HSE Mental Health Service

Delivering Specialist Mental Health Services **2018**

HSE Mental Health Services

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

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Acknowledgements

This report is based on the dedicated and consistent work of the staff of the mental health services nationally who compile and collate data on the activities of their teams. The data provided is essential in ensuring that information on service activity can be used to highlight the important work taking place in patient care. It is also a very valuable tool in allowing scarce resources to be allocated to areas of greatest need.

This report details the work in mental health service delivery across a range of specialist services. Mental Health Services are increasingly focused on recovery and on facilitating active partnerships between service users, carers and mental health professionals. It is important to note that the continued investment of Programme for Government funds plays a key role in allowing mental health services to develop and provide additional recovery orientated services.

The key acknowledgement is of the frontline staff in mental health services who provide high quality treatment services and on whose work this report is based. The report demonstrates the committed and consistent work of frontline staff in mental health services nationally.

The work of the Planning and Business Information (PBI) Unit of the Deputy Director General's Office for supporting the Service in the production of the Report is also noted with thanks. Finally, there were a number of individuals who gave their time to authoring sections of the Report and these include, Philip Flanagan Mental Health Service, Dr Siobhan Ni Bhrian National Clinical Advisor and Group Lead for Mental Health and Professor Harry Kennedy National Forensic Mental Health Services.

Jim Ryan
Head of Mental Health Services
October 2019

FOREWORD Specialist Mental Health Report 2018

On behalf of the HSE Mental Health Services, I am delighted to present the report on delivering Specialist Mental Health Services, 2018.

The vision for the mental health services is to support the population to achieve their optimal mental health through the following key strategic priorities:

- Ensure that the views of service users, family members and carers are central to the design and delivery of mental health services.
- Design integrated, evidence based and recovery focused Mental Health Services.
- Deliver timely, clinically effective and standardised safe mental health services in adherence to statutory requirements.
- Promote the mental health of our population in collaboration with other services and agencies including reducing loss of life by suicide.
- Enable the provision of mental health services by highly trained and engaged staff, through the development of clinical leadership at all levels in the organisation, and through fit for purpose infrastructure.

The mental health strategy is mandated by the Report of the Expert Group on Mental Health Policy - *A Vision for Change* (2006) (VFC). VFC is a progressive, evidence-based document that proposed a new model of service delivery which would be service user-centred, flexible and community based.

The strategy for mental health services is also informed by more recent documents focused on the change agenda in health services particularly the recently published cross party strategy document *"Report of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report"*. Sláintecare is a ten-year programme to transform our health and social care services and plans to:

- Promote the health of our population to prevent illness
- Provide the majority of care at or closer to home
- Create a system where care is provided on the basis of need not ability to pay
- Move our system from long waiting times to a timely service – especially for those who need it most
- Create an integrated system of care, with healthcare professionals working closely together

In Mental Health Services, we have already achieved a number of these aims in that care is community-oriented and delivered as close to home as possible, waiting lists in many parts of the country do not exceed three months for the majority of patients and we work for the most part in multi-disciplinary teams that are well integrated. We will continue to improve on these services and work with our colleagues in other specialties to develop services that are integrated across the spectrum of care needs, including physical healthcare. Mental Health Services will play a key role in delivering on the Slaintecare agenda over the next ten years.

The spectrum of services provided through the Mental Health Services which has operational and financial authority and accountability for all mental health services, extends from promoting positive mental health through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness.

The National Office for Suicide Prevention (NOSP) is a core part of the Mental Health Service and through its coordinating work will deliver on the actions arising from the Connecting for Life Policy 2015–2020.

Services are provided in a number of different settings including the service user's own home, community settings such as day hospitals and acute settings. The modern mental health service is integrated with primary care, acute hospitals, services for older people, services for people with disabilities and with a wide range of community / voluntary sector partners.

Mental Health Services are fully committed to and play an active part in internal service improvement processes both within mental health and in the wider health system reform agenda.

Regionally the 9 Community Health Organisations (CHO's) have responsibility for the delivery of community health care services in their areas of responsibility. While the Chief Officer of the CHO has 8 overall responsibility, the Head of Service for Mental Health (in conjunction with the Executive Clinical Director), is responsible for the delivery of Mental Health Services in the CHO's. The Forensic Mental Health Service operates on a national basis. Details of CHO's, Heads of Service and area population are provided in Appendix 1.

Dr Siobhan Ni Bhriain

National Clinical Lead Mental Heath

Executive Summary

The Mental Health Services and its staff are fully committed to the provision of high quality evidence based mental health. One of the key requirements for the delivery of quality services is the provision of information about the mental health services to stakeholders. This report is intended to meet this requirement for information.

Mental Health Services consistently strive not only to develop mental health services but also to collect and analyze the data generated by services to inform continuous quality improvement. The focus on data collection is both to drive service improvement and to inform service users and other stakeholders on activities in mental health services. This Report is one strand in ensuring that activity data is disseminated as widely as possible and that the good practice, and the challenges in mental health services is collected and the data used to inform and improve service delivery.

Building on the success of the annual reports which were published by the Child and Adolescent Mental Health Services up to 2013 and on the Delivering Specialist Mental Health Services Report 2014 to 2017, this 2018 report will provide an overview of the work of the specialist mental health services, describing the services delivered, detailing the resources available to the services and showing the activity of those services in 2018.

The Service faces challenges in providing detailed information about its service provision as the information systems in place are reliant on manual data collection processes and are very labour intensive. This limits the type of data provided, and creates challenges in respect of validation, verification and analysis.

The term mental health describes a spectrum that extends from enjoying positive mental health through to severe and disabling illness. Over 90% of mental health needs can be successfully treated within a Primary Care setting, with less than 10% being referred to specialist community based mental health teams.

Specialist secondary care mental health services are provided to respond to the varied and complex clinical needs of those individuals with greater need.

The mental health services provided include Community Health Organisation (CHO) based Mental Health Services which comprise acute inpatient units, community based mental health teams (Child and Adolescent Mental Health, General Adult, MHID and Psychiatry of Later Life etc.), day hospitals, out-patient clinics, continuing care settings and community residential services. There is also the

National Forensic Mental Health Service. Within the main specialties, certain sub-specialities including rehabilitation and recovery, liaison psychiatry, and perinatal psychiatry are provided.

The community-based mental health service are coordinated and delivered through Community Mental Health Teams (CMHTs), which are designed to serve the needs of particular care groups across the lifespan from childhood to later life.

Within this multidisciplinary team, a range of skilled professionals combine their unique expertise to provide integrated care to service users in the context of their local community.

Workforce

- In December 2018 there was a total of 704 staff in the Child and Adolescent Community Mental Health Teams nationally (608 Clinical). This represents 58.1% of the clinical staffing levels recommended in *A Vision for Change* which is an increase of 1.9% nationally on the 2017 position
- In December 2018 there was a total of 1,687 staff in the General Adult Community Mental Health Service (1,495 Clinical), which represents 74.8% of the clinical staffing levels recommended in *A Vision for Change*
- In December 2018, there were 355 staff (clinical 314) working in 31 Psychiatry of Later Life Service teams, which represents 60% of the clinical staffing level as recommended in *A Vision for Change*

Child and Adolescent Mental Health Services

- In 2008 there were 49 CAMHS Community Mental Health Teams. There are 70 teams in place in 2018
- There has been a 24% increase in referrals accepted between 2012 and 2018
- 11,954 new appointments were offered in 2018
- 50% of new appointments were seen within 4 weeks
- A quarter of new cases seen are aged over 16 years
- 10% of new patients did not attend their first appointment
- In 2007, 3,609 individuals were waiting to be seen; in 2018, 2,526 individuals were waiting to be seen.

General Adult Mental Health Services

- There are 114 Community General Adult Mental Health Teams
- 2% decrease in referrals accepted from 2017 to 2018
- 35,002 new appointments offered in 2018
- A fifth of new appointments seen within 1 week
- 30.9% are seen within 2 weeks & 48.9% seen within 4 weeks
- Over 1 in 5 new patients did not attend their first appointment.

Psychiatry of Later Life Mental Health Services

- In 2013 there were 22 POLL teams; there were 31 POLL teams in place in 2018
- 3.8% increase in referrals from 2017 to 2018
- 8,804 new appointments offered in 2018
- 38.5% new appointments seen within 1 week
- 81.9% new appointments seen within 4 weeks
- 2.9% new patients did not attend their first appointment.

Child and Adolescent Acute Inpatient Services

- In 2008, there were 16 CAMHS Acute Inpatient beds. By the end of 2018, there were 74 CAMHS Acute Inpatient beds
- In 2008, 25% of admissions of children were to CAMHS acute inpatient beds. By the end of 2018, 71% of admissions of children were to CAMHS acute inpatient beds
- 93% of the total bed days used by children who were admitted were in Child and Adolescent Acute Inpatient Units
- Of the 29% (84) admitted to Adult Approved Centres, 92% (77) were 16/17 years old with 38% (32) of these discharged either the same day or within 3 days and 62% (52) within a week.

Adult Acute Inpatient Mental Health Services

- There are 29 Adult Acute Inpatient units
- In line with national policy to enhance community services and reduce hospital admission in 2007, there were 16,293 admissions to acute units, in 2018, there were 12,106 admissions
- In 2007, there was a 72% re-admission rate; and in 2018 this rate reduced to 63%
- Median length of stay was 11.5 days.

Chapter 1

Supporting the Delivery of Quality Mental Health Services

Mental Health Services consistently strive to develop and progress programmes of work to deliver on its priorities. This has included the development of the Project Management Office in Mental Health Services to drive service improvement nationally.

The Mental Health Services places a major emphasis on the quality of services delivered and on the safety of those who use them. One of the key supports to the delivery of quality services is the provision of information about the mental health services to stakeholders.

All Community Health Services including Mental Health Services remain challenged in providing detailed information about service provision as the information systems in place are reliant on manual data collection processes and are very labour intensive. This limits the type of data provided, and creates challenges in respect of validation, verification and analysis. Mental Health Services are fully committed to providing ICT enabled solutions to meet its information and decision support requirements, and is working to develop a business case for a national electronic health record (EHR) that will capture the interaction between patients and clinicians and provide detailed information on activities on mental health services. Pending the implementation of an EHR Mental Health serices are committed to extracting maximum value from the current information system.

Chapters one and two of this report provide the context and describe the delivery of secondary care specialist mental health services, giving an overview of the components of service and how they

are accessed by service users. Chapter three describes the investment made in mental health services including the Programme for Government funding available to mental health since 2012.

Chapter four outlines the Mental Health Workforce in the General Adult, Psychiatry of Old Age and Child and Adolescent Mental Health Services. The workforce data provided is an average of the staffing over the given year based on these returns.

Chapters five to ten of the Report focus on the activity of the Child and Adolescent, General Adult, Psychiatry of Old Age and Forensic Mental Health Services respectively, including inpatient activity.

This information is derived from the data collected as part of the national performance indicator suite. Data relating to the activity of community mental health teams in the adult mental health services is only being collected and reported since 2014. The limitation of the available data is acknowledged and it is an objective of Mental Health services to incrementally expand the data collected and to develop its capacity for information analysis.

In that context, Chapter elevenof the Report provides an overview of the development of specialist and subspecialist mental health services including the National Forensic Mental Health Services, the development of Mental Health Intellectual Disability (MHID) services as well as Liaison Psychiatry and Rehabilitation services.

It is planned to continue to publish a report annually as a resource to the mental health services, service users, family members and carers; and other stakeholders to inform service planning, delivery, monitoring and evaluation; as part of continuous service improvement in mental health.

Overview

The World Health Organisation states that “Mental health can be conceptualized as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. The term mental health describes a spectrum that extends from enjoying positive mental health through to severe and disabling illness.

The Healthy Ireland Survey (2016) found in respect of positive mental health that:

- Higher positive mental health was reported among men than women (69.8 and 65.9 respectively)
- Similarly, higher positive mental health was reported among younger people than older people (15-24: 69.1; 75 and older: 61.6). Men aged 15-24 have higher positive mental health than women of the same age (72.9 and 65.2 respectively).

The survey found in respect of attitudes to mental health that:

- Approximately half (52%) have had some experience of people with mental health problems. These experiences are most likely through friendship (36%), with approximately a fifth having experience through work, neighbourhood or living with someone (22%, 20% and 18% respectively)
- Those aged 45 to 54 were more likely (58%) to have had experience of someone with a mental health problem than those younger or older (15-24: 51%, 75 and older: 35%)
- While at least 7 in 10 would be willing to work with, live nearby to or continue a relationship with someone who has a mental health problem (70%, 77% and 83% respectively), a lower proportion (54%) would be willing to live with someone who has a mental health problem.

Strategic Direction of Mental Health Services

Over the past thirty years, mental health services have undergone significant transformation, and in many areas have gone further in developing multi-disciplinary, community-based alternatives to hospital than any other part of the health system.

Specialist Mental Health Services have moved from large hospital based services, that were largely based on a medical model that focused on illness and treatments to a largely community based service that supports people with varying degrees of mental illness to live in their own local community setting with appropriate mental health supports. This has coincided with a fundamental re-orientation and cultural shift in service provision that has been underpinned by a philosophy that embraces the principles of recovery, which in turn reflect a pursuit of the broader social determinants of health. Recovery is best understood as being about the person in their life. It is about how they want to live a life of their own choosing to achieve self-determined goals, dreams and ambitions, with or without the presence of mental health challenges, and regardless of the severity of those challenges.

Central to the strategy of the Mental Health Services is a programmatic approach to service change improvement and reform. The programme of change attempts to address mental health as a societal issue in terms of the need to develop cross-sectoral and inter-sectoral approaches, to respond to the growth in population and growth in demand whilst also responding to changing expectations of service users and the need for increased safe and standardised services that meet regulatory requirements and emerging best practice guidance on quality improvement. Appendix 2 provides an overview of Service Improvement Initiatives taking place in mental health services.

Accessing Specialist Mental Health Services

Primary care services are usually the first point of contact for individuals when mental health problems initially present. Primary Care refers to health care delivered in local communities by GPs, Public Health Nurses, Psychologists, Social Workers and others in non-specialist settings. The first point of contact for professional support will be to the primary care system directly via a GP or other health service professional.

The Report of the Expert Group on Mental Health Policy - *A Vision for Change* (2006) and more recently the Slaintecare Report recognises a 'pivotal role' for primary care in providing mental health services.

The policy assigns a key role to GPs as 'gatekeepers' to specialist mental health services who will detect and diagnose mental health difficulties and either treat the individual or refer them to specialist services.

Where an individual presents in a crisis at an Emergency Department, a psychiatric assessment is offered and is available 24/7 as recommended in *A Vision for Change*.

Community Mental Health Teams

Community Mental Health Teams are the key component of service delivery for mental health services in all specialties.

The Community Mental Health Team is the first line of acute secondary mental health care provision and individuals are supported in their recovery in their own community.

The community-based mental health service are coordinated and delivered through Community Mental Health Teams (CMHTs), which are designed to serve the needs of particular care groups across the lifespan from childhood to later life.

Within this multidisciplinary team, skilled professionals combine their unique expertise to provide integrated care to service users in the context of their local community. The rationale for cooperative teamwork is that it increases the clinical capacity and quality of care available to service users by including a variety of professional perspectives in case formulation, care planning and service delivery.

The CMHT coordinates a range of interventions for individuals in a variety of locations, including home care treatment, day hospital, outpatient facilities and in-patient units, and interacts and liaises with specialist catchment or regional services to coordinate the care of individuals who require special consideration.

Service delivery is informed by international evidence for clinical best practice. Standards for service provision are set in consultation with the teams, health managers and service users, to ensure consistency and equity. Each team agrees flexible protocols for its clinical and operational practice, adapted to the needs and social context of its sector population.

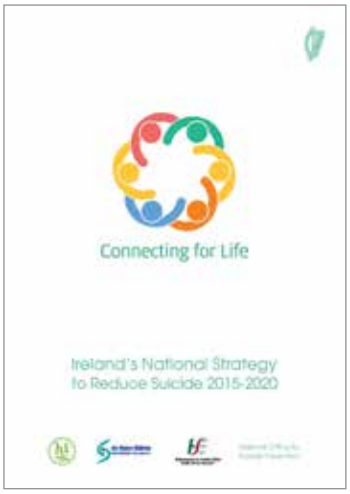
CMHTs have a number of core functions. They are there to:

- provide support and advice to primary care providers on the management of mental health problems in the community, and to facilitate appropriate referrals
- provide prompt assessment and treatment of complex mental health disorders
- provide a range of interventions for service users with specific mental health needs, drawing on evidence based and best-practice interventions, and to ensure provision and co-ordination of any additional specialist care required.

In certain situations, particularly where people are experiencing acute symptoms of a serious psychiatric disorder, this may involve a stay in an acute inpatient unit. This is in line with best practice and international evidence and following clinical assessment by a Consultant Psychiatrist. This is a key intervention in alleviating distress and in the treatment of the acute phase of the illness. Such treatment is determined by the nature, severity and complexity of presenting problems and will always be accompanied by other therapeutic interventions.

Where a person is subsequently discharged following a stay in an acute unit, their clinical condition/ diagnosis and discharge plan will inform the treatment plan for each individual. A range of interventions may be indicated in line with the agreed care plan which may include counselling, psychotherapeutic interventions, occupational therapy, social work input, behavioural therapies, self-help strategies, and other forms of support and intervention. This will be provided through the community mental health team to address the identified biological, psychological and social factors that will contribute to an improvement of a person's mental health.

The Strategic Context for Suicide Prevention



Connecting for Life, Ireland's National Strategy to Reduce Suicide, 2015-2020, was published in 2015 and continues to inform targeted suicide prevention initiatives and services across the country. The strategy was developed in line with national and international evidence associated with effective suicide prevention strategies. This evidence base continues to grow and develop across the world.

Connecting for Life is designed to coordinate and focus the efforts of a broad range of government departments, state agencies, non-statutory organisations and local communities in suicide prevention. The HSE National Office for Suicide Prevention (NOSP) has a pivotal role to play in driving the implementation of the strategy. The NOSP supports, informs, coordinates and monitors the implementation of *Connecting for Life* across the HSE, government departments, statutory agencies and NGOs (non-governmental organisations).

Key Developments in 2018

- The publication of 5 local *Connecting for Life* Action Plans – the last of 17 to be developed nationally. These local plans are all strongly aligned to the national strategy, articulating local implementation of national actions, and committing to actions that respond to particular local needs, strengths and challenges. Key responsibility for local plans lies within the HSE Mental Health and Healthcare Areas structures and the Resource Officers for Suicide Prevention (ROSPs) nationwide.
- The coordination and provision of free, evidence informed suicide and self-harm training in communities nationwide. In 2018, almost 13,000 individuals completed programmes such as safeTALK, ASIST, STORM and Understanding Self-Harm.
- Funding of almost €12m was allocated to NOSP. This represents a significant increase in investment over the last 10 years. In 2018, the NOSP invested almost €7m of this in agencies and front-line services making coordinated efforts to meet *Connecting for Life* objectives and actions, across seven overarching strategic goals. This was an increased investment, of +11% on the year previous and is reflective of the abundance of suicide prevention initiatives aligned with *Connecting for Life,* that are underway nationally.

For more information on *Connecting for Life,* its implementation and Annual Reports from the HSE NOSP, visit;

- www.connectingforlifeireland.ie
- www.nosp.ie

Connecting for Life

Chapter 2

National Mental Health Clinical Programmes

Clinical Design & Innovation

Office of Chief Clinical Officer

The introduction of clinical programmes within the mental health service supports the provision of evidence based interventions in a timely manner to service users and their families. The HSE (Clinical Design & Innovation and the Mental Health Services) in partnership with the College of Psychiatrists of Ireland have identified a number of Clinical Programmes, reflecting an on-going strategy to improve mental health services.

