaviour, aggression, antisocial behaviour, stealing, and fire-setting.          | 76.3%  | 23.7%    |
| Substance abuse: Refers to drug and alcohol misuse.   | 62.5%  | 37.5%    |
| Gender role / Identity disorder / problems: Refers to gender role or identity problems or disorder.   | 62.5%  | 37.5%    |
| More than 1 disorder / problem: Only use if is not possible to identify one 'primary presenting disorder'.                                    | 61.9%  | 38.1%    |
| Developmental disorders / problems: Refers to delay in acquiring certain skills such as speech, and social abilities.                         | 75.2%  | 24.8%    |
| Habit problems / problems: Includes tics, sleeping problems, and soiling.   | 71.8%  | 28.2%    |
| Not possible to define: Only use if it is impossible to define the primary disorder / problem.  | 55.0%  | 45.0%    |
| Other: Primary presentation is not included in the list.  | 64.1%  | 35.9%    |
| Psychotic disorders / problems: Includes schizophrenia, manic depressive disorder, or drug-induced psychosis.                                 | 41.6%  | 58.4%    |
| Emotional disorders / problems: Includes anxiety, phobias, somatic complaints, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder. | 47.0%  | 53.0%    |
| Depressive disorders / problems: Includes depression.   | 34.0%  | 66.0%    |
| Deliberate self harm: Includes lacerations, drug/medication, and/or alcohol overdose.   | 22.5%  | 77.5%    |
| Eating disorders / problems: Includes pre-school eating problems, anorexia nervosa, and bulimia nervosa.                                      | 17.4%  | 82.6%    |



## 4.12 Length of Treatment

The length of treatment measures how long a case had been seen for up to being seen in the course of the month of November (Figure 4.12 (i)).

Figure 4.12 (i) Duration of Treatment (2012)



- 24.3% of cases were in treatment less than 13 weeks.
- 11.1% of cases were in treatment from 13 to 26 weeks.
- 14.1% of cases were in treatment from 26 to 52 weeks.
- 17.6% of cases were in treatment greater than 1 year but less than 2 years.
- 12.3% of cases were in treatment greater than 2 years but less than 3 years.
- 20.5% of cases were in treatment greater than 3 years.

Over all there were 50.4% of cases were in treatment greater than 1 year.

## 4.13 Day services

A total of 40 children and adolescents attended St. Joseph's Adolescent & Family Day Service at St. Vincent's Hospital, Fairview and Dunfillan Young Person's Unit at St. John of God Lucena Clinic Rathgar, Dublin, in the month of November 2012.

Fifteen new cases commenced attendance during the month. Twelve were referred from Community CAMHS teams and three from a Hospital Liaison CAMHS Team. In seven of the cases a reason for referral included suicidal ideation or a history of deliberate self harm. Five of the young people had commenced attendance in less than 2 weeks of referral, seven had commenced within 2 to 4 weeks of referral and three within 8 weeks.

Table 4.13 (a) Age and gender profile

| Age          | Male      | Female    | Total     |
|--------------|-----------|-----------|-----------|
| < 12 years   | 0         | 0         | 0         |
| 12/13 years  | 3         | 4         | 7         |
| 14/15 years  | 6         | 9         | 15        |
| 16/17 years  | 6         | 12        | 18        |
| 18 years     | 0         | 0         | 0         |
| <b>Total</b> | <b>15</b> | <b>25</b> | <b>40</b> |

Thirty-three (83%) of children attending the day programmes were aged 14 years or older. There were a greater number (63%) of females than males attending. Nine children (23%) had previously been admitted for inpatient treatment. Ten children (25%) were in contact with social service (residing with family) and 1 (3%) was in foster care with a non-relative and 1 (3%) had a history of contact with HSE or Social Services but not currently in contact with them, the remaining 28 (70%) had no previous contact with HSE social services.

**Table 4.13 (b) Primary presentation**

| Primary Presentation  | %   |
|---|-----|
| Presentation consistent with autistic spectrum disorder             | 25% |
| ADHD and other attentional disorders                                | 18% |
| Depression  | 18% |
| Schizophrenia, manic depressive disorder, or drug-induced psychosis | 18% |
| Anxiety, phobias, somatic complaints, OCD, and PTSD                 | 13% |
| Lacerations, drug/medication, and/or alcohol overdose               | 8%  |
| Pre-school eating problems, anorexia nervosa, and bulimia nervosa   | 3%  |

Autistic Spectrum (25%) was the most frequent primary presentation followed by ADHD (18%), Depression (18%), Mania (18%) and Anxiety (13%).

**Table 4.13 (c) Duration of treatment**

| Duration of treatment         | No.       |
|-------------------------------|-----------|
| < / = 4 weeks                 | 11        |
| > 4 weeks but < / = 6 weeks   | 1         |
| > 6 weeks but < / = 8 weeks   | 14        |
| > 8 weeks but < / = 10 weeks  | 2         |
| > 10 weeks but < / = 12 weeks | 2         |
| > 12 weeks but < / = 26 weeks | 10        |
| > 26 weeks                    | 0         |
| <b>Total No.</b>              | <b>40</b> |

Thirty (75%) of the young people had attended for less than 3 months.

## 4.14 Paediatric hospital liaison services

A total of 96 new cases were seen by the liaison teams at the three Dublin paediatric hospitals in November 2012.

**Table 4.14 (a) New cases seen by paediatric liaison teams**

| Paediatric Hospital                                    | New Cases |
|--|-----------|
| Temple St. Children's University Hospital (CUH)        | 65        |
| Our Lady's Hospital for Sick Children, Crumlin (OLHSC) | 10        |
| National Children's Hospital, Tallaght (NCH)           | 21        |
| <b>Total</b>   | <b>96</b> |

A total of 96 new outpatient appointments, consultations on the ward or in the A & E department took place in November 2012. Thirty-nine percent took place in the outpatient department, 33% on the ward and 28% in the A & E department. The nonattendance rate at outpatient appointments was 19%.

**Table 4.14 (b) First Appointments / Consultations**

| Appointments / Consultations  | Children's University Hospital | Our Lady's Hospital for Sick Children | National Children's Hospital | Total     | %           |
|-------------------------------|--------------------------------|---------------------------------------|------------------------------|-----------|-------------|
| Attended appointments OPD     | 30                             | 1                                     | 6                            | 37        | 39%         |
| Consultations on the ward     | 15                             | 2                                     | 15                           | 32        | 33%         |
| Consultations in A & E Dept.  | 20                             | 7                                     | 0                            | 27        | 28%         |
| <b>Total</b>                  | <b>65</b>                      | <b>10</b>                             | <b>21</b>                    | <b>96</b> | <b>100%</b> |
| No. of OPD Apts. not attended | 3                              | 0                                     | 0                            | 3         | 8%          |

A total of 301 children and adolescents were seen by liaison services in November 2012. The much larger size of the liaison team at Temple St. Children's University Hospital was reflected in the greater number seen by that service. Seven children were in contact with or in the care of HSE social services.

Fifty-one percent of the children were female, 47% were between the age of 10 and 14 years and 20% were over the age of 14 years.

**Table 4.14 (c) Age and gender profile**

| Age          | 0 – 4 yrs. |          | 5 – 9 yrs. |           | 10 – 14 yrs. |           | 15 yrs.    |           | 16 / 16+ yrs. |           |
|--------------|------------|----------|------------|-----------|--------------|-----------|------------|-----------|---------------|-----------|
|              | Male       | Female   | Male       | Female    | Male         | Female    | Male       | Female    | Male          | Female    |
| CUH          | 25         | 7        | 31         | 22        | 55           | 67        | 14         | 12        | 8             | 11        |
| OLHSC        | 0          | 0        | 1          | 2         | 1            | 5         | 2          | 3         | 0             | 5         |
| NCH          | 2          | 1        | 2          | 2         | 4            | 11        | 3          | 4         | 1             | 0         |
| <b>Total</b> | <b>27</b>  | <b>8</b> | <b>34</b>  | <b>26</b> | <b>60</b>    | <b>83</b> | <b>19</b>  | <b>19</b> | <b>9</b>      | <b>16</b> |
| <b>2012</b>  | <b>11%</b> |          | <b>20%</b> |           | <b>47%</b>   |           | <b>12%</b> |           | <b>8%</b>     |           |
| <b>2011</b>  | <b>15%</b> |          | <b>24%</b> |           | <b>36%</b>   |           | <b>12%</b> |           | <b>13%</b>    |           |
| <b>2010</b>  | <b>16%</b> |          | <b>19%</b> |           | <b>35%</b>   |           | <b>15%</b> |           | <b>15%</b>    |           |
| <b>2009</b>  | <b>9%</b>  |          | <b>29%</b> |           | <b>40%</b>   |           | <b>11%</b> |           | <b>11%</b>    |           |

The most frequent primary presentation was anxiety problems/disorders (23.92%), followed by ADHD and other attentional disorders (14.62%), deliberate self harm (12.29%), and autistic spectrum disorders (8.31%).

Table 4.14 (d) Primary presentation hospital liaison services

| Primary Presentation   | National Children's Hospital | Our Lady's Hospital | Children's University Hospital | Total      | %              |
|--|------------------------------|---------------------|--------------------------------|------------|----------------|
| <b>1. Hyperkinetic disorders / problems: Includes ADHD and other attentional disorders.</b>  | 0                            | 0                   | 44                             | 44         | 14.62%         |
| <b>2. Depressive disorders / problems: Includes depression.</b>  | 0                            | 6                   | 10                             | 16         | 5.32%          |
| <b>3. Emotional disorders / problems: Totals</b>   | 2                            | 4                   | 66                             | 72         | 23.92%         |
| 3.1 Emotional disorders / problems anxiety & phobias   | 1                            | 2                   | 14                             | 17         | 23.61%         |
| 3.2 Emotional disorders / problems psychosomatic   | 0                            | 0                   | 13                             | 13         | 18.06%         |
| 3.3 Emotional disorders / problems somatic complaints  | 0                            | 0                   | 8                              | 8          | 11.11%         |
| 3.4 Emotional disorders / problems psychological adjustment reaction   | 0                            | 0                   | 13                             | 13         | 18.06%         |
| 3.5 Emotional disorders / problems Obsessive Compulsive Disorder   | 0                            | 0                   | 2                              | 2          | 2.78%          |
| 3.6 Emotional disorders / problems Post Traumatic Stress Disorder.   | 1                            | 1                   | 4                              | 6          | 8.33%          |
| 3.7 Emotional disorders / problems other   | 0                            | 1                   | 12                             | 13         | 18.06%         |
| <b>4. Conduct disorders / problems: Includes oppositional defiant behaviour, aggression, antisocial behaviour, stealing, and fire-setting.</b> | 1                            | 1                   | 5                              | 7          | 2.33%          |
| <b>5. Eating disorders / problems: Totals</b>  | 4                            | 1                   | 14                             | 19         | 6.31%          |
| 5.1 Eating disorders / problems Includes pre-school eating problems  | 0                            | 0                   | 9                              | 9          | 47.37%         |
| 5.2 Eating disorders / problems anorexia nervosa   | 0                            | 1                   | 3                              | 4          | 21.05%         |
| 5.3 Eating disorders / problems bulimia nervosa  | 0                            | 0                   | 0                              | 0          | 0.00%          |
| 5.4 Eating disorders / problems EDD NOS  | 2                            | 0                   | 0                              | 2          | 10.53%         |
| 5.5 Eating disorders / problems other  | 2                            | 0                   | 2                              | 4          | 21.05%         |
| <b>6. Psychotic disorders / problems: Totals</b>   | 3                            | 2                   | 1                              | 6          | 1.99%          |
| 6.1 Psychotic disorders / problems schizophrenia   | 0                            | 0                   | 1                              | 1          | 16.67%         |
| 6.2 Psychotic disorders / problems manic depressive disorder   | 0                            | 0                   | 0                              | 0          | 0.00%          |
| 6.3 Psychotic disorders / problems drug-induced psychosis  | 0                            | 0                   | 0                              | 0          | 0.00%          |
| 6.4 Psychotic disorders / problems other   | 3                            | 2                   | 0                              | 5          | 83.33%         |
| <b>7. Deliberate self harm/Suicidal Ideation: Totals</b>   | 11                           | 3                   | 23                             | 37         | 12.29%         |
| 7.1 Deliberate self harm: Includes lacerations, drug/medication, and/or alcohol overdose.  | 3                            | 1                   | 10                             | 14         | 4.65%          |
| 7.2 Deliberate self harm with Suicidal ideation  | 2                            | 1                   | 9                              | 12         | 3.99%          |
| 7.3 Suicidal ideation without Deliberate self harm   | 4                            | 1                   | 4                              | 9          | 2.99%          |
| <b>8. Substance abuse: Refers to drug and alcohol misuse.</b>  | 2                            | 0                   | 0                              | 2          | 0.66%          |
| <b>9. Habit problems / problems: Totals</b>  | 0                            | 0                   | 19                             | 19         | 6.31%          |
| 9.1 Habit problems / problems tics   | 0                            | 0                   | 5                              | 5          | 26.32%         |
| 9.2 Habit problems / problems sleeping problems  | 0                            | 0                   | 1                              | 1          | 5.26%          |
| 9.3 Habit problems / problems soiling  | 0                            | 0                   | 9                              | 9          | 47.37%         |
| 9.4 Habit problems / problems other  | 0                            | 0                   | 4                              | 4          | 21.05%         |
| <b>10. Autistic Spectrum Disorders / problems: Refers to presentation consistent with autistic spectrum disorder.</b>                          | 6                            | 1                   | 18                             | 25         | 8.31%          |
| <b>11. Developmental disorders / problems: Refers to delay in acquiring certain skills such as speech, and social abilities.</b>               | 3                            | 0                   | 19                             | 22         | 7.31%          |
| <b>12. Gender role / Identity disorder / problems: Refers to gender role or identity problems or disorder.</b>                                 | 0                            | 0                   | 0                              | 0          | 0.00%          |
| <b>13. Not possible to define: Only use if it is impossible to define the primary disorder / problem.</b>                                      | 0                            | 0                   | 3                              | 3          | 1.00%          |
| <b>14. Other: Primary presentation is not included in the list.</b>  | 0                            | 1                   | 21                             | 22         | 7.31%          |
| <b>15. More than 1 disorder / problem: Only use if is not possible to identify one 'primary presenting disorder'.</b>                          | 0                            | 0                   | 5                              | 5          | 1.66%          |
| <b>16. Assessment for Medical/Surgical Treatment</b>   | 0                            | 0                   | 4                              | 4          | 1.33%          |
| <b>Totals</b>  | <b>30</b>                    | <b>19</b>           | <b>252</b>                     | <b>301</b> | <b>100.00%</b> |

## SECTION 5

# Inpatient Child and Adolescent Mental Health Services

### 5.1 Inpatient Services Child and Adolescent Mental Health Services

The aim of admission to a child and adolescent inpatient unit is to:

- Provide accurate assessment of those with the most severe disorders.
- Implement specific and audited treatment programmes.
- Achieve the earliest possible discharge of the young person back to their family and ongoing care of the Community team.

Inpatient psychiatric treatment is usually indicated for children and adolescents with severe psychiatric disorders such as schizophrenia, depression, and mania. Other presentations include severe complex medical-psychiatric disorders such as anorexia / bulimia. Admission may also be required for clarification of diagnosis and appropriate treatment or for the commencement and monitoring of medication. The increasing incidence of the more severe mental health disorders in later adolescence increases the need for inpatient admission.

As Adult Mental Health Services were responsible for the care of the 16/17 year age group, the majority of admissions of young people under the age of 18 years were to Adult facilities. *A Vision for Change* (2006) stated that services for children up to the age of 18 years should be provided by Child and Adolescent Mental Health services and admissions from this age group must be to age appropriate facilities. The HSE has made the provision of additional child and adolescent inpatient units a priority, such that all young people under the age of 18 years are admitted to such age appropriate facilities.

The Mental Health Commission set a timeline for achievement of this goal. From July 2009 no admission of children under the age of 16 years, except in specified exceptional circumstances, to adult units was to take place. In December 2010 this age limit increased to include children under the age of 17 years. In December 2011 this increased to include all children under the age of 18 years.

In 2007 there were a total of 12 beds available for the admission of children under the age of 18 years. Over the last number of years significant investment in the construction of new inpatient facilities has resulted in significant progress being made in achieving the targets set out in *A Vision for Change* (2006) with regard to the provision of child and adolescent inpatient facilities.

**Table 5.1 (a) HSE inpatient services and bed capacity (2008 to 2013)**

| Child & Adolescent Inpatient Units                      | 2008      | 2009      | 2010      | 2011      | 2012      | 2013      |
|---|-----------|-----------|-----------|-----------|-----------|-----------|
| St. Anne's Inpatient Unit, Galway                       | 10        | 10        | 10        |           |           |           |
| New Unit, Merlin Park Hospital, Galway                  |           |           |           | 20        | 20        | 20        |
| Warrenstown Inpatient Unit, Dublin                      | 6         | 6         | 6         | 6         |           |           |
| Interim Linn Dara Unit, Palmerstown, Dublin (May 2012*) |           |           |           |           | 8         | 8         |
| St. Vincent's Hospital, Fairview, Dublin                |           | 6         | 6         | 6         | 12        | 12        |
| Interim Eist Linn Unit, St. Stephen's Hospital, Cork    |           | 8         | 8         |           |           |           |
| Eist Linn Unit, Bessboro, Cork                          |           |           |           | 20        | 20        | 20        |
| <b>Total No. of Beds</b>                                | <b>16</b> | <b>30</b> | <b>30</b> | <b>52</b> | <b>60</b> | <b>60</b> |

\* Transfer from Warrenstown to Interim Linn Dara Unit May 2012

In March 2009 the first phase of development of the adolescent inpatient services at St. Vincent's Hospital, Fairview, Dublin was completed with the opening of a 6-bed adolescent unit. In November 2009 the Interim Eist Linn 8-bed child and adolescent unit was opened at St. Stephen's Hospital, Cork. In January 2011 the child and adolescent unit at St. Anne's, Taylor Hill moved to the new purpose built 20-bed unit at Merlin Park Hospital. In March 2011 the Interim Eist Linn unit transferred to a refurbished and redesigned 20-bed unit at Bessboro.

In May 2012 the Warrenstown unit transferred to the 8-bed Interim Linn Dara unit in Palmerstown, Dublin. This unit will eventually transfer, together with the planned 6-bed older adolescent unit, to a new purpose built 24-bed unit in the grounds of Cherry Orchard Hospital which is due to be completed in 2015. In September 2012 the second phase of development of the adolescent inpatient services at St. Vincent's Hospital was completed with the opening of the new 12-bed adolescent unit.

## 5.2 Admission of children and adolescents to inpatient units

There were 438 admissions of children and adolescents in 2012. Of this total 329 (75%) admissions were to child and adolescent inpatient units and 109 (25%) to adult units. The 438 admissions compared with a total of 432 in 2011, 435 in 2010, 367 in 2009, and 406 in 2008.

Table 5.2 (a) Place of admissions by age (2008 to 2013)

| Year | Admissions               | Age (Yrs) | < 12 | 12 | 13 | 14 | 15 | 16 | 17  | Total | %   |
|------|--------------------------|-----------|------|----|----|----|----|----|-----|-------|-----|
| 2008 | Adult Units              |           | 0    | 3  | 0  | 7  | 17 | 82 | 154 | 263   | 65% |
| 2008 | Child & Adolescent Units |           | 8    | 8  | 11 | 28 | 38 | 31 | 19  | 143   | 35% |
| 2009 | Adult Units              |           | 0    | 0  | 1  | 1  | 9  | 71 | 130 | 212   | 58% |
| 2009 | Child & Adolescent Units |           | 3    | 6  | 15 | 19 | 40 | 38 | 34  | 155   | 42% |
| 2010 | Adult Units              |           | 0    | 0  | 1  | 3  | 9  | 49 | 101 | 163   | 37% |
| 2010 | Child & Adolescent Units |           | 5    | 6  | 18 | 46 | 49 | 96 | 52  | 272   | 63% |
| 2011 | Adult Units              |           | 0    | 0  | 1  | 0  | 6  | 34 | 91  | 132   | 31% |
| 2011 | Child & Adolescent Units |           | 5    | 10 | 25 | 35 | 58 | 81 | 86  | 300   | 69% |
| 2012 | Adult Units              |           | 0    | 0  | 0  | 2  | 5  | 33 | 69  | 109   | 25% |
| 2012 | Child & Adolescent Units |           | 3    | 7  | 26 | 36 | 80 | 79 | 98  | 329   | 75% |

In the period January to September 2013 there was a total of 306 admissions of children and adolescents under the age of 18 years. 238 (78%) were admitted to child and adolescent units and 68 (22%) to adult units. A total of 21 (31%) of adolescents admitted to adult inpatient units were subsequently transferred to a child and adolescent units. Seventeen (81%) of those cases transferred were to Health Service Executive funded units and four (19%) to a private unit.