There are currently five Mental Health Clinical Programmes:

- National Clinical Design & Innovation for the Assessment and Management of patients presenting to the Emergency Department following Self Harm
- Early Intervention in Psychosis
- Eating Disorders
- Attention Deficit Hyperactivity Disorder (ADHD) in Adults
- Dual Diagnosis (Co-occurring Mental Illness and Substance Misuse).

1. National Clinical Programme for the Assessment and Management of patients presenting to the Emergency Department following Self Harm

This Clinical Programme aims to provide a standardised specialist response to individuals presenting with self-harm and, by so doing, reduce the numbers leaving Emergency Departments without an assessment; it aims to link people into appropriate care, involve families and friends as appropriate with an overall aim of reducing repetition of self-harm / ED visits which is known to be associated with an increased risk of completed suicide.

Impact of the clinical programme in 2018

- The programme is delivered in 24 of the 26 Adult Emergency Departments (ED) that are open 24/7.
- The national clinical lead conducted quarterly reviews with each service. Qualitative and quantitative information is used to improve quality of the service delivered.
- The data collected each month from each emergency department was refined with conjunction with Office of the Chief Information Officer (OoCIO). Data was collated and placed on HSE dashboard. Individual sites can now view their own data on a monthly basis.
- Key findings from data show an improvement in responses to patients presenting to the ED, with a higher percentage receiving written emergency care plans, next of kin involvement and follow up. The data is currently undergoing full validation and may be subject to some changes. Table 1. Outlines the data.

Table 1.
Attendances to 24 emergency department hospitals for self-harm related behaviors in 2018.*

	ED attendances 2018 n (%)
No. of Patients Presenting	12,318
Number of Patients Assessed (ED and Medical Wards)	11,107 (90.2%)
No. of patients leaving the ED Without biopsychosocial ass.	1,211 (9.8%)
Age groups	
<15	291 (2.3%)
16-17	559 (4.5%)
18-19	933 (7.6%)
20-29	3,711 (30.1%)
30-39	2,676 (21.7%)
40-49	2,050 (16.6%)
50-59	1,286 (10.4%)
60-64	333 (2.7%)
>65	441 (3.6%)
Self-harm act	
1st episode of self-harm	3,791 (30.7%)
Overdose	3,304 (26.8%)
Poison (non-accidental)	367 (3%)
Cutting	1,575 (12.8%)
Hanging	426 (3.4%)
Shooting	3 (0.02%)
Drowning	158 (1.3%)
Other	319 (2.6%)
Suicidal or Self-Harm Ideation only – no self-harm act.	5,272 (47.5%)
Emergency Care Plan (ECP)**	6,932 (75.5%)
Next of kin involvement	
Given Advice on suicide prevention**	7,798 (70.2%)
Follow up of patients assessed	
Letter sent to GP within 24 hours of discharge from ED**	8,526 (76.6%)
Number followed up with a phone call to the patient	4,155 (45.5%)

** Data is currently undergoing validation. Some figures may be changed in future.*

*** Expressed as a percentage of patients presenting minus those who are admitted to the Approved centre.*

- Two training seminars were facilitated for Clinical Nurse Specialist (CNS) clinicians in April and October. Continuing Professional Development (CPD) points were awarded from the relevant professional training bodies.

- Joint training on safety planning was facilitated with National Office for Suicide Prevention (NOSP) in October. Non-consultant hospital doctors (NCHDs) and Clinical Nurse Specialists attended this one day training.
- Funding was approved for 3 Clinical Nurse Specialist posts in Dublin Paediatric Hospitals, 4 Clinical Nurse Specialist posts across the country and 0.2 WTE nurse lead for the National Clinical Design & Innovation.
- A National Implementation Advisory Group and a Research and Audit Group were established. The composition of the groups represents all stakeholders in the process.
- A National Audit of Emergency Department Mental Health Assessment Rooms was completed and found 19/26 Assessment rooms to be fully or substantially compliant with accepted standards. This was an improvement from 2017 with 12/26 rooms fully or substantially compliant.
- Data can now be presented in graphs and this is available in real time for each service.

2. Early Intervention in Psychosis

The key overall aims of the Early Intervention in Psychosis (EIP) Clinical Programme are:
- The early detection of psychosis (first episode and at risk mental state (ARMS)) through detailed assessment and engagement.
- The provision of standardised evidence based bio psychosocial interventions in a timely manner.

Model of Care

The Model of Care was approved by the HSE National Working Group and the Clinical Advisory Group of the College of Psychiatrists' of Ireland in December 2018.

Demonstration sites

3 sites were selected from 11 applications. The sites based in South Lee Cork, Meath and Sligo/Leitrim commenced planning for the establishment of hub and spoke structure to deliver EIP services for first episode psychosis in line with agreed model of care. An agreement with TCD was signed to complete a process evaluation of the project. Sites visits were completed and a joint learning set was held.

Behavioural Family Therapy (BFT)

In 2018 monthly data was collected from individual services on the number of families offered Behavioural Family Therapy (BFT) and engaged in the process.

BFT - NATIONAL	2018	2017	2016
Number of families contacted and offered BFT	252	300	305
% uptake of BFT intervention	65%	68%	67%
Number of mental health professionals on BFT register at year end	184	191	199
Number of BFT trainers/Supervisors	26	31	31
Number of trainers who completed accreditation of work with Meriden NHS UK	2	4	2

Cognitive Behavioural Therapy for psychosis (CBTp)

The sub group met on 6 occasions and progressed the development of a Standard Operating Procedure for CBTp. The programme worked with NALA towards a plain English mark for a service user manual.

Individual Placement Support (IPS)

The sub group completed its work on developing a SOP for IPS.

3. Eating Disorders: National Clinical Programme for adults and children

Model of Care

The MOC was approved by the HSE and launched by Minister Daly TD in January 2018. The MOC is a comprehensive and evidenced based road-map for the future development of HSE eating disorder service in Ireland. It includes recommendations for regional and national delivery of ED treatment and care pathways, and outlines the resource implications.

Eating Disorders Specialist Teams

Further funding was received to commence the second year of recruitment of the regional hub community based specialist eating disorder teams for CAMHS in CHO2 and Adults/ CAMHS in CHO 4. The clinical work of the pre-existing 2017 teams in CHO 6, 7, 8 commenced in mid-2018. Although neither team was fully recruited and one had a legacy waiting list, a total of 48 new assessments of service users took place by December 2018 in addition to 16 direct consultations and service data collection commenced for the first time.

Source of referral	No of referrals	Time to assessment	No of assessments by gender	Eating Disorder Diagnosis	Outcome of assessment	Time from assessment to first therapy
22 GP 15 (MHS) 2 (ED) 2 (Liaison) 1 (Paeds) 4 (Medicine) 4 (Other)	14 urgent 34 routine 2 not accepted	11 within 7 days (22.9%) 22 within 4 weeks (45.8%) 15 within 8 weeks (31.3)	41 female 7 male	23- AN 3-BN 2 ARFID 3 BED 8 OSFED 5 UFED 4 none	41- ongoing 6- closed 2- MHS	31 (64.58 %) within 4 weeks 5 (10.4%) >8 weeks
Total = 50	50	48	48	48	48	

Developing a specialist, skilled workforce

Specialist CAMHS eating disorder teams commenced specialist Family Therapy and Multifamily Group Therapy training programmes

Building on the work of 2016 and 2017 the supervision group network of 5 Family Based Therapy groups was facilitated on a monthly basis with 66 CAMHS clinicians attending. A Family Therapy national training seminar took place in April.

Cognitive behavioural therapy – enhanced (CBTe)

CBTe group supervision provided via an external provider continued to be supported in 2018.

Bodywhys

The National Clinical Programme continued to partner with Bodywhys to deliver a 4 week family education programme called PiLaR. In 2018 the programme in collaboration with UCD and Bodywhys the programme was evaluated using a mixed method research approach.

Primary Care

Agreement was reached with UCC Student health Department to undertake a number of projects in relation to primary care and eating disorders that are in line with model of care including GP assessment, bibliotherapy and training needs planning.

4. ADHD in Adults National Clinical Programme

Attention Deficit Hyperactivity Disorder (ADHD) in the European Consensus Statement on Diagnosis and Treatment of Adult ADHD is described as one of the most common psychiatric disorders of childhood. It is now known to persist into adulthood (Kooij 2010), with approximately 65% of children continuing to have symptoms in adulthood and 15% meeting the full diagnostic criteria (Barkley 2002; Faraone 2006).

The HSE National Clinical Programme for ADHD is a joint initiative between the HSE and the College of Psychiatrists of Ireland. A Clinical Lead and Programme Manager were appointed and a key priority for the HSE National Service Plan in 2018 was the development of the clinical programme for ADHD in Adults. A working was established to develop a National Model of Care for the ADHD in Adults National Clinical Programme (aADHD NCDI). This working group was multidisciplinary with service user representation from HADD Ireland.

The three core features of the disorder are inattention, hyperactivity and impulsivity (DSMV:APA 2013). The symptoms related to inattention are those most often complained of and these include forgetfulness, difficulties in organisation particularly of routine tasks, being easily distracted by thoughts or external events.

The 2018 HSE National Service Plan included the continued development of the clinical programme for ADHD in Adults and the completion of the Model of Care. Work on the recruitment of staff for the National Clinical Programme commenced in the three demonstration sites.

The three demonstration sites are:

1. CHO3 – Limerick, Clare and North Tipperary – 1 full team
2. CHO1 – Sligo/Leitrim/Donegal – 1 half team.
3. CHO7 – Dublin – 1 full team.

National Model of Care

Based on the above, the second draft of the national Model of Care for the ADHD in Adults National Clinical Programme was sent to the College of Psychiatry of Ireland (COPI) in Q1 2018, they established a Clinical Advisory Group (CAG) to review the Model of Care (MOC). Its role is to ensure that what the Clinical Programme was recommending was in line with best evidenced based practice.

Actions undertaken 2018

1. Forging links with HADD-ADHD Ireland and with other ADHD groups in the country
2. Clinical lead presented information to date at the National ADHD HADD-Ireland meetings in Trinity College and met with service users through HADD-ADHD Ireland
3. A data set to record activity was developed and revised on implementation. This has been piloted by the only public service in Ireland based in the Sligo-Leitrim MHS and will be reviewed on commencement of the demonstration site.
4. Likewise data on treatment outcomes was considered with the aim of including these as a routine part of data collection. This data will assist in evaluating the interventions implemented by the National Clinical Design & Innovation
5. Education and training required for the ADHD in Adults service was also actively explored.

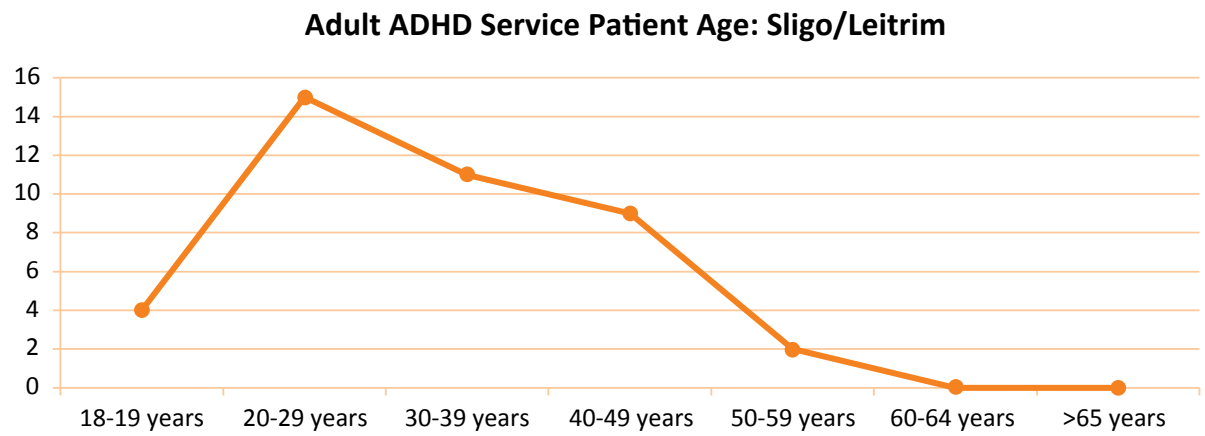
This National Clinical Programme is addressing an important clinical service need. It is known that symptomatic ADHD in adults is associated with distress and functional impairments with life-long consequences for adults with ADHD, their families and partners.

The Youth Mental Health Taskforce emphasises the need for improved and timely access to the appropriate level of mental health care with clear referral pathways across and between services for the 0-25 years age range. It particularly focuses on transition between child and adult mental health services at 18yrs, stating this requires oversight and coordination. In recognition of this, the HSE in association with the College of Psychiatrists of Ireland has included in the national MOC a pathway for transition for those approaching their 18th birthday for the assessment and management of young adults with ADHD where continued support is necessary.

Data from Sligo-Leitrim pilot 2018

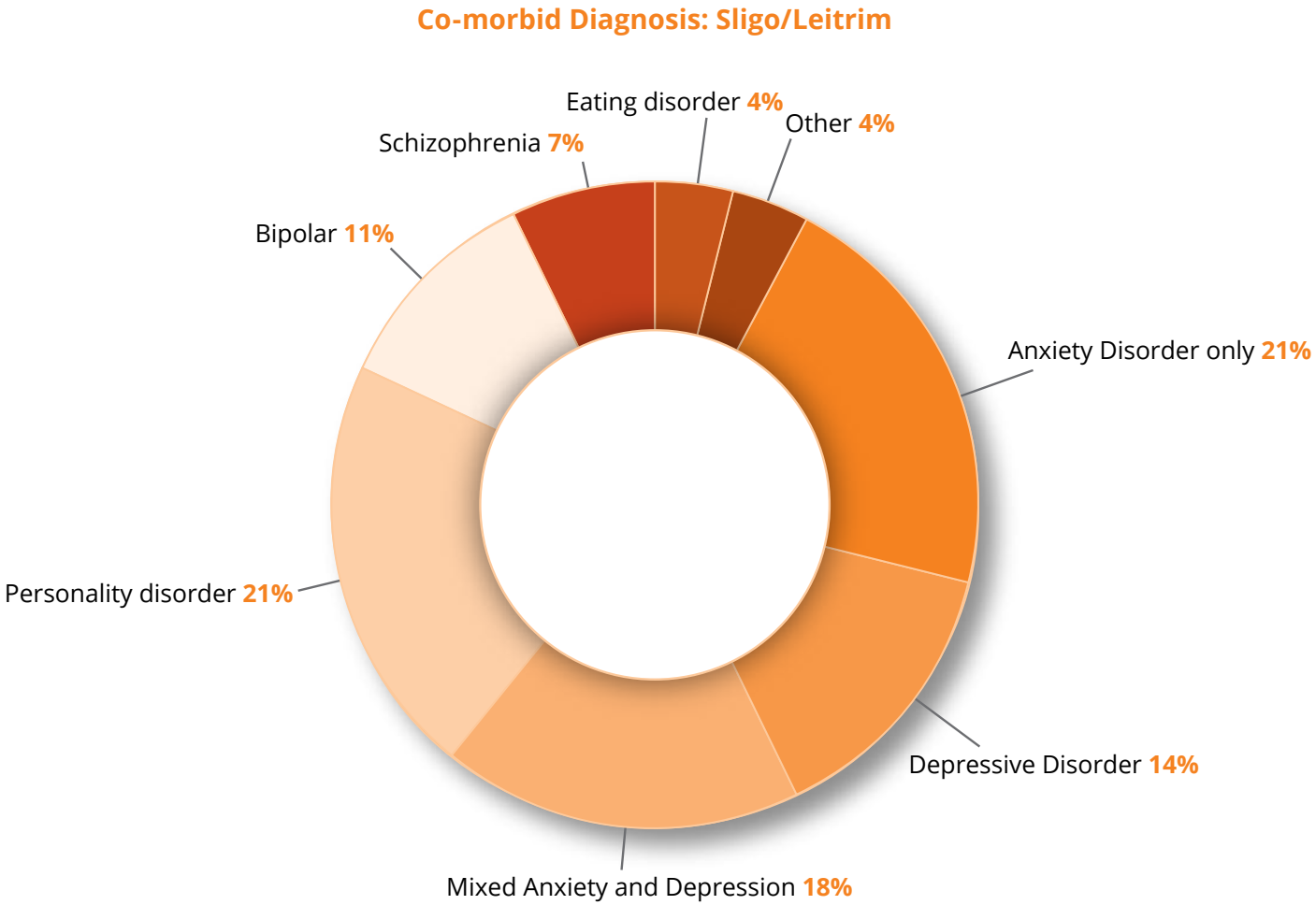
Data was collected by the consultant providing one session per week for adults with ADHD. It is shown below. The first table illustrates the numbers of adults seen within the very minimal ring-fenced clinical time available. This illustrates the need for a service for adults, typically younger adults. Table 2 shows the high rate of comorbidity with over half having anxiety and/or depression.

Table 1: Adult ADHD service Patient Age – 2018.



Note: this is based on information in 2018 from the only public service (1 consultant session /week).

Table 2: Adult ADHD service Patient main co-morbidity – 2018



Note: this is based on information in 2018 from the only public service (1 consultant session /week).

5. Dual Diagnosis (Co-occurring Mental Illness and Substance Misuse)

The National Clinical Programme for Dual Diagnosis is a joint initiative between the HSE and the College of Psychiatrists of Ireland. The term "dual diagnosis" is used to describe a person who presents with a concurrent mental health disorder and a substance use disorder (SUD).

Scope of the program

An integral part of the Dual Diagnosis (DD) NCDI is to devise a model of care that will ensure that all adolescents and adults suspected of having a moderate to severe mental illness coexisting with significant substance misuse have access to timely mental health service nationally. *A Vision for Change (AVFC)* recommends that mental health services for both adults and adolescents are responsible for providing a mental health service only to those individuals who have both substance use disorder and mental health problems. It further advocates that the Dual Diagnosis service is based on multidisciplinary provision; similar to other mental health services and that those working with such teams should have a special interest and expertise in supporting people with SUD and moderate to severe mental health problems.

The Dual Diagnosis Clinical Programme National Working Group (NWG) was established in October 2017 and has met on a monthly basis throughout 2018. It is multidisciplinary including representation from service users. The programme will also work collaboratively with other relevant clinical programmes in terms of presentations in other settings.

Terms of Reference

The aims of the programme are to develop a standardised evidence based approach to the identification, assessment and treatment of people with both moderate to severe mental illness and substance use disorder.

Tasks completed in 2018 included

- Continued the development of a national Model of Care for Dual Diagnosis services based on international best practice;
- Established links with other key clinical areas including Primary Care;
- Collaboration with the College's Clinical Advisory Group;
- Identified HSE resource requirements;
- Defined HSE staff competencies and training requirements;
- Defined a core clinical outcome dataset.

Chapter 3

Investing in Mental Health Services

This Chapter will provide an overview of the investment in mental health services including the additional allocations under the Programme for Government. Mental Health Services adopts a multi-year approach to budgeting the key aim of which is the delivery and development of safe and responsive services across the country, in line with the recommendations of VFC and with an increased use of an equitable evidence-based approach. The 2018 final budget for Mental Health, inclusive of 2012-2018 Programme for Government (PFG) funding was €917.8 million.

Between 2012 and 2018, €230m in ring-fenced new development funding was allocated under the PFG to invest in modern mental health services which are recovery focused and community- based. On a year-by-year basis, however, the HSE mental health budget has also been subject to restrictions which have applied to health expenditure generally, including downward adjustments for public service pay reductions and procurement savings similar to other HSE service areas. In addition, in 2013 and 2014 only, unspent development funds due to recruitment restrictions were used to meet unavoidable costs in other areas on a once-off basis only with all funds available on a recurring basis at the start of the next year. In total, taking account of the various movements, an additional €206.8 million increase in the Mental Health budget is identified in the HSE Service Plans between 2012 and 2018 inclusive. It should be noted that minimal/no development funding has been re-directed to non-mental health services in 2015, 2016, 2017 and 2018 as underspends in PFG allocations were used towards other mental health related costs.