Table 5.2 (b) Place of admissions

| Child and Adolescent Units                  | 2007       | 2008       | 2009       | 2010       | 2011       | 2012       | 2013*      |
|---|------------|------------|------------|------------|------------|------------|------------|
| St. Anne's, Galway                          | 32         | 31         | 29         | 33         |            |            |            |
| Merlin Park Inpatient Unit, Galway          |            |            |            |            | 38         | 71         | 57         |
| St. Joseph's, Fairview, Dublin              |            |            | 29         | 34         | 42         | 36         | 30         |
| Warrenstown Unit, Blanchardstown, Dublin    | 46         | 42         | 37         | 37         | 39         |            |            |
| Interim Linn Dara Unit, Palmerstown, Dublin |            |            |            |            |            | 24 †       | 24         |
| Eist Linn, St. Stephen's Hospital, Cork     |            |            | 4          | 44         | 5          |            |            |
| Eist Linn, Bessboro, Cork                   |            |            |            |            | 32         | 38         | 35         |
| Private Units                               | 68         | 70         | 56         | 124        | 144        | 160        | 92         |
| <b>Total Child</b>                          | <b>146</b> | <b>143</b> | <b>155</b> | <b>272</b> | <b>300</b> | <b>329</b> | <b>238</b> |
| Adult Units                                 |            |            |            |            |            |            |            |
| HSE Adult Units                             | 190        | 223        | 185        | 155        | 129        | 109        | 68         |
| Central Mental Hospital                     |            |            |            | 1          | 1          |            |            |
| Private Adult Units                         | 28         | 40         | 27         | 7          | 2          |            |            |
| <b>Total Adult</b>                          | <b>218</b> | <b>263</b> | <b>212</b> | <b>163</b> | <b>132</b> | <b>109</b> | <b>68</b>  |
| <b>Total</b>                                | <b>364</b> | <b>406</b> | <b>367</b> | <b>435</b> | <b>432</b> | <b>438</b> | <b>306</b> |

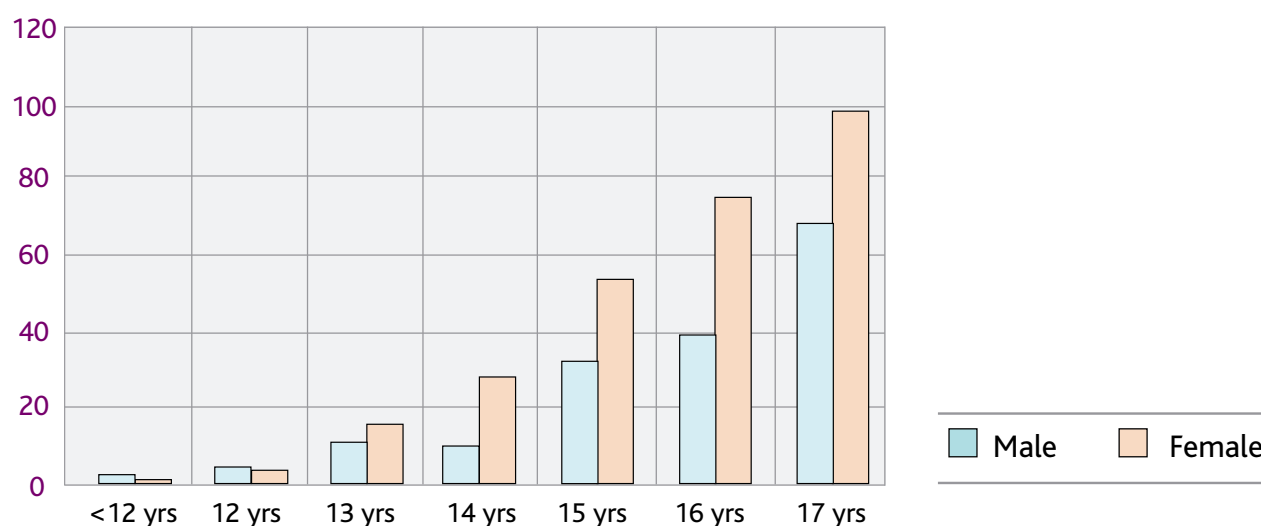
\*Jan to Sept 2013

† 6 of these admissions were the Warrenstown unit before its closure

### 5.3 Age and gender of admissions (2012)

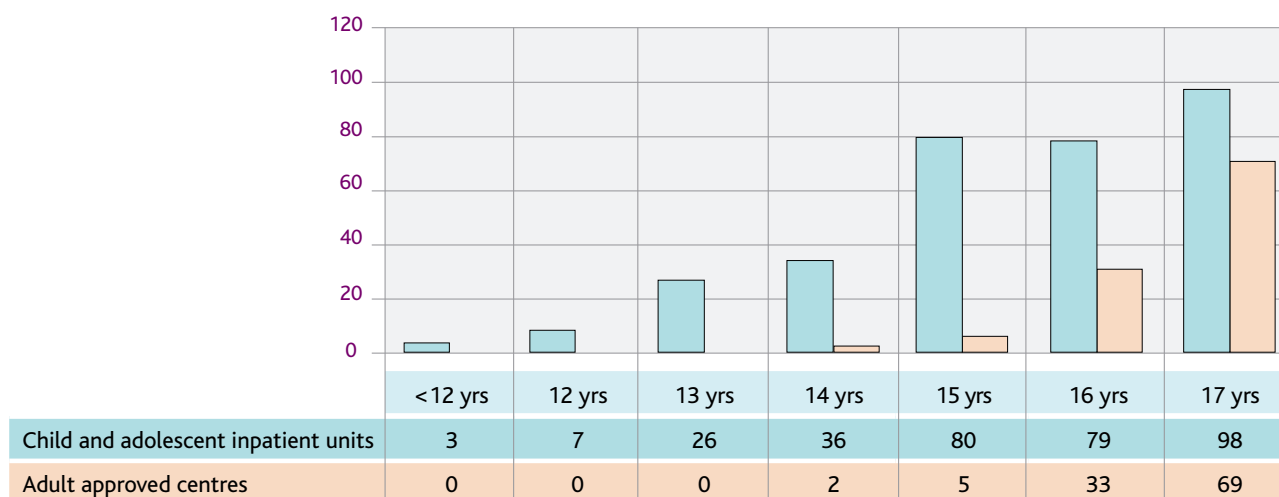
Of the 438 admissions of children and adolescents in 2012 females accounted for 62% of admissions. Thirty-eight percent of all admissions were aged 17 years on admission, 26% were aged 16 years, 19% were aged 15 years, 9% were aged 14 years, 6% were aged 13 years, 2% aged 12 years and 1% less than 12 years of age (Figure 5.3 (i)).

Figure 5.3 (i) Age and gender of admissions (2012)



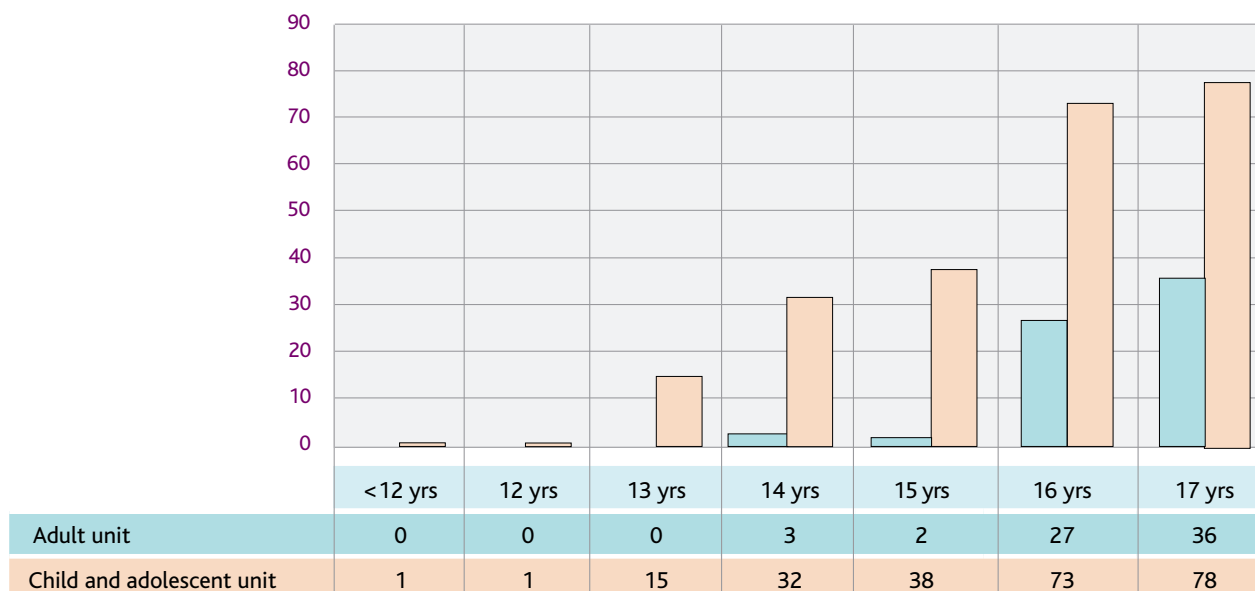
Of the 329 (75%) admissions to the child and adolescent inpatient units in 2012 30% were aged 17 years on admission, 24% were aged 16 years, 24% were aged 15 years, 11% were aged 14 years, 8% were aged 13 years, 2% were aged 12 years and 1% were aged less than 12 years. Of the 109 (25%) admissions to adult approved centres 63% were aged 17 years on admission, 30% were aged 16 years, and 7% (7) were less than 16 years of age on admission (Figure 5.3 (ii)).

Figure 5.3 (ii) Place of Admission by Age (2012)



In the period January to September 2013 there was a total of 306 admissions of children and adolescents under the age of 18 years. 238 (78%) were admitted to child and adolescent units and 68 (22%) to adult units. The breakdown of the admissions by age is shown in Figure 5.3 (iii).

Figure 5.3 (iii) Place of Admission by Age (January to September 2013)



Seventy-eight percent (238) of admissions were to child and adolescent units. Of these admissions, 33% (78) were 17 years of age, 31% (73) were 16 years of age, 16% (38) were 15 years of age, 13% (32) were 14 years of age, 6% (15) were 13 years of age, and 1% (2) were 12 years of age and under.

Twenty-two percent (68) of admissions were to adult units; 53% (36) of these admissions were 17 years of age, 40% (27) were 16 years of age, 3% (2) were 15 years of age, and 4% (3) were 14 years of age.

Table 5.3 (a) Admissions to adult units by service provider (January to September 2013)

| Service Provider        | No. of units  | No. of admissions Jan to Sept 2013 | %           | No. of admissions Jan to Sept 2012 |
|-------------------------|---------------|------------------------------------|-------------|------------------------------------|
| HSE Dublin Mid Leinster | 7 Adult units | 14                                 | 15%         | 11                                 |
| HSE Dublin North East   | 4 Adult units | 18                                 | 16%         | 12                                 |
| HSE South               | 6 Adult units | 20                                 | 21%         | 16                                 |
| HSE West                | 4 Adult units | 16                                 | 48%         | 36                                 |
| <b>Total</b>            | <b>21</b>     | <b>68</b>                          | <b>100%</b> | <b>75</b>                          |

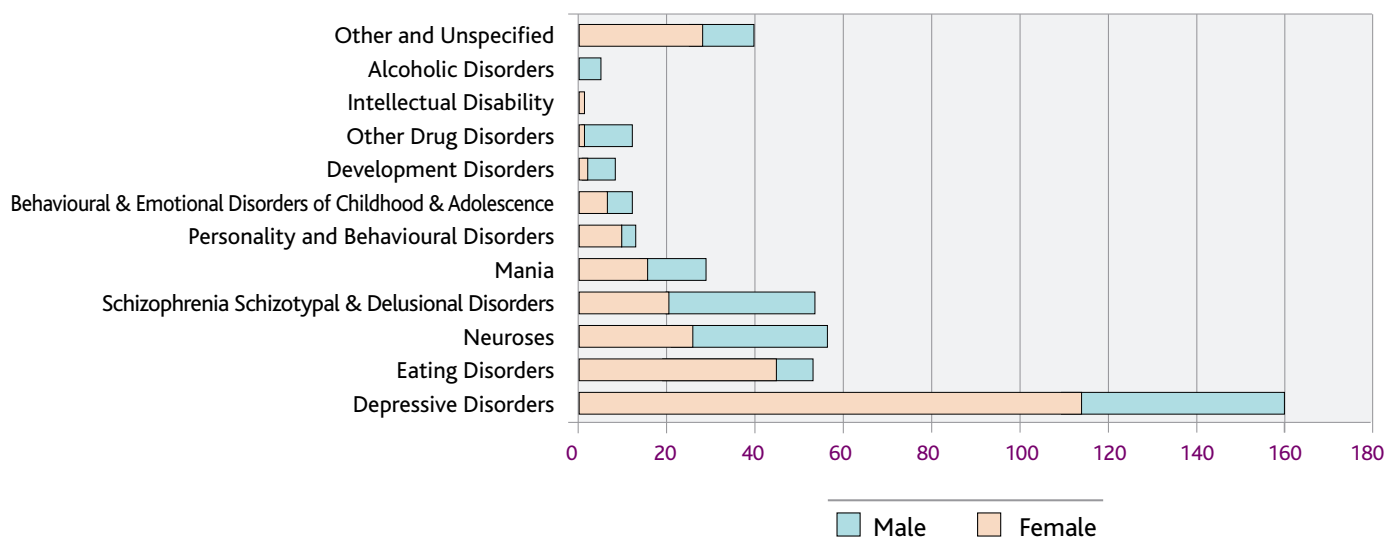


Of the 68 a total of 21 (31%) of adolescents admitted to adult inpatient units were subsequently transferred to child and adolescent units.

## 5.4 Diagnostic categories

Depressive disorders accounted for 37% of all admissions in 2012 (see Figure 5.4 (i)). The next largest diagnostic category was neuroses at 13%, eating disorders at 12%, schizophrenia and delusional disorders at 11%, mania at 7%, and behavioural and emotional disorders of childhood and adolescence, personality and behavioural disorders, and other drug disorders at 3% each. Development disorder, alcoholic disorder, and intellectual disability were all less than 2%. A total of 10% of admissions were returned in the other and unspecified category.

Figure 5.4 (i) Diagnostic categories by gender (2012)



In 2012 females accounted for 85% of all admissions with eating disorder, 77% of all admissions with personality and behavioural disorders, 71% of all admissions with depressive disorders, 58% of all admissions with behavioural and emotional disorders of childhood & adolescence, and 55% of all admissions with mania.

Males accounted for 100% of all admissions with alcoholic disorders, 92% of all admissions with other drug disorders, 75% of all admissions with developmental disorders, 57% of all admissions with schizophrenia and delusional disorders, 54% of all admissions with neuroses, and 45% of all admissions with mania.

In 2011 females accounted for 85% of all admissions with personality and behavioural disorders, 83% of all admissions with eating disorder, 67% of all admissions with depressive disorders and 59% of all admissions with neuroses. Males accounted for 87% of all admissions with other drug disorders, 75% of all admissions with alcoholic disorders, 71% of all admissions with developmental disorders, 68% of all admissions with behavioural and emotional disorders of childhood & adolescence, 67% of all admissions with schizophrenia and delusional disorders, and 52% of all admissions with mania.

## 5.5 Duration of admission

The average length of stay (for those admitted and discharged in 2012) was 37.7 days (median length of stay 22 days), increasing from 36.2 days in 2011. The average length of stay was significantly longer in the child and adolescent units, at 52 days (median 40 days), than in adult units, at 8 days (median 4.5 days).

Table 5.5 (a) Length of admission (2012)

| Admissions              | No. of Days | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|-------------------------|-------------|------|------|------|------|------|------|
| Child & Adolescent unit | Mean        | 51.3 | 49.7 | 61.9 | 47.1 | 48.3 | 52   |
|                         | Median      | 39.5 | 41   | 58   | 41   | 39   | 40   |
| Adult unit              | Mean        | 16   | 12.1 | 14.6 | 11.3 | 9.9  | 8    |
|                         | Median      | 7    | 6    | 6    | 5    | 5    | 4.5  |
| All units               | Mean        | 29.7 | 24.5 | 34.4 | 33.2 | 36.2 | 37.7 |
|                         | Median      | 14   | 13   | 17   | 23.5 | 21   | 22   |

Thirty-six percent were discharged within two days of admission, and sixty-five percent of young people admitted to adult units were discharged within one week of admission. Eighty-six percent were discharged within one to two weeks of admission, and ninety-four within two to four weeks of admission. A further seven percent were discharged within four to eight weeks of admission.

Fourteen percent of young people admitted to child and adolescent units were discharged within one week, 6% were discharged within one to two weeks of admission, 17% were discharged within two to four weeks, 25% were discharged within four to eight weeks, 19% were discharged within eight to twelve weeks, and a further 19% were discharged after admissions of greater than twelve weeks duration.

Figure 5.5 (i) Duration of admissions (2012)

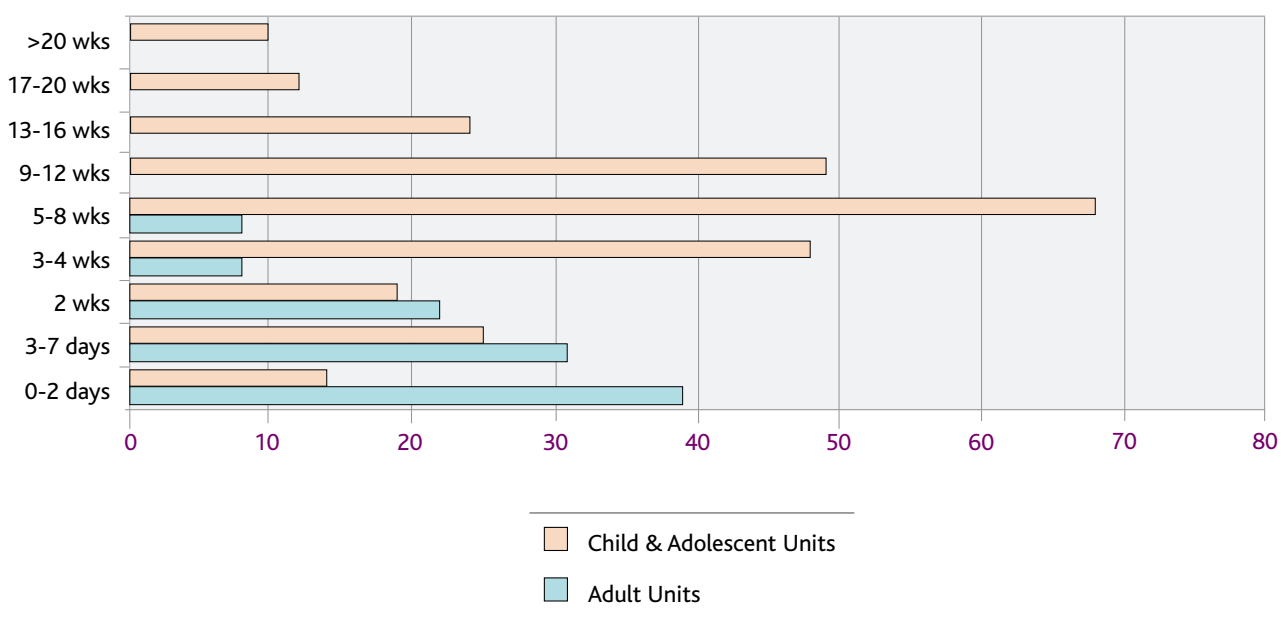


Table 5.5 (b) Duration of admission by diagnosis (2012)

|  | Length of stay in days |                |                        |                       |
|--|------------------------|----------------|------------------------|-----------------------|
|  | Number of discharges   | Inpatient days | Average number of days | Median number of days |
| Alcoholic Disorders  | 5                      | 31             | 6.2                    | 7                     |
| Other Drug Disorders   | 12                     | 130            | 10.83                  | 4                     |
| Schizophrenia, Schizotypal and Delusional Disorders            | 40                     | 1870           | 46.75                  | 24                    |
| Depressive Disorders   | 113                    | 4385           | 38.81                  | 21                    |
| Mania  | 25                     | 1011           | 40.44                  | 28                    |
| Neuroses   | 48                     | 1602           | 33.38                  | 24                    |
| Eating Disorders   | 33                     | 2544           | 77.09                  | 73                    |
| Personality and Behavioural Disorders                          | 13                     | 228            | 17.54                  | 4                     |
| Intellectual Disability  | 1                      | 5              | 5                      | 5                     |
| Development Disorders  | 7                      | 171            | 24.43                  | 26                    |
| Behavioural and Emotional Disorders of Childhood & Adolescence | 11                     | 336            | 30.55                  | 7                     |
| Other and Unspecified  | 29                     | 484            | 16.69                  | 6                     |
| <b>Total</b>   | <b>337</b>             | <b>12797</b>   | <b>37.97</b>           | <b>22</b>             |

## 5.6 Involuntary admissions

There were 11 involuntary admissions of children to approved centres, under Section 25 of the Mental Health Act 2001, in the first 9 months of 2013. Seven of these involuntary admissions were to child units and four were to adult approved units.

There were 18 involuntary admissions of children to approved centres in 2012 under Section 25 of the Mental Health Act 2001. The majority (15) of involuntary admissions was to child units and three were to adult units. This represented a decrease from a total of 21 involuntary admissions in 2011.

## 5.7 Development of inpatient services

The HSE continues to progress the development of inpatient services so as to meet the recommendations as set out in *A Vision for Change* (2006).

Table 5.7 (a) Developments of inpatient services

| HSE Region          | Capital Project                         | Capacity | Status             |
|---------------------|---|----------|--------------------|
| West                | New Merlin Park Unit, Galway            | 20 Bed   | Open 2011          |
| South               | New Eist Linn Unit, Bessboro, Cork      | 20 Bed   | Open 2011          |
| Dublin North East   | New St. Joseph's Adolescent Unit        | 12 Bed   | Open 2012          |
| Dublin Mid Leinster | Interim Under 16 yrs. Unit              | 8 Bed    | Open 2012          |
| Dublin Mid Leinster | Interim 16 & 17 yrs. Unit               | 6 Bed    | To Open 2013 (Q4)  |
| Dublin Mid Leinster | New Unit at Cherry Orchard Hospital     | 22 Bed   | Construction phase |
| National            | New Adolescent Secure Unit              | 10 Bed   | Design stage       |
| National            | New Unit in The New Children's Hospital | 20 Bed   | Proceeding         |

In January 2013 two additional beds were opened in St. Joseph's unit increasing their operational capacity from six to eight beds.

The new unit at Linn Dara is scheduled to open at the end of the 4th Quarter. Both of the Linn Dara units will transfer to the new 22 bed unit in Cherry Orchard in 2015. The building project is at tender stage with construction expected to commence in 2014, with an 18 month completion timeframe.

The new 10 bed adolescent secure unit is part of the redevelopment of the National Forensic Service at Portrane and is currently at the design stage. The 20 bed unit in the new National Children's Hospital, which includes an 8 bed eating disorder service, is at initial planning stage.

## HSE West

The Merlin Park Inpatient Unit opened on January 14th 2011 with a capacity of 10 Beds. The inpatient service transferred from St. Anne's Inpatient Unit (10 beds), Taylor's Hill, Galway. Approval for additional staff was granted and the recruitment process commenced to facilitate the completion of the team and the commissioning of additional inpatient beds. In May 2011 the Mental Health Commission granted permission to increase the Inpatient Bed capacity to 12, and in September 2011 this was increased to 15 beds. In 2012 it achieved full operational capacity. In the course of 2013 the unit has had 15 operational beds.

### Merlin Park Child and Adolescent Unit, Galway



## HSE South

The Eist Linn service transferred to Bessboro on the March 12th 2011 from the interim 8 Bed Unit at St. Stephen's Hospital. The unit comprises of a 20 bed residential facility, and a separate educational facility commissioned by the Department of Education. It currently accommodates 15 children and young people. It is planned to further increase its capacity in 2014.

## Eist Linn Inpatient Unit, Bessboro, Cork



## HSE Dublin North East

The second phase of development of adolescent inpatient services at St. Vincent's Hospital, Fairview was completed in September 2012 with the opening of the new 12-bed unit. The existing unit has been taken over for use by the Adolescent Day Service. From mid January 2013 the unit has had 8 operational beds. There are plans to increase to 12 operational beds in 2014.

## HSE Dublin Mid Leinster

Planning application has been granted for the new 24 bed unit on the Cherry Orchard Hospital site replacing the Interim Linn Dara 8 bed child and adolescent unit, and the planned 6 bed interim older adolescent unit, located in the grounds of St. Loman's Hospital, Palmerstown. The new building will comprise of an 11 bed unit for children and younger adolescents, an 11 bed unit for older adolescents, a 2 bed intensive care area, school building, sports hall, gym and a family apartment (where families can stay on the unit). Construction is due to begin in 2014 with an expected 18 month completion timeframe.

## Linn Dara Child and Adolescent Inpatient facility at Cherry Orchard Hospital, Dublin



## New Children's Hospital of Ireland

It was announced in November 2012 that the New Children's Hospital will be developed at the campus of St. James's Hospital in Dublin. The St. James's site ensures that the planned co-location with an adult hospital and, ultimately, tri-location with a maternity hospital, will be delivered. It will accommodate the national specialist eating disorder service with 8 inpatient beds and a 12 bed general inpatient unit. Construction scheduled to be completed by the end of 2017 or early 2018.

## National Forensic Hospital

The new National Forensic Hospital will be built in Portrane, North Co. Dublin. The development will include a 10 bed secure adolescent inpatient unit. The project which started in 2012 will take five years to complete.