Net Mental Health Funding 2012 to 2018

NET MENTAL HEALTH FUNDING 2012 TO 2018

Heading	2012 €m	2013 €m	2014 €m	2015 €m	2016 €m	2017 €m	2018 €m
Budget per NSP	711.0	737.0	766.0	791.6	826.6	867.8	917.8
Spend in MH		709.0	735.8	785.4	825.0	867.5	920.3

New Development Posts 2012 to 2018

NEW DEVELOPMENT POSTS 2012 TO 2018

Type of Post	2012	2013	2014	2015	2016	2017	2018	Total
New Development Posts:								
- Approved (WTE)	416	477	251	334	308	228	177	2,191
- Filled at Feb 2018 (WTE)	403	469	227	252.9	264.5	105.6	15	1,737
- % Filled at Feb 2018	97%	98%	90%	75%	86%	46%	8%	79%

The investments in 2012 and 2013 prioritised the addition of health and social care professionals for General Adult and CAMHS (Child and Adolescent) community mental health teams supporting the provision of multidisciplinary mental health care. It also provided investment for suicide prevention initiatives, including Suicide Resource Officers, SCAN nurses in general practice, funding of agencies providing support services etc. and the establishment of the Counselling in Primary Care service.

- 403 or 97% of the 416 development posts for 2012 have started where the remaining posts relate to largely Psychology and other specialist posts.
- 469 or 98% of the 477 development posts for 2013 have started where half of the remaining posts are medical and the other specialist posts as above.

The 2014 investment extended the focus of investment to address gaps in services for certain populations including additional Psychiatry of Old Age Community Mental Health Teams, services for those with a mental illness and intellectual disability, mental health services for the homeless, national forensics, liaison psychiatry, the physical health of mental health users as well as continuing investment in General Adult and CAMHS Mental Health Services. This was also the first year that the Mental Health Services began to invest in capacity to deliver on other enabling recommendations of Vision for Change, such as Service User/Mental Health Engagement (MHE), Quality & Service User Safety (QSUS), Clinical Programmes and programmatic service improvement.

- 227 or 90% of the 251 development posts for 2014 have started. Over one third of the remaining unfilled posts are medical and remain difficult to recruit.

The funding of €35m in 2015 has provided for continued investment in community mental health teams of €15m including over 40 MHID posts, as well as the beginning of a specialist CAMHS Eating Disorder Service and both Adult & CAMHS Forensic service of €3m. It embedded the role of service user in the mental health services, invested in clinical programmes for Early Intervention Psychosis, Self-Harm & Eating Disorders. This 2015 funding also supported the implementation of the suicide reduction policy Connecting for Life, extended Jigsaw services by a further €3m and funded the opening of the new acute beds in Cork at €1.8m and the anti-stigma Green Ribbon campaign.

- 247 or 74% of the approximate 334 development posts for 2015 have started.

The funding of €35m in 2016, in addition to the consolidation and on-going development of services arising from this previous investment in teams and acute/continuing care in-patient provision including opening of the Drogheda Unit, Station C in Galway & Deerlodge in Killarney as well as increased capacity for CHO 6 & in SJOG and Portlaoise respectively(€5m). Funding was provided that year of €3m to begin to develop responses to those with severe mental illness and challenging behaviour. 2016 funding is also providing for continued significant enhancement of primary care based counselling services (€5m) and prevention and early intervention services (e.g. Jigsaw of €5m) as well as further specialist teams for Eating Disorders of €1.5m and those who are Homeless with Mental Health issues. It is also significantly advanced investment in structures and services to deliver the planned improved service user engagement and delivery of clinical programmes in mental health. Recognising the challenges in staffing mental health services, mental health invested in increased post graduate nurses in mental health of €0.5m and additional clinical psychology training places of €0.2m. It also provided for the introduction of Peer Support Workers in mental health at €1.0m.

- 261 or 85% of the approximate 308 development posts for 2016 have started.
- 114 of these recruited posts relate to the Assistant Psychology in Primary Care initiative.

The funding of €35m in 2017 PFG has continued the multi annual plan for the enhancement of existing models of service such as community adult, child and older age teams, further development of newer models of care and teams such as MHID, Perinatal etc., as well as stabilising the overall provision of services through investment in capacity building of staffing and improved and safer service infrastructure. This includes the following specific allocations:

- Mental Health nursing capacity and retention of €5.8m through increased under graduate, post graduate and ANP capacity.
- Provision of a recurring fund to continue to invest in the safety and compliance of mental health service infrastructure of €3m.
- Considerable provision for out of hours service responses through enhancement of 7/7 services of €4.5m and 45 new posts.
- Further investment in community teams of €5m and 48 posts across all CHOs.
- Further investment in-patient services of €4.5m including Linn Dara and Deerlodge and provision for opening of new unit in Galway.

- Investment in new Clinical programmes of €1m responding to Adult ADHD.
- Enhancement of services for those who are homeless with mental illness of €1m,
- Improved responses to the physical health needs of those with mental illness of €1m,
- Funding to support delivery of the recommendations from the youth mental health task force report of €1m.
- Investment in Psychological/Talking Therapies of €1m through enhanced BFT and CIPC.
- Implementation of the agreed new Perinatal MH model of care through funding of further 15 posts at a cost of €1m.
- Funding of €1m to support reimbursement of involvement of mental health service users in design and delivery of services.
- Investment of over €1m in development of Forensic Community In-Reach teams.
- 102 or 45% of the 228 development posts for 2017 have commenced.

The recurring 2018 PFG funding of €35m with maximum expenditure in 2018 of €15m was allocated in a way that continued to build on the agreed models of care and service stabilisation priorities that had been the feature in the PFG investment programme since 2015. Further funding was agreed aligned to the headings as outlined in the above previous years providing for a further 177 posts including the following:

- Further investment in community teams of €10.5m and over 130 posts across all CHOs including CAMHs, general adult, POA, MHID and Rehabilitation.
- Enhancement of a recurring fund to continue to invest in the safety and compliance of mental health service infrastructure of €3m.
- Mental Health nursing capacity and retention of €2.4m
- Further investment of €2.5m in enhanced responses to those with severe mental illness and challenging behaviour building on 2016 investment.
- Further development of perinatal mental health services of €2m building on 2016 investment and recently launched new model of care.
- Enhanced development of Eating Disorder services of €1.5m building on 2016 investment and recently launched new model of care.
- Funding for more expensive and more effective drug therapies of €1m.
- Further provision for out of hours service responses through enhancement of 7/7 services of €1m
- Funding to support delivery of the recommendations from the youth mental health task force report of €1m
- Investment in Psychological/Talking Therapies of €1m
- Funding of €1m to develop recovery pathways for specific Forensic patients.
- The start of the required additional investment for the opening of the new National Forensic Service through allocation of €1m.
- Support NOSP through investment of €1m to meet training and research needs, coronial data management and development of outcomes indicators etc.
- Enhancement of services for those who are homeless with mental illness of €0.5m,
- Investment in Self Harm Clinical programmes of €0.5m through appointment of further self-harm nurses in both adult and paediatric hospitals.
- 13 or 7% of the 177 development posts for 2018 have commenced with the remaining posts at recruitment stage.

Allocation of Programme for Government Funding 2012 to 2018								
Funding Use	**2012 €**	**2013 €**	**2014 €**	**2015 €**	**2016 €**	**2017 €**	**2018 €**	**Total €**
Service Staff for Community Teams, Specialist services and supports (in-patient below)	22,838,338	31,129,426	20,000,000	21,520,000	12,710,000	22,330,000	18,600,000	149,127,764
Counselling in Primary Care (CIPC)	5,000,000	2,465,299						7,465,299
National Office for Suicide Prevention & CFL	3,000,000	1,000,000		2,750,000	550,000		1,000,000	8,300,000
In Patient Capacity/ Placements				6,330,000	8,970,000	4,170,000	4,000,000	23,470,000
Jigsaw & Limerick Youth Service & SHIP Counselling				3,200,000	5,300,000			8,500,000
Genio & Misc	2,102,662							2,102,662
Enhanced Teamworking	1,547,000							1,547,000
Advancing Recovery & Service User Engagement				1,000,000		1,000,000	500,000	2,500,000
Information Systems		405,275			1,500,000			1,905,275
Clinical Programs	402,000				270,000	1,000,000	500,000	2,172,000
Specialist Rehabilitation Services					3,000,000		2,500,000	5,500,000
Homeless funding					2,000,000	1,000,000	500,000	3,500,000
Stigma Reduction				200,000				200,000
Advocacy in Mental Health	110,000							110,000
Minor Works fund to meet compliance and safety requirements						3,000,000	3,000,000	6,000,000
Clinical Psychology Training & Post Graduate/Under Graduate Nursing					700,000	2,500,000	2,400,000	5,600,000
New Forensic Service							1,000,000	1,000,000
Drugs & Medicines increased costs for Improved Regimes							1,000,000	1,000,000
Total	35,000,000	35,000,000	20,000,000	35,000,000	35,000,000	35,000,000	35,000,000	230,000,000

2012–2018 Investment In Posts Specifically For Community Teams

Teams	2012 WTE	2013 WTE	2014 WTE	2015 WTE	2016 WTE	2017 WTE	2018 WTE	Total WTE
General Adult Community Mental Health Teams	254	180	38	88	-	123	46.5	729.5
Child and Adolescent Community Mental Health Teams	150	80	53	42	21	33	85.3	464.3
POA Community Mental Health Teams	-	100	25	30	-	4	15.5	174.5
MHID Community Mental Health Teams	-	40	24	41	-	4	19	128
Forensic Teams (In-reach, MHID and CAMHS)	-	28	-	39	-	11		78
Homeless MH Teams	-	-	7	-	-	15		22
Liasion Teams	-	-	10	5	-	-		15
In-Patient & Continuing Care	-	-	-	31	100	23		154
Primary Care Assistant Psychology Under 18s	-	-	-	-	134	-	-	134
Mental Health Engagement	-	-	-	-	18	-	-	18
Physical Health	-	-	-	8	-	8		16
Traveller Mental Health	-	-	-	9	-	-		9
Peer Support	-	-	-	-	20	-		20
Transgender funding						2	1	3
Clinical Programmes	-	-	-	32	-	15	7.2	54.2
ICT/E-Rostering	-	-	-	23	10	-		33
Sub Total	404	428	157	348	303	238	174.5	2,052.5
National Support/NOSP/CFL	12	49	94	28	2	2	2	189

Chapter 4

Mental Health Workforce

As can be seen from the previous Chapter Mental Health Services have made significant investment to enhance and develop its workforce. Skilled and well trained staff are a key requirement for the treatment of mental illness.

The workforce data used in this chapter is an average of the staffing over the year based on the returns from the Mental Health Services to the Planning and Business Information Unit. The figures relate to the Child and Adolescent Mental Health Services, General Adult Mental Health Services and Psychiatry of Later Life Mental Health Services and reflect direct staffing. These figures do not include posts filled through agency and overtime.

Child and Adolescent Mental Health Services Workforce

A Vision for Change (2006) recommends that there should be two Child and Adolescent Community Mental Health teams for each 100,000 population with individual Child and Adolescent Community Mental Health Teams including 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.

A survey of the staffing of the Child and Adolescent Mental Health Services including Community CAMHS teams, Day service programmes, Hospital Liaison teams, and Inpatient services was carried out at various stages in 2018. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in CAMHS services in 2018 was 952.5.

Vision for Change Recommendations v. Actual Staffing (2018)

CAMHS Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2018
Staff Community MHTs	1 : 50,000	79	70	1,238	704.5
Adolescent Day Service Teams		16	2[1]		13.56
Hospital Liaison MHTs	1 : 300,000	16	3	208	36.26
Total		111	77	1,446	789.22
Inpatient Services				4 Units	198.2
				Total Staff	952.5

[1]*The Adolescent Day services at the St. John of God Lucena clinic in Rathgar Dublin closed in late 2017 for operational reasons and the staff were reallocated within the Child & Adolescent Mental Health Services. The Lucena clinic continue to try to provide services in our outpatient teams such as Dialectical Behaviour Therapy (DBT) work etc. but the staffing is from the CAMHS outpatient teams only.*

For operational reasons it was necessary to review the operation of the Linn Dara Day service in the summer of 2018 due to staffing availability. It was decided to reconfigure the Day Service so as to provide an enhanced educational programme and other therapeutic interventions, both individual and family based, in line with the identified needs of the patient group.

Staffing of CAMHS Acute Inpatient Units

The total number of staff at the four inpatient units was 198.2 (December 2018). The table below shows the breakdown of the inpatient staffing by profession between 2014 and 2018.

Staffing of Child and Adolescent Inpatient Units by profession 2014-2018

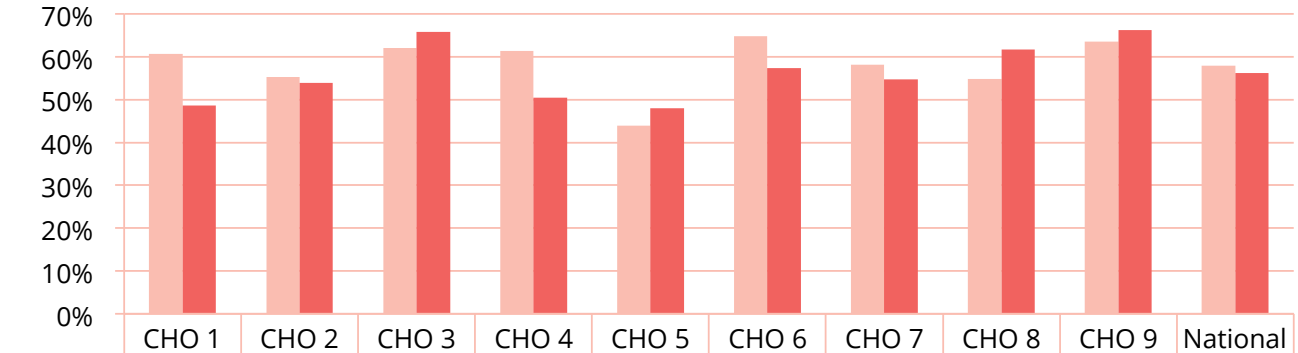
	2014	2015	2016	2017	2018
Consultant Psychiatrist	5.10	6.00	6.40	6.40	7.40
Senior Registrar	3.00	4.00	2.50	4.00	5.00
Registrar/SHO	3.00	4.00	9.50	7.00	6.00
Other Staff (Interns)					2.00
Director of Nursing	1.00	1.00	1.50	3.00	1.40
Assistant Director of Nursing / CNM III	2.70	4.70	4.20	6.70	6.20
CNM II	6.00	12.00	11.00	12.00	11.00
CNM I	7.50	7.50	7.50	8.00	8.00
Clinical Nurse Specialist	2.00	2.50	3.50	3.00	3.50
Staff Nurse	94.00	84.50	84.50	90.00	84.60
Clinical Psychologist	4.00	3.81	6.61	6.41	6.60
Occupational Therapist	4.30	2.80	4.30	4.20	4.00
Speech and Language Therapist	2.70	2.90	2.30	1.00	2.00
Social Worker	6.30	6.20	6.30	6.80	6.50
Childcare Worker	1.00	1.00	2.00	2.00	1.00
Dietician	1.70	1.20	1.70	2.10	2.20
Clinical Specialist Dietician					1.00
Physiotherapy	0.00	0.30	0.00	0.00	0.00
Other Therapist	0.00	0.00	0.00	0.00	0.00
Administrative Support staff	7.75	7.75	6.50	8.50	7.50
Non-Nursing Care Assistant/Multi Task Attendant	9.00	9.00	11.00	11.00	9.00
Non-Nursing Chef (Household)	1.00	1.00	1.00	1.00	1.00
Non-Nursing Catering Assistant	2.50	5.19	5.69	3.00	3.00
Non-Nursing Driver/Porter	2.00	2.00	4.00	4.00	5.00
Teaching Staff	4.00	10.00	11.30	12.30	12.70
Teaching Support Staff	2.00	2.00	3.60	3.60	1.60
Other Staff	0.00	2.00	2.40	2.00	0.00
Total	172.55	183.35	199.30	207.51	198.20

Staffing of CAMHS Community Mental Health Teams

In Ireland, 25% of the population is under 18 years of age and in December 2018 there was a total of 704.5 staff in the Child and Adolescent Community Mental Health Teams nationally (608.5 Clinical). This represents 58.1% of the clinical staffing levels recommended in *A Vision for Change* which is an increase of 1.9% nationally on the 2017 position. The largest increase was in CHO 1 at 11.8%.

In the period from 2011 to 2018, arising from the Programme for Government investment in CAMHS services from 2012, staffing in the community CAMHS teams had a net gain of 240.24 whole time equivalents over this period, exclusive of staff leaving and retiring etc.

Community CAMHS Teams Staffing vs. VFC recommendations in 2017 – 2018

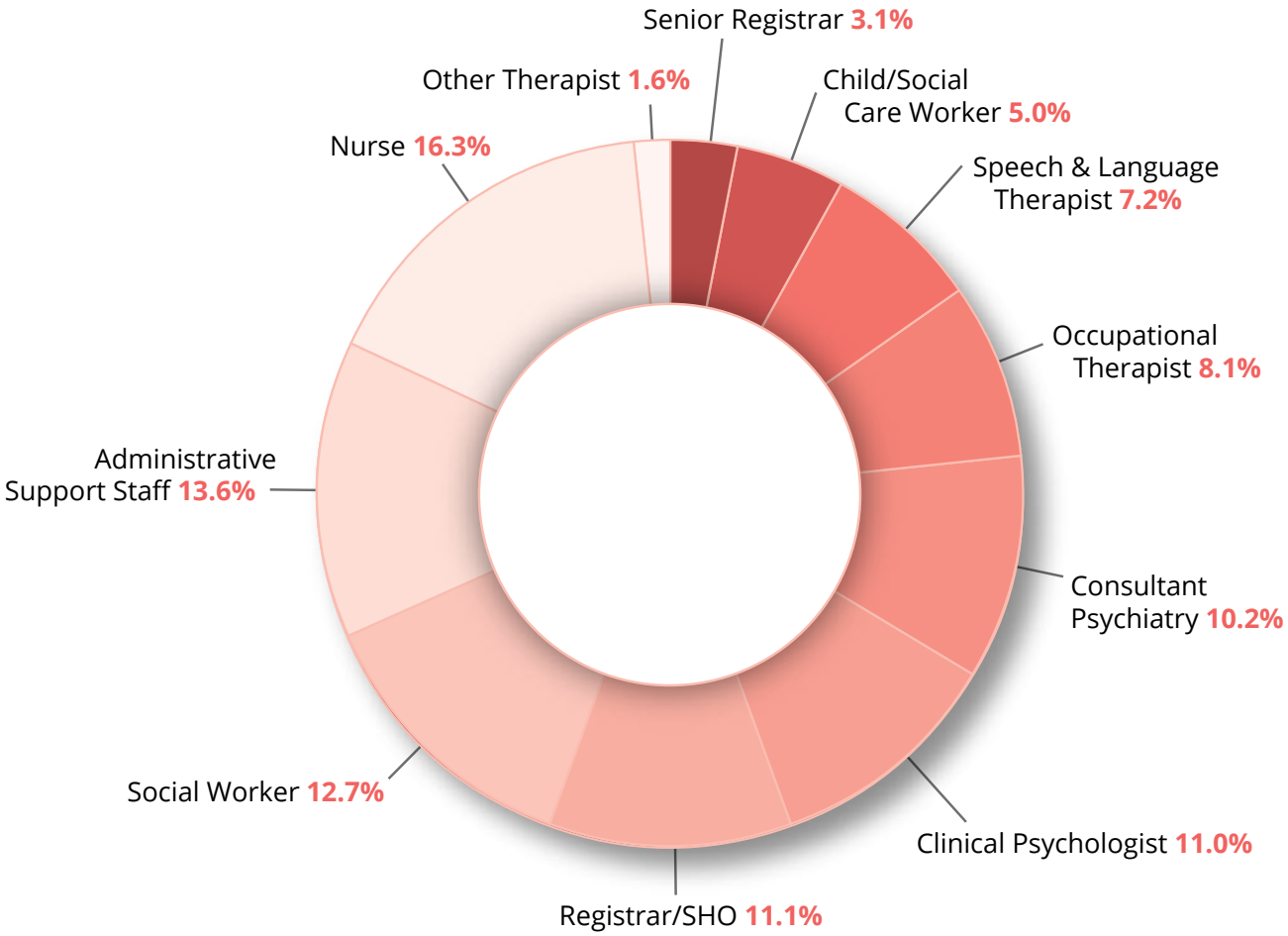


	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2018	60.6%	55.6%	62.1%	61.3%	44.2%	64.8%	57.8%	54.9%	63.1%	58.1%
2017	48.7%	53.9%	65.3%	50.5%	48.0%	57.3%	54.7%	61.1%	66.3%	56.2%

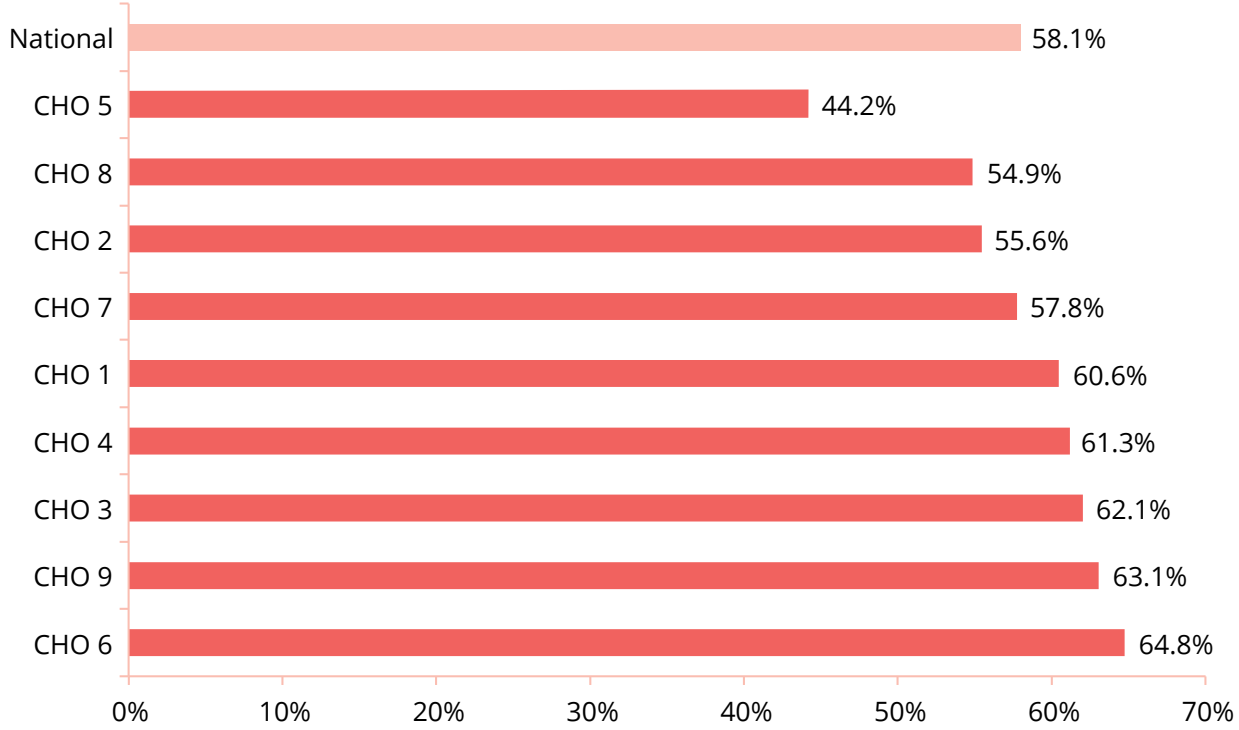
In December 2018, there was 704.8 staff (clinical 608.5) working in 70 Community CAMHS teams, with an average of 10.06 staff, 8.69 of which were clinical staff. The range of team size varies from the smallest team of 4.8 (3.8 clinical) to the largest which comprises of 14.8 (13.2 clinical). The variation in team size can arise due to team development or population size etc.

	2011	2012	2013	2014	2015	2016	2017	2018	Change +/-
Consultant Psychiatrist	57.69	60.44	60.37	65.39	64.15	68.22	72.85	71.70	14.01
Senior Registrar	19.8	20.6	10.4	13.30	10.70	13.22	16.31	21.98	2.18
Registrar/SHO	43.49	45.2	47.03	48.58	59.52	66.99	69.28	78.50	35.01
Social Worker	68.01	67.29	72.09	76.47	77.60	78.54	91.59	89.60	21.59
Clinical Psychologist	57.78	57.78	55.75	61.61	66.54	68.81	74.00	77.70	19.92
Nurse	61.33	59.64	68.77	88.37	98.27	105.41	112.24	114.90	53.57
Occupational Therapist	26.7	25.72	50.53	47.99	52.19	50.92	52.66	56.90	30.20
Speech & Language Therapist	29.22	29.72	46.14	51.61	42.61	50.57	52.06	50.50	21.28
Child/Social Care Worker	15.74	12.74	33.54	41.35	41.13	39.47	36.89	35.20	19.46
Other Therapist	9	6.45	6.6	5.70	8.70	13.72	11.26	11.50	2.50
Administrative Support Staff	75.48	76.36	80.54	79.83	82.54	87.63	88.15	96.00	20.52
Total	464.24	461.94	531.76	580.20	603.95	643.50	677.29	704.48	240.24

Community Child & Adolescent workforce by profession 2018



Community CAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2018



Staffing of CAMHS Day Services and CAMHS Liaison Teams

Each of the three Dublin paediatric hospitals have a liaison team and the total number of staff on these teams is 36.26 (clinical 30.76).

There are two adolescent day services one in Dublin and one in Galway with a total staff of 13.56 (clinical 11.56).

1. St. Joseph's Adolescent and Family Service at St. Vincent's Hospital, Fairview
2. Merlin Park Adolescent Day Programme is located in Galway.

Staffing of Day Services and Liaison Teams

Dec-18	Day Service	Paediatric Hospital Liaison	Total
Medical	2.00	13.16	15.16
Nursing	8.50	6.30	14.80
Health Care Professional	1.06	11.30	12.36
Support Staff	2.00	5.50	7.50
Total	13.56	36.26	49.82

Staffing of Community General Adult Mental Health Services

A survey of the staffing of community general adult mental health teams was carried out in December 2018. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 1,686.70

Vision for Change recommendations – actual staffing (2018)

General Adult Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2018
Staff Community MHTs	1 : 50,000	95	114	2,185	1,687

Community GAMHT staffing compared against Vision for Change recommendations

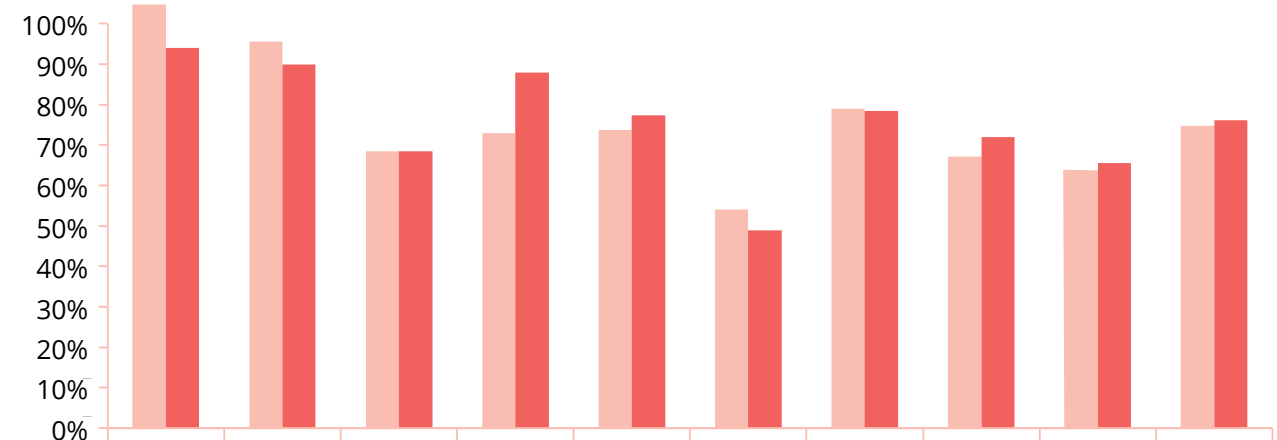
Vision for Change (2006) recommends that there should be one General Adult Community Mental Health Team for each sector of 50,000 population with individual General Adult Community Mental Health Team comprising of the following:

- Two consultant psychiatrists
- Two doctors in training
- Two psychologists
- Two psychiatric social workers
- Eight psychiatric nurses
- Two occupational therapists
- One addiction counsellors/psychotherapists
- Two mental health support workers
- Two administrative support staff.

The staff complement for a General Adult Community Mental Health Team, as recommended in *A Vision for Change* (2006), is 23 per 50,000 head of population, comprising of 21 clinical and 2 administrative support staff.

In December 2018 there was a total of 1,686.7 staff in situ (1,495 Clinical), which represents 77% (74.8% clinical) of the staffing levels recommended in *A Vision for Change*.

Community GAMHS Teams Clinical Staffing vs. VFC recommendations for 2017 - 2018



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2018	105.0%	95.7%	68.8%	73.1%	73.9%	54.3%	79.1%	67.1%	64.1%	74.8%
2017	94.3%	90.2%	68.6%	87.9%	77.4%	48.9%	78.8%	72.0%	65.5%	76.1%

In 2018 the clinical staffing level as recommended in *A Vision for Change* had decreased by 1.3% nationally on the 2017 position. The largest increase was in the CHO 1 which was 10.7% and the largest decrease was in CHO 4 at -14.8%

Community General Adult Mental Health teams

In the period from December 2017 to December 2018, the clinical staff of the Community General Adult Mental Health Teams decreased by 26.68. Variations in staffing numbers can occur due to staff retiring and or changing role and the posts can remain unfilled due to various factors including shortage of qualified applications etc.

Community General Adult Mental Health Teams (2017 to 2018)

	Clinical Staff 2017	Clinical Staff 2018	Change +/- 2018
CHO 1	156.10	173.9	17.80
CHO 2	171.57	182.2	10.63
CHO 3	110.96	111.3	0.34
CHO 4	254.87	212.0	-42.87
CHO 5	165.91	158.5	-7.41
CHO 6	91.54	101.6	10.06
CHO 7	213.5	214.5	1.00
CHO 8	186.34	173.7	-12.64
CHO 9	170.90	167.3	-3.60
Total Clinical	1,521.69	1,495.00	-26.68
Admin/support	191.90	191.70	-0.20
Total Staff	1,713.59	1,686.70	-26.89

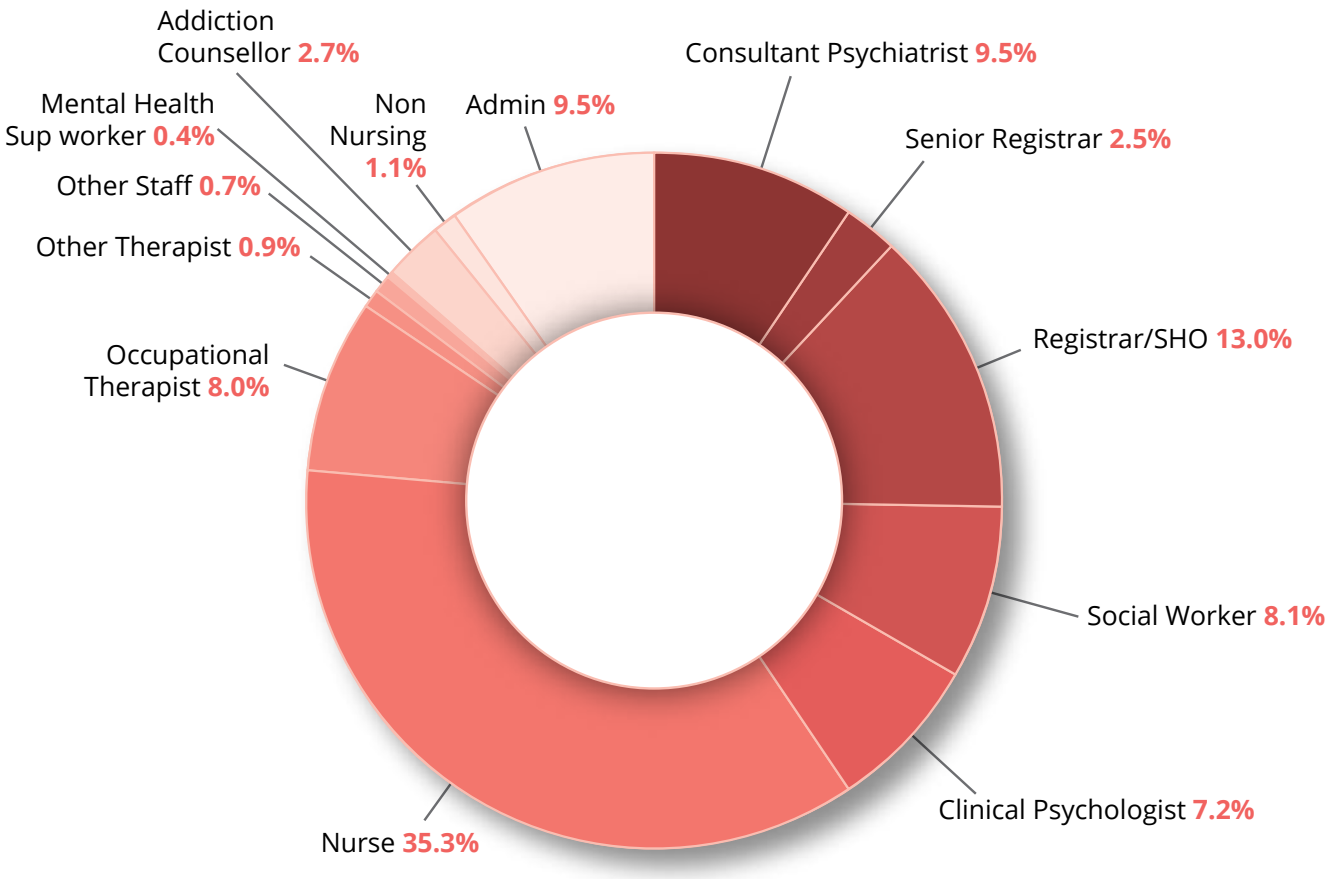
In December 2018 there was 1,713.59 staff (clinical 1,495) working in 114 Community General Adult Mental Health teams, with an average of 14.8 staff per team, of which 13.11 were clinical staff.

The General Adult Community Mental Health Teams as shown in the table below had a net gain of 65.62 whole time equivalents over the period 2013 to 2017, exclusive of staff leaving and retiring etc.

Community General Adult Mental Health Teams Staffing by discipline 2013 to 2018

	2013	2014	2015	2016	2017	2018	Change +/-
Consultant Psychiatrist	157.34	157.92	159.97	155.64	159.1	159.5	2.16
Senior Registrar	35.40	35.30	30.43	41.23	31.6	41.7	6.30
Registrar/SHO	203.60	208.31	217.60	212.6	223.3	219.0	15.40
Social Worker	138.11	132.99	148.73	139.18	141.4	136.0	-2.11
Clinical Psychologist	110.72	126.26	132.39	128.75	128.7	121.1	10.38
Nurse	604.21	613.13	648.92	621.58	623.2	595.5	-8.71
Occupational Therapist	116.05	123.76	124.48	112.55	128.0	135.1	19.05
Other Therapist e.g. SLT Creative/Recreational	12.98	14.58	15.92	14.69	13.6	15.9	2.92
Other Staff	14.28	17.78	16.33	16.43	18.5	12.6	-1.68
Mental Health Support Worker	15.30	17.00	7.00	9.00	13.0	13.2	-2.10
Addiction Counsellor	48.58	46.00	46.02	43.62	41.5	45.4	-3.18
Non Nursing	32.32	35.61	43.80	40.50	21.8	18.6	-13.72
Administrative Support Staff	146.08	159.71	166.79	170.99	170.2	173.1	27.02
Total	1,634.97	1,688.35	1,758.38	1,706.76	1,700.59	1,686.70	51.73

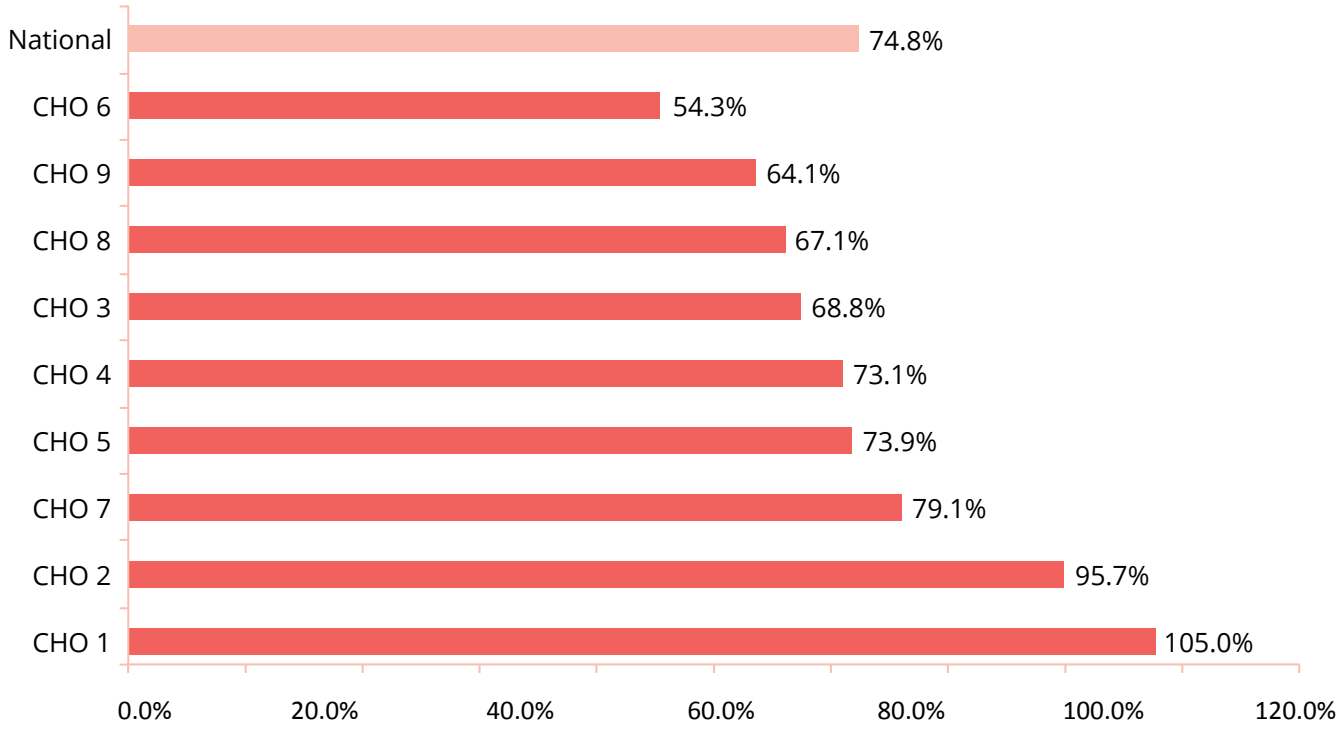
Community GAMHT work force by profession (2018)



Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2017-2018

	Population Census 2016	Clinical Staff 2018	% of VFC rec 2018	Clinical Staff 2017	% of VFC rec 2017
CHO 1	394,333	173.9	105.0%	156.10	94.3%
CHO 2	453,109	182.2	95.7%	171.57	90.2%
CHO 3	384,998	111.3	68.8%	110.96	68.6%
CHO 4	690,575	212.0	73.1%	254.87	87.9%
CHO 5	510,333	158.5	73.9%	165.91	77.4%
CHO 6	445,59 0	101.6	54.3%	91.54	48.9%
CHO 7	645,293	214.5	79.1%	213.50	78.8%
CHO 8	616,229	173.7	67.1%	186.34	72.0%
CHO 9	621,405	167.3	64.1%	170.90	65.5%
National	4,761,865	1,495.0	74.8%	1,521.69	76.1%

Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2018



Psychiatry of Later Life Workforce Staffing of Community Psychiatry of Later Life Services

A survey of the staffing of Psychiatry of Later Life (POLL) was carried out in December 2018. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 354.57

Vision for Change recommendations – actual staffing (2018)

Psychiatry of Later Life Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2018
Staff POA service	1 : 100,000*	48	31	571	354.57

**Equates to 1: 13,400 over 65 year old population based on 2016 census.*

Currently there are 31 POLL community teams (December 2018) with a number of teams in development which have been resourced from the Programme for Government investments in recent years. The plan is to move to full resourcing of POLL services which will ensure national coverage.