## 6.1 Accommodation of CAMHS teams

Community CAMHS teams are located in a range of accommodation. The capacity of a CAMHS team to provide service, to expand and develop can be adversely affected by the size and suitability of accommodation available to it and this needs to be taken account of in future development plans.

Table 6.1 (a) Location of community CAMHS teams (2012)

| Location of Team  | Very good  | Good       | Adequate   | Inadequate | Unsuitable | Total       |
|---|------------|------------|------------|------------|------------|-------------|
| Rented Premises – Located in the Community                            | 5          | 4          | 2          | 2          | 1          | 14          |
| Premises owned by Voluntary Service Provider located in the community | 6          |            | 3          | 2          |            | 11          |
| Hospital Site (+/- Community Building )                               |            | 1          | 1          | 5          |            | 7           |
| HSE Building located in the community – Sole Occupant                 |            | 1          |            | 3          | 1          | 5           |
| HSE Building located in the community – Shared                        | 8          | 3          | 3          | 3          | 2          | 19          |
| HSE Building & Rented Premises (in the Community)                     |            |            |            | 1          | 1          | 2           |
| <b>Total</b>  | <b>19</b>  | <b>9</b>   | <b>9</b>   | <b>16</b>  | <b>5</b>   | <b>58</b>   |
| <b>2012 %</b>   | <b>33%</b> | <b>16%</b> | <b>16%</b> | <b>28%</b> | <b>9%</b>  | <b>100%</b> |
| <b>2011 %</b>   | <b>27%</b> | <b>16%</b> | <b>25%</b> | <b>16%</b> | <b>16%</b> | <b>100%</b> |
| <b>2010 %</b>   | <b>29%</b> | <b>9%</b>  | <b>33%</b> | <b>22%</b> | <b>7%</b>  | <b>100%</b> |

## 6.2 Suitability of premises

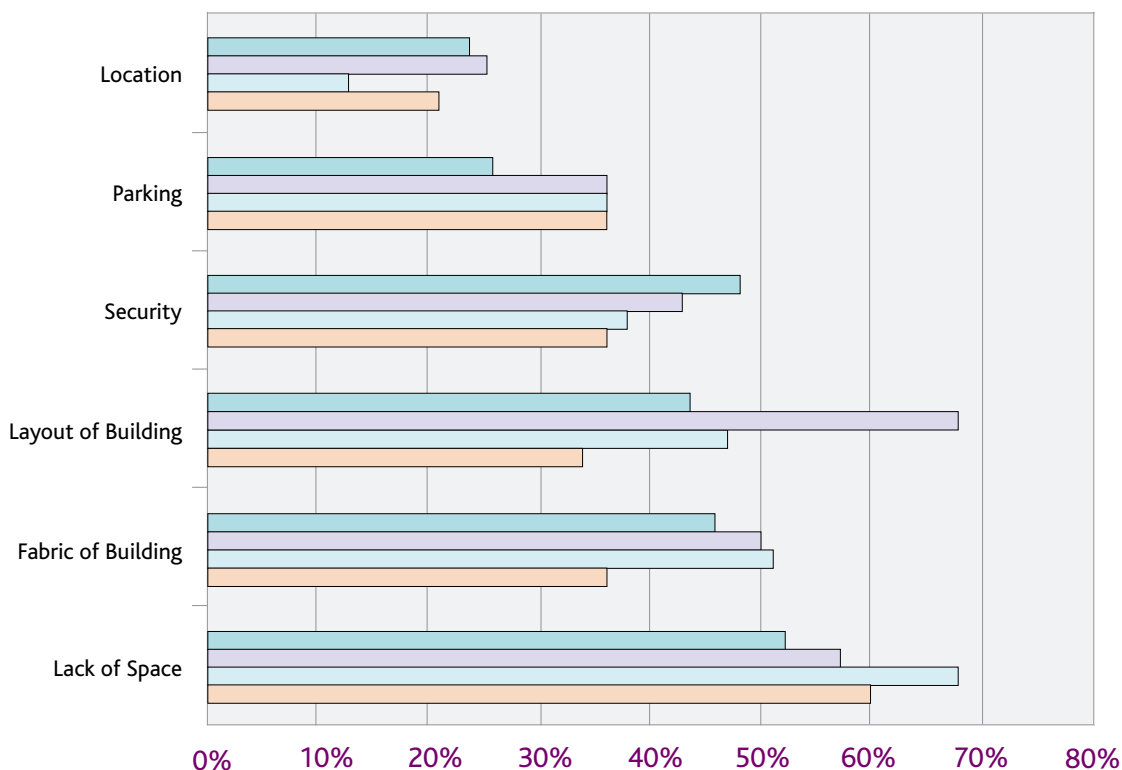
Each team rated the suitability of their premises in order to provide a service:

- 37 (64%) teams rated their premises as adequate, good or very good.
- 5 (9%) teams rated their premises as inadequate or totally unsuitable.
- The number of teams that reported their accommodation as being inadequate or unsuitable increased when compared with the results from the 2011 survey.

## 6.3 Difficulties encountered with premises

Lack of space was the most frequently encountered problem reported by 60% of teams. This was followed by concerns with regard to fabric of the building (36%), layout of the building (34%), security (36%), and parking problems (36%).

Figure 6.3 (i) Difficulties encountered with premises



|        | Lack of Space | Fabric of Building | Layout of Building | Security | Parking | Location |
|--------|---------------|--------------------|--------------------|----------|---------|----------|
| Nov 09 | 52%           | 46%                | 44%                | 48%      | 26%     | 24%      |
| Nov 10 | 57%           | 50%                | 68%                | 43%      | 36%     | 25%      |
| Nov 11 | 68%           | 51%                | 47%                | 38%      | 36%     | 13%      |
| Nov 12 | 60%           | 36%                | 34%                | 36%      | 36%     | 21%      |

## 6.4 Infrastructure developments

The new HSE Linn Dara Child and Adolescent Mental Health facility in the grounds of Cherry Orchard Hospital opened in May 2012. It comprises of three suites for community CAMHS teams and a new Adolescent Day Programme team serving South West Dublin and Co. Kildare. The building also includes a lecture theatre, library and administration section.



Child and Adolescent Mental Health facility at Cherry Orchard Hospital, Dublin



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# SECTION 7 Demands on Community CAMHS

## 7.1 Services for young people of 16 and 17 years of age

The Child and Adolescent Mental Health Services were organised, primarily for the 0-15 year's age group. Mental health disorders increase in frequency and severity above the age of 15 years and it was recognised that existing specialist CAMHS would require significant additional resources in order to extend services up to the age of 18 years.

*A Vision for Change Policy (2006)*, recommended that Child and Adolescent Mental Health Services take over responsibility in providing mental health service for young people up to the age of 18 years. Additional resources have been put in place, however continuing investment needs to take place such that the recommended level of service, as set out in the policy, can be delivered.

During the month of November (2012) 16.9% of the cases seen by Community CAMHS teams were aged 16/17 years and 1.6% were over 18 years of age. Teams were asked as to their current arrangements with regard to the 16/17 year age group of young people who previously were the responsibility of Adult Mental Health Services in most areas of the country. From 2006 the practice of teams keeping on existing cases beyond their 16th birthday was extended, without the provision of additional resources at that time.

**Table 7.1 (a) Arrangements for 16 and 17 year old age group**

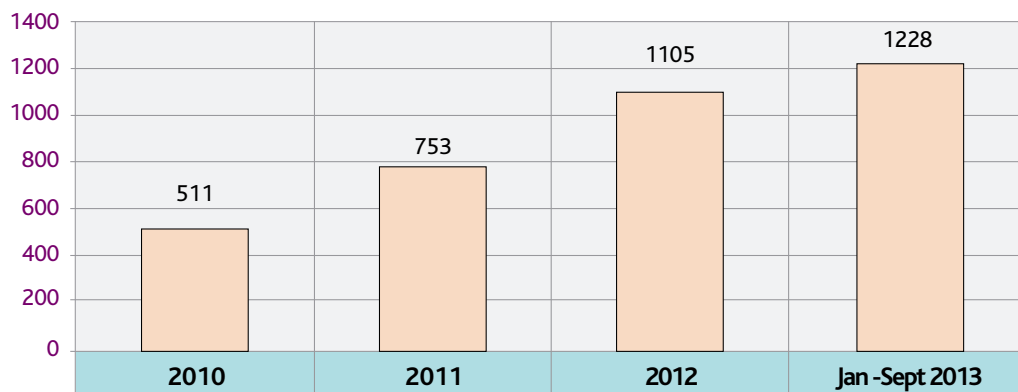
| Operational Criteria of CAMHS teams   | 2009      | 2010      | 2011      | 2012      |
|---|-----------|-----------|-----------|-----------|
| Continue to see existing open cases beyond their 16th birthday as appropriate. Consider re referral of previously known cases after their 16th birthday. Do not see new cases aged 16 / 17 years                                    | 37        | 39        | 37*       | 32*       |
| Continue to see existing open cases beyond their 16th birthday as appropriate. Consider re referral of cases of known cases after their 16th birthday. Consider new referrals of young people over 16 years on a case by case basis | 5         | 4         | 2         | 5         |
| Accept referral of all young people up to and including 16 years  | 3         | 3         | 3         | 2         |
| Accept referral of all young people up to and including 17 years  | 5         | 9         | 14        | 19        |
| <b>Total</b>  | <b>50</b> | <b>55</b> | <b>56</b> | <b>58</b> |

(\* 2 child teams accept referrals to age 12 years)

- The number of teams accepting referrals of young people up to and including 17 years increased from 14 (25%) to 19 (33%). A further 2 (3%) teams accept referrals of young people up to and including 16 years of age. Five teams accept new referrals of young people aged 16/17 years on a case by case basis.
- Child and Adolescent Mental Health Services currently provide a significant level of service to this age group.
- Some young people are transferred to Adult Mental Health Services after their 16th birthday due the nature of their illness and care / treatment needs.
- As the older age group present with more acute mental health difficulties access to services by younger children to child and adolescent mental health services with less acute presentations may be affected if additional resources are not in place.

In the period January 2013 to September 2013 the number of new (including re-referred) cases seen which were aged 16 years and over was 1,228 and this represented 16.8% of the total number of new (including re-referred) cases seen. Over the course of 2012 the number (including re-referred) cases was 1,105 (12.6%), in 2011 the number was 753 (9.3%) and in 2010 there was 511 (6.8%).

Figure 7.1 (i) Number of New (including re-referred) cases seen aged 16 years & over



55 (95%) of the 60\* teams have seen new (including re-referred) adolescents cases over 16 years of age in 2013.

Table 7.1 (b) Number of new (including re-referred) cases seen aged 16 years and over from January 2013 to September 2013

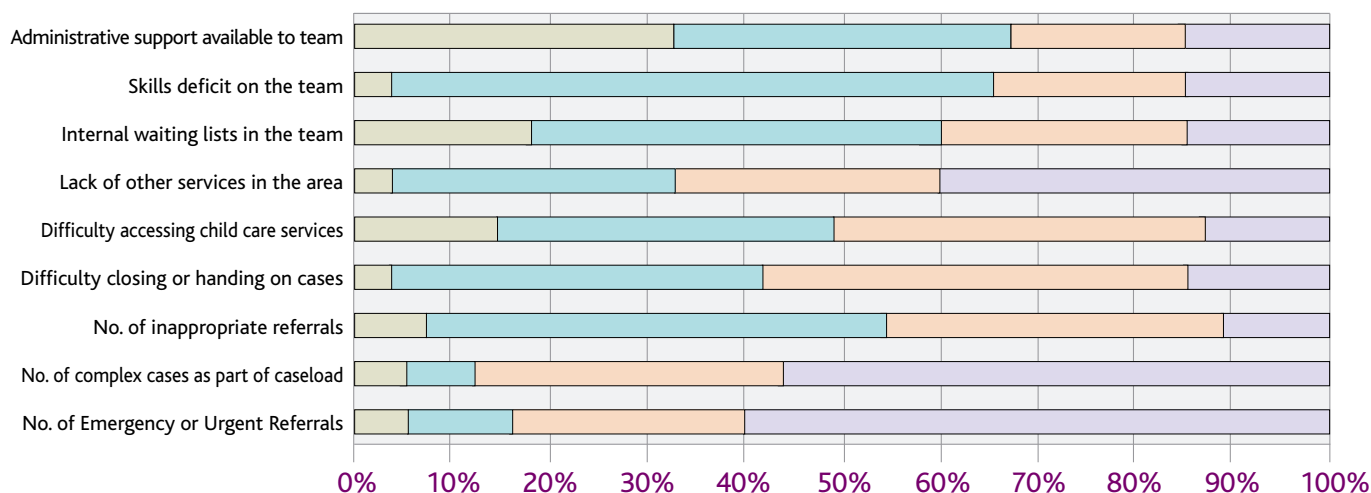
| HSE Region      | No. of New (including re-referred) cases seen aged 16 years and over | % of New (including re-referred) cases seen | % of teams who have seen new (including re-referred) cases aged 16 years and over |
|-----------------|--|---|---|
| DML             | 323  | 14.9%                                       | 89%*  |
| DNE             | 101  | 8.9%  | 92%   |
| South           | 277  | 20.4%                                       | 100%  |
| West            | 527  | 19.4%                                       | 100%  |
| <b>National</b> | <b>1,228</b>   | <b>16.6%</b>                                | <b>95%</b>  |

\* Two teams in the Lucena Service are specifically dedicated to seeing those less than 13 years of age therefore lowering the cohort to 58 teams.

## 7.2 Capacity of CAMHS teams to respond to demand

Many factors can affect the capacity of a team to respond to the demand placed on it. CAMHS teams were asked to rate the following factors as to their degree of impact on their capacity to respond to demand.

Figure 7.2 (i) Factors which impact on a team's capacity to respond to demand (2012)



|                     | No. of Emergency or Urgent Referrals | No. of complex cases as part of caseload | No. of inappropriate referrals | Difficulty closing or handing on cases | Difficulty accessing child care services | Lack of other services in the area | Internal waiting lists in the team | Skills deficit on the team | Administrative support available to team |
|---------------------|--------------------------------------|--|--------------------------------|--|--|------------------------------------|------------------------------------|----------------------------|--|
| <b>Very Often</b>   | 60.0%                                | 56.4%                                    | 10.9%                          | 14.5%                                  | 12.7%                                    | 40.0%                              | 14.5%                              | 14.5%                      | 14.5%                                    |
| <b>Often</b>        | 23.6%                                | 30.9%                                    | 34.5%                          | 43.6%                                  | 38.2%                                    | 27.3%                              | 25.5%                              | 20.0%                      | 18.2%                                    |
| <b>Occasionally</b> | 10.9%                                | 7.3%                                     | 47.3%                          | 38.2%                                  | 34.5%                                    | 29.1%                              | 41.8%                              | 61.8%                      | 34.5%                                    |
| <b>Never</b>        | 5.5%                                 | 5.5%                                     | 7.3%                           | 3.6%                                   | 14.5%                                    | 3.6%                               | 18.2%                              | 3.6%                       | 32.7%                                    |

As in 2011 Community CAMHS teams rate the number of complex cases, the number of emergency cases and the lack of other services in the area as the factors having the greatest impact on their capacity to respond to demand which can in turn lead to increased numbers on waiting lists and longer waiting times for routine assessments.

## 7.3 Provision of dedicated ADHD clinics by community CAMHS teams

As children suffering from ADHD account for the largest diagnostic category attending community CAMHS teams dedicated ADHD clinics have developed to meet this demand.

Table 7.3 (a) ADHD Clinics

| ADHD Clinic | Dublin Mid Leinster | Dublin North East | South | West | Total |
|-------------|---------------------|-------------------|-------|------|-------|
| Number      | 18                  | 4                 | 10    | 13   | 45    |
| All Teams   | 19                  | 11                | 14    | 14   | 58    |
| 2012 %      | 95%                 | 36%               | 71%   | 93%  | 78%   |
| 2011 %      | 94%                 | 45%               | 79%   | 93%  | 80%   |
| 2010 %      | 94%                 | 45%               | 57%   | 93%  | 75%   |

Eighty percent of teams are employing such dedicated ADHD clinics. Over 90% of teams in the West and in Dublin Mid Leinster run ADHD clinics, 71% of teams in the South while only 36% of teams in Dublin North East do so.

The majority (62%) of clinics take place on a weekly or fortnightly basis. The majority of the clinics are run by nurses and psychiatrists (including consultants and doctors in training).

**Table 7.3 (b) Frequency of ADHD Clinics**

| Frequency             | Number    | %           |
|-----------------------|-----------|-------------|
| Every week            | 19        | 42%         |
| Every 2 weeks         | 9         | 20%         |
| Every 3 weeks         | 0         | 0%          |
| Every 4 weeks / month | 9         | 20%         |
| Other                 | 8         | 18%         |
| <b>Total</b>          | <b>45</b> | <b>100%</b> |

## 7.4 Referral Protocols and Referral Forms

A total of 46 (79%) community CAMHS teams had a referral protocol in place and 33 (57%) teams utilised a referral form.

**Table 7.4 (a) Referral Protocols**

|                     | Dublin Mid Leinster | Dublin North East | South     | West      | Total 2012 | Total 2011 | Total 2010 |
|---------------------|---------------------|-------------------|-----------|-----------|------------|------------|------------|
| Referral Protocol   | 13                  | 9                 | 13        | 11        | 46         | 41         | 40         |
| Referral Form       | 10                  | 11                | 8         | 4         | 33         | 33         | 29         |
| <b>No. of Teams</b> | <b>23</b>           | <b>20</b>         | <b>21</b> | <b>15</b> | <b>58</b>  | <b>56</b>  | <b>55</b>  |

## SECTION 8

# Deliberate self harm in children aged from 10 to 17 years in the Republic of Ireland

### 8.1 The National Registry of Deliberate Self Harm

The National Registry of Deliberate Self Harm is a national system of population monitoring for the occurrence of deliberate self harm. It was established, at the request of the Department of Health and Children, by the National Suicide Research Foundation and is funded by the Health Service Executive's National Office for Suicide Prevention.

The Registry collects data on persons presenting to hospital emergency departments as a result of deliberate self harm in the Republic of Ireland. In 2012 the Registry recorded 12,010 presentations to hospital due to deliberate self-harm nationally, involving 9,483 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital following deliberate self harm in 2012 was 211 per 100,000.

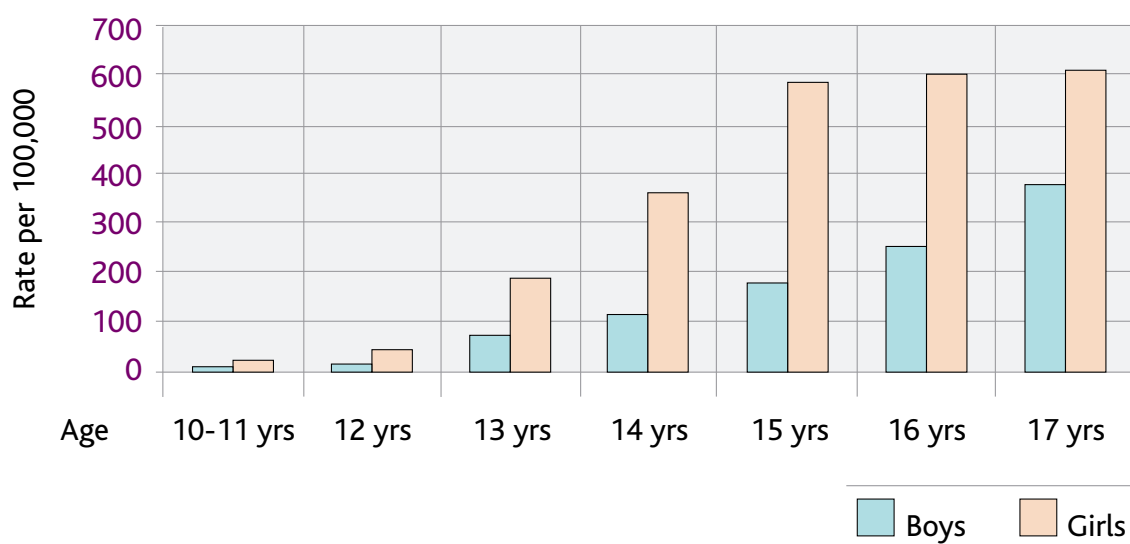
### 8.2 Hospital Presentations

For the period from 1st of January to 31st of December 2012, the Registry recorded 1,118 deliberate self harm presentations to hospital that were made by 960 children (296 boys and 664 girls) aged from 10 to 17 years.

The national rate for all children (aged from 10 to 17 years) presenting to hospital in the Republic of Ireland following deliberate self harm in 2012 was 204 per 100,000. Looking at the rates in terms of gender, the male rate was 122 per 100,000 and the female rate was 289 per 100,000. Rates were based on population figures available from the National Census 2011.

Of the recorded presentations for all children aged from 10 to 17 years in 2012, 30% were made by boys and 70% were made by girls.

Figure 8.2 (i) Person based rate of deliberate self harm in the Republic of Ireland by age and gender, 2012

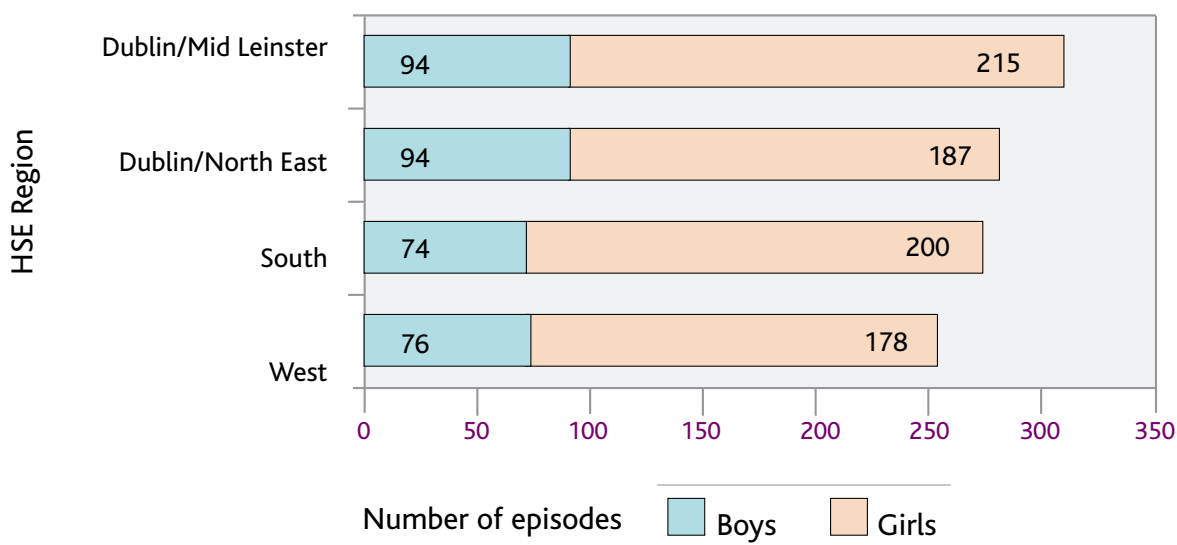


\* Please note the rates in children aged 10 and 11 years are combined as the numbers are too small.

## 8.3 Deliberate self harm by HSE Regions

The number of deliberate self harm presentations by girls outnumbered those by boys in all of the four HSE Regions (Figure 8.3 (i)).