Psychiatry of Later Life Service staffing compared against Vision for Change recommendations

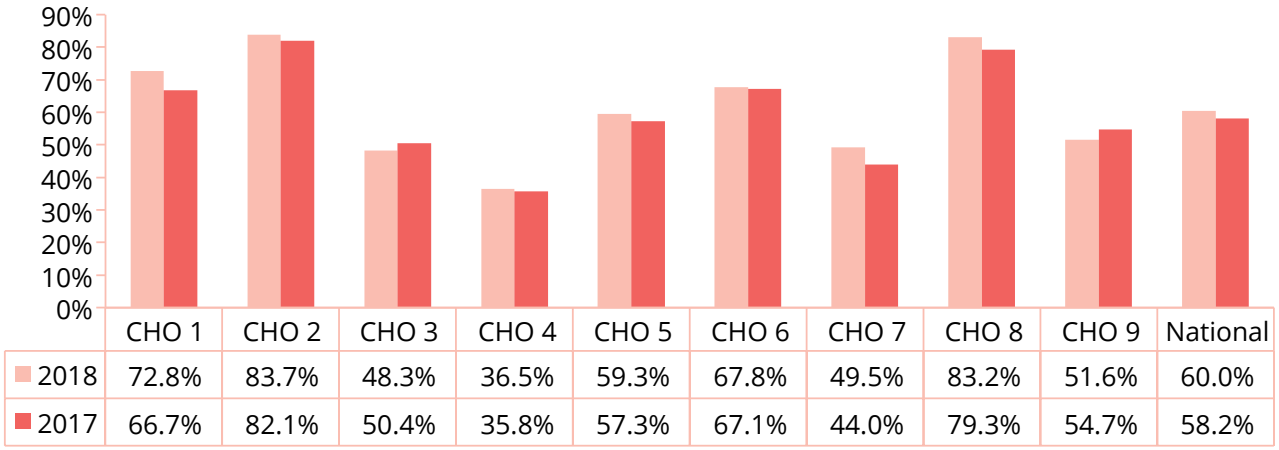
A Vision for Change (2006) recommends that there should be one Psychiatry of Later Life Service team for each sector of 100,000 population. The staff complement for a Psychiatry of Later Life team is 12 per 100,000 head of population, (11 clinical and 1 administrative support staff) and is comprised of:

- One consultant psychiatrist (with specialist expertise in later life psychiatry)
- One doctor in training
- One senior nurse manager
- Three psychiatric nurses
- One clinical psychologist
- One social worker
- One occupational therapist
- Two mental health support workers/care assistants
- One administrative support.

The composition of each Psychiatry of Later Life Service team should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions.

In December 2018, there were 354.57 staff (clinical 314.10) working in 31 Psychiatry of Later Life Service teams, with an average of 11.44 staff (of which 10.13 were clinical staff) per team. This represents 62.1% (60% clinical) of the staffing level as recommended in *A Vision for Change*.

Community POLL Team Staffing vs. VFC recommendations in 2017 - 2018



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2018	72.8%	83.7%	48.3%	36.5%	59.3%	67.8%	49.5%	83.2%	51.6%	60.0%
2017	66.7%	82.1%	50.4%	35.8%	57.3%	67.1%	44.0%	79.3%	54.7%	58.2%

In 2018 the Clinical staffing level as recommended in *A Vision for Change* had increased by 1.8% nationally on the 2017 position. The largest increase was in the CHO 1 which saw an increase of 6.1%.

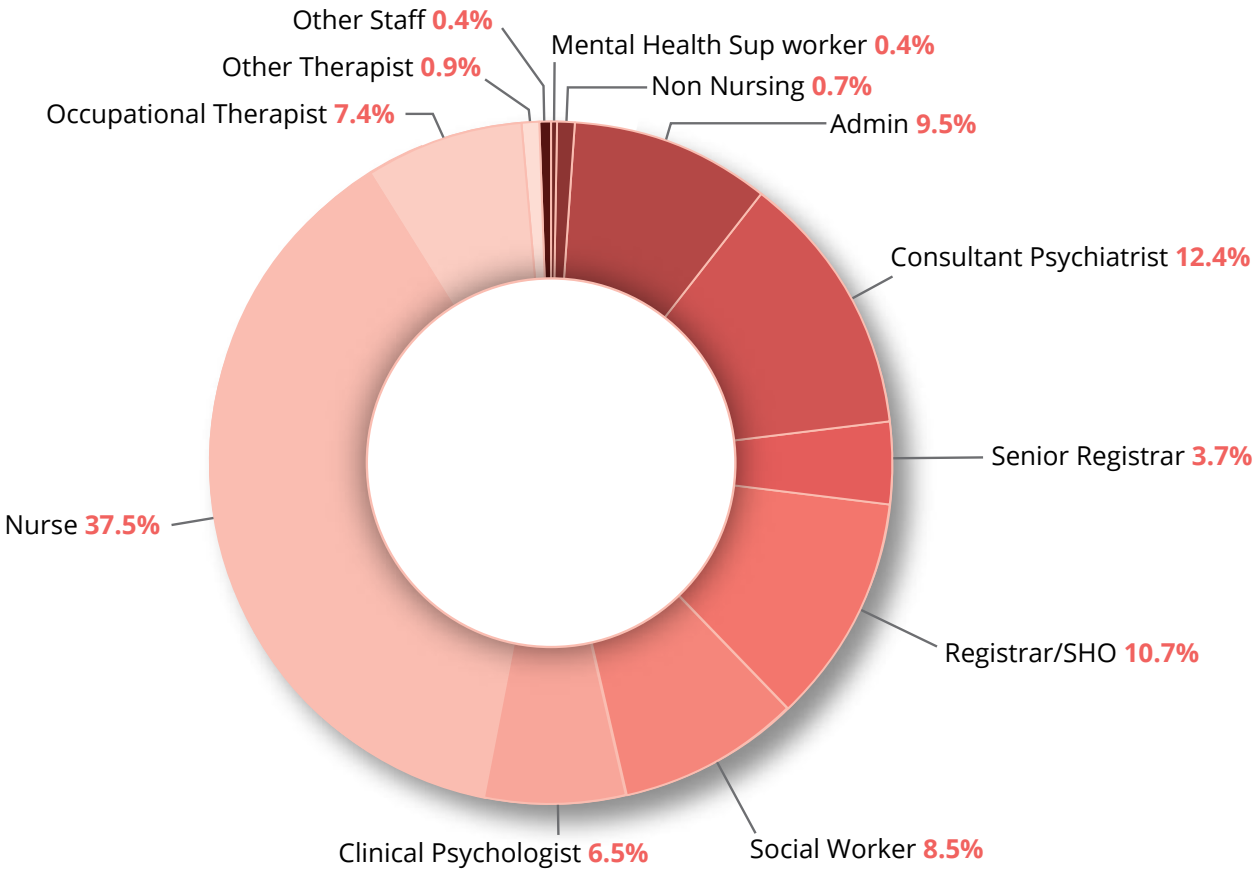
Psychiatry of Later Life Service Teams

The staffing of Psychiatry of Later Life Service increased by 19.16 WTE's in the period from December 2016 to December 2017. In the period from 2013 to 2017, Community Psychiatry of Later Life Service had a net gain of 86.07 whole time equivalents over this period, exclusive of staff leaving and retiring etc.

Psychiatry of Later Life Service Teams (2017 to 2018)

	Clinical Staff 2017	Clinical Staff 2018	Change +/-
CHO 1	32.9	35.9	3.00
CHO 2	46.2	47.1	0.90
CHO 3	23.16	22.2	-0.96
CHO 4	29.03	29.6	0.57
CHO 5	34.96	36.2	1.24
CHO 6	28	28.3	0.30
CHO 7	30	33.7	3.70
CHO 8	48.32	50.7	2.38
CHO 9	32.2	30.4	-1.80
Total Clinical	304.77	314.10	9.33
Admin/support	39.1	40.5	1.38
Total	343.86	354.57	10.17

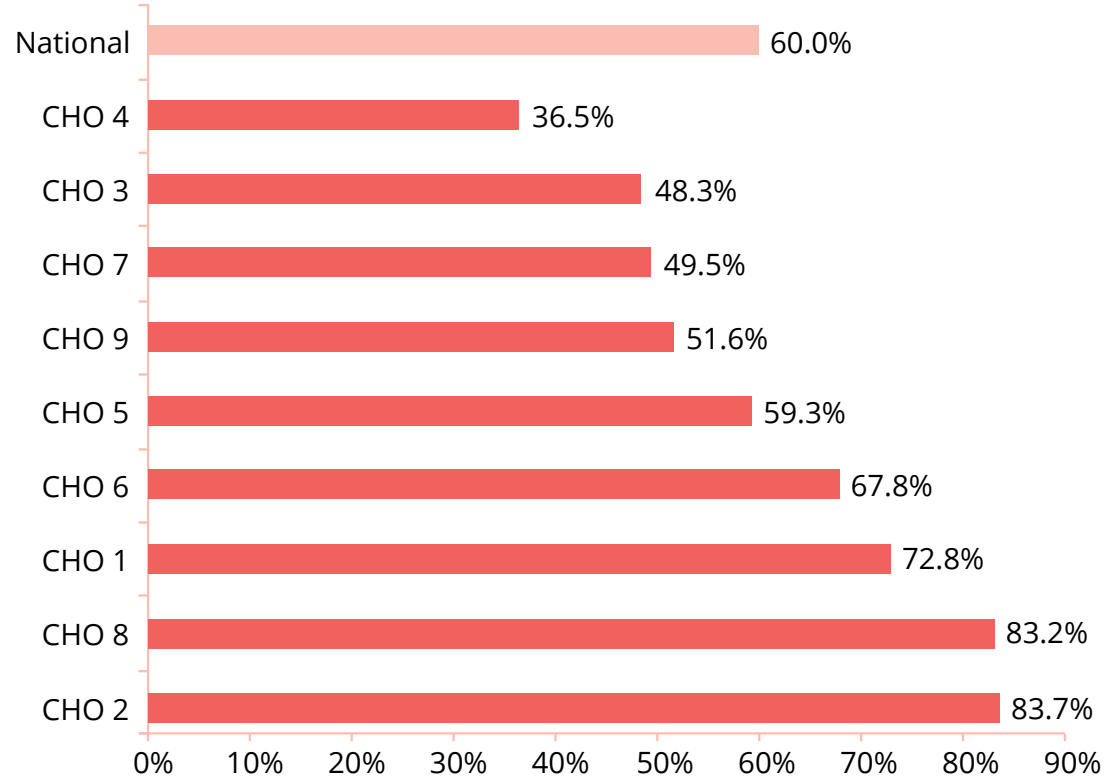
Psychiatry of Later Life Service Workforce by discipline (2017)



Psychiatry of Later Life Service Staffing by discipline 2013 to 2018

	2013	2014	2015	2016	2017	2018	Change +/-
Consultant Psychiatrist	32.30	36.30	36.95	40.2	43.5	44.0	11.70
Senior Registrar	10.00	11.00	10.55	15	12.0	13.0	3.00
Registrar/SHO	27.00	26.00	26.50	32	33.4	37.8	10.80
Social Worker	16.00	25.00	26.90	26.8	30.7	30.2	14.20
Clinical Psychologist	10.85	16.50	17.80	22.1	22.0	23.2	12.35
Nurse	102.12	114.83	119.12	123.3	128.6	133.0	30.88
Occupational Therapist	20.32	24.22	23.27	23	26.6	26.3	5.98
Other Therapist e.g. SLT Creative/Recreational	1.20	2.00	1.30	1.6	3.2	3.2	2.00
Other Staff	1.00	0.88	2.63	1.9	2.0	1.4	0.40
Mental Health Support Worker	3.00	3.00	1.00	1	2.8	2.0	-1.00
Addiction Counsellor	0.40	0.40	0.20	0	0.0	0.0	-0.40
Non Nursing	3.29	6.32	2.91	2.9	2.9	2.4	-0.89
Administrative Support Staff	30.31	35.24	33.41	34.9	36.2	38.0	7.69
Total	257.79	301.69	302.54	324.70	343.86	354.50	96.71

POLL Team Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2018



Chapter 5

Community Child and Adolescent Mental Health Services

Key Facts

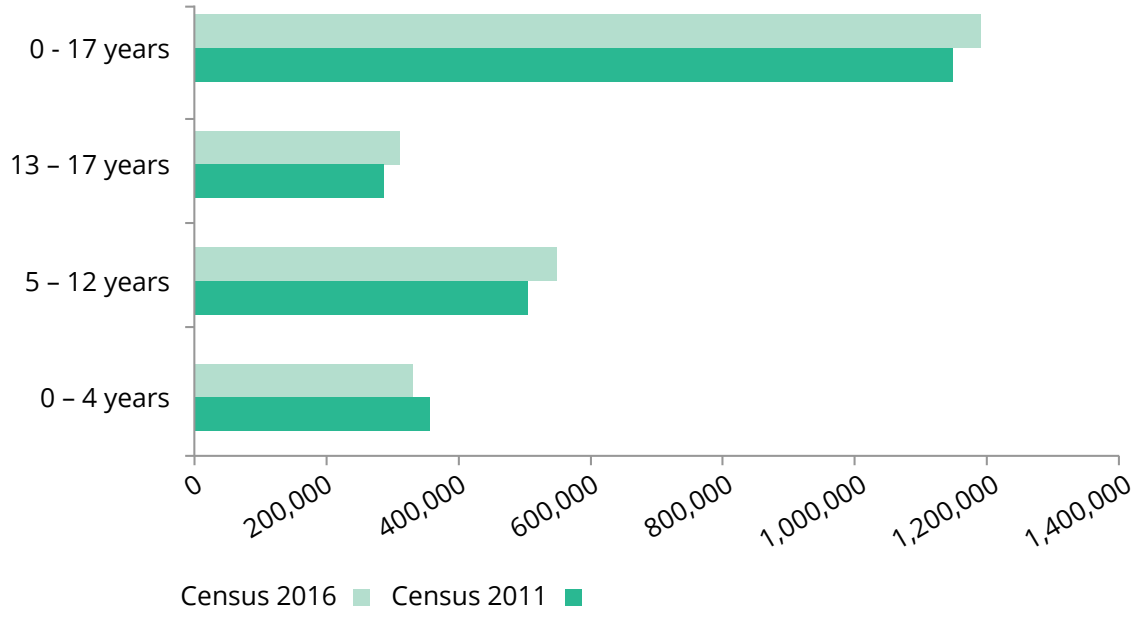
- 2008 - 49 CAMHS teams; 2018 – 70 CAMHS Teams
- 2008 – 351.63 Clinical WTE's; 2018 – 643.4 Clinical WTE's
- 61.4% of the Clinical staffing levels recommended in *A Vision for Change*
- 2% increase in referrals accepted from 2016 to 2018
- 11,954 new appointments offered in 2018
- 50.2% new appointments seen within 4 weeks
- A quarter of new cases seen are aged over 16 years
- 9.7% of new patients did not attend their first appointment
- 2007 – 3,609 individuals were waiting to be seen; 2018 – 2,526 individuals were waiting to be seen.

Children in the Population

The preliminary total for the population enumerated on census night Sunday the 24th of April 2016 was 4,757,976 persons, compared with 4,588,252 persons in April 2011, an increase of 169,724 persons or 3.7%. This translates into an average increase each year of 33,945 persons or 0.7%.

The total population under 18 years in the 2016 census was 1,190,502 persons, an increase of 41,815 or 3.6% on the 2011 figure. The proportion of the population under 18 years remains at 25% of the total population.

2016 & 2011 Census by Age



2016–2011 Census by Age

Age	Census 2016	Census 2011
0 - 4 years	331,515	356,329
5 - 12 years	548,693	504,267
13 - 17 years	310,294	288,091
0 - 17 years	1,190,502	1,148,687

The population of pre-school children (aged 0-4 years) of 331,515, showed a decrease of 24,814 (-7%) since 2011. The greatest decrease in pre-school children was in CHO 1 at -10.4%, followed by CHO

8 (-9.3%) and CHO 5 (-9.1%), while the slowest reduction was recorded in CHO 6 (-0.9%). Given the low level of referral of this age range to CAMHS services in general, the impact of this demographic change on CAMHS referral patterns is likely to be minimal.

The population of the primary school age group (aged 5-12 years) of 548,693, showed an increase of 44,426 (8.8%) since 2011. The greatest increase in primary school aged children was in CHO 9 at 13.4%, followed by CHO 7 (11.1%) and CHO 8 (10.4%), while the slowest decline was recorded in CHO 2 (5.3%).

The population of the secondary school age group (aged 13-17 years) of 310,294, showed an increase of 22,203 persons, or 7.7% since 2011. Given that this age cohort is most likely to avail of CAMHS services it is expected that this will lead to increased referrals in the coming years.

2016 Census by Age 0 – 17 years by CHO Area

CHO Areas	Total	0-17 yrs.	%
CHO 1	394,333	103,778	26.32%
CHO 2	453,109	111,880	24.69%
CHO 3	384,998	96,266	25.00%
CHO 4	690,575	168,542	24.41%
CHO 5	510,333	131,522	25.77%
CHO 6	549,531	116,264	21.16%
CHO 7	541,352	144,296	26.65%
CHO 8	616,229	172,373	27.97%
CHO 9	621,405	145,581	23.43%
National	4,761,865	1,190,502	25.00%

Prevalence of Childhood Psychiatric Disorders

The majority of the illness burden in childhood and more so in adolescence, is caused by mental disorders and the majority of adult mental 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, undermine compliance with health regimens, and reduce the capacity of societies to be safe and productive."

1 in 10 children and adolescents suffer from mental 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.

A study to determine the prevalence rates of psychiatric disorders, suicidal ideation and intent, and parasuicide in populations 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.

- The prevalence of mental disorders in young people is increasing over time.
- 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.
- A range of efficacious psychosocial and pharmacological treatments exists for many mental disorders in children and adolescents.
- 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).

Children Attending CAMHS

The total population under 18 years in the 2016 census was 1,190,502 and in Quarter 3 of 2018 the number of active open cases recorded by CAMHS Community Mental Health Teams was 19,093 or 1.6% of the child population nationally.