Figure 8.3 (i) Gender balance of deliberate self harm presentations in children aged 10 to 17 years by HSE Region, 2012

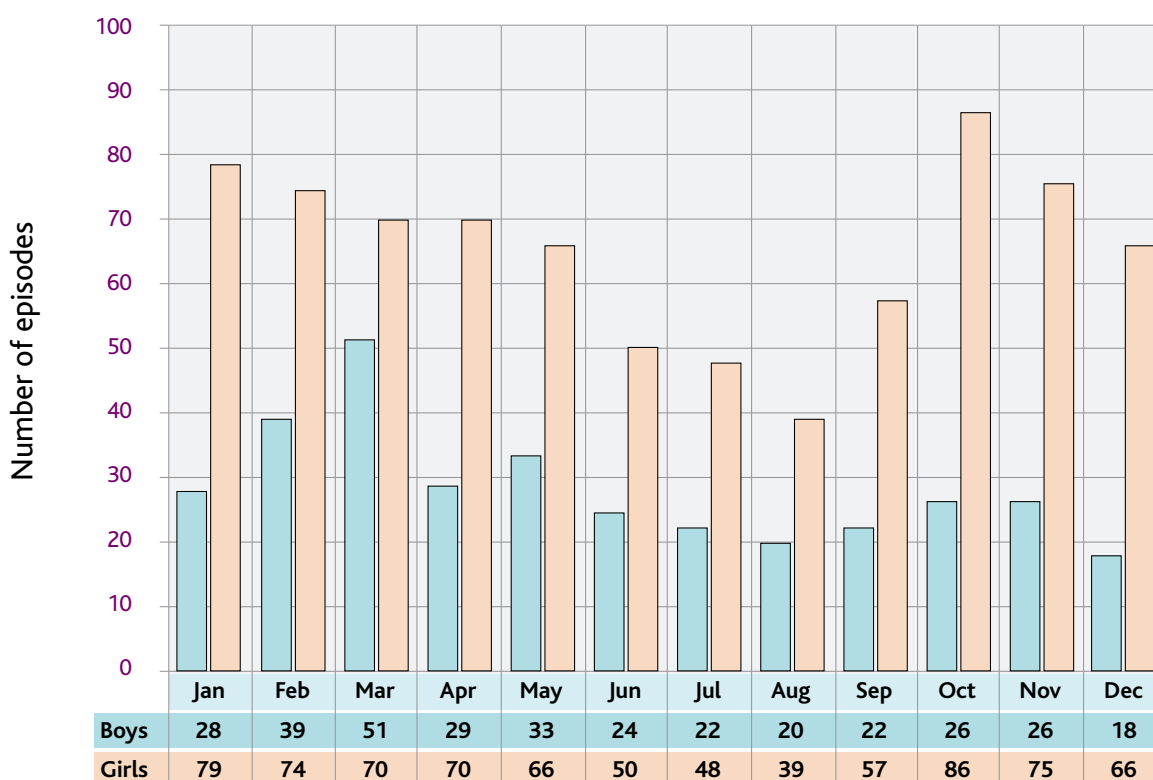


## 8.4 Episodes by Time of Occurrence

### Variation by Month

There is a clear pattern of deliberate self harm presentations over the course of the year with a late Winter/early Spring peak, followed by a drop in self harm presentations during the Summer months and then a further peak towards the end of year in October. In boys, the lowest number of deliberate self harm presentations to hospitals occurred in December and in girls the lowest number of self-harm presentations to hospitals occurred in August. The highest number of deliberate self harm presentations to hospitals for boys occurred in the month of March and for girls it was the month of October.

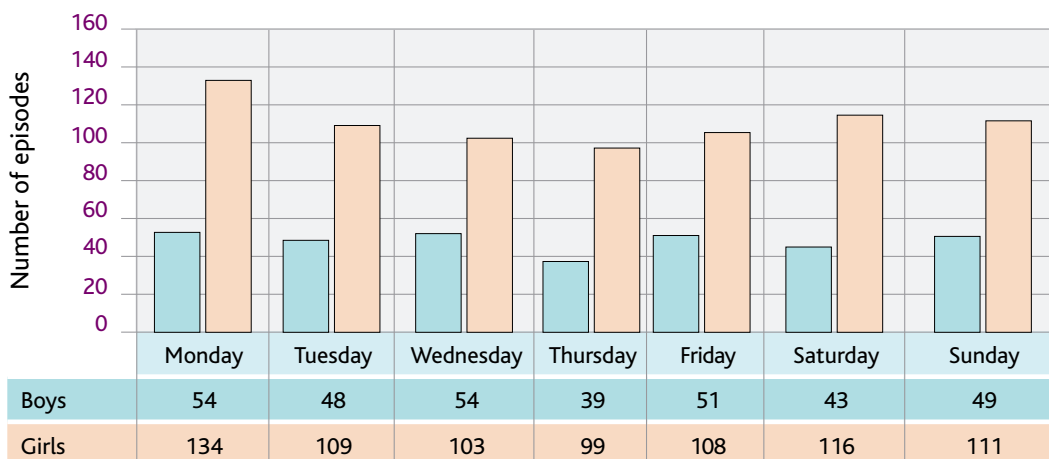
Figure 8.4 (i) Number of deliberate self harm presentations by month for boys and girls, 2012



## 8.5 Variation by Day

The number of deliberate self harm presentations was highest on Mondays (17%), with a slight dip in the number of presentation being found midweek followed by an increase in presentations at the weekend. The number of deliberate self harm presentations was lowest on Thursdays. Thursday accounted for 12% of all presentations.

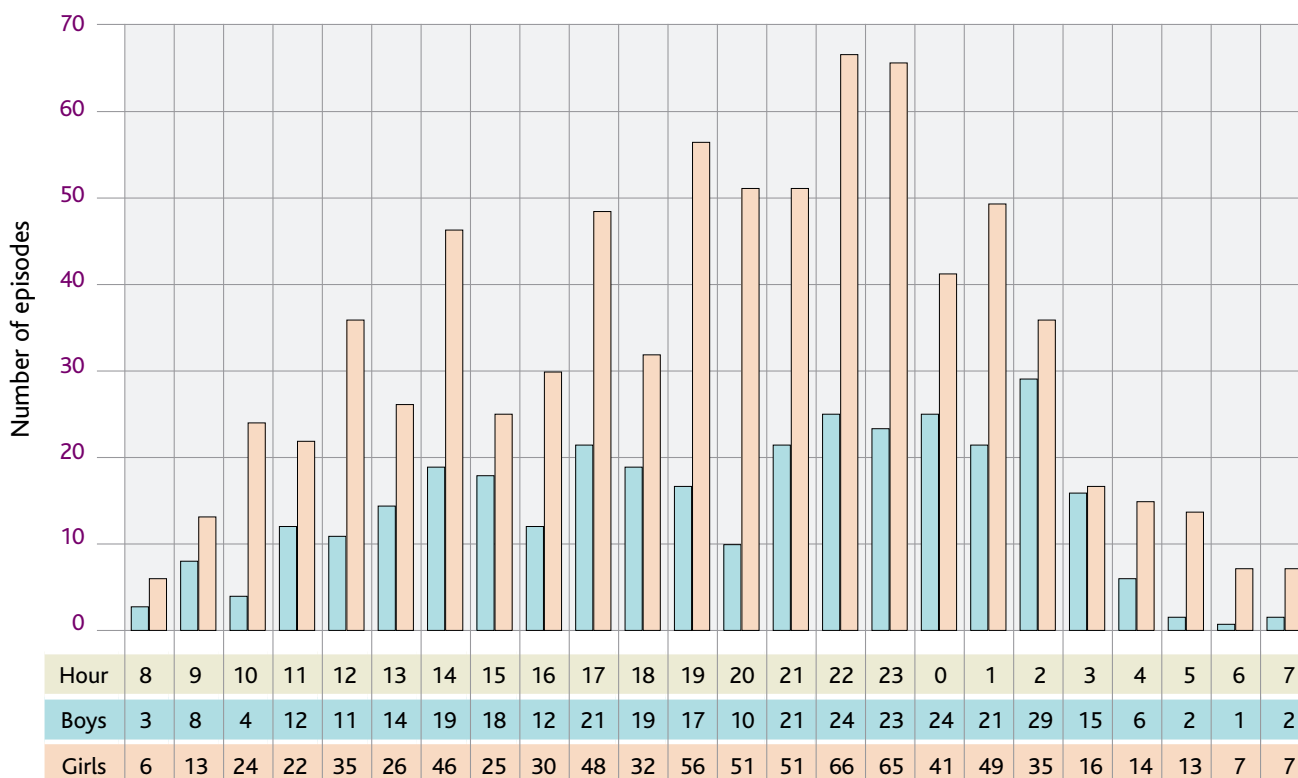
Figure 8.5 (i) Number of presentations in children aged 10 to 17 years by weekday, 2012



## 8.6 Variation by Hour

There was a striking pattern in the number of deliberate self harm presentations seen over the course of the day. The number of presentations for both boys and girls gradually increased during the day. The peak for boys was 2am and for girls it was 10pm. Over half (52%) of the total number of presentations were made during the eight-hour period 7pm-3am. This contrasts with the quietest eight-hour period of the day, from 5am-1pm, which accounted for just 15% of all presentations.

Figure 8.6 (i) Number of presentations by time of attendance in children aged 10 to 17 years, 2012





## 8.7 Method of self harm

Over half (63%) of all deliberate self harm presentations involved an overdose of medication. Drug overdose was more commonly used as a method of self harm by girls than by boys. It was involved in 52% of male presentations and 68% of female episodes. In children aged 10 to 17 years the number of deliberate self harm presentations to hospital involving overdoses in 2012 (705) showed a slight increase compared to the numbers recorded in 2011 (688).

While rare as a main method of self harm, alcohol was involved in 14% of all cases. The involvement of alcohol was more common in deliberate self harm episodes for boys (18%) than in episodes for girls (12%).

Cutting was the only other common method of self harm, involved in 29% of all episodes. The use of cutting was similar across episodes in boys (33%) and girls (28%). In 90% of all cases that involved self-cutting, the treatment received was recorded. Under half (47%) required no treatment, 34% required steristrips or steribonds, 8% required sutures while 2% were referred for plastic surgery. The treatment received was similar for boys and girls.

Attempted hanging was involved in 7% of all deliberate self harm presentations (12% for boys and 4% for girls).

**Table 8.7 (a) Methods of self harm involved in presentations to hospital by children aged 10 to 17 years, 2012**

|              | Overdose   | Alcohol    | Poisoning | Hanging   | Drowning  | Cutting    | Other     | Total       |
|--------------|------------|------------|-----------|-----------|-----------|------------|-----------|-------------|
| <b>Boys</b>  | 177        | 62         | 10        | 42        | 3         | 111        | 27        | 338         |
|              | (52.4%)    | (18.3%)    | (3%)      | (12.4%)   | (0.9%)    | (32.8%)    | (8%)      | (100%)      |
| <b>Girls</b> | 528        | 94         | 27        | 31        | 7         | 217        | 33        | 780         |
|              | (67.7%)    | (12.1%)    | (3.5%)    | (4%)      | (0.9%)    | (27.8%)    | (4.2%)    | (100%)      |
| <b>Total</b> | <b>705</b> | <b>156</b> | <b>37</b> | <b>73</b> | <b>10</b> | <b>328</b> | <b>60</b> | <b>1118</b> |
|              | (63.1%)    | (14%)      | (3.3%)    | (6.5%)    | (0.9%)    | (29.3%)    | (5.4%)    | (100%)      |

**Table 8.7 (b) Method of self harm used by Boys aged 10 to 17 years, 2012**

| % Boys                  | 10-13yrs | 14yrs | 15yrs | 16yrs | 17yrs |
|-------------------------|----------|-------|-------|-------|-------|
| Drug overdose only      | 34       | 53    | 58    | 44    | 42    |
| Self-cutting only       | 24       | 28    | 16    | 26    | 30    |
| Overdose & self-cutting | 3        | 3     | 5     | 4     | 5     |
| Attempted hanging only  | 14       | 8     | 9     | 10    | 9     |
| Attempted drowning only | 3        | 0     | 2     | 0     | 0     |
| Other                   | 21       | 10    | 11    | 16    | 14    |

**Table 8.7 (c) Method of self harm used by Girls aged 10 to 17 years, 2012**

| % Girls                 | 10-13yrs | 14yrs | 15yrs | 16yrs | 17yrs |
|-------------------------|----------|-------|-------|-------|-------|
| Drug overdose only      | 50       | 64    | 55    | 62    | 69    |
| Self-cutting only       | 27       | 18    | 23    | 23    | 16    |
| Overdose & self-cutting | 5        | 4     | 7     | 4     | 4     |
| Attempted hanging only  | 1        | 3     | 4     | 3     | 2     |
| Attempted drowning only | 1        | 0     | 1     | 1     | 0     |
| Other                   | 15       | 11    | 10    | 7     | 7     |

## 8.8 Drugs Used in Overdose

The total number of tablets taken was known in 77% of all cases of drug overdose. The average number of tablets taken in the episodes of deliberate self harm that involved drug overdose was 20. On average, boys and girls took the same number of tablets in an overdose act (mean: 22 vs. 20). Figure 8.8 (i) illustrates the pattern of the number of tablets taken in drug overdose episodes for both genders.

Figure 8.8 (i) The pattern of the number of tablets taken in male and female acts of drug overdose in children aged 10 to 17 years, 2012

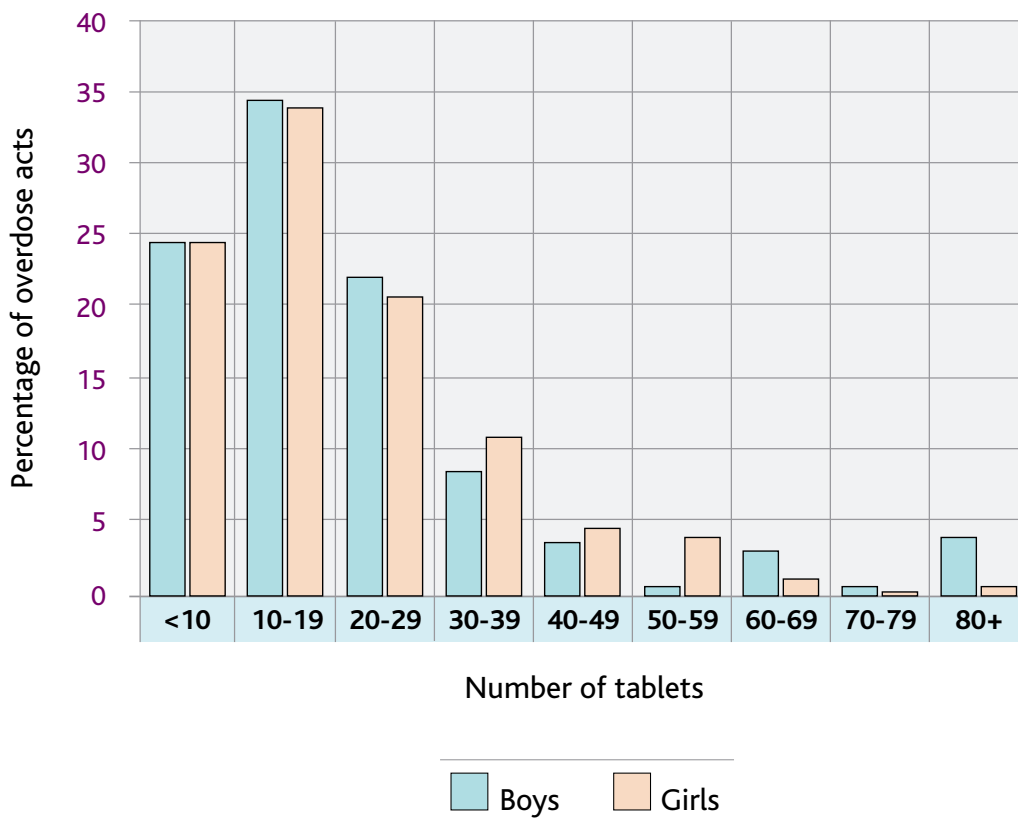
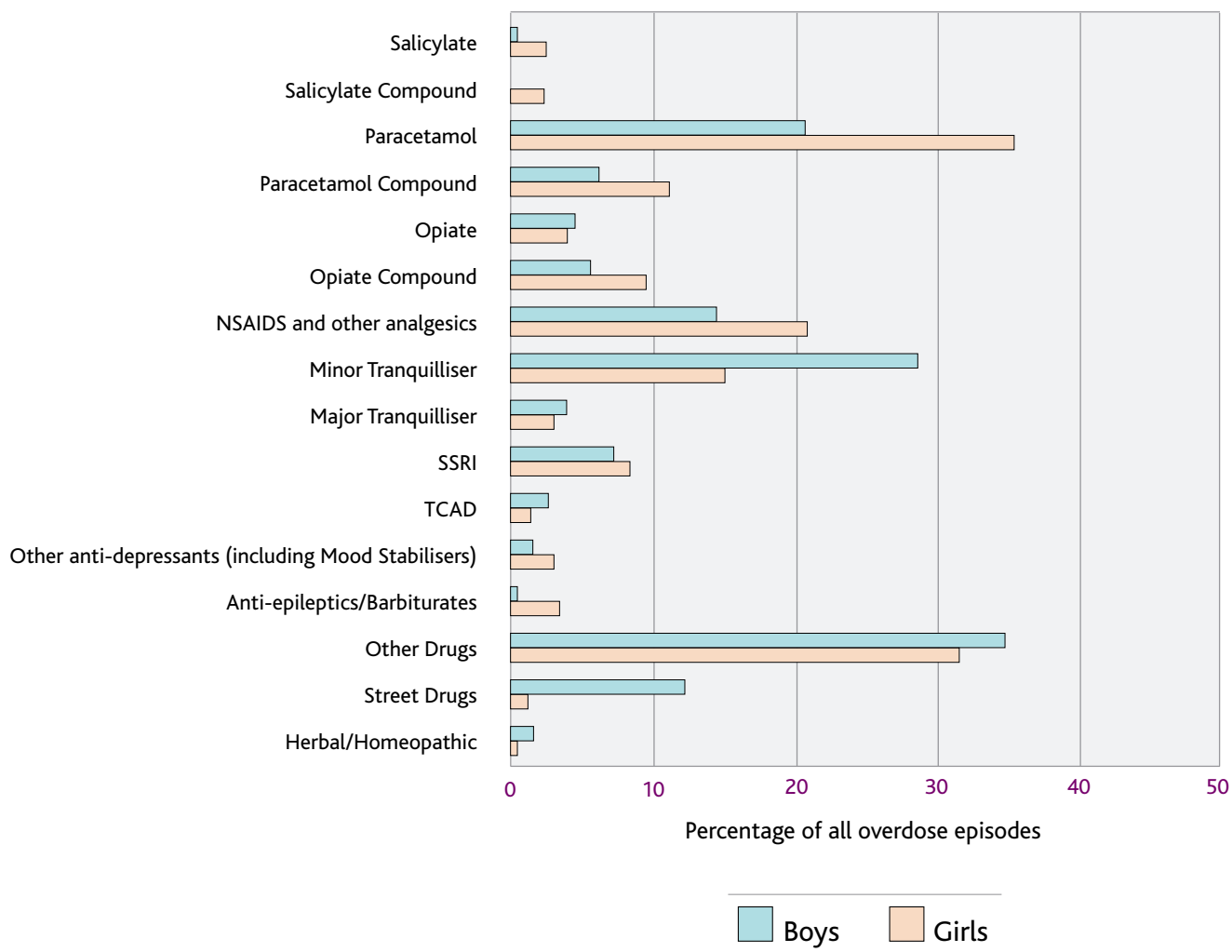


Figure 8.8 (ii) illustrates the frequency with which the most common types of drugs were used in overdose. Paracetamol was the most common analgesic drug taken, being involved in some form in 40% of overdoses. Paracetamol was used more often by girls (45%) than boys (26%). Minor tranquillisers were involved in 19% of overdoses and such a drug was used more often by boys (29%) than by girls (15%). This high rate of usage of anxiolytic/ sedative drugs is reflective of the high levels of these drugs in the general population. A major tranquilliser was involved in 3% of overdose cases. An anti-depressant/mood stabiliser was involved in 12% of deliberate overdose acts. The group of anti-depressant drugs known as Selective Serotonin Reuptake Inhibitors (SSRIs) were present in 8% of overdose cases. Street drugs were involved in 12% of male and just 1% of female intentional drug overdose acts. "Other drugs" were taken in 33% of all overdoses which reflects the wide range of drugs taken deliberately in acts of drug overdose.

Figure 8.8 (ii) The variation in the type of drugs used in children aged 10 to 17 years, 2012



Note: Some drugs (e.g. compounds containing paracetamol and an opiate) are counted in two categories

## 8.9 Recommended Next Care

In 5% of cases involving children aged 10 to 17 years, the child left the emergency department before a next care recommendation could be made. Following their treatment in the emergency department, inpatient admission was the next stage of care recommended for 41%, irrespective of whether general or psychiatric admission was intended and whether admission was refused or not. Of all deliberate self-harm cases, 37% resulted in admission to a ward of the treating hospital. In just 1% of cases, admission for either general or psychiatric care was refused. Most commonly, 53% of cases were discharged following treatment in the emergency department.

Next care recommendations in 2012 were broadly similar for boys and girls. However, girls were more often admitted to a ward of the treating hospital than boys (40% vs. 32%) and boys were more likely to leave the department before a recommendation could be made (8% vs. 4%).

Recommended next care varied according to the main method of self harm. General inpatient care was most common following cases of drug overdose, self-poisoning and cases involving alcohol (45%, 38% and 32%, respectively), and less common after attempted hanging and attempted hanging and self-cutting, (32% and 25%, respectively), and least common after attempted drowning (10%).

## 8.10 Repetition of deliberate self harm

There were 960 children aged 10 to 17 years treated for 1,118 deliberate self harm episodes in 2012. This implies that 14% (158) of the presentations in 2011 were due to repeat acts. Of the 960 deliberate self harm patients treated in 2012, 125 (13.0%) made at least one repeat presentation to hospital during the calendar year.

The rate of repetition varied significantly according to the main method of self harm involved in the deliberate self harm act (Table 8.10 (a)). Of the commonly used methods of self harm, cutting was associated with an increased level of repetition.

**Table 8.10 (a) Repeat presentation after index deliberate self harm presentation by method of self harm in children aged 10 to 17 years, 2012**

|                         | Overdose | Alcohol | Poisoning | Hanging | Drowning | Cutting | Other | Total        |
|-------------------------|----------|---------|-----------|---------|----------|---------|-------|--------------|
| <b>Children treated</b> | 625      | 137     | 23        | 64      | 9        | 264     | 50    | <b>960</b>   |
| <b>No. who repeated</b> | 68       | 20      | 3         | 8       | 2        | 49      | 6     | <b>125</b>   |
| <b>% who repeated</b>   | 10.9%    | 14.6%   | 13.0%     | 12.5%   | 22.2%    | 18.6%   | 12.0% | <b>13.0%</b> |

Similar rates of repetition of deliberate self harm were seen across HSE Regions Dublin/Mid Leinster, Dublin / North East, and South (12.3%, 12.9% and 12.3%, respectively), while the highest repetition rate was found among patients treated in HSE South (14.7%).

**Table 8.10 (b) Repetition by gender and HSE Region in children aged 10 to 17 years, 2011**

|                         |              | HSE Dublin / Mid Leinster | HSE Dublin / North East | HSE South    | HSE West     | National     |
|-------------------------|--------------|---------------------------|-------------------------|--------------|--------------|--------------|
| <b>Children treated</b> | Boys         | 87                        | 82                      | 67           | 60           | <b>296</b>   |
|                         | Girls        | 182                       | 158                     | 160          | 164          | <b>664</b>   |
|                         | <b>Total</b> | <b>269</b>                | <b>240</b>              | <b>227</b>   | <b>224</b>   | <b>960</b>   |
| <b>No. who repeated</b> | Boys         | 11                        | 7                       | 6            | 13           | <b>37</b>    |
|                         | Girls        | 22                        | 24                      | 22           | 20           | <b>88</b>    |
|                         | <b>Total</b> | <b>33</b>                 | <b>31</b>               | <b>28</b>    | <b>33</b>    | <b>125</b>   |
| <b>% who repeated</b>   | Boys         | 12.6%                     | 8.5%                    | 9.0%         | 21.7%        | <b>12.5%</b> |
|                         | Girls        | 12.1%                     | 15.2%                   | 13.8%        | 12.2%        | <b>13.3%</b> |
|                         | <b>Total</b> | <b>12.3%</b>              | <b>12.9%</b>            | <b>12.3%</b> | <b>14.7%</b> | <b>13.0%</b> |

## 9.1 Monitoring progress and evaluating outcomes

A multidisciplinary Child and Adolescent Mental Health Service Advisory Group was established to address and advise on the challenges facing CAMHS which include providing greater clarity about priority groups, developing relationships with primary care and other services by putting in place clear care pathways and agreement about the nature of supports CAMHS provide for other services working with children and young people with mental health problems, improving access for older adolescents who can find it difficult to engage with services, having a stronger focus on outcomes and measuring the quality and effectiveness of interventions through the increased involvement of service users and carers in service development and evaluation.

The Specialist CAMHS Advisory Group reports to Mr. Stephan Mulvany, National Director of Mental Health Services and advises the Office of the Chief Operating Officer and Deputy Director General of Health Service Executive on issues relating to child and adolescent mental health services.

**This group, in consultation with Child and Adolescent Mental Health Service providers and other stakeholders:**

- Continued to develop and refine the minimum dataset for CAMHS that is completed and returned by each team on a monthly basis and reported through CompStat and Performance Reports.
- Advice on the development of key performance indicators linked to the dataset that takes into account resource allocation, case mix, demographic and other factors.
- Fostered service user involvement in the planning and evaluation of services through engagement with youth service user panels.
- Is developing a strategy to foster sharing of best practice and service innovation.
- Inputting into manpower planning process.
- Has extended the collection of information from child and adolescent inpatient mental health services.
- Finalisation of the operational guidelines for child and adolescent mental health services based on the Mental Health Commission Quality Framework Document.

The Sixth Annual Report on Child and Adolescent Mental Health Services will be published in the fourth quarter of 2014.

### Membership of the Specialist CAMHS Advisory Group

1. **Dr. Brendan Doody**, Chair, Consultant Child and Adolescent Psychiatrist, Clinical Senior Lecturer, Clinical Director HSE Linn Dara CAMHS.
2. **Ms. Pamela Carroll**, Child Care Leader, HSE Child & Family Mental Health Service, Sligo.
3. **Ms. Lisa Corrigan**, Occupational Therapy Manager, Mater Child & Adolescent Mental Health Service.
4. **Dr. Antoinette D'Alton**, Consultant Child and Adolescent Psychiatrist, HSE Longford / Westmeath CAMHS.
5. **Dr. Maura Delaney**, Consultant Child and Adolescent Psychiatrist, Eist Linn Child and Adolescent Inpatient Unit, Cork.
6. **Dr. Michael Drumm**, Principal Clinical Psychology Manager, Mater Child & Adolescent Mental Health Service.
7. **Mr. Philip Flanagan**, Business Analyst, HSE Planning, Performance and Business Information, Dr. Steevens' Hospital, Dublin.
8. **Ms. Sarah Houston**, Social Worker, St. John of God Lucena Clinic Child & Adolescent Mental Health Service.
9. **Ms. Sinead Kennedy**, Speech and Language Therapist Manager, Mater Child and Adolescent Mental Health Service.
10. **Dr. Susan O'Hanrahan**, Consultant Child and Adolescent Psychiatrist, HSE Mid Western CAMHS.
11. **Ms. Aoife Price**, Youth Advisor, Headstrong.
12. **Mr. Michael Walsh**, Clinical Nurse Specialist, Wexford Child and Adolescent Mental Health Service.

## DUBLIN MID LEINSTER

### 1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Family therapy feedback obtained from clients through completion of feedback forms. Feedback obtained from parents via feedback forms, following all seminars and groups, including ASD information evening, Talkability group and Handwriting seminar (Lucena Team A).

Seek feedback following group participation (children and parents) – mix of user feedback and questionnaire (Longford / Westmeath).

Completion and publication of feedback report on young people's views of mental health services (Lucena Team C).

Pre- and post- ASCEND parent group evaluation forms which are currently being audited. Qualitative feedback gathered from service users who attended the Chill Out group one month post group. Qualitative feedback from participants at Sensory Diet Workshop (Lucena Tallaght, Team 2).

Incredible Years (IY) Group Programme feedback. ASCEND Group Programme feedback. Chill Out Group feedback one month post final session. Sensory Diet Workshop feedback sought at final session (Lucena Tallaght, Team 1).

Use of individual care plans with service users. Invitation to parent of service user to present at academic meeting on the CODA on 06.02.13 (Linn Dara CAMHS, Lucan).

Care Plans: agreed on by clients and staff (Linn Dara CAMHS, St. James's & Clondalkin).

A significant amount of early half of year was spent in anticipating and organising the move of our clinic to a new purpose built building which finally happened in May 2012. Because of an urgent set of circumstances there became a need to relocate two additional teams to this new building. This placed the original plan for the Ballyfermot team in doubt. The focus therefore of senior personnel was in attempting to achieve the best possible outcome in terms of accommodation. This year as a team we rolled out the use of care plans with our patients (Linn Dara CAMHS, Ballyfermot).

ADHD Clinic satisfaction survey was completed and a report summarising the findings. We have also noted an increased volume of complaints to the service over the last year (Linn Dara CAMHS, Mid Kildare).

Not currently. User feedback occurred in the past in the team but this has been discontinued due to limited clinically available WTEs (Laois / Offaly). Implementation of the Choice and Partnership Approach (CAPA) (Linn Dara CAMHS, North Kildare).

Written feedback from meetings and groups (Lucena Wicklow – Bray).

### 1B. MEASUREMENT OF OUTCOME:

Standardised forms completed pre and post psychotherapeutic interventions. This included the Spence Anxiety Scale and Becks' Depression Inventory. Child Behaviour Checklist and Spence Anxiety Scale (Parent and Child) completed pre and post Friends Anxiety management group (Lucena Team A).

Seek feedback following group participation (children and parents) – mix of user feedback and questionnaire (Longford / Westmeath).

Use of clinical rating scales as pre and post-treatment measures (Linn Dara CAMHS, South Kildare).

Standard outcome measures as applicable to intervention delivered. Subjective outcome and Likert scales also utilised (Lucena Team C).

Outcome Measure for Chill Out Group: Strengths and Difficulties Questionnaire pre and post-group (Lucena Tallaght, Team 2).

IY Specific evaluation form. ASCEND Programme specific evaluation form. Informal verbal feedback encouraged. Chill Out Group measures included SDQ and parent/child interview. Sensory Diet Workshop specific feedback questionnaire. (Lucena Tallaght, Team 1).

Questionnaires: e.g. Conners Questionnaires, CDI, Spence Anxiety Scales, DBT specific questionnaires (before and after treatment) i.e. CORE Questionnaire and Personality Structure Questionnaire (Linn Dara CAMHS, St. James's & Clondalkin).

We are using the key performance indicators as an outcome measurement and our progress is frequently reviewed at team meetings (Linn Dara CAMHS, Mid Kildare).

Pre and post intervention assessment of teenagers attending the adolescent CBT group (Laois / Offaly).

Video recording for Incredible Years training (Lucena Wicklow – Bray).

## 1C. RESEARCH / AUDIT PROJECTS:

Twice yearly Case Audit. Audit of Service wide pre medication screening (Lucena Dun Laoghaire, < 12 years, Team 1).

Audit of screening prior to ADHD medication (Lucena Dun Laoghaire, < 12 years, Team 2).

Registrar (NCHD) conducting study on the effectiveness of sleep hygiene education in adolescents attending a CAMHS service. Audit of monitoring of antipsychotic medication (Lucena Team A).

"Achievement Goal Orientations and Emotional well-being of Adolescents with ADHD" (A. Cusack) UCD/CAMHS. "Transition from CAMHS to Adult Mental Health Services in Ireland" ITRACK Project (UCD) (Longford / Westmeath).

Waiting list initiative audit. Use of care plans audit. Participated in research/review of Multi-Agency Adolescent Forum (MAAF) initiative (Linn Dara CAMHS, South Kildare).

Multiple Research projects: transitions in services from CAMHs to Adult Mental Health Service; improving attendance rates at appointments; GP referral patterns; analysis of music therapy group; stigmatising accounts of Child and Adolescent mental health in the media; mental health and schools (Lucena Team C).

Audit of gender difference in time to ASD diagnosis. Development of research project exploring the usefulness of CBCL questionnaires and ADOS assessments in girls relative to boys, who are diagnosed with ASD (Lucena Tallaght, Team 2).

Audit: Audit of all case open more than 18 months. Audit of GP letters sent following initial assessments. Research Projects: SLT involved in Selective Mutism Parent Focus Group evaluation. Comparison study of Reactive Attachment Disorder vs. Disorganised attachment Disorder (Social Work & Psychology). Cyber bullying research (Consultant Psychiatrist). Epidemiology of psychiatric disorders in community – longterm follow up study (Consultant Psychiatrist) (Lucena Tallaght, Team 1).

Use of service individual plans (Linn Dara CAMHS, Lucan).

"Survey of Linn Dara staff re Treatment of Adolescents with Recurrent Self Harm/Borderline Personality Traits (BPD)" by Dr. Gillian Hughes, Dr. Maria Migone & Dr. Lisa Kelly, results sent to Senior Management Team. "Survey of GPs attitudes to shared care of ADHD patients" by Dr. Catherine Conway & Dr. Maria Migone, results presented to Linn Dara Journal Club. Audit of staff stress relating to BPD, results presented at Linn Dara Monthly Academic Meeting and accepted for presentation at ESCAP Conference July 2013 (Linn Dara CAMHS, St. James's & Clondalkin).

An audit programme on the number of hours spent working with young people aged 16 and over was completed. The team participated in the 'week in the life' audit (Linn Dara CAMHS, Ballyfermot).

ADHD Client satisfaction (Linn Dara CAMHS, Mid Kildare).

Team participation in the multi centre Itrack study of 16 – 18 year old. Clinical audit of developmental issues in children attending the ADHD clinics. Audit of care plans. The team is facilitating a research project on the neuro-cognitive profile of children with ADHD attending our service (Laois / Offaly).

Implementation of CAPA (Linn Dara CAMHS, North Kildare).

Use of DARE option + outcomes (Lucena Dun Laoghaire, 12 – 15 years).

## 1D. WAITING LIST OR OTHER INITIATIVES:

Drive to clear waitlist from May to September 2011. Resulted in huge number of open cases to be processed. Abrupt cessation in September with loss of Consultant: Reduction in team Clinical staff since last year: 50% in Social Work, 40% Psychiatry, 50% OT. Consultant input reduced by 50% over November 2011 (Lucena Dun Laoghaire, < 12 years, Team 1).

Drive to reduce wait list, large numbers of new cases seen May to August (Lucena Dun Laoghaire, < 12 years, Team 2).

Ongoing reviews of waiting list and screening to ensure referrals are appropriate for CAMHS service. This includes regular communication with referrers (Lucena Team A).

Active screening of Referrals (by two consultants) to ensure only appropriate referrals offered appointment/waitlisted. Children/adolescents seen from Waiting List as capacity allows (Longford / Westmeath).

Waiting list blitz. CAPA implementation. Phone calls used as screening tools to explore need for CAMHS input. Allocation of 2 new cases to each WTE on a monthly basis (Linn Dara CAMHS, South Kildare).

Ongoing Active Management of Waiting List. New Appointments Policy to Reduce DNA rates (Lucena Team C).

Running abbreviated ASCEND programme over 4-5 sessions with larger groups of parents (approx 70 parents attended all 4 sessions offered in November 2012). Sensory Diet Workshop Initiative to address significant numbers of children referred to OT with sensory difficulties; workshop offered to parents and teachers of children. Waiting time for occupational therapy reduced from 8 months to 3 months, mainly as a result of this initiative (Lucena Tallaght, Team 2).

Abbreviated ASCEND Programme (Parent psychoeducation group for those with children with ASD) – adapted to cope with demand and ensure access for all. Emergency assessment rota established Nov/Dec to cope with demand and increase in urgent referrals. Sensory diet Workshop provided due to high levels of referrals to OT of children with sensory difficulties. Has significantly reduced waiting time for intervention (Lucena Tallaght, Team 1).

Ongoing (Linn Dara CAMHS, Lucan).

Urgent referrals/semi-urgent referrals slots to ensure timely appointments, all team members involved in this new rota (Linn Dara CAMHS, St. James's & Clondalkin).

We are working as a team towards implementing CAPA. It is a concern to us that the stretch to see a new referral has increased although we still are largely meeting target of seeing cases within 12 weeks. Our clinical WTE has reduced from 5.4 in 2011 to 4.6 in 2012 (Linn Dara CAMHS, Ballyfermot).

For the first number of months of 2011, we did use a number of screeners which were sent to home and school prior to accepting a new referral. These screeners helped identify children that were experiencing difficulties in the clinical range and those whose difficulties might be best dealt with by primary care intervention rather than a specialist mental health service (Linn Dara CAMHS, Mid Kildare).

A quarterly team day looking at referral pathways, team processes and service planning. Group assessments of children referred with ADHD/developmental issues. This involves initial assessment of the child with their parents, followed by an assessment in a group setting which is observed. Groups are facilitated by the occupational therapist and another clinician. Ongoing meetings with other services/stakeholders involved in providing services for children. Use of the social and communication questionnaires as screening tools for ASD. This diagnosis is considered clinically. The purpose is for a diversion of children and families to specific ASD/disability service for further assessment. Sub team development committee set up to look at the proposed transfer of the team to an alternative site (Laois / Offaly).

CAPA model adapted and adopted (Linn Dara CAMHS, North Kildare).

Eating Disorder Clinic (Lucena Dun Laoghaire, 12 – 15 years).

Discharge policy on inactive cases. Assertiveness Group (Lucena Wicklow – Bray).

## 1E. FOR CHILDREN WITH ADHD:

Continuation of ADHD clinic. Rationalisation of screening prior to meds (Lucena Dun Laoghaire, < 12 years, Team 2).

Weekly ADHD clinic (Lucena Team A).

Specific ADHD Clinics run on regular basis. Team ethos is to offer multimodal interventions i.e. biopsychosocial model. "Emotion Regulation" Group – see later (Longford / Westmeath).

Group information session for parents on ADHD and medication (Linn Dara CAMHS, South Kildare).

ALERT Programme. Study Skills Seminars. Stream-lining of ADHD Clinic Procedures (Lucena Team C).

Sensory Diet Workshop Initiative helped parents and teachers of children with ADHD by providing education and strategies re management of overactivity and inattention (Lucena Tallaght, Team 2).



Sensory Diet Workshop provided education & strategies for parents & teachers of children with ADHD symptomatology (Lucena Tallaght, Team 1).

ADHD clinic (Linn Dara CAMHS, Lucan).

ADHD clinic, although we no longer have a Clinical Nurse Specialist (retired and not replaced) to run the ADHD clinic with NCHDs, which is a real pity as the behavioural therapy element and parenting advice/training is no longer provided (Linn Dara CAMHS, St. James's & Clondalkin).

As part of our ongoing file audit we are identifying all our ADHD cases and are beginning a team discussion on how we might work more efficiently with these children (Linn Dara CAMHS, Ballyfermot).

Developed and agreed a pathways to ADHD diagnosis on the team. ADHD satisfaction survey as describes above (Linn Dara CAMHS, Mid Kildare).

ADHD/developmental review clinic 2 – 4 per month. A parents plus programme provided for parents of children with ADHD. Social skills groups provided for children presenting with developmental difficulties. The alert programme run by our Occupational Therapist. DCD group provided by our Occupational Therapist for children with ADHD and co-morbid dyspraxia (Laois / Offaly).

None, due to lack of registrars (Lucena Wicklow – Arklow).

## 1F. GROUPS PROVIDED:

ASCEND Psychoeducational group for parents of Children with ASD. Social use of Language groups. Narrative Groups. School Transition group. OT and SLT groups in Special school setting (Lucena Dun Laoghaire, < 12 years, Team 1).

ASCEND Psychoeducation for parents of Children with ASD. Social use of Language and Narrative groups. School Transition for children moving to secondary school (Lucena Dun Laoghaire, < 12 years, Team 2).

Friends Anxiety Management groups for 9-12 year olds and 13-15 year olds. ASD Parent Information evening. Talkability group (SLT). School Transition group and Handwriting seminar (OT). Study skills seminar planned for the new year (OT) (Lucena Team A).

Social Communication Skills Groups – Talk about for Children (Boys 10-12 years). Adolescents (Boys 13-15). These groups addressed the development of social communication skills (including non verbal communication and interpretation of emotion). The goal is to expand a child's awareness of self and others. Two groups for Adolescents (13-16) based on Mindfulness and DBT. This group is based on Dialectical Behaviour Therapy, to help adolescents manage their emotions, stress, relationships and impulsive behaviours. There are 3 Blocks of 4 week groups offered to adolescents and their parents. Emotion Regulation Group, this group is designed to promote positive relationships, to increase co-operation and to reduce verbal and physical aggression in the younger age group (5-12 years). Triple P (Parent Management Training). Friends for Life Group. A 10 week CBT informed group for adolescents (13-17 years) with the goal of helping them cope with anxiety and or depression (Longford / Westmeath).

Transition to Secondary School – group for children and parents (Linn Dara CAMHS, South Kildare). CBT and mindfulness Group. ALERT Group. Talkability Group. Incredible Years. Music Group. School Transition Group. Social Skills Group. Art Group. Psychoeducation group. Handwriting seminar (Lucena Team C).

Parent groups: Incredible Years group. ASCEND parent psycho-education group (70+ service users). Sensory Diet workshop for parents and teachers of children with sensory difficulties (18 service users). Child groups: Diagnostic groups for school aged children. Chill Out group for children with emotional and behavioural regulation difficulties (11 service users). School transition group run twice for children moving up to secondary education (11 service users) (Lucena Tallaght, Team 2).

Three ASCEND Programmes (1 abbreviated and 2 full programmes, one for younger age range and one for parents of adolescents with ASD). 2 Incredible Year Parenting Programmes (1 for parents of middle year age range and other for parents of adolescents). 1 Occupational Therapy Chill Out Group. 2 Sensory Diet Workshops facilitated by OT for both parents and teachers. 1 Psychoeducation Group for children with Asperger's Syndrome. 2 School Transition Groups re: preparation for transition to secondary school (Lucena Tallaght, Team 1).

Anxiety management group planned and due to commence (Linn Dara CAMHS, Lucan).

Social Skills Group. Anxiety Management Group. Diagnostic Groups (for children with complex presentations to clarify diagnosis) with self harm/borderline personality disorder features. Coping Skills Group. SLT Pragmatic skills group (Linn Dara CAMHS, St. James's & Clondalkin).

Our speech and language therapist offers regular group interventions (Linn Dara CAMHS, Ballyfermot).

Anger therapy group facilitated by a clinical psychologist in training and a trainee social worker (Linn Dara CAMHS, Mid Kildare).

ADHD/developmental review clinic 2 – 4 per month. A parents plus programme provided for parents of children with ADHD. Social skills groups provided for children presenting with developmental difficulties. The alert programme run by our Occupational Therapist. DCD group provided by our Occupational Therapist for children with ADHD and co-morbid dyspraxia. Adolescent CBT group (Laois / Offaly).

Group for parents of children with social communication disorders (Linn Dara CAMHS, North Kildare).

O/T Group for Organisational Skills. Skills group - ASD (Lucena Dun Laoghaire, 12 – 15 years).

Parenting Group – Incredible Years. Transition to secondary School Group. Mindfulness Group (Lucena Wicklow – Bray).

ASCEND, for parents of children on the autistic spectrum. School Transition Group, for those students moving on from Primary Education. Incredible Years Parenting Groups. Teenage Asperger's Groups (Lucena Wicklow – Arklow).

## 1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Children First (Lucena Dun Laoghaire, < 12 years, Team 1).

Management training. Sensory Integration training. Children First training (Lucena Team A).

Systemic psychotherapy (one team member) (Longford / Westmeath).

STORM Training. Eating Disorders training. Working with School-Aged Children who Stammer. Solution Focused Brief Therapy. MSc course in Cognitive Behavioural Therapy for children and adolescents (Linn Dara CAMHS, South Kildare).

CBT Training. Eating Disorder Workshops. Report Writing. Child Protection. Communication. ADOS. Early Psychosis. Family Therapy. Research Skills. Mindfulness. M.Psych.Sc Psychological Science (Lucena Team C).

Research workshops, Journal Club (Lucena Tallaght, Team 2).

Limited skills training undertaken due to lack of funding. 6 MDT members attended Children's First Training. 2 Psychologists attended ADOS training (1 self-funded). 1 Psychologist & 1 SW attended Mentalisation Training in UK (self funded). Consultant Psychiatrist attended relevant CPD events (Lucena Tallaght, Team 1).

STORM Training. Individual CPD assessments. Anxiety Training Workshops. Mental Health Commission Strategy for individual planning. Academic meetings (Linn Dara CAMHS, Lucan).

STORM Training. ADOS training was undertaken by our Speech and Language Therapist (Linn Dara CAMHS, Ballyfermot).

Storm Training. Radical Open Behaviour Therapy (ROBT) – attended by some team members (Linn Dara CAMHS, Mid Kildare).

This has been seriously impacted on due to limited resources for training and an embargo on travelling expenses. One of our Clinical Nurse Specialists participated in training specific for children with eating disorders. Regular journal clubs and case presentation with the Longford/Westmeath CAMHS team (Laois / Offaly).

No training due to reduction in funding (Lucena Dun Laoghaire, 12 – 15 years).

Sensory Integration. SIPS (Lucena Wicklow – Bray).

No training due to lack of funding (Lucena Wicklow – Arklow).

## 1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Consultation / training to Medical OT, SLT, and Social work students (Lucena Dun Laoghaire, < 12 years, Team 1).

Consultation to schools. Training to Students in all disciplines (Lucena Dun Laoghaire, < 12 years, Team 2).

Lecturing and practice teaching (SW and Psychology). Medical student placements. Presentation at in-house research meetings (Lucena Team A).

Provide Liaison consultation to other medical practitioners e.g. GP, Paediatricians, Physicians, Dieticians, Community Social Work (Longford / Westmeath).