Number of children attending CAMHS by year and CHO

	2018		2017		2016	
	Q1	Q3	Q1	Q3	Q1	Q3
CHO 1	1,733	1,737	1,782	1,645	1,973	1,842
CHO 2	2,523	2,512	2,437	2,441	2,328	2,291
CHO 3	2,222	2,239	2,258	2,527	2,380	2,366
CHO 4	2,416	2,487	2,376	2,309	2,412	2,447
CHO 5	1,396	1,421	1,499	1,459	1,538	1,562
CHO 6	3,160	3,079	3,145	2,908	3,274	3,150
CHO 7	2,025	2,059	2,136	2,005	1,870	1,955
CHO 8	2,209	2,222	1,541	1,864	1,905	1,814
CHO 9	1,368	1,337	1,467	1,304	1,518	1,461
National	19,052	19,093	18,641	18,462	19,198	18,888

Percentage of CHO Population under 18 years old attending CAMHS 2018

	<18 years Population	Caseload 2018	Percentage
CHO 1	103,778	1,737	1.7%
CHO 2	111,880	2,512	2.2%
CHO 3	96,266	2,239	2.3%
CHO 4	168,542	2,487	1.5%
CHO 5	131,522	1,421	1.1%
CHO 6	116,264	3,079	2.6%
CHO 7	144,296	2,059	1.4%
CHO 8	172,373	2,222	1.3%
CHO 9	145,581	1,337	0.9%
National	1,190,502	19,093	1.6%

Referral Process and Criteria for Child and Adolescent Mental Health Services

CAMHS Community Mental Health Teams are the first line of specialist mental health services for children and young people who are directly referred to the Community CAMHS team from a number of sources. The Child and Adolescent Mental Health Services Operational Guidelines* set out the referral criteria to Community CAMHS as follows:

- Children aged up to their 18th Birthday.
- Children where the severity and complexity of the presenting mental health disorder is such that treatment at primary care service level has been unsuccessful.
- Children presenting for the assessment and treatment of disorders such as:
  - Moderate to severe depression;
  - Mood disorders including Bipolar Affective Disorder;
  - Psychosis;
  - Moderate to severe anxiety disorders;
  - Moderate to severe Attention Deficit Hyperactive Disorder (ADHD/ADD);
  - Moderate to Severe Eating Disorder; and
  - Suicidal behaviours and ideation where intent is present.

The following are more appropriately dealt with by Primary Care and Social Care Services:

- Children with a moderate or severe intellectual disability.
- Children whose presentation is a developmental disorder, where there are no co-morbid mental health disorders present.
- Assessments or interventions that pertain to educational needs specifically.
- Where there is custody/access or legal proceedings pertaining to family breakdown in progress without evidence of a severe or complex mental health disorder.
- Child abuse assessments and investigations.

The Referring Agents are:

a) GPs - usually the first point of contact for families who seek help for various problems hence they are ideally placed to recognise risk factors for mental health disorders and to refer to more appropriate community care personnel or specialist services such as CAMHS where this is indicated.

b) Paediatricians (informing the child's GP).

c) Consultant liaison psychiatrist (informing the child's GP).

d) General adult psychiatrists (informing the child's GP).

e) National educational psychologists - senior (in collaboration with GP**).

f) Community based clinicians (at senior/team leader level or above, in collaboration with GP**).

g) Tusla – Child and Family Agency (Team leader level or above in collaboration with the GP**).

h) Assessment officers (as defined under the Disability Act, 2005).

i) Jigsaw – senior clinician (in collaboration with GP).

** Child and Adolescent Mental Health Services Operational Guidelines effective from September 2019 https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/operational-guideline/*

*** In collaboration with the GP means the referring agent must ring the GP and discuss and agree the potential referral so it is a truly collaborative referral.*

Access to Child and Adolescent Community Mental Health Services

In 2018, there were 13,255 referrals accepted by the Community Child and Adolescent Mental Health service which is a 2% increase on 2017. In the period from 2014, the number of referrals accepted has increased overall by 1% nationally.

Referrals accepted 2014 – 2018

	2018	2017	+/- Variance 17 vs. 18	2016	+/- Variance 16 vs. 18	2015	+/- Variance 15 vs. 18	2014	+/- Variance 14 vs. 18
CHO 1	1,030	837	23%	957	8%	1,026	0%	1,005	2%
CHO 2	1,247	1,109	12%	1,049	19%	1,064	17%	1,035	20%
CHO 3	1,593	1,994	-20%	1,941	-18%	1,813	-12%	1,866	-15%
CHO 4	1,573	1,466	7%	1,566	0%	1,578	0%	1,539	2%
CHO 5	1,178	1,210	-3%	1,458	-19%	1,502	-22%	1,283	-8%
CHO 6	1,650	1,604	3%	1,639	1%	1,625	2%	1,670	-1%
CHO 7	1,796	1,689	6%	1,688	6%	1,694	6%	1,955	-8%
CHO 8	2,319	2,093	11%	2,094	11%	1,881	23%	1,642	41%
CHO 9	869	986	-12%	1,107	-21%	1,173	-26%	1,067	-19%
National	13,255	12,988	2%	13,499	-2%	13,356	-1%	13,062	1%

Length of time waiting to be seen

When a referral is accepted, Child and Adolescent Community Mental Health Teams are expected to offer an appointment and to see the individual within 12 weeks. All CAMHS Community Mental Health Teams screen the referrals received and those deemed to be urgent are seen as a priority, which can impact on seeing individuals within three months.

At the end of December 2018, 1,136 individuals were expected to be seen within three months and a further 1,390 individuals were on the waiting list. This represented an increase of 107 (4%) from the total number of 2,419 waiting at the end of 2017.

In the context of an overall 24% increase in the number of referrals accepted, between 2012 and 2018, the Child and Adolescent Mental Health Service waiting list has increased by only 4% (104 cases) since 2012.

At the end of 2018 there were 2,526 cases waiting to be seen. This is an increase of 107 cases on the same period in 2017. The number of cases waiting over 12 months decreased by 6 to 314 in 2018. The Mental Health Services set up a CAMHS Waiting List Initiative to focus on reducing waiting lists with a particular focus on those waiting >12 months. The CHOs with individuals waiting over 12 months are taking dedicated actions to ensure no child is waiting more than 12 months. However these increases are attributed to the challenges presented by the increase in population, increase in referrals, staffing retention issues and challenges in recruiting.

Length of Wait time by CHO - December 2017 vs. December 2018

	2018						2017					
	0-3 months	3-6 months	6-9 months	9-12 months	12+ months	TOTAL	0-3 months	3-6 months	6-9 months	9-12 months	12+ months	TOTAL
CHO 1	156	40	33	21	13	263	118	36	27	12	10	203
CHO 2	27	2	0	0	0	29	33	2	1	0	0	36
CHO 3	63	34	42	32	68	239	91	59	41	21	43	255
CHO 4	220	109	140	120	163	752	196	103	118	115	205	737
CHO 5	82	31	22	20	31	186	81	26	19	11	3	140
CHO 6	163	102	38	45	5	353	264	56	23	28	2	373
CHO 7	134	34	12	3	0	183	169	39	24	8	1	241
CHO 8	183	58	41	16	31	329	137	42	25	43	52	299
CHO 9	108	31	33	17	3	192	73	23	25	10	4	135
National	1,136	441	361	274	314	2,526	1,162	386	303	248	320	2,419

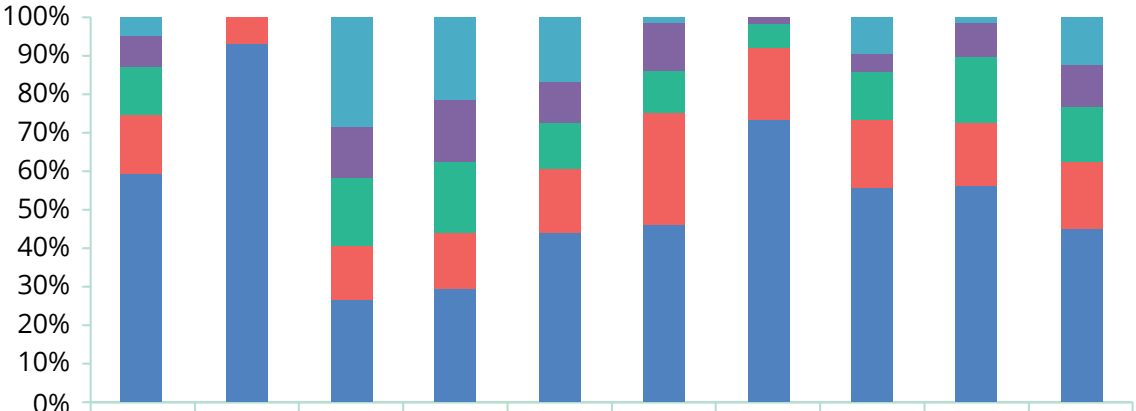
Referrals Accepted Trend vs. Waiting List trend

Referrals accepted		+/- Trend on previous year	Wait List	+/- Trend on previous year
2011	8,663		1,983	
2012	10,705	24%	2,422	22%
2013	12,319	15%	2,602	7%
2014	13,062	6%	2,869	10%
2015	13,356	2%	2,319	-19%
2016	13,499	1%	2,513	8%
2017	12,988	-4%	2,419	-4%
2018	13,255	2%	2,526	4%
2012 v 2018	2,550	24%	104	4%

Numbers waiting by length of time per CHO in 2018

The number of cases waiting to be seen varied in Child and Adolescent Community Mental Health Teams. 80% (56) of the teams had less than 50 cases on the waiting list, with 96% (67) having a waiting lists below 100.

Breakdown of Waiting Lists by CHO Area 2018



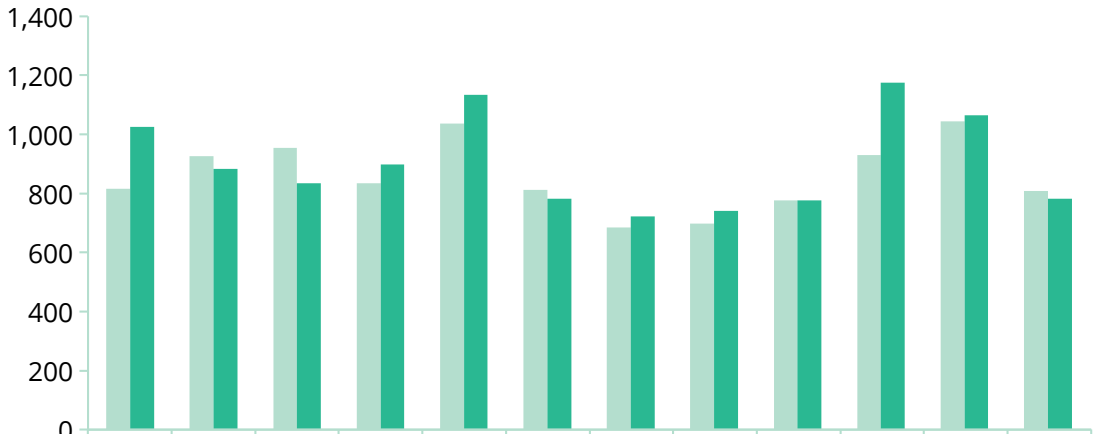
	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
12+ months	13	0	68	163	31	5	0	31	3	314
9-12 months	21	0	32	120	20	45	3	16	17	274
6-9 months	33	0	42	140	22	38	12	41	33	361
3-6 months	40	2	34	109	31	102	34	58	31	441
0-3 months	156	27	63	220	82	163	134	183	108	1,136

New (including re-referred) cases seen by Community CAMHS teams in 2018

In 2018, 11,954 new cases were offered an appointment by Community CAMHS Teams compared to 11,498 cases in 2017.

Of these, 10,796 (10,304 in 2017) were seen and 1,158 (1,194 in 2017) did not attend (DNA). This shows a slight decrease in the non-attendance rate to 9.7% nationally from 10.4% in 2017.

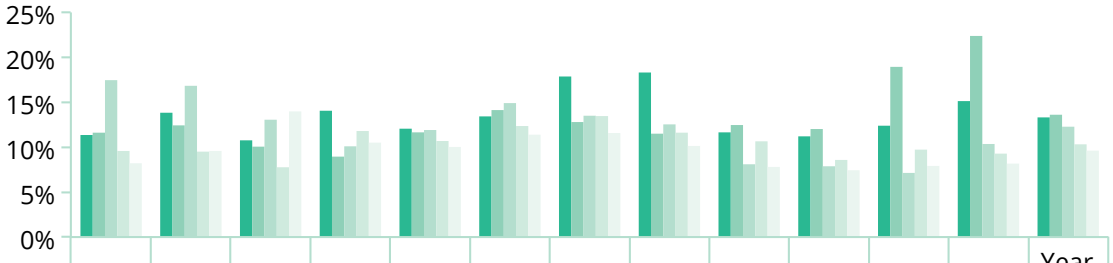
Number of New (including re-referred) cases seen 2017 vs. 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2017	814	925	953	833	1,036	811	683	696	774	929	1,043	807
Seen - 2018	1,023	881	832	896	1,133	781	720	739	774	1,173	1,063	781

Figure below shows the variation by month in the DNA rates, reflecting the seasonal impact on attendance, as the rates range from 14% (March) to 7.5% (October) across 2018. This compares to 13.5% (July) to 7.8% (March) in 2017 and 17.5% (January) to 7.2% (November) in 2016 and 22.5% (December) to 9% (April) in 2015 and 18.4% (August) & 10.8% (March) in 2014.

DNA rates 2014 to 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Year-end
2014	11.4%	13.9%	10.8%	14.1%	12.1%	13.5%	17.9%	18.4%	11.7%	11.3%	12.5%	15.2%	13.4%
2015	11.7%	12.5%	10.1%	9.0%	11.7%	14.2%	12.9%	11.6%	12.5%	12.1%	19.0%	22.5%	13.7%
2016	17.5%	16.9%	13.1%	10.2%	12.0%	15.0%	13.6%	12.6%	8.2%	7.9%	7.2%	10.4%	12.3%
2017	9.7%	9.6%	7.8%	11.9%	10.8%	12.4%	13.5%	11.7%	10.7%	8.7%	9.8%	9.3%	10.4%
2018	8.3%	9.6%	14.0%	10.6%	10.1%	11.5%	11.7%	10.2%	7.9%	7.5%	8.0%	8.2%	9.7%

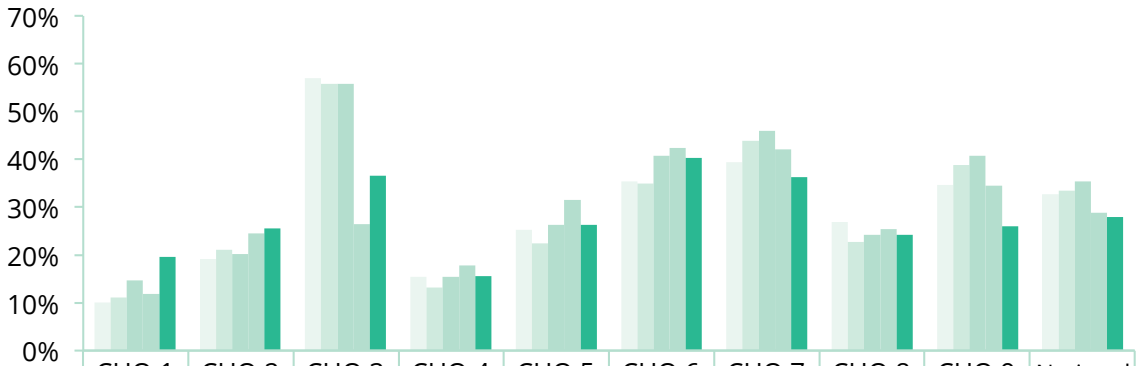
Breakdown of New Cases (New vs. Re-referred Cases)

A proportion of the new cases seen, will have previously attended the service and been discharged.

In 2018, of the 10,796 cases seen, a total of 3,026 had been re-referred to the service. In 2017, of the 10,304 cases seen, a total of 2,979 had been re-referred to the service. This reflects a decrease in rereferral rate from 28.9% in 2017 to 28%.

The proportion of re-referred cases seen in the CHOs over 2018 varied from 19.7% in CHO 1 to 40.4% in CHO 6 (see figures below).

Percentage of Re-referred cases between 2014 and 2018



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2014	10.1%	19.2%	57.2%	15.6%	25.4%	35.5%	39.5%	27.0%	34.7%	32.9%
2015	11.2%	21.2%	55.9%	13.3%	22.5%	35.1%	44.0%	22.7%	39.0%	33.6%
2016	14.8%	20.3%	56.0%	15.6%	26.3%	40.8%	46.0%	24.3%	40.8%	35.5%
2017	12.0%	24.6%	26.5%	17.9%	31.7%	42.5%	42.3%	25.5%	34.6%	28.9%
2018	19.7%	25.6%	36.7%	15.6%	26.5%	40.4%	36.3%	24.4%	26.2%	28.0%

Breakdown of new cases (New vs. Re- referred cases) 2018

New and re-referred Cases seen by age profile

In 2018, a total number of 10,796 new and re-referred cases were seen by Community CAMHS teams. Of these, 75% (8,100) were under 16 years of age and 25% (2,696) were over 16 years of age.

In 2017, a total number of 10,304 new and re-referred cases were seen by Community CAMHS teams. Of these, 75% (7,703) were under 16 years of age and 25% (2,601) were over 16 years of age.

It should be noted that there are a small number of community CAMHS Teams that are still building capacity and do not as yet see 16 and 17 year olds (currently being supported by Adult CMHT).

Number of new (including re-referred) cases seen aged 16 years and over 2018

2018	Total No. of New (including re- referred) cases seen	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
CHO 1	863	164	19.0%
CHO 2	1,172	289	24.7%
CHO 3	1,352	336	24.9%
CHO 4	1,449	386	26.6%
CHO 5	869	248	28.5%
CHO 6	1,224	295	24.1%
CHO 7	1,271	290	22.8%
CHO 8	1,751	447	25.5%
CHO 9	845	241	28.5%
National	10,796	2,696	25.0%

Number of new (including re-referred) cases seen aged 16 years and over 2017

2017	Total No. of New (including re- referred) cases seen	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
CHO 1	842	164	19.5%
CHO 2	1,041	290	27.9%
CHO 3	1,571	411	26.2%
CHO 4	1,008	297	29.5%
CHO 5	1,079	298	27.6%
CHO 6	1,185	317	26.8%
CHO 7	1,214	242	19.9%
CHO 8	1,658	387	23.3%
CHO 9	706	195	27.6%
National	10,304	2,601	25.2%

Timeliness of access to CAMHS Community Mental Health Teams

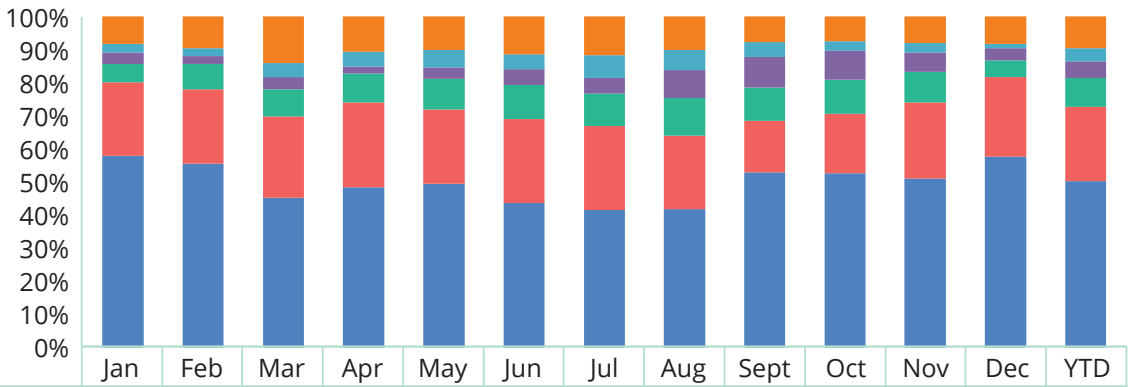
In 2018, a total of 11,954 individuals were offered an appointment of which 10,796 new cases were seen by Community CAMHS teams.

The expectation is that the CAMHS Community Mental Health Teams will offer an appointment and see an individual within three months. In 2018, 72.6% of new cases were seen within three months and of these, 50.2% were seen within one month.

The breakdown is as follows:

- 50.2% of new cases were seen within 1 month of referral.
- 72.6% seen within 3 months.
- 8.8% 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.
- 9.7% did not attend their appointment.

Timeframe for 1st appointment to be seen in 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
DNA	8.3%	9.6%	14.0%	10.6%	10.1%	11.5%	11.7%	10.2%	7.9%	7.5%	8.0%	8.2%	9.7%
>12 mth	2.8%	2.5%	4.2%	4.6%	5.4%	4.4%	7.0%	6.0%	4.5%	2.8%	2.9%	1.4%	4.0%
6-12 mth	3.4%	2.2%	3.8%	2.1%	3.3%	4.9%	4.7%	8.4%	9.2%	8.9%	5.7%	3.6%	5.0%
3-6 mth	5.6%	7.7%	8.2%	8.8%	9.4%	10.2%	9.7%	11.5%	9.9%	10.1%	9.4%	5.2%	8.8%
1-3 mth	22.0%	22.5%	24.6%	25.5%	22.5%	25.3%	25.4%	22.1%	15.7%	17.9%	22.8%	23.9%	22.4%
<1 mth	58.0%	55.6%	45.1%	48.4%	49.4%	43.8%	41.6%	41.8%	52.9%	52.8%	51.2%	57.7%	50.2%

Timeframe for 1st appointment by CHO

Length of wait to 1st appointment by CHO						
	<1 month	**1 - 3 months**	**3 -6 months**	**6 - 12 months**	**>12 months**	**DNA**
CHO 1	49.8%	27.1%	7.7%	5.9%	4.5%	5.0%
CHO 2	82.5%	9.6%	1.0%	0.1%	0.1%	6.7%
CHO 3	55.4%	25.6%	6.8%	4.0%	3.7%	4.5%
CHO 4	40.7%	19.6%	8.2%	5.8%	15.2%	10.4%
CHO 5	57.2%	22.5%	3.9%	3.5%	0.4%	12.5%
CHO 6	41.3%	27.0%	15.7%	9.2%	2.0%	4.7%
CHO 7	36.6%	31.2%	12.7%	5.3%	1.2%	12.9%
CHO 8	46.7%	20.0%	10.4%	4.2%	3.0%	15.7%
CHO 9	49.2%	20.2%	10.2%	7.5%	2.7%	10.2%
National	50.2%	22.4%	8.8%	5.0%	4.0%	9.7%

Discharge from the CAMHS Community Mental Health Teams

In 2018, 12,201 individuals were discharged by Community CAMHS Teams compared to 12,923 cases in 2017.

88.9% (88.2% in 2017) of the individuals were discharged to the care of their general practitioner or Primary Care Team (PCT), 3.4% (5.1% in 2017) to a Community Based Service, 4.5% (2.8% in 2017) to another CAMHS service, and 3.1% (3.8% in 2017) to an Adult Mental Health Service.

Percentage of receiving services following discharge from CAMHS Community Mental Health Team by CHO

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service
CHO 1	84.8%	8.0%	0.8%	6.4%
CHO 2	92.7%	1.0%	2.3%	4.1%
CHO 3	91.0%	3.0%	1.7%	4.4%
CHO 4	84.5%	2.4%	6.6%	6.6%
CHO 5	87.3%	5.3%	2.9%	4.6%
CHO 6	92.9%	1.2%	3.9%	2.0%
CHO 7	82.0%	4.6%	11.6%	1.8%
CHO 8	89.0%	5.2%	2.9%	2.9%
CHO 9	98.0%	1.8%	0.0%	0.2%
National	88.9%	3.4%	4.5%	3.1%

Detail of receiving services following discharge from CAMHS Community Mental Health Team by CHO

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service	Total
CHO 1	636	60	6	48	750
CHO 2	947	10	23	42	1,022
CHO 3	606	20	11	29	666
CHO 4	1,133	32	88	88	1,341
CHO 5	978	59	32	51	1,120
CHO 6	1,843	24	78	39	1,984
CHO 7	1,923	108	271	42	2,344
CHO 8	1,299	76	43	42	1,460
CHO 9	1,484	27	0	3	1,514
National	10,849	416	552	384	12,201

Chapter 6

Community General Adult Mental Health Services

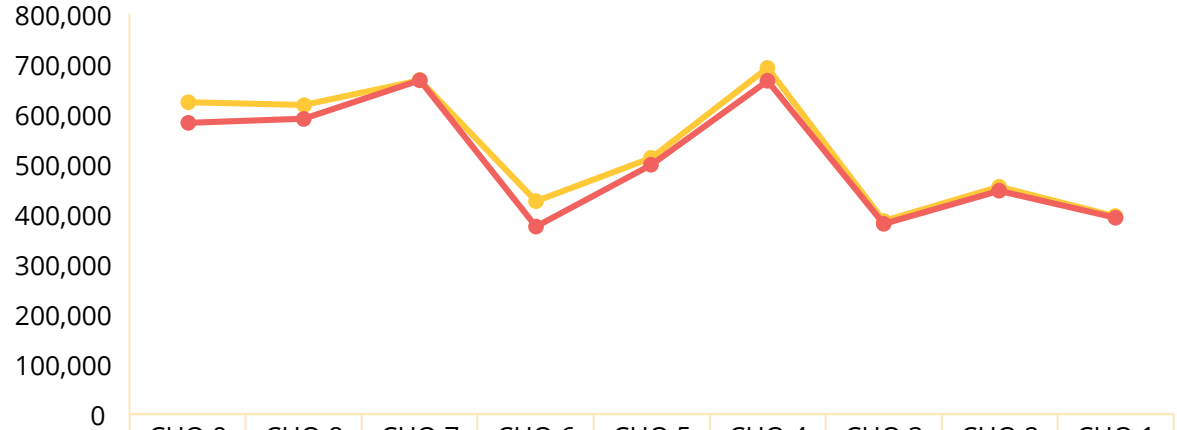
Key Facts

- 114 Community General Adult Mental Health Teams
- 2013 – 1,456.57 Clinical WTE's; 2018 – 1,495 Clinical WTE's
- 74.8% of the Clinical staffing levels recommended in *A Vision for Change*
- -2% decrease in referrals accepted from 2017 to 2018
- 35,002 new appointments offered in 2018
- A fifth of new appointments seen within 1 week
- 30.9% are seen within 2 weeks & 48.9% seen within 4 weeks
- Over 1 in 5 new patients did not attend their first appointment.

Adults in the Population

The preliminary total for the population enumerated on census night Sunday the 24th of April 2016 was 4,761,865 persons, compared with 4,588,252 persons in April 2011, an increase of 173,613 persons since 2011 or 3.8%. This translates into an average increase each year of 34,723 persons or 0.8%.

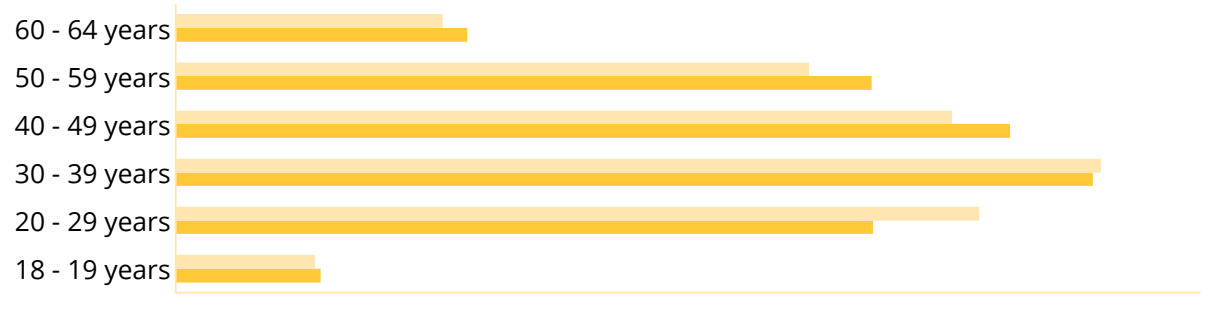
2016 & 2011 Census by CHO*



	CHO 9	CHO 8	CHO 7	CHO 6	CHO 5	CHO 4	CHO 3	CHO 2	CHO 1
2016	621,405	616,229	661,111	424,772	510,333	690,575	384,998	453,109	394,333
2011	581,486	589,442	665,443	373,092	497,578	664,534	379,327	445,356	391,994

**NB CHO Areas not in place until 2014*

2016 census by Age



	18 - 19 years	20 - 29 years	30 - 39 years	40 - 49 years	50 - 59 years	60 - 64 years
2011	113,922	658,353	758,206	635,997	518,908	218,786
2016	118,866	571,071	751,396	683,570	570,037	238,856

Access to Community General Adult Mental Health Teams

Referrals

Between 2014 and 2018, there has been a decrease of -3.9% nationally in the number of referrals accepted by the community general adult mental health service. From 2017 to 2018 there was a -2% decrease as outlined in the table below.

Referrals accepted 2014 vs. 2018

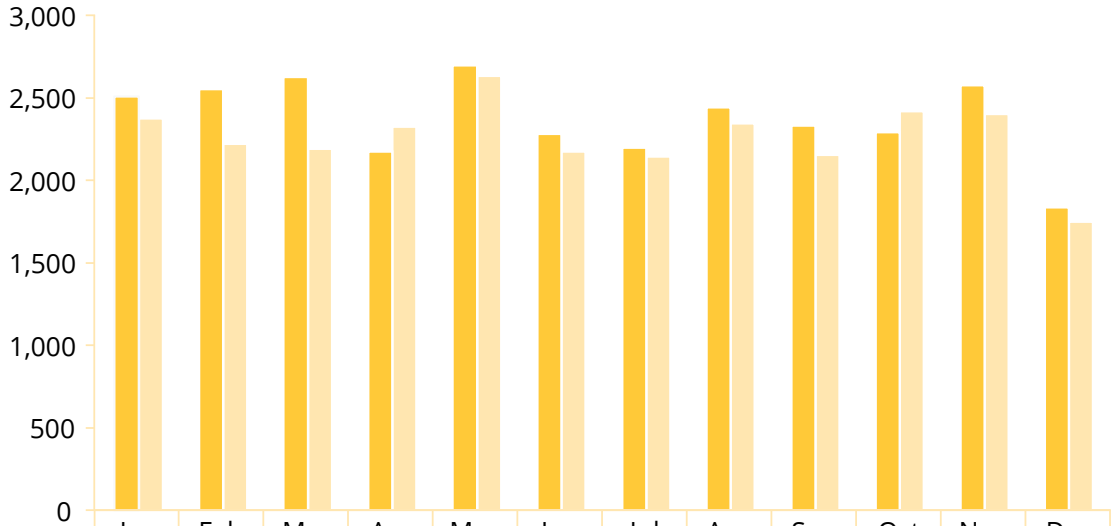
Referrals Accepted									
	2018	2017	+/- Variance 17 vs. 18	2016	+/- Variance 16 vs. 18	2015	+/- Variance 15 vs. 18	2014	+/- Variance 14 vs. 18
CHO 1	3,095	3,412	-9.3%	3,334	-7.2%	3,264	-5.2%	3,889	-20.4%
CHO 2	5,594	5,865	-4.6%	6,463	-13.4%	6,551	-14.6%	6,537	-14.4%
CHO 3	3,595	3,798	-5.3%	3,701	-2.9%	3,738	-3.8%	3,523	2.0%
CHO 4	5,703	5,926	-3.8%	6,471	-11.9%	6,202	-8.0%	5,906	-3.4%
CHO 5	3,873	3,910	-0.9%	4,078	-5.0%	3,917	-1.1%	3,984	-2.8%
CHO 6	2,411	2,186	10.3%	2,214	8.9%	2,240	7.6%	2,275	6.0%
CHO 7	4,426	4,354	1.7%	4,033	9.7%	3,745	18.2%	3,967	11.6%
CHO 8	5,396	5,331	1.2%	5,278	2.2%	5,417	-0.4%	5,118	5.4%
CHO 9	3,427	3,519	-2.6%	3,591	-4.6%	3,678	-6.8%	3,828	-10.5%
National	37,520	38,301	-2.0%	39,163	-4.2%	38,752	-3.2%	39,027	-3.9%

New cases seen by Community General Adult Mental Health Teams 2018

In 2018 a total number of 35,002 new cases were offered an appointment by community general adult mental health teams which compares to 36,277 cases in 2017.

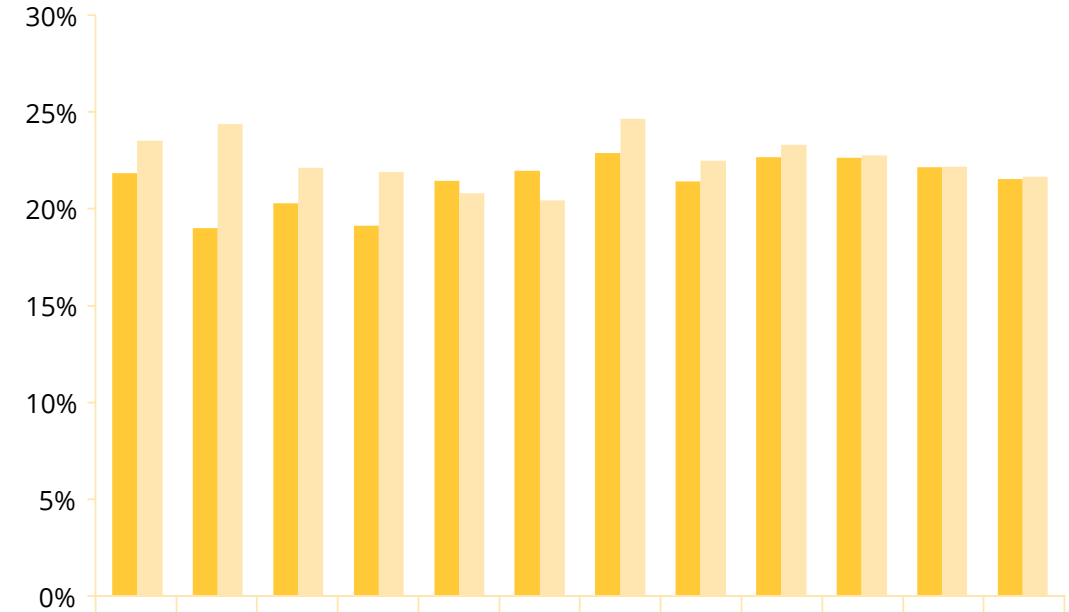
A total of 27,124 (28,513 in 2017) were seen and 7,878 (7,764 in 2017) did not attend (DNA). This gives a non-attendance rate of 22.5% compared with 21.4% in 2017.

New (including re-referred) cases seen 2017 vs. 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2017	2,507	2,552	2,626	2,175	2,697	2,282	2,196	2,441	2,331	2,292	2,577	1,837
Seen - 2018	2,374	2,220	2,190	2,324	2,633	2,173	2,143	2,346	2,153	2,419	2,401	1,748

DNA Rate 2017 vs. 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2017	21.8%	19.0%	20.3%	19.1%	21.4%	22.0%	22.9%	21.4%	22.7%	22.6%	22.1%	21.5%
2018	23.5%	24.4%	22.1%	21.9%	20.8%	20.4%	24.6%	22.5%	23.3%	22.7%	22.2%	21.6%

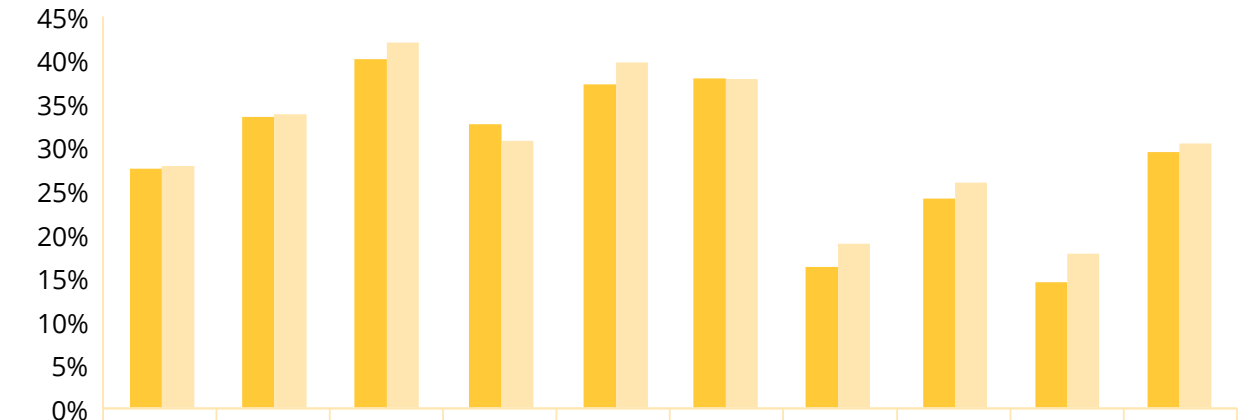
Breakdown of New Cases (New vs. Re-referred Cases)

A proportion of the new cases seen will have previously attended the service and been discharged. In 2018 of the 27,124 cases seen, a total of 8,238 had been re-referred to the service. This represents a 30.4% re-referred rate.

In 2017 of the 28,513 cases seen, a total of 8,377 had been re-referred to the service. This represents a 29.4% re-referred rate

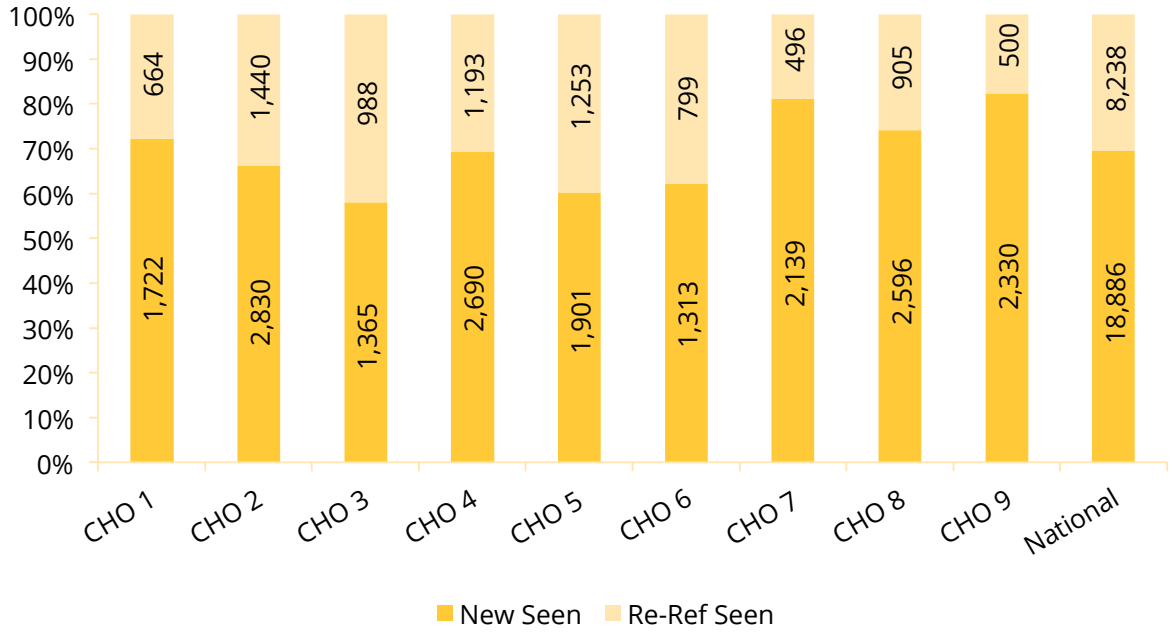
The proportion of re-referred cases in 2017 varied from 14.4% in CHO 9 to 40.1% in CHO 3 (see figures below).

Percentage of Re-referred cases 2017 vs. 2018



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2017	27.5%	33.4%	40.1%	32.6%	37.2%	37.9%	16.1%	24.0%	14.4%	29.4%
2018	27.8%	33.7%	42.0%	30.7%	39.7%	37.8%	18.8%	25.8%	17.7%	30.4%

Breakdown of New Cases Seen (New vs. Re-referred cases) 2018



New Cases including re-referred seen by age profile

In 2018 a total number of 27,124 new cases were seen by Community General Adult Mental Health Teams. Of these, 0.4% (102) were under 18 years of age and 99.6% (27,022) were over 18 years of age. This compares to 0.5% (156) of cases in 2017.