Training of the entire team in administration of the ADOS assessment. Communication skills and ASD. Presentation to General Practitioners and Primary Care Staff on the role and remit of CAMHS. Mental State Assessment (Linn Dara CAMHS, South Kildare).

Training provided to teachers, parents, students (medical, social work, psychology, OT). Consultation to MDT colleagues outside of CAMHS, voluntary groups, academic courses (Lucena Team C).

Clinic supported the clinical placement of students of nursing, OT, social work and medicine (Lucena Tallaght, Team 2).

Speech and Language Therapists (SLT): Teaching on UCD Child Mental Health Postgrad. Dip. course. SLT: Internal service consultation to other SLTs re: selective Mutism. SW: teaching on UCD H.Dip. Psychoanalytical Psychotherapy course. SW & Psychology: Internal service consultation re: Attachment Disorders. Psychiatry: Teaching to medical students. OT: Training provide to teachers & other school staff working through the Sensory Diet Workshop (Lucena Tallaght, Team 1).

Consultant and Social Worker involved in training all Linn Dara staff in STORM (a risk management intervention for suicidal patients) (Linn Dara CAMHS, St. James's & Clondalkin).

Two trainees on placements – one social work and one psychology. Trainee social worker in conjunction with Senior Social Worker provided training to Family Support Workers in relation to Asperger's Syndrome. Journal club once a month whereby staff members provided training to each other. Consultation provided on a number of local committees including the Youth mental Health Forum, The Kildare Mental Health Planning Forum, and MAAF. There is also a specific initiative in relation to a community in our catchment area that has had numerous suicides and we have a representative from the team (Psychologist) who attends and advises (Linn Dara CAMHS, Mid Kildare).

Psychology, Occupational Therapy and Art Psychotherapy students rotate regularly throughout our department. In 2012 this was extended to include post graduate medical students from the University of Limerick. Consultation provided to Community Social Work and Community Psychology. Joint assessment promoted with our colleagues in Community Psychology and cases shared and consulted on. Fortnightly participation in Paediatric Psychosocial meeting (Laois / Offaly).

Trainees, Psychology, Psychiatry, and Art Psychotherapy (Linn Dara CAMHS, North Kildare).

Handwriting Workshop. Nursing Student Placements. Social Skills training for Parents & Teachers (Lucena Wicklow – Bray).

ASCEND & Incredible Years Training (Lucena Wicklow – Arklow).

## DUBLIN NORTH EAST

### 1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Client feedback Questionnaire from New Client Assessment Clinic (Louth).

Introduction of use of Individual Service Plans at initial assessments, agreed with and signed by service users (Linn Dara CAMHS, Blanchardstown).

Quantitative analysis of clients' experience of attendance at CAMHS (Meath North).

Individualised service plans. Feedback to parents of children attending therapeutic groups (Linn Dara CAMHS, Castleknock).

As part of Service User initiative in CAMH Service – fundraising in response to service user feedback, to provide resources to clinic (Mater Team A).

In 2011 the team embarked on a joint service user involvement initiative with Jigsaw Young Ballymun, including a site visit and detailed feedback from current service users and prospective service users in the 16-18 year old age range as part of service planning for the expansion of service to this age band. In 2012, action points were extracted from this initiative and a plan was developed for the implementation of the recommendations, including seeking funding for some changes to the clinic. Mater CAMHS – Feedback forms are available to all clients in the waiting area in all clinics (+ anything else from a service level that comes from SUP group) (Mater Team B).

Ongoing service user participation initiative presented at Mater CAMHS 50th anniversary conference by clinician and service user. Feedback forms now available in all clinics and will be added to Mater CAMHS website in due course. Fundraising instigated to address some of service user's recommendations regarding environmental modifications to the waiting areas etc. Service user focus groups are planned in the future. Departmental Policy has been built on and groups working on practical arrangements at different levels (Mater Team C & D).

Team E Mater CAMHS participates in an ongoing service wide user feedback system involved in soliciting direct feedback from clients through questionnaire and through reflection and response on feedback and ongoing awareness within the service of the importance of client views. Child and Parent views on service provision are routinely sought formally and informally in the development of care plans for individual clients. Mater CAMHS Feedback forms have been introduced in the waiting areas in all clinics. As a result of service user feedback, Team E in Swords has developed an action plan to address some of the issues raised to help improve the service provided. Many of the issues raised by service users are related to structural and resource issues that are outside of the team's ability to address and which we continue to advocate for. However, a sub-committee have addressed the issues that can be addressed locally. Notice Boards placed in Waiting Areas with relevant information for Clients. Group email facility to clients has been implemented. Parent Information Evenings offered. Development of Parents Support Group. Service Development Plan developed (Mater Team E).

## 1B. MEASUREMENT OF OUTCOME:

Use of CGAS as an outcome measure (Louth).

Clinicians rating of all discharges according to outcome – week (Meath North).

Some team members attended a Linn Dara organised PCMOS Web demonstration on outcome measurement assessment. This is currently being explored by the Senior Management Team (Linn Dara CAMHS, Castleknock).

YBOCS, BOI, Conners, BA7, SDQ, Anxiety CBT questionnaires, ICDSADS, Child Outcome Rating Scales, Neurofeedback in ADHD/EEG outcome measures (Mater Team A).

Service user outcomes/satisfaction continues to be monitored (Mater Team B).

Service exploring the use of outcome measures with clients and families, including the recovery star tools, WRAP, CAPA and storm. Occupational therapy department actively using group outcome measures such as parent/child problem and goal sheets, parent stress index, outcome and session rating scales, Beck Youth Inventories and strengths and difficulties questionnaires. Also using goal attainment scaling to measure outcomes in individual cases (Mater Team C & D).

Monitoring of Waiting Areas. Qualitative measures are used pre/post Groups – Parents Plus Programme, Working Things Out Group. SLT assessments – pre/post assessment evaluation to monitor progress. The Strengths and Difficulties Questionnaire and Mental Health Recovery Star and Becks Depression Inventory are being used by members of the team (Mater Team E).

## 1C. RESEARCH / AUDIT PROJECTS:

The registrar (NCHD) in child psychiatry is currently auditing the Team's adherence to the NICE guidelines in the monitoring of side-effects of the psychostimulants with particular reference to height and weight (Monaghan).

The service introduced an audit of child protection referrals and has developed a policy for the reporting and liaison with child protection services in the local area. The Primary Cool School Anti-Bullying Programme liaised with the Child Abuse Prevention Programme for the primary anti-bullying lessons to be incorporated into the Stay Safe Programme for primary schools. This proposal was submitted to the Government anti-bullying forum. "A friend in Deed" published in Every Child Journal 2012. Paper accepted for publication "It's a girl thing" do boys engage in relational aggression. Accepted for publication in Pastoral Care in Education (Meath South).

Audit Forum with monthly meeting. Audit of use of ICTP. Audit and presentation of New Assessment (NAC). Urgent Rota Audit (Louth).

National survey of child psychiatrist's experience of prescribing Clozapine (Linn Dara CAMHS, Blanchardstown).

Audit of physical investigations for anti-psychotic prescription – Guidelines agreed. Audit of parental satisfaction with information given regarding ADHD. Audit of transfers to Adult Mental Health Service (Meath North).

Audit of ADHD clinic. Audit of 16 to 18 year olds attending CAMHS (Linn Dara CAMHS, Castleknock).

On going evaluation of WTO control group/welcome project (Mater Team A).

The team is in collaboration with UCD on a pilot research project to monitor the introduction of service delivery to 16-18 year olds in the team. There is a research project underway with a Clinical Psychology trainee to examine the relationship with referral agents in the transition to taking 16-18 year olds. The team is involved in research examining the views of past clients in relation to having a mental health diagnosis. The team carried out an audit of longterm cases with a view to improving throughput. The data from this audit have been collated and are at analysis stage. Clinical activity within the service is monitored through the Fios system within Mater CAMHS and the wider CAMHS audit systems (Mater Team B).

Audit of caseload and number of new cases seen by individual team members in 2011 and plan developed re meeting KPIs in 2012 within targets set for individual team members and review dates. Clinical activity within the service is monitored through the Fios system within Mater CAMHS and the wider CAMHS audit systems. Doctoral Psychology Trainee from TCD Trinity began research in Mater CAMHS in 2012. Looking at the Impact of Receiving a Mental Health Diagnosis in Adolescence. This is a Qualitative Study involving Focus Groups & Individual Interviews using grounded Theory (Mater Team C & D).

Wait List co-ordinator role established and continues to review and manage referrals. Team E Working document constantly reviewed and updated to keep ahead of changes. Information is now provided on community resources available to clients whilst on our waiting list. Meetings with Primary Care Team, Assessment of Need staff and Community Care Social Work Departmental liaison meetings arranged in order to improve interagency working. North Fingal Jigsaw Project – members of our team are on the Management Group and Implementation Group (Mater Team E).

#### 1D. WAITING LIST OR OTHER INITIATIVES:

Continued development of the Regional Specialist Eating Disorder Interest Group. This includes all interested parties from PCCC, Dublin North East including CAMHS teams, St. Joseph's Adolescent in-patient unit and paediatric hospitals such as Temple Street. This group secured funding from Nursing and Midwifery Continuing Educational Council to organize its second conference on Eating Disorders in children and adolescents. This took place on 14th December 2012. The training was given by Professor Rachel Bryant Waugh and covered a systemic approach to the topic. The Regional Paediatric Liaison Service which covers the 4 counties of Louth/Meath/Cavan and Monaghan is based in Our Lady of Lourdes Hospital. It continues to have monthly meetings with the Cystic Fibrosis team and the Diabetic team. Unfortunately in March 2012, the paediatric liaison nurse who worked 19 hours per week left the service. Despite considerable efforts to secure approval for replacement and support for same from ECD, ISA Manager, Head of Paediatrics in the Lourdes Hospital, approval has not been granted. This has resulted in a decrease in the service that can be offered as the only other member of the team is the Consultant who has 2 dedicated sessions per week. This is particularly disappointing given that in March 2011 approval had been given following submission of a detailed business case proposal for additional psychological support to children with chronic illness e.g. Diabetes and Cystic Fibrosis. This proposal is in line with the recommendations of the National Expert Advisory Group on Diabetes. It is also very disappointing given that after 10 years, the Paediatric Liaison Service had finally succeeded in obtaining permanent accommodation in St. Theresa's Unit which is located on the campus of the Lourdes Hospital.

The Consultant on the team continued as Chair of the Child & Adolescent Faculty of the College of Psychiatry of Ireland. Activities have included meeting with the first Minister for Children Frances Fitzgerald, meeting with the Junior Minister Kathleen Lynch, meeting with the National Clinical lead for the Clinical programmes Dr. Ian Daly and meeting with the Assistant National Director for Mental Health Martin Rogan. The Consultant on the team was also nominated by Minister Lynch to serve on the Mental Health Commission for a 5 year term. In addition to attending the Commission's monthly meetings, the Consultant was a member of the subgroup of the MHC that prepared a formal response to the Task Force report on the Child and Family Support Agency (December 2012) (Monaghan).

The service was instrumental in the introduction of a joint Journal Club for professionals working in the Adult Mental Health Services and the Child and Adolescent Mental Health Services and this Journal Club is run under the Crosslinks initiative (Meath South).

New Assessment clinic. Urgent Rota update and development. Team Planning and Development days. Jigsaw and Youth Café. Developing links with community agencies and inviting presentations (NEPs, SENO, Wilderness Project) (Louth).

Introduction of CAPA discussed and planned. Consultant sessions dedicated to development of the Jigsaw Project in Dublin 15 (Linn Dara CAMHS, Blanchardstown).

East Meath Outreach Clinic in Drogheda. Eating Disorder Special Interest Group. Family Therapy Special Interest Group (Meath North).

Waiting list blitz at regular intervals. Regular review of waiting lists to clarify issues such as consent so as to ensure efficiency re: new assessments. Regular review of team caseload so as to enable appropriate discharges and increase capacity. Several planning meetings to initiate CAPA process. Meetings with community based agencies (Linn Dara CAMHS, Castleknock).

Opt in letter sent to those waiting > 1 year (5 removed from waiting list as a result) (Cavan).

Referrals Committee. Team Co-ordination of referrals (Mater Team A).

There is an ongoing initiative to reduce numbers on the routine waiting list. There was particular team focus on the routine waiting list, including the use of a specific routine rota for appointments. This has resulted in a significant improvement with the current routine waiting list at just 8 clients waiting. The team continues to operate a policy and rota for the team-based management of risk/urgent cases. The Referrals Committee is reviewing its structure in order to manage optimum gate keeping (Mater Team B).

Audit of new cases seen in order to better meet HSE KPI's in relation to access. Introduced a priority new assessment rota in addition to the urgent new assessment rota. Occupational therapy department recruited volunteer basic grade occupational therapists to enable the department to run a range of group programmes for children and young people that would not have been possible with current resources. Occupational therapy held a range of parents evenings and parent training sessions for parents of all children on the OT waitlist (Mater Team C & D).

ADHD database maintenance. ADHD clinic under development. SLT Group for children with ADHD provided (Mater Team E).

## 1E. FOR CHILDREN WITH ADHD:

There is a standardised protocol for the assessment and diagnosis of children and adolescents presenting with ADHD and all team members have been trained in this (Monaghan).

The service provided training on ADHD, assessment, treatment and intervention for primary school resource teachers. The service developed school based interventions for child presenting with ADHD and other behavioural and emotional difficulties. This initiative involves the CAMHS therapist working in the school alongside the teacher (Meath South).

Social Skills group (Linn Dara CAMHS, Blanchardstown).

Information pack re-designed as a result of audit of parental participation with information given (Meath North).

Dedicated ADHD clinic. Also 5 module parenting course specifically for ADHD, jointly provided by Castleknock and Blanchardstown teams (Linn Dara CAMHS, Castleknock).

ADHD Medication Review Clinic – twice monthly. Neurofeedback – ADHD assessment and treatment for children and adolescents (Mater Team A).

A multi-disciplinary group was run for parents of children with A.D.H.D. (Mater Team B).

Occupational therapy department ran several ALERT programmes for self-regulation and also provide individual sessions for children with ADHD to educate them and their parents on calming strategies to promote attention and concentration (Mater Team C & D).

School Transition Group. Working Things Out Group. Parents Plus Programme - Middle Years and Adolescent Years Groups. Adolescent Mental Health Group. Separated Parents Group. SLT ADHD Group (Mater Team E).

## 1F. GROUPS PROVIDED:

The service introduced a number of three and four day workshops for adolescents based on the use of creative arts. The service introduced the use of mindfulness techniques in social skills groups for younger children (Meath South).

Anxiety group (WOW) Children age 8 – 12 modelled on CBT principles. Parenting Groups x3. Dramatherapy Group. Funfriends. Ongoing Young Persons Group (YPG) (Louth).

ADHD Parenting group (joint group with Castleknock CAMHS). Social Skills group (Linn Dara CAMHS, Blanchardstown).

Parenting groups for parents of children with ADHD. Parenting groups for parents of teenagers with ADHD. Social Skills Group for children attending CAMHS (Meath North).

Social Skills, Parenting for ADHD, Transition into Secondary school for children with diagnosis of Autism Spectrum Disorder (Linn Dara CAMHS, Castleknock).

Anger/Stress management to children in National Schools. O.T. Parent information evening. Working Things Out Group. Parents Plus Group. Schools Transition Group. Friends Group (Mater Team A).

Communication intervention groups – early adolescent expressive language and narrative/ social skills groups. Alert programme. Introduction to OT for parents and teachers. School transition programme (Mater Team B).

Multidisciplinary groups have included Parents Plus early years, middle years and adolescents groups, Working Things Out (WTO) adolescent Group and Social Skills group. Occupational therapy department involved in running teenage girls group, ALERT groups for self-regulation, school transition groups and the FUN FRIENDS group for building resilience in toddlers. In addition a Yallom Group (8 sessions) process group which supported teenagers in reflecting on their own behaviour & their connections with their peer group. Participants viewed Video footage of the group & this encouraged feedback & learning (Mater Team C & D).

School Transition Group. Working Things Out Group. Parents Plus Programme - Middle Years and Adolescent Years Groups. Adolescent Mental Health Group. Separated Parents Group. SLT ADHD Group (Mater Team E).

## 1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Weekly journal club. Monthly complex case presentations. Attendance at regional CAMHS conferences run by Louth/Meath/Cavan/Monaghan teams April 2012, June 2012 and October 2012. Three members of the team attended the Eating Disorder Special Interest Group meetings which took place on 15/5/2012, 23/10/2012, and 27/11/2012. The format is a case presentation, a journal article, and discussion of any training attended or available. One team member attended the Dublin North East Family Therapy Group on 23/2/2012, 17/5/2012, 28/6/2012, 28/8/2012, and 9/11/2012. One team member undertook Media training in February 2012. The team undertook forensic training from Dr. Kenny Ross and Maeve Murphy from the Greater Manchester West Mental Health Foundation Trust. The aims of the training were to be able to take a full history including forensic and psychosexual history, and to assess, formulate and communicate risk and needs including court reports. The Family Therapy Group organised training on "Systemic Therapy and Attachment narratives" given by Rudi Dallos and Arlene Vetere. On 10/12/2012 Dr. Helen Gogarty, Attachment and Jungian Therapist presented to the regional CAMHS teams. The title of the presentation was "Attachment, Fear and Exploration" (Monaghan).

Attachment Narrative Therapy Training for most of the team. Eating Disorders training x3. Family therapy Training. Mindfulness training. Attachment Therapy Training. Sensory Integration Training. Infant mental Health training (x2 members). Regional In-service Academic Training (3 times a year). Substance Misuse and Addiction Course. Successful completion of Diploma in Clinical Psychiatry. Supervision of Counselling and Psychotherapy (Diploma completed) (Louth).

STORM Training (training in risk management) (Linn Dara CAMHS, Blanchardstown).

Mindfulness with adolescents. Children First Training. Eating Disorders Training (CBT, Family (systemic)). Attachment narratives (Meath North).

Storm training in DSH. Updating on mental state presentations to multidisciplinary team members i.e. Psychosis, Adolescent mental health (Linn Dara CAMHS, Castleknock).

Systemic Family Therapy and Attachment Narratives. Attended by all team (Consultant, Registrar, Nurse, OT, Social Worker) 1 day training course in Ardee. Eating Disorder Workshop (attended by OT and Nurse). Eating Disorder Workshop (attended by OT and Nurse). Motivational Interviewing Workshop (attended by Nurse and OT). Introduction to CBT Workshop (attended by Nurse and OT). Children's First Update (Nurse). Child Development Course. Sensory Attachment Intervention Training (OT). Sensory Integration Module (attended by OT) (Cavan).

Certificate in counselling and psychotherapy. Motivational Interviewing. Training in BBT. Online Bio feedback (BFE) Training (Mater Team A).

Team: Introduction to DBT. Forensic assessment and intervention. Individual clinicians: UCD conference on Stigma and youth mental health. Introductory training in Dyadic Developmental Psychotherapy with Dan Hughes. Working Things Out 2 Facilitator training. Parents Plus. Young Ballymun conference – An area-based strategy to tackle child poverty. La Touche Bond Solon – Legal issues for clinical psychologists. Advanced Diploma in Professional Development: Diploma in The Therapeutic and Educational Application of the Arts. Hanen, It Takes Two to Talk, Children First, Motivational Interviewing. Clinical Audit Management Supervision (Mater Team B).

Diploma in Creative Therapy (SW). Training in Jungian Bodywork (Psychology). Diploma in counselling, psychotherapy and psychoanalysis (OT). Masters in Trans-cultural issues in Mental Health (SW). 2 Day Psychotherapy training. Attendance at Jim Wilson Conference. Members attend Academic Programme. Supervision attendance (Mater Team C & D).

Monthly Academic Programme attendance and participation. Infant Mental Health Training. Monthly Infant Mental Health Training. Short Term Memory Training. Speech & Language Mental Health Special Interest Group. Social Work CAMHS Special Interest Group. Court Room Training for Psychologists. What Can Standardised Assessments Tell Us Training.

Trauma Attachment Training. CBT for Eating Disorder Training. DBT Training. Eating Disorder Specialist Interest Group Training. ADOS Update Training. CBT Training. SR Training. Management Training (Mater Team E).

## 1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Three team members presented to 5 different secondary schools during the year. These were Our Lady's College, Castleblayney, Patrician High School, Beech Hill College, St. Macartan's College and Largy College. The title of the presentation was "Knowing Me Liking Me". At the Monaghan Regional CAMHS conference 2 team members presented on Psychological Maltreatment and Neglect – The Impact on Children's Mental health with a clinical case presentation. 1 Team member wrote and delivered a training course entitled "Assessment and Early Intervention in Eating Disorders to primary care practitioners, adult mental health and child psychiatry as part of the regional training prospectus on 14/3/2012. 1 team member developed a three day training course for the Association for Psychological Therapies entitled CBT for Eating Disorders and provided this training to an adult mental health team in the UK. This same team member has just recently been accredited formally as a trainer for the Association for Psychological Therapies. 1 team member has enrolled in the Nurse Prescribing Course organised by the School of Nursing at Dublin University (Monaghan).

The service gave a presentation on communicating with adolescents to the conference of guidance teachers in Ireland. The service developed and presented a one day training programme on the impact of parental mental illness. The service was involved in the establishment and running of the inaugural conference of the special interest family therapy group (North East CAMHS). The service liaised with schools and was involved in giving presentation during the mental health week initiative in local schools (Meath South).

Regular consultation with Social Work. Occupational Therapy student. Nursing student placements in conjunction with DKIT. Art Psychotherapy student on placement. Dramatherapy student on placement. 4 day training on Child Development led by member of team. Workshop on child and adolescent mental health to guidance counsellors. Liaison with paediatricians. Delivery of CAMHS component of induction programme for Paediatric NCHDs (Louth).

Placement for psychology students. Subspecialty training for medical students. Placement for student on visual art psychotherapy course (Linn Dara CAMHS, Blanchardstown).

Consultation to Community Care Psychology. Consultation to Child Protection Services. Consultant to Childrens' Disability Team (Meath North).

Teaching to medical and postgraduate psychiatry students. Teaching to educational psychologists (U.C.D.). Organisation of Summer School for 4th year medical students. Teaching provided to the Special Education Special Services programme in Galway. Teaching on Postgraduate Diploma in Special Educational Needs in NUI Galway (Linn Dara CAMHS, Castleknock).

In service Day hosted by Cavan CAMHS, in rotation every 3 months with Navan, Drogheda and Monaghan CAMHS (Cavan).

Sensory processing presentation. Alert Programme. Consultation to Residential Services (Client Based). Lectures to Visual Art Psychotherapy Course (Mater Team A).

Training to Masters Mental Health in Trinity College. Doctorate in Clinical Psychology training provided on Critical Psychology. Supervision of trainees in Clinical psychology, Speech and Language Therapy, Occupational Therapy and Art Therapy. Consultation and training for staff of residential units (Mater Team B).



Workshops on Play Therapy and Narrative Therapy to the D. Clin. Psych. Course in TCD. Workshop on Creative Therapy to the Social Work discipline. Occupational therapy department presented to parents groups in local school and staff in high support unit. Supervision provided to a total of 7 clinical psychology trainees. Lectures given on Narrative Therapy. Participation on Steering Group Northside Interagency Project. Supervision provided to Trainees (Mater Team C & D).

Consultation to Home Start. Parents Plus Programme training provided to Community Services. Infant Mental Health Programme – Consultation provided. Academic Programme – Presentations by Team Members. Training for Registrars in preparation for clinical examinations. Consultation to VEC's on management of self-harm. SLT Student Supervision. Lectures to DCU Students. Consultation to CAMHS Teams on Forensic Risk Assessment. Registrar and Senior Registrar Supervision (Mater Team E).

## SOUTH

### 1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Analysis of the Client Satisfaction Study in which the service participated in 2009/2010 is ongoing (parental data). Feedback to the team in relation to Young People and Parents will be given in 2013 based on preliminary analysis (North Lee East).

Focus Group for 9-12 age group (areas of focus on clinic environment, waiting room, preferred communication and feedback). Monthly review of feedback / suggestion forms formalised at Service development meeting (South Lee 3).

Routinely sought on the completion of Parents Plus Groups and Groups held for young people (North Cork).

Feedback from groups: parents and child (Waterford / South Kilkenny).

CHI questionnaire given to young persons and parents and recommendations implemented (Brothers of Charity Kerry). Verbal (Wexford South).

Pre and Post Parenting Groups (North Lee West).

Awaiting box to collect feedback forms from service users. Integrated Goal setting at intake proform and assessment to inform care plan and enhance engagement – ongoing process (South Tipperary).

CHI Service User feedback form given to families regarding their experience of the service (South Lee 2).

We have a specific service user group within wider service governance process, we have sought user views and improved material comforts within clinic waiting areas (Carlow / Kilkenny, Team 1).

### 1B. MEASUREMENT OF OUTCOME:

CORC Gaol forms are beginning to be incorporated within the team. SDQ's beginning to be incorporated as a screening measure with a view to it being used as a measurement of outcome in the future (North Lee East).

Audit of Clinical Outcome Evaluation (Cycle 1). Introduction of goal sheets for individual. Follow up meetings x2 from Evaluating Clinical Outcomes in CAMHS training – network meetings (South Lee 3).

SDQ, Eyeberg, parenting scales, Dass, parenting tasks checklists (Waterford / South Kilkenny).

CHI questionnaires. Conners ADHD Rating Scales. Goal Setting (Brothers of Charity Kerry).

Six monthly audit of services completed twice a year, which included measure of progress for each case (Brothers of Charity West Cork).

Questionnaires and clinical decision making (North Lee West).

Goal Based outcomes for parents perspective developed and commenced. Goal based outcomes for young person now ready for development. Rating scales used to measure functional improvement on ongoing basis (South Tipperary).

Pre and Post measures for individual and group work. Family outcomes measured qualitatively (South Lee 2).

We employ various measures to specific conditions for clinical use only. We do not have adequate administrative support to implement full use of such approaches (Carlow / Kilkenny, Team 1).

## 1C. RESEARCH / AUDIT PROJECTS:

Revision of Local Guidelines on Psychopharmacological management of ADHD (2012). Devising a Risk Management protocol. Audit of record keeping within the department. Audit of re-referrals to the department (North Lee East).

ADHD clinic audit – cycle 2. Audit of use of Clinical Outcome Evaluation (Cycle 1). Clinician Perspectives on Clinical Outcome Evaluation in C.A.M.H.S. (poster presented at ACAMH research meeting). Service user Involvement in CAMHS (paper presented at PSI Annual meeting). Multifamily therapy for Young people with Anorexia nervosa: A Qualitative exploration of Participants Experiences – paper presented at PSI (South Lee 3). Audit of Deliberate Self Harm (Carlow / Kilkenny, Team 2).

Clinical Audit twice a year. Candidates interviewed by Consultant for ICE award position (SEYLE - Saving and Empowering Young Lives in Europe Project). Consultant met with CIT to arrange Biomedical Research with Senior Registrar regarding ADHD/ASD. Consultant involved with medical student on ASD project. Consultant and Senior Registrar on ESCAP local organising committee (North Cork).

Corc Training. Strengths and Difficulties Questionnaires. Measurement of goals. Session feedback questions (Brothers of Charity South Lee 1).

Review of NICE Guidelines before and after prescribing medication in children with ADHD (Audit Project) (Brothers of Charity Kerry).

Two audits performed through the year (Brothers of Charity West Cork).

Phase II of ADHD Audit (Wexford South).

Infant Mental Health Awareness amongst professionals presented at college meeting. ITrack study with Prof. McNicholas – monitoring transition of graduates from CAMHS to Adult services HSE policies translated into use (South Tipperary).

Research study on the understanding of child protection teams regarding the work of CAMHS (South Lee 2).

Consultation liaison service offered by Carlow Kilkenny CAMHS to St. Luke's Hospital Kilkenny (Carlow / Kilkenny, Team 1).

## 1D. WAITING LIST OR OTHER INITIATIVES:

A Waiting List Initiative ongoing since November 2011. We have seen significant improvement the waitlist is now 4 months (North Lee East).

Volunteer scheme – 2 assistant psychologists joined on 6 month placement for work experience, and 1 x OT for 2 months. Special Interest group on Attachment and Resource library established. Waiting room handouts: Managing anger, cyber bullying, managing bullies. Updated standardised assessment form: expanded to include information on siblings, internet risk etc. Paired working (FRIENDS for anxiety). Group Protocol (South Lee 3).

No waiting list (Carlow / Kilkenny, Team 2).

One staff member (Clinical Nurse Specialist) employed through Agency from June 2012 to date, two days per week (North Cork).

Two dedicated new assessment clinic mornings for new service users from the waiting list (Brothers of Charity South Lee 1).

Waiting list initiative across teams to prioritise children waiting over 12 months for assessment (Brothers of Charity Kerry).

Wait list is small and children are seen fairly quickly (Brothers of Charity West Cork).

Initiation and implementation of Nurse Lead and provided ADHD service in the absence of a multidisciplinary team. To be presented at ESCAP 2013 in Dublin (Wexford South).

Community based Preliminary face to face triaging/risk assessments done for urgent referrals or referrals that may not be appropriate to service. Increases capacity for shorter assessments, decreased waiting times overall, meets the urgent need for risk assessment (South Tipperary).

We do not operate a waiting list and have not done so for 2 years. Referrals are discussed at weekly team meeting and either accepted and allocated and seen within 4 weeks or declined and referrer notified (Carlow / Kilkenny, Team 1).

## 1E. FOR CHILDREN WITH ADHD:

Alongside the ADHD clinic, most children attending the clinic were appointed a Key Worker in response to parental feedback about the value of continuity of care, as a point of reference for parents and team when issues arise (North Lee East).

ADHD Psychoeducation workshop – parents ADHD and success in school; introduced for those with sensory needs. Access to Life skills and parenting programmes as described below (South Lee 3).

Established ADHD clinic (Wexford North).

Psychoeducation programmes for parents of children with ADHD (Waterford / South Kilkenny).

Implementation of NICE guidelines in ADHD medication clinics. ADHD adolescent girls group (Brothers of Charity Kerry).

Establishment of ADHD Clinic. Social Skills Programme for children with ADHD provided (Brothers of Charity West Cork).

Initiation and implementation of Nurse Lead and provided ADHD service in the absence of a multidisciplinary team. To be presented at ESCAP 2013 in Dublin (Wexford South).

Planning goal based outcome measures for service users (South Tipperary).

ADHD Clinic. Webster-Stratton Incredible Years Parent Programme (South Lee 2). We have had only negative service development as the only team psychologist went on maternity leave and was not replaced. We have suspended specialist ADHD assessment clinic slots which utilised parallel assessment by psychologist and psychiatrist (Carlow / Kilkenny, Team 1).

## 1F. GROUPS PROVIDED:

Friends Group. Social Skills Group. Social and Communication Group. Two Sensory Motor Groups – June/July 2012. Mid-Years Parenting Plus. Working Things Out. Adolescent Parenting Plus (North Lee East).

Resourceful adolescent recovery and resilience group. Living with Tics' psychoeducation group for parents and YP living with Tics / Tourette's. Parent's plus– adolescent. ADHD Psychoeducation workshop– parents. Life skills x3: 8-10 years, 10-12 years, and adolescent. FRIENDS x1: midyears. Parents plus: mid years x1, adolescent x1 (South Lee 3).

Working Things Out (Adolescent Group) – Feb/Mar 2012. Parents Plus Group – Middle Years – Feb/Mar 2012. Parents Plus Group – Adolescents – Feb/Mar 2012 (North Cork).

Incredible Years Parenting Programme. Advanced incredible Years Parenting Programme. Mindfulness in Art Therapy Group – Empowerment Through Art. Parent Plus Adolescent Group (Brothers of Charity South Lee 1).

Triple P Parenting group x3. Social skills group. School Transition Group (Waterford / South Kilkenny).

Parenting Plus programmes 6 to 11 years. Social Sills Groups. Life Skills Groups. CBT Anxiety Management Groups (Brothers of Charity Kerry).

Parents Plus Programme provided (May/June 2012) and part group programme in October 2010 (which was cancelled after some weeks). Social Skills Programme provided (April/May 2012). Multi-family Group for Eating Disorders (Brothers of Charity West Cork).

None, one would need a multidisciplinary team to deliver this (Wexford South).

Friends Group for 8-12 year olds. Moving on Up Group-Sensory/Motor Skills Group. Food Group for 6-9 years. Parenting Group for teenagers. Parent's education provided by Occupational Therapy (North Lee West).

Insufficient staff and no room in building for same (South Tipperary).

Webster-Stratton basic and advanced parent programmes (South Lee 2).

None we had a team comprising of a psychiatrist, social worker and nurse therapist (Carlow / Kilkenny, Team 1).

## 1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Sensory Attachment Intervention – March 2012. Motivational Interview Training. Cognitive Behavioural Skills Training – April 2012. Self-harm Conference (1 day). Supervision Training. Mater CAMHS Training (North Lee East).

Child Attachment Interview training (Psychologist). Ongoing Masters: Family therapy, Medical Education (Social Work, Psychiatry). Evidence and Research skills in Clinical practice (OT). Assessment of Risk: DSH training day – Killarney (all team). Developmental Groups for adolescents who self harm (OT). Enhanced CBT for Depression Workshop (Psychiatry). Eating Disorder practitioner training (GOSH). Non Violent resistance training (IFT) – Social work. Tics and Tourette's training Day (ACAMH) (South Lee 3).

Eating disorders training two days CNS (Wexford North).

No funding available (Carlow / Kilkenny, Team 2).

Senior Registrar – training academic placement taken up by research days, study leave and academic days. Senior Registrar – Therapeutic Play Skills – 8 week Certificate from September to November 2012. Senior Registrar – Attachment Training with Patricia Crittenden. Senior Clinical Psychologist – Autism Conference in Galway (2 days) – Jan 2012. Senior Clinical Psychologist – monthly attendance at Infant Mental Health network meetings including literature reviews, case discussion and reflective practice. Principal Social Worker – One day Conference on Intercounty Adoption in Jan 2012. Principal Social Worker – A half day training in Cork; four mornings with local Infant Mental Health network / reflective practice. Principal Social Worker – Fire Training at Mallow Primary Healthcare Centre on 14 November 2012 attended. Principal Social Worker – IASW / Social Work Training on 19 November 2012. Office Administrator – Training and Certificate in Lean Sigma Greenbelt. Much of the above was self-funded (North Cork).

Deliberate self-harm. First Aid/C.P.R. Training. Training on the Children's Act. Ongoing Journal Clubs. Education/Training Committee Meetings – to plan training based on clinical need (Brothers of Charity South Lee 1).

Breakaway Technique Training. DBT Training. Emotion Focused Therapy Training. CAT Training (Waterford / South Kilkenny).

Risk assessment self harm training. Group psychotherapy self harm training (Brothers of Charity Kerry).

Very little. No time. Clinical work too great (Wexford South).

No funding available (North Lee West).

Decider course for group based anxiety management (by nursing). Parents Plus course (South Tipperary).

CPR training. Intellectual Disability training. Self-harm assessment and management training. 2 day conference on trauma and distress in mental health. British Association for Behavioural and Cognitive Psychotherapy conference attended included skills workshop. Children in Care assessment framework training (South Lee 2).

Art therapy, pharmacotherapy, systemic family therapy, computer training (Carlow / Kilkenny, Team 1).

## 1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Medical Students – alternate weeks during academic year (North Lee East).

Student training placements: Medical students, Clinical psychology, Social work students, (UCC) and Nursing (UCD – CBT). Formal teaching: Medical Management of Anorexia to paediatric department. Introduction to CAMHS to local GP scheme. Tics and Tourette's syndrome to D Clin Psychology Programme (UL) Induction for CAMHS registrars on Child Development, Clinical Psychology, Mental Health Act. Teachers Information session (FRIENDS). Outcome Evaluation training (D Clin Psychology UL) (South Lee 3).

Consultant is Clinical Supervisor on Reachout youth mental health website and is on the boards of Inspire Ireland and the National Suicide Research Foundation. Interface Meeting with Community Psychology Service regularly. Team representation on Early Intervention Forum Meeting. Irish College of Psychiatry Faculty Meetings attended by Consultant (North Cork).

Supervision of Nursing Student. Supervision of Art Therapy Student (Brothers of Charity South Lee 1).

OT/SLT provide training for teachers in relation to implementation of programmes (Waterford / South Kilkenny).

CAMHS O.T's delivered training on ADHD OT group interventions to Primary Schools in County Kerry. Team Members provided training to Jigsaw Project, Kerry. Consultant Child Psychiatrist provided training to GP Trainee (Brothers of Charity Kerry).

Staff have provided Journal Club to CAMHS Brothers of Charity and feedback from Multi- Family Training (Brothers of Charity West Cork).

Liaison with Social Work Department. Consultation with community care psychology and ASD service (Wexford South).

Teaching provided fortnightly to Undergraduate Medical Students. Placement provided to Social Work Students. Placement provided to Student Occupational Therapists. Induction programme for Student Occupational Therapists in College. Lecture to S.W. Students facilitated in college. Lecture to SLT students facilitated in college (North Lee West).

Ongoing on case by case basis to social work, SLT, Psychology, Paeds as required and capacity permitting. Consultation to NEPS/SENO. Participate in Adult psychiatry CPD programme. Ongoing training in Multidisciplinary Infant Mental Health study group. Clinical Supervision and training of Art Therapist, Psychology Trainees, Nursing undergraduate (South Tipperary).

Consultation with fostering research unit re mental health needs of children in care. Regular consultation with childcare manager re mental health needs of children in care. Regular consultation with Trasna Behavioural Support Services for children with intellectual disability. Consultation with Regional ASD service (arranged quarterly) (South Lee 2).

None this is not feasible with resources (Carlow / Kilkenny, Team 1).

## WEST

### 1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Group Parental Evaluation – social skills (West Galway).

Service user nominees to Youth Advisory Panel under Jigsaw Youth Mental Health Initiative. Feedback forms continue for Children and parents (Donegal South).

Service user feedback sought through questionnaires on name of service, and on signage for new premises. Draft information leaflets on service – what to expect at initial assessment appointment etc. developed for parents, children and adolescents, and circulated to service users for their feedback (South Galway).

Feedback from Adolescents admitted to Inpatient Unit. Occupational Therapy Group Feedback Forms (North Galway).

We have been unable to initiate new developments as 4.8/10 MDT posts are vacant since February 2012 (Mayo South).

Ongoing – feedback forms for children and parents. Service users sat on Youth Advisory panel for Jigsaw (Donegal North).

Service users asked for feedback informally. Team has 3.8 clinical staff – we have to focus on managing clinical risk for our 0 – 18 population (Limerick Central).

Ongoing audit of service user feedback on the quality of the current accommodation. Service user feedback on ADHD service as below (East Limerick).

Did this audit in 2011 (Clare).

### 1B. MEASUREMENT OF OUTCOME:

Social Skills self-assessment pre and post group intervention (West Galway).

CGAS scores recorded on newly assessed cases and at 6 monthly follow up (West Limerick).

Service user feedback forms. Exit Interviews. Group Feedback (Donegal South).

Becks Combination Inventory. New Edition of Connor's Questionnaires for young people with ADHD/ADD (South Galway).

Pre and Post Beck Depression Rating Scales. Pre and Post Beck Anxiety Rating Scales. Pre and Post Conners Rating Scales (for ADHD). Multi-centre Study of the client satisfaction questionnaire in CAMHS (North Galway).

We have been unable to initiate new developments as 4.8/10 MDT posts are vacant since February 2012 (Mayo South).

Various rating scales where appropriate. Service user feedback forms, analysis done. ADHD Group feedback forms (Donegal North).

Use specific questionnaires regarding patient outcome i.e. Connors, BDI. Not sufficient team members (3.8 in team) to do anything more detailed currently (Limerick Central).

Goal setting sheet developed for use with parents and children at initial assessment and used for regular review to measure treatment outcomes. Three goals are identified with the family and measured on a Likert scale (East Limerick).

## 1C. RESEARCH / AUDIT PROJECTS:

CBT Computer game. One staff member – staff attitudes to working with self harming adolescents. Audit of ASD Clinical Notes (West Galway).

CGAS scores recorded on newly assessed cases and at 6 monthly follow up (West Limerick).

Audit of Transition to Adult MHS. Research into antipsychotic use by Child Psychiatrists (Donegal South).

Open Case Chart review and updating of clinical data base (focusing on clarifying ICD-10 diagnosis, ensuring each case had an allocated key worker and that a care plan was in place) – involved all MDT members. Clinical Audit of ADHD clinic involved ADHD Clinic Team. Evaluation of the ASD diagnostic process in South Galway CAMHS. Description: This research project involves audit of the records of patient with diagnosis of ASD. Initial audit has already been conducted. Currently second audit is being carried out and the audit cycle is planned to be completed in June 2013. Second Audit follows the introduction of a new structured ASD assessment path. The result of this project is to show how the new diagnostic path has improved clinical standards in ASD evaluation in South Galway CAMHS (South Galway).

Establishment of New Audit Committee. Autism Audit - looking at assessment measures and diagnostic assessments for Autistic Spectrum Disorder. Research Project (Published) looking at attitudes of parents to ADHD Medication. Double Blind Study with Gary O'Reilly, UCD - a Computer Game for children (10-16yrs) with Internalising Disorder (North Galway).

Monitoring blood pressure changes in children receiving stimulant medication by NCHD / Consultant (Mayo South).

Compiling of electronic record for current cases. Audit of current cases over age 18 (Sligo / Leitrim / West Cavan).

Ongoing audit of Transition to Adult Mental Health Service initiative (not county wide at present). Further audit of updated care plan forms (Donegal North).

Only 3.8 team members currently not able to do this and manage clinical commitments safely – so no audit or research project done (Limerick Central).

Audit of open cases\CAMHS activity for the county and mapping of same and review of census data to assist drawing of geographical boundary and separation of north and south CAMHS teams within Mayo (Mayo North).

Audit of children with autism spectrum disorders attending the service (Roscommon / East Galway).

6 monthly audit of all open cases. Research into views of parents of children with ADHD, their view of current service and what they would like. Booklet and adolescent group developed as a result (East Limerick).

Audit of admissions to Inpatient Units. Waiting Times and Admission to Local Units (Clare).

SPACE programme: research into effectiveness of it (North Tipperary).

## 1D. WAITING LIST OR OTHER INITIATIVES:

No Waiting List. Key worker and multidisciplinary pathway assessments for ASD referrals. Provision of Multidisciplinary Report (West Galway).

Ongoing attempt to reduce (West Limerick).

Critical Incident intervention (school and community based). Joint referral strategies with Psychology and Jigsaw (Donegal South).

Standardisation of ASD assessments / development of ASD assessment protocol (incorporating 3-DI semi-structured parental interview and ADOS) (South Galway).

No Waiting List (North Galway).

We have been unable to initiate new developments as 4.8/10 MDT posts are vacant since February 2012 (Mayo South).

A week's blitz. Allocated days for new assessments (2 days per week) (Sligo / Leitrim / West Cavan).

Transition to Adult Mental Health Services protocol jointly with AMHS (Donegal North).

No waiting list – used elements of CAPA – unable to fully implement CAPA as service executive team would not agree to our team coming off several emergency rota to allow us to implement CAPA fully (Limerick Central).

Initiative to clear ASD waiting list (children with mental health problems are not wait-listed) (Roscommon / East Galway).

ADHD booklet as below. Introduction of CAPA. We have developed an East Limerick Individual Care Plan document which is used for each new assessment and reviewed on a regular basis (East Limerick).

Fifteen cases taken off our waiting list by Central team in Limerick due to seriously low levels of staffing in North Tipperary (North Tipperary).

## 1E. FOR CHILDREN WITH ADHD:

Multidisciplinary core team liaising with Speech and Language Therapist (West Galway).

Regular clinics at two locations (West Limerick).

Liaise with Community and Social Work Parenting Initiatives. Advise and support schools (regular liaison meetings) (Donegal South).

Restructuring of ADHD Clinic to improve efficiency and continuity of key workers. Team Day focusing on review of best practice guidelines for assessment and management of ADHD (NICE Guidelines, ACCAP Practice Parameters) and further development of ADHD Clinic protocol in line with same. Development of a 8 week solution focused parents support programme 'Sharing Family Life with ADHD' (including exploring ADHD's influence in family life, sharing experiences of parents and carers, building on parents strengths and skills, focusing attention on creating the family life they want, concentrating on goals and values, reflecting on positive parenting) – first programme ran September/October 2012. Audit of medical equipment available within the ADHD clinic and procurement of required items. Ongoing OT Sensory Strategies Group for parents to assist in managing ADHD (South Galway).

No Waiting List (North Galway).

ADHD clinics suspended November 2012 due to inadequate staffing levels (Mayo South).

Regular ADHD Clinics. Produce electronic records of ADHD cases. Standardised form to record progress (Sligo / Leitrim / West Cavan).

Parenting group for ADHD (Donegal North).

Specific ADHD review clinics only run by doctors so more efficient and effective, as most children are on medication and require medical review. Nurses used to be part of ADHD clinics (Limerick Central).

The team have developed a new booklet on ADHD for the parents and Children with ADHD. The content has been informed by service user feedback as a result of a research project looking at views of the service of parents of children with ADHD (East Limerick).

Regular ADHD Clinics (Clare).

ADHD clinics continue (North Tipperary).

## 1F. GROUPS PROVIDED:

Parents Plus. OT assessment Group 9 – 12 year old. Organisational Skills 12 – 15 year old. Plan for OCD Adolescent Girls Group. Social Skills Group A: 5 – 8 year old. Social Skills Group B: 9 – 12 year old. Transition to secondary school Group (West Galway).

Social experiential group for young teenage boys. Parents plus course for national school aged children. Space programme for parents whose young people self harm (West Limerick).

ADHD Parents Group. Strengthening Families Programme (Donegal South).

'Sharing Family Life with ADHD' – 8 week programme (September – October 2012). Adolescents Emotional Skills Group with DBT focus 3 week summer group with autumn follow up x2 sessions. Parenting Programmes. OT Art Group Feb/ Mar 2012 x6 sessions when children created art pieces that were then framed and displayed in the clinic. Sessions used to develop children's social skills. Sensory Strategies Group ongoing once a week for 1½ hours per a 4 week period and a follow up review after 6 weeks. ASD Summer Groups 3 summer groups ran for one week ½ day sessions for 5-6 year olds, 7-8 year olds and 10-12 year olds (South Galway).

Transition group for vulnerable children transitioning from Primary to Secondary School. Social Skills Groups. Occupational Therapy Groups. Parenting Groups including Parenting Plus Group. Autistic Spectrum Disorder Assessment Groups. Autistic Spectrum Disorder Therapy Groups (North Galway).

We have been unable to initiate new groups as 4.8/10 MDT posts are vacant since February 2012 (Mayo South).

Social Language Group for 8 years old. Transition group: Two groups – one for boys and one for girls. Social Language Group /team building in Special Needs School organised by SLT and Art Therapist (Sligo / Leitrim / West Cavan).

ADHD group as above (parents only). Body Image group with CAWT Eating Disorders Therapists and CAMHS team member (Donegal North).

Group planned for anxiety management of teenagers in October – November 2012 had to be cancelled as a member of the team was on sick leave and another one was on a career break. Groups had to be postponed (Limerick Central).

Social and communication group for children with ASD, in collaboration with local Neighbourhood Youth Project. Parenting programmes (Roscommon / East Galway).

CBT group for Adolescents who have suffered severe mental health difficulties developed as an 8 week group now running on a 2 weekly basis ongoing as a result of positive feedback and service user request. Parenting group for separated parents. Space programme run for the parents of Children and Adolescents who self harm. Parenting group for the parents of Children with ADHD. Planning a group for adolescents with ADHD in the summer months (East Limerick).

Anger Management Group, SPACE Groups for Parents, Non Violent Resistance Programme (Clare).

SPACE programme. Mindfulness based programme to prevent depression and anxiety relapse (North Tipperary).

## 1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

CBT training – 3 members of staff. Masters in Family Therapy – 1 member of staff. CBT for Eating Disorders. Substance Misuse in mental health. Evidence based practice and anxiety in adolescence. Floor-time training. ADHD training. CBT computer games for children. Post graduate in social work practice teaching and management. ADOS and 3di. Children First Training. CPR training. Standards in record keeping. Speech & Language therapy online training. (Many of these training events were self funded by staff) (West Galway).

Ongoing fortnightly in-service training for all disciplines (West Limerick).

Dialectical Behavioural Therapy. Family Therapy. CBT. Attachment Assessments (Donegal South).

Six team members completed on site Extended Training in CBT (The Association for Psychological Therapies (APT), UK). This training consisted of a 3 – day course on CBT: Key Knowledge and Skills; and 2-day courses in CBT with Depression, CBT with Stress & worry, and CBT with Anger & Irritability. Participants were also required to complete written exams and case study reports following each module. All team members completed one day training in Children's First. All team members completed one day training in Basic Life Support. Three members were trained in the administration and scoring of ADOS Module 3. Two team members attended a two day training in Dialectical Behaviour Therapy: Treating adolescents with multiple Problems (provided by Behavioural Teck, LLC). Advanced Floortime Training (Occupational Therapy). Advanced Willbarger Therapressure training (Occupational Therapy). Training in Sensory Processing Disorder. Registrar attended "Child & Adolescent Psychopharmacology Day" by College of Psychiatry in Ireland held 7th June 2012 in Lucena Clinic (South Galway).

Masters in Clinical Teaching. Diploma in Management. CBT Training. ADOS Training. 3Di Training. Drugs Addiction Training. LaTouche Bond Training – (mental health records security). Basic Life Support Training (North Galway).

Eating disorders conference attended by 2 MDT members, with key topics then presented to Camhs team at monthly Skills training event. Self help CBT conference attended by 1 MDT member, with key topics then presented to Camhs team at monthly Skills training event. Foetal Alcohol Spectrum Disorders workshops x2 attended by several MDT members. Wellness and Recovery Training ½ day workshop. Children's First Workshop attended by all medical staff. Introduction to Family Therapy workshop attended by NCHD (Mayo South).

Handwriting course – OT. Mindfulness training by Social Work. Non Violent resistance training by Social Work. Children first. Assist training by SLT (Sligo / Leitrim / West Cavan).

DBT by 3 team members (Donegal North).



CAPA. Deliberate Self Harm (Limerick Central).

Mindfulness Based Cognitive Therapy introduction 3 days – Psychologists. Crisis Prevention Intervention – Occupational Therapist. Trust in Care – All team members. Attendance Management – Social Work Team Leader and Senior Psychologist. People Management; The Legal Framework: SWTL. A Psychoanalytic Perspective on Working with Autistic, Borderline and Hard to Reach Children: Clinical Conference with Dr Anne Alvarez:- SWTL. Eating Disorder Skills Training with Rachel Bryant-Waugh; SW (Mayo North).

Three team members attended a course in Cognitive Behavioural Therapy. A nurse is undertaking diploma in Child and Adolescent Mental Health (Roscommon / East Galway).

Some individual team members have paid themselves for training as no funding available. Play therapy. DBT training. Training on treatment of Eating Disorders (East Limerick).

NVR Programme (Clare).

Survival skills required at this time (North Tipperary).

## 1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Occupational Therapy student placement x2 months. Social Work student – 2 student placement x14 weeks each. Lectures, seminars and clinical placements for medical students. CBT for eating disorders – peer training. Consultation with Paediatrics Department. Community Care Social Work Department. Inter-agency consultation on feeding disorder. (West Galway).

Involved in UL GEMS programme. Training to Specialist Registrar and SHO/REG when available (West Limerick).

In-house training (Journal Club and Case Conferences). Critical Incident Support and Intervention. Open Day with training on ADHD. Adult ADHD and other service issues. Supporting Transition to Adult MHS (Donegal South).

Medical: NUIG Medical Students seminars, lectures and clinical placements. Nursing: 1 x 6 week Community Mental Health Nurse placement (Higher Diploma, St. Angela's College, Sligo); 1 x 1 week Child & Adolescent Mental Health Nurse placement (Diploma, Trinity College, Dublin). Occupational Therapy: Masters Student from University Limerick completed 8 week full time placement in CAMHS. Social Care: Social Care – BA Social Care Studies/A.I.T 10 week placement completed in CAMHS by student. Psychology: Seminar on CAMHS provided to Clinical Psychologist PHD Programmes in NUIG. Art Therapy: Post Graduate in training from Cranford College of Art, Cork, undertook art psychotherapy weekly with patient x6 months under supervision of Senior Registrar. Clinical Case Consultation was provided to: PCCC Clinical Psychology, Jigsaw, Enable Ireland, PCCC Social Work, Paediatrics, University College Galway (South Galway).

Supervision of Social Work Students on Placement. Consultation to: YAP Workers, Brothers of Charity, Early Intervention Schools, Community Care Services. Social Work Students Seminars / Placements. Medical Students Placements / Seminars. OT Students Seminars / Teaching (North Galway).

Introduction to Camhs lectures for 4th year Medical students NUIG. Interagency Consultation to PCCC professionals, Psychology and Social Work (Mayo South).

Traveller support group by SLT. Peer supervision groups by SLT group and O.T. group. On going consultation work with S/W & School (Sligo / Leitrim / West Cavan).

In house training. Medical Student training (on placements) (Donegal North).

Medical students from UL attend team meetings and OP clinics for training, teaching also provided to medical students during psychiatry rotation. CAMHS staff members consult with primary care staff as and when requested. Team too small to set up a more regular arrangement (Limerick Central).

Presentation on the assessment of motor and processing skills given to Occupational Therapists in CAMHS Galway – Senior Occupational Therapist. Reflective Practice presentation to social workers in CAMHS National Special Interest Group by SWTL. Foetal Alcohol Spectrum Disorder Level 1&2 Training Clinical Psychologist. NOTA Conference; Re-attaching the Brain; a developmental approach to understanding trauma. Clinical Psychologist. Adolescent Intervention Model (AIM 2) – Clinical Psychologist (Mayo North).

Whole service has twice monthly multidisciplinary teaching, case presentation and journal club presentation (East Limerick).

Medical Students, Student Nurses, and Inhouse Educational Programme (Clare).

## DAY HOSPITAL

### 1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Weekly Community meeting where any queries or concerns are directly brought to the weekly MDT meeting, with action plans in place to address these. In November 2013, a focus group was held with a group of past parents whom have utilised the service. This focused on Parental experience of the service from point of referral to Discharge. The findings of same are to play a pivot role in informing future practice via our monthly service Development Meeting. Clinical Specialist in Speech and language Therapy & Clinical Nurse Specialist – Continuing to record testimony upon discharge from service from young people/carers. Young people involvement in a series of focus groups in Summer of 2012, focusing on the development and furnishing of the new Day Hospital which we moved to in November 2013. The feedback from the young people also informed the development of a new weekly timetable and also the content of the day programme (St. Joseph's Adolescent & Family Service).

### 1B. MEASUREMENT OF OUTCOME:

Recording of the CGAS continues from admission to Discharge (St. Joseph's Adolescent & Family Service).

### 1C. RESEARCH / AUDIT PROJECTS:

Audit of A.D.O.S. outcomes January – December 2012 (Dunfillan Day Hospital).

### 1D. WAITING LIST OR OTHER INITIATIVES:

All efforts were made to reduce the waiting time of young people on the waiting list by offering screening assessments. Liaison with the local CAMHS team in developing links re: the implementation of the presence of nursing staff on Mater CAMHS Teams. MDT: weekly planning and development Forum Focusing on the development/ procurement of the Adolescent Day Hospital building (St. Joseph's Adolescent & Family Service).

### 1E. FOR CHILDREN WITH ADHD:

None.

### 1F. GROUPS PROVIDED:

We ran a very successful MDT Summer programme, which involved the following groups, Resourcing group, mindfulness, a socialisation programme, a life skills programme and targeted groups to the cohort, which we had at the time. Incorporated into this were various Parent / young person mornings which involved various activities whereby parents and young engaged in these together. Throughout the year the following was offered; Arts and crafts, socialisation, Media Matters, Community Meeting, 'On your feet' (physical education group), Narrative group, and various psycho education groups targeted at the cohort throughout the year (St. Joseph's Adolescent & Family Service).

### 1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Motivational interviewing. CBT to Masters level x2 nurses, CNM3 & CMHN. Children First training x2 nurses. 1 nurse – working things out training. ADOS training. TCI training. Masters in Mental Health x1 CMHN (Dunfillan Day Hospital).

**Nursing:** Attended lecture on SPACE programme delivered in Ballymun CAMHS. CNM 2 involved in a HSE Pilot programme called 'Leading in Uncertain Times' – Delivered within St. Vincent's Hospital, Fairview. Nursing attendance at 'FINCAMH' throughout the year. Attendance at the bi monthly Eating Disorder Special Interest Group in SVHF. CNS & RPN completion of a certificate in REBT. Nursing staff completion of introduction to CBT. Nursing In-House skills training (SVHF). Lecture on Mental health issues and intellectual disabilities. All nursing staff attended a one day training programme in the application of 'Motivational Interviewing'. Fire safety training. Hand hygiene. Manual Handling. Staff training in de escalation strategies with young people in distress. Breakaway Techniques. Psychosocial interventions seminar for all staff.

**Psychology:** 7.2.12 a seminar: Recovery Focused Care in Dublin. 24.8.12 workshop: Drama therapy at the National University Maynooth. 28.9.12 workshop: developing children's creativity through dance in Belfast.

**Medical:** Courses attended from July to Nov 2012. Non-violent Crisis intervention Training – 25/07/12. BLS training – 17/08/2012. St John of Gods Research study day – 25/09/12. Managing yourself and others course D1 – 27/09/2012. Ethics in Psychiatry – 03/10/2012. Master class in Psychopharmacology – 05/10/12. CBT 3 day course – SVF Hospital. Psychiatry Winter conference 1 day 14/11/12. Managing yourself and others D2 – 23/11/12.

**SLT:** January: 19/01: National SLT in Mental Health SIG Conference Planning Activity: 1 hour. February: 15/02: National SLT in Mental Health SIG AGM and study day attendance: 7 hours. March: 22/02: Nursing Student Orientation to SLT role: 1 hour. March: 9/03: Attendance at ACAMH Emanuel Miller Conference: Speech, Language, Communication and Child and Adolescent Mental Health: 7 hours. 13/03: Visiting Clinical Psychologists' Orientation to SLT role: 45 mins. April: 17/04: Lecture Presentation: "Meeting the needs of Adolescents with Language and Communication Deficits in the context of Special Educational Need"; Church of Ireland College of Education; Post Graduate Diploma in SEN, Dublin. 3 hours. 23/04: Nursing Student Orientation to SLT role: 1 hour. 24/04: Attendance at TCD, CPD Course: What can standardised assessment tell us? 2.5 hours. May: 31/05: attendance at ACAMH committee meeting as National SLT SIG in Mental Health representative 1 hour. June: 25/06: Organisation of and attendance at ACAMH Twilight Meeting: Inequalities and Adolescent Mental Health 3 hours. August: 17/08: attendance at ACAMH committee meeting as National SLT SIG in Mental Health representative 1 hour. 28-29 / 08: Attendance at HSE Course on Group Facilitation Skills 10.5 hours. September 6-7/09: attendance at Hearing voices Training, TCD School of Nursing and Midwifery 14 hours. October: 09/10: attendance at hearing Voices network Meeting, TCD School of Nursing and Midwifery. 2 hours 24/10: Contribution to IASLT subgroup for review of Standards of SLT Practice in Mental Health Document 1 hour. 24/10: National SLT in Mental Health SIG AGM and study day attendance: 3.5 hours. November: Compilation of materials for lecture presentation to Postgraduate student in UL Masters Programme in SLT Compilation/review of literature for IASLT Standards of Practice in Mental Health Document. 15/11: Organisation and attendance at ACAMH Masterclass in Mindfulness. 7 hours. 20/11: Nursing Student Orientation to SLT role: 1 hour. 22/11 Delivery of lecture presentation to Postgrad. Student in UL Masters Programme in SLT.

**Education:** Child Protection Training: c/o Amy Thorn, Social Worker, St Joseph's (3/2/12). Seminar: 'Literacy and Numeracy for Learning' (PDST), Portlaoise. (10/05/12). BOM Training: 'The Board as Corporate Entity', Clonliffe College. (24/05/12). CPR Training: St Vincent's Hospital, Fairview (30/05/12). IATSE Conference, St Patrick's College, Drumcondra. (08/06/12). NAMBSE Conference, Tullamore, Co Offaly (18/10/12). ICT Training: Education Centre, Drumcondra; 3 Evenings – 7 hours (8/11/12, 15/11/12, 22/11/12). Special Ed. Course, Post-Grad, Church of Ireland College, Rathmines (Jan 16-27) – 12 Days. Special Ed. Course, Post-Grad, Church of Ireland College, Rathmines (April 16- 28) – 12 Days (St. Joseph's Adolescent & Family Service).

## 1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Diploma Child Mental Health UCD. UCD Medical undergraduates. UCD / DCU Nursing student placements / instruction (Dunfillan Day Hospital).

**Psychology:** 26.9.12 Talk delivered re: "Movement and Psychoanalysis" at the Psychology Department Journal Club. 3 day Hearing Voices Group facilitation course. 2 day Facilitating Groups. 2 day Skills for Safer Living Course (PISA). 3 day Schema therapy training.

**SLT:** February – May: education and SLT: Adapted Fetac 3 communications Module 1 hour weekly. June – July: Nursing and SLT: Provision of Summer of Sports/leisure group programme to young people attending DH/AIPU programme: 6 hours weekly. October: education and SLT: Lift your Language: oral-literate group: 45 minutes weekly.

**Education:** February – May: education and SLT: Adapted Fetac 3 communications Module 1hour weekly. Training from education staff to new nursing staff – October 2012.

**Nursing:** Preceptorship of Nursing students (St. Joseph's Adolescent & Family Service).

## LIAISON HOSPITAL

### 1A. SERVICE USER INVOLVEMENT / FEEDBACK:

A Quality Improvement Plan in Service User Involvement was initiated in the mental health department in December 2010/January 2011. Following this two service user panels – an adult and a youth panel were established and worked together and with department management in 2011 and into 2012. As the department is a liaison service we have integrated this work with the emerging work on Engagement in the broader hospital. In particular, two parents from the department sit on the hospital Engagement Advisory Group and two are trainers on the Informing Families Initiative. The Principal Mental Health Social Worker sits on the Hospital Engagement Steering Group and the Hospital Diversity Group. There is a specific project being run between the Deliberate Self Harm Team and Pavee Point Travellers' Centre to ensure that the Deliberate Self Harm team is more accessible for members of the Travelling community and that they are fully informed of the service. The Adult Service User panel will meet on specific issues e.g. to review feedback sheets and to input to planning on accommodation developments and on service developments as appropriate (Children's University Hospital).

### 1B. MEASUREMENT OF OUTCOME:

None.

### 1C. RESEARCH / AUDIT PROJECTS:

"Reviewing IQ and Adaptive Behaviour in children under 4 years with a diagnosis of ASD". Myra Barry, Senior Clinical Psychologist, Emma Conway, Research Psychologist and Dr. Suzanne Guerin, School of Psychology UCD (ongoing) (Children's University Hospital).

An Audit of Self Harm Presentations and service provision to the National Children's Hospital was reviewed by our team along with the Paediatricians and presented to the Irish Paediatric Association Annual Meeting. Involved in the development of the 'The National Children's Hospital Child Safety Policy'. Audit in Autistic Spectrum Disorder referrals and diagnosis and changes made to the assessment process (National Children's Hospital Tallaght).

Ongoing audit of emergency admissions for Psychiatric treatment in 2011. International multi site pharmaceutical research study for children with ADHD between the ages of 6 – 17 years. Study of Attachment disorder (REALTA) (Our Lady's Children's Hospital, Crumlin).

### 1D. WAITING LIST OR OTHER INITIATIVES:

Development of joint Occupation Therapy and Speech and Language Therapy SLT programme for children with sensory feeding restrictions. Formalised and launched Hungry Hippos programme in CUH (Children's University Hospital).

The 'Management of the agitated Child Guidelines' have been reviewed by the Paediatric Medical Advisory Committee along with the hospitals guidelines committee. Initiatives/policies in relation to the management of complex case and risk management of these inpatient cases. Developed information pack for newly diagnosed children with Autistic Spectrum Disorder (National Children's Hospital Tallaght).

### 1E. FOR CHILDREN WITH ADHD:

Due to staffing cuts in the OT department the existing OT service to this team has been cut. The assessment and intervention service was closed in May 2011 and the waiting list was closed in September 2011. Unfortunately the OT department has continued to work at a shortfall and this service remains closed until staffing is increased (Children's University Hospital).

Ongoing clinical research study evaluating the use of a new medication (Guanfacine HCl) in children & adolescents (aged 6-17) with a diagnosis of ADHD. The research team meets at least once weekly for the assessment and review of patients (Our Lady's Children's Hospital, Crumlin).

### 1F. GROUPS PROVIDED:

Space programme (support programme for parents and carers of young people where there is concern regarding self harm). Hungry Hippos Programme: Joint Occupational Therapy and Speech & language Therapy Intervention for children

with Sensory Food Aversion. Age groups 2y-3y11m and 4y-5y11m. Earlybird programme for parents of children with autism (Social work and Autism Services Co-ordinator). 2 x Circle of Security Attachment based Parent Education programmes (Social Work). Monthly support group for parents of children with challenging conditions (Social Work/Psychology). Diabetes Information Group (Social Work and Psychology). Diabetes group for young people (Social Work and Psychiatry). 2 x SPACE programmes for parents/carers of children who have self harmed (Nursing and Social Work). Parent Support Group for children with chronic illness - a 6 week support programme. Senior Educational Psychologist and Principal Mental Health Social Worker. Parent group for newly diagnosed children and adolescents with Diabetes - a 4 week support programme by Senior Clinical Psychologist. A group was run in the neurology department for adolescents (12-16 years) who had recently transitioned to secondary school. ADHD Parents Group. Parent Support Group (whose child has a chronic medical condition) (Children's University Hospital).

## 1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Cognitive Orientation to daily Occupational Performance (CO-OP) Training for children experiencing motor difficulties. Attendance at the Model Of Human Occupation (MOHO) international institute conference in Stockholm. GAS – Goal Attainment Training. Dyspraxia – Clinical Assessment and Practical Intervention for Praxis. Mindfulness Meditation – course for clinicians working in the mental health setting. MSc in Cognitive Behavioural Therapy (Anna Freud Centre). 3 day training in Mentalization Based Family Therapy (Anna Freud Centre). Play Therapy (1st Year). Introductory Year in Group Analytic Psychotherapy. Supervisory Training. Parent/Infant Attachment Training. Supervision Training – Psychological Society of Ireland. Masterclass on CBT- ACAMH, London 1 day. 9th IPSAD Science School for Health Professionals on Research Skills – 3 day workshop Istanbul, Turkey. Training in Supervision (organised by Psychological Society of Ireland). Master Class in Cognitive Behaviour Therapy: increasing access (organised by The Association of Child & Adolescent Mental Health) (Children's University Hospital).

A member of our team attended a work shop on 'Court Report Writing' (National Children's Hospital Tallaght).

ADOS – G training. Treating young people with Eating Disorders and their families. CPR/TCI (Our Lady's Children's Hospital, Crumlin).

## 1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Supervision of Msc Occupational Therapy student within Mental Health placement. OT Manager is OT Rep on Paediatrics & Neonates QCCP. Facilitation of site visits and informal peer support to OT setting up services. Inputs to Mental Health Nurse Training Day on Attachment. Child Protection Training to staff of hospital. Interview Board for Social Work Training Course UDC. Input to Group Analytic Training Course, School of Psychotherapy, St. Vincent's Hospital. "Global Initiative for PLS". IACAPAP, France, July 2012, Dr. Norbert Skokauskas, Dr. Margo Anglim, Prof. Fiona McNicholas. Presentation to Regional Psychologists in Disability on "Examining IQ and Adaptive Behaviour in young children with Autism". Symposium in Clinical Psychology at 42nd PSI Annual Conference "Living with a Sibling with Refractory Epilepsy - children's experience of having a sibling with epilepsy" – Senior Clinical Psychologist. "Parent Groups for children with Diabetes" – presentation to Psychologists and Psychotherapists in Diabetes study day – Senior Clinical Psychologist. Lectures were provided by to the nursing module for epilepsy and for the healthcare assistant airways dysfunction module during the year as requested through the nursing education centre at CUH. Irish College of Psychiatry Training Day, Dr. Brian Houlihan (Children's University Hospital).

One of the members of our team is a regular presenter on the Hospitals mandatory 'Child Protection Awareness Training' for front line staff and ancillary staff. Two of our team members attend the Hospitals 'Child Protection Committee' which is held monthly and where all child protection issues, guidelines and cases are discussed. Regular case presentations and teaching to the hospitals NCHD's and nursing staff. Regular child psychiatry based lectures to Trinity Medical Students. Regular Lectures are given to the Post Graduate Children's nurses as part of their training programme. Facilitation and supervision of the nursing degree students by our team while on 1 week placements within the child and adolescent liaison team. Facilitation of the placements of post graduate students for their experience in Children's Mental Health while undergoing a MSc Course in Child and Family Mental Health in Trinity College. Multidisciplinary Team Journal Clubs (National Children's Hospital Tallaght).

Training/teaching to clinical and lay personnel including parent and teacher information talks. Education and promotion of mental health practice to ward staff & student nurses (Our Lady's Children's Hospital, Crumlin).











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