Some General Adult Community Mental Health Teams continue to provide mental health services to children between 16 and 18 while the Child and Adolescent Mental Health Services in those areas are building capacity to provide treatment to this cohort.

Waiting Times for New Cases Seen

In 2017 a total number of 35,002 were offered an appointment of which 27,124 new cases were seen by Community General Adult Mental Health Teams. The waiting time to be seen was recorded for each case.

Length of wait to 1st appointment by CHO

	< 1 week	> 1 to 2 weeks	> 2 to 3 weeks	> 3 to 4 weeks	> 4 to 8 weeks	> 8 to 12 weeks	> 12 Weeks	DNA
CHO 1	33.7%	8.3%	6.2%	6.6%	16.8%	8.0%	5.0%	15.5%
CHO 2	32.1%	16.8%	12.3%	10.0%	13.4%	3.8%	0.7%	10.8%
CHO 3	21.9%	12.2%	9.7%	6.9%	14.9%	4.0%	2.3%	28.1%
CHO 4	14.3%	9.3%	7.9%	7.9%	17.5%	10.3%	3.9%	28.9%
CHO 5	21.0%	12.0%	13.8%	7.1%	22.9%	9.8%	3.2%	10.2%
CHO 6	24.5%	13.2%	18.4%	10.8%	12.8%	3.5%	0.8%	16.0%
CHO 7	14.0%	8.3%	7.5%	7.5%	17.2%	13.2%	9.6%	22.6%
CHO 8	14.7%	9.4%	8.4%	8.9%	14.4%	6.1%	5.7%	32.3%
CHO 9	10.4%	9.0%	8.3%	5.8%	16.2%	8.4%	11.5%	30.3%
National	20.0%	10.9%	10.0%	8.0%	16.2%	7.6%	4.8%	22.5%

Cases Closed or Discharged

In 2018 – 25,133 cases were closed and discharged by Community General Adult Mental Health Teams. This compares to 25,035 cases closed in 2017. Of these, 89% of the cases closed were discharged to care of the General Practitioner or Primary Care Team (PCT), 5.4% to General Practitioner and other primary / community care services, 2.8% to another Adult Mental Health Service, 1.2% to other services and 1.6% were due to death.

No. of Cases closed and discharged by Community General Adult teams in 2018

	Closed / Discharged to GP/Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed / Discharged to other Adult Mental Health Service	Closed / Discharged to other Service	Closed due to Death	Total Closed Discharged
CHO 1	2,441	39	130	6	33	2,649
CHO 2	2,092	76	138	31	48	2,385
CHO 3	2,216	321	93	20	67	2,717
CHO 4	4,046	102	106	9	81	4,344
CHO 5	2,097	45	11	46	46	2,245
CHO 6	1,279	390	72	19	30	1,790
CHO 7	2,030	303	47	149	32	2,561
CHO 8	3,685	3	26	1	36	3,751
CHO 9	2,470	72	87	23	39	2,691
National	22,356	1,351	710	304	412	25,133

Percentage of Cases closed and discharged by Community General Adult teams in 2018

	Closed / Discharged to GP/Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed / Discharged to other Adult Mental Health Service	Closed / Discharged to other Service	Closed due to Death
CHO 1	92.1%	1.5%	4.9%	0.2%	1.2%
CHO 2	87.7%	3.2%	5.8%	1.3%	2.0%
CHO 3	81.6%	11.8%	3.4%	0.7%	2.5%
CHO 4	93.1%	2.3%	2.4%	0.2%	1.9%
CHO 5	93.4%	2.0%	0.5%	2.0%	2.0%
CHO 6	71.5%	21.8%	4.0%	1.1%	1.7%
CHO 7	79.3%	11.8%	1.8%	5.8%	1.2%
CHO 8	98.2%	0.1%	0.7%	0.0%	1.0%
CHO 9	91.8%	2.7%	3.2%	0.9%	1.4%
National	89.0%	5.4%	2.8%	1.2%	1.6%

Chapter 7

Psychiatry of Later Life
Mental Health Services

Key Facts

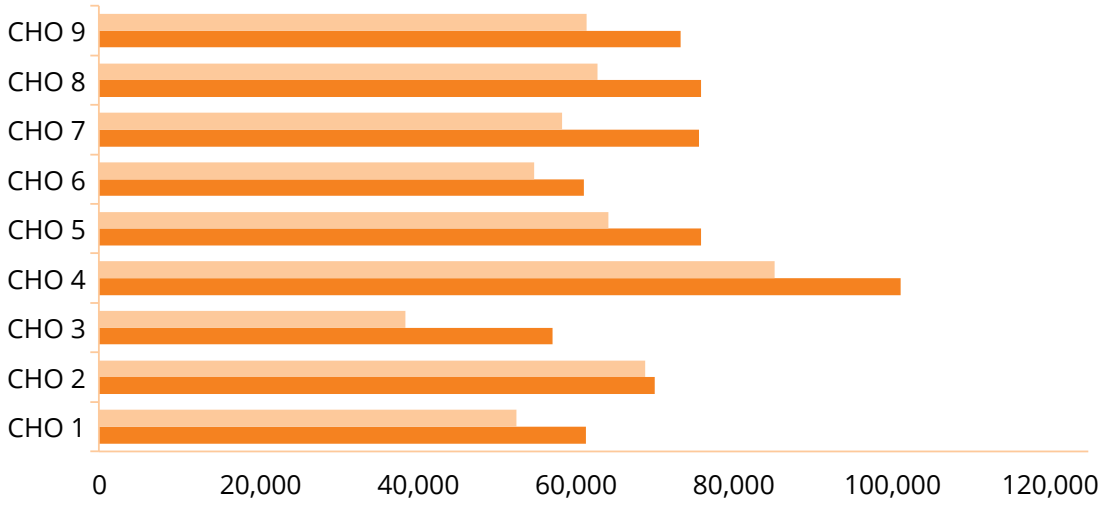
- 2013 – 22 POLL teams; 2018 – 31 POLL teams
- 2013 – 224.19 Clinical WTE's; 2018 – 314.10 Clinical WTE's
- 60% of the Clinical staffing levels recommended in *A Vision for Change*
- 3.8% increase in referrals received from 2017 to 2018
- 8,804 new appointments offered in 2018
- 38.5% new appointments seen within 1 week
- 81.9% new appointments seen within 4 weeks
- 2.9% new patients did not attend their first appointment.

Over 65 year of age population

The preliminary total for the population enumerated on census night Sunday the 24th of April 2016 was 4,761,865 persons, compared with 4,588,252 persons in April 2011, an increase of 173,613 persons since 2011 or 3.8 per cent. This translates into an average increase each year of 34,723 persons or 0.8 per cent.

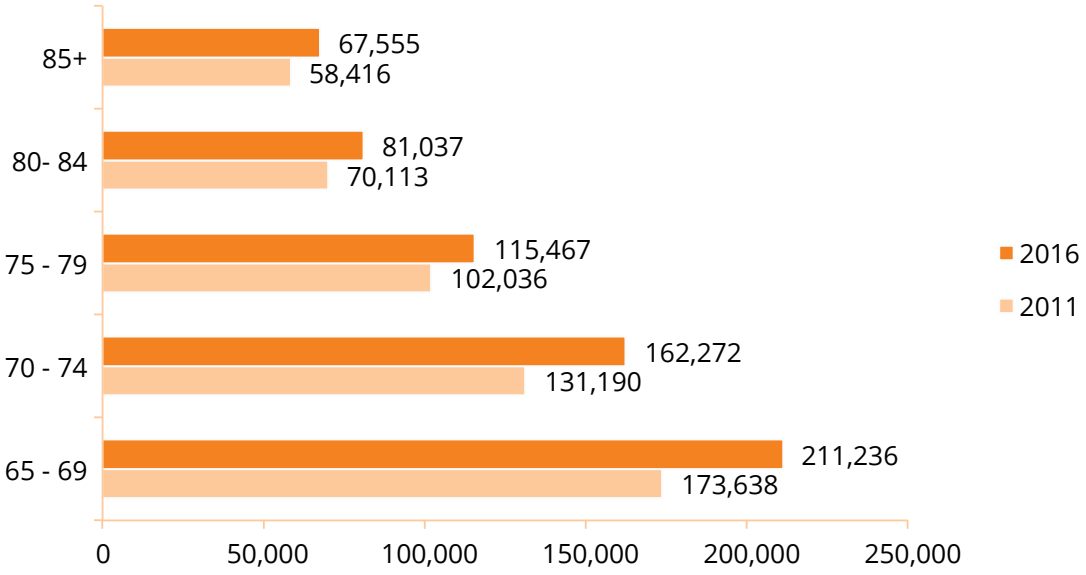
In line with other European countries, the population over 65 years is increasing in Ireland and now forms 13.4% of the total population. From 2011 to 2016 there was a 19% increase in the over 65 year's population. This significant increase in population will result in increased demand for POLL services.

2016 & 2011 Census – Number over 65



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
Census 2011	51,546	67,380	37,832	83,368	62,821	53,679	57,109	61,487	60,171
Census 2016	60,063	68,558	55,935	98,877	74,302	59,799	74,014	74,258	71,761

2016 Census by Age



2016 vs. 2011 census by Age 65 + years by CHO

>65 Years Population of Ireland			
	Total Pop	**65 +**	**% of Population**
CHO 1	394,333	60,063	15.2%
CHO 2	453,109	68,558	15.1%
CHO 3	384,998	55,935	14.5%
CHO 4	690,575	98,877	14.3%
CHO 5	510,333	74,302	14.6%
CHO 6	424,772	59,799	14.1%
CHO 7	666,111	74,014	11.1%
CHO 8	616,229	74,258	12.1%
CHO 9	621,405	71,761	11.5%
National	4,761,865	637,567	13.4%

Prevalence of mental disorders in later life

Mental disorders in later life that are both common and treatable but left unrecognised and/or untreated are associated with increased morbidity and mortality (Lenz 2005, Schulz 2000).

Depression is the most common illness with a rate of 10.3% identified in a Dublin community study (Kirby, 1997) with a considerably higher prevalence of 17 - 35% of those in hospital or residential care (Blazer, 2003). The causes are complex and arise from an interaction of biological, psychological and social factors. Depression is most prevalent in those with functional limitations with causality in both directions. Effective treatment improves both functioning and quality of life (Unutzer, 2002).

Dementia affects 5% of people over 65 and the prevalence is age related increasing to 20% of those over 80 years. The prevalence of dementia in Ireland is projected to rise from approximately 42,000 people in 2011 to over 103,000 by 2036 (O'Shea, 2007). Over 90% of adults with dementia experience behavioural and/or psychological symptoms of dementia (BPSD) at some time in the course of their illness (Steinberg, 2008). If untreated, these are the most common reasons why families are no longer able to care for their relative at home (Gallagher, 2011).

Other disorders include anxiety with 13% of older people in Ireland experiencing such symptoms (O'Regan, 2011), either alone or co-morbidly, particularly with depression. The lifetime prevalence of both schizophrenia and bipolar disorder are each 1%.

Whilst delirium is a manifestation of underlying medical or surgical conditions, it presents as a mental disorder. It is particularly common in those admitted to acute hospitals and is notably associated with prolonged length of stay and increase morbidity and mortality (RCPsych, 2005).

Psychiatry of Later Life Services

Psychiatry of Later Life services have been developed throughout the country since the 1980s, with the remaining areas without such services being targeted for development in 2013 and 2014 through the special allocation of funding provided by the Minister of Health with special responsibility for Mental Health.

These services have been developed in response to the following factors:

- Many people develop mental illness for the first time over the age of 65 years. This may reflect bereavement, physical ill health, functional impairment and social isolation but also increased neurological vulnerability secondary to degenerative and vascular pathologies.
- More people are surviving to old age and, therefore, are at increased risk of age-related disorders such as dementia. In addition, the numbers of older adults with functional psychiatric disorders will necessarily increase given the ageing population.
- Older adults with mental health difficulties have specific needs. The underlying causes and presenting symptoms are frequently different in later life compared to earlier life. There are often co-morbid medical conditions which must be considered. In many instances there are complex social circumstances and legal issues which require a particular approach.

Psychiatry of Later Life Team - Assessment

Uniquely amongst mental health specialties, the lynchpin of Psychiatry of Later Life Service is the provision of accessible and acceptable assessment by means of domiciliary assessment.

The rationale for this approach is:

- This service is maximally accessible to older people who may, by reason of physical frailty, dementia or hesitation accepting a referral to a mental health service, be provided with a service as required.
- Particularly for those with cognitive impairment, it enables a baseline assessment of the person i.e. at their best level of cognitive function because they are in familiar surroundings.
- The home assessment also allows the person to be seen in their home environment, which is crucial in terms of drawing up an integrated care plan taking into account not just biological but also social and psychological factors.
- It allows maximal access to any carers involved with the person, assisting in getting both a complete history and in being made aware of who is available to be active in the care plan.

All of these issues require the mental health specialist in later life to have specialist knowledge and skills to fully assess and meet the complex needs of older adults, in collaboration with professionals from other disciplines (National Clinical Programme for Older Persons: Mental Health Service Model of Care, 2015).

Prevalence of common mental health disorders in community and hospital populations (adapted from 'Who Cares Wins', RCPsych 2005)

Disorder	Community	Acute Hospital
Delirium	1-2%	20%
Dementia	5%	31%
Depression	12%	29%
Anxiety Disorders	3%	8%
Alcohol misuse	2%	3%
Schizophrenia	0.5%	0.4%

Access to Psychiatry of Later Life Services

Between 2014 and 2018, there was an increase of 7.7% nationally in the number of referrals accepted by the Psychiatry of Later Life Service as outlined in the table below.

	2018	2017	+/- Variance 18 vs. 17	2016	+/- Variance 18 vs. 16	2015	+/- Variance 18 vs. 15	2014	+/- Variance 18 vs. 14
CHO 1	1,188	1,297	-8.4%	1,296	-8.3%	1,380	-13.9%	1,494	-20.5%
CHO 2	1,668	1,633	2.1%	1,748	-4.6%	1,807	-7.7%	1,375	21.3%
CHO 3	1,140	1,016	12.2%	1,021	11.7%	965	18.1%	989	15.3%
CHO 4	700	551	27.0%	647	8.2%	339	106.5%	454	54.2%
CHO 5	1,270	1,360	-6.6%	1,416	-10.3%	1,487	-14.6%	1,439	-11.7%
CHO 6	1,042	975	6.9%	1,035	0.7%	1,031	1.1%	957	8.9%
CHO 7	768	867	-11.4%	856	-10.3%	839	-8.5%	980	-21.6%
CHO 8	1,620	1,675	-3.3%	1,625	-0.3%	1,523	6.4%	1,514	7.0%
CHO 9	1,637	1,255	30.4%	1,181	38.6%	1,073	52.6%	1,046	56.5%
National	11,033	10,629	3.8%	10,825	1.9%	10,444	5.6%	10,248	7.7%

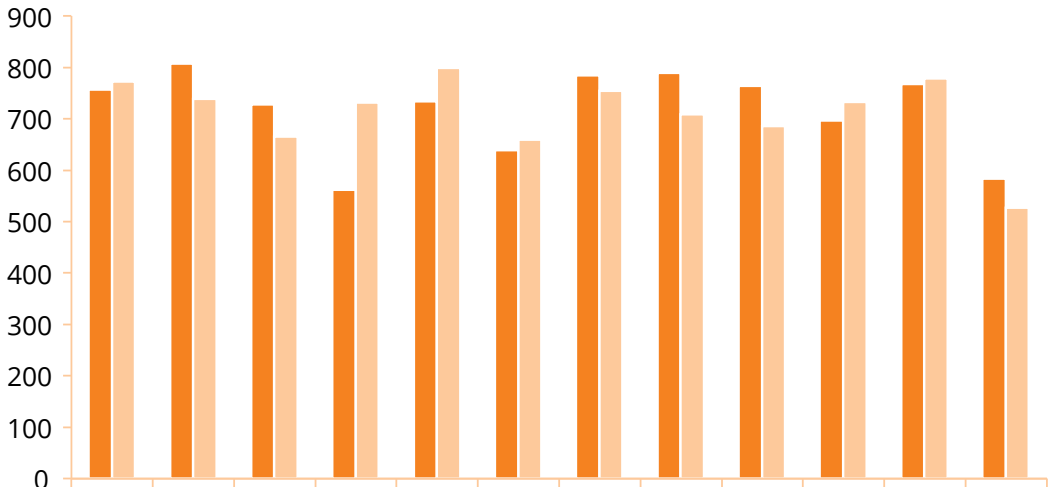
New cases seen by Psychiatry of Later Life Service 2018

In 2018 a total number of 8,804 new cases were offered an appointment by Psychiatry of Later Life Services. This compares to 8,829 cases in 2017.

A total of 8,553 (8,614 in 2017) were seen and 251 (215 in 2017) did not attend (DNA).

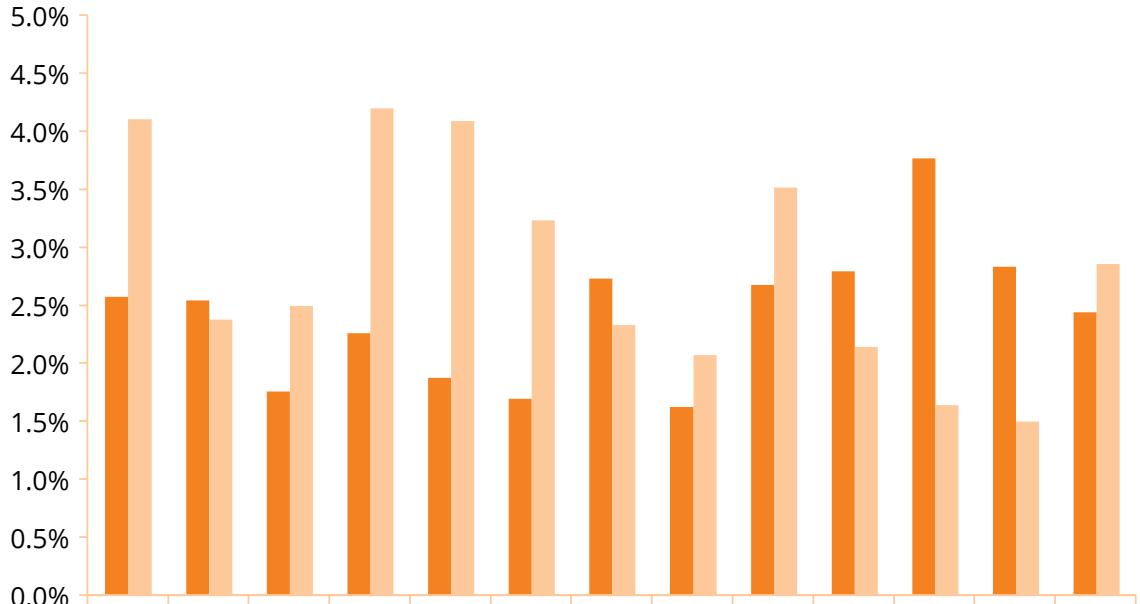
This gives a non-attendance rate of 2.9%, ranging from 1.5% to 4.2% across the 12 month period. The national DNA rate is impacted by particular challenges experienced by one area over this period, which have been addressed with planned improvement in 2018.

New (including re-referred) Cases Seen 2017 vs. 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2017	757	807	728	562	734	639	785	789	764	697	768	584
Seen - 2018	772	739	665	731	799	659	754	709	686	733	779	527

New (including re-referred) DNA 2017 vs. 2018



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2017	2.6%	2.5%	1.8%	2.3%	1.9%	1.7%	2.7%	1.6%	2.7%	2.8%	3.8%	2.8%	2.4%
2018	4.1%	2.4%	2.5%	4.2%	4.1%	3.2%	2.3%	2.1%	3.5%	2.1%	1.6%	1.5%	2.9%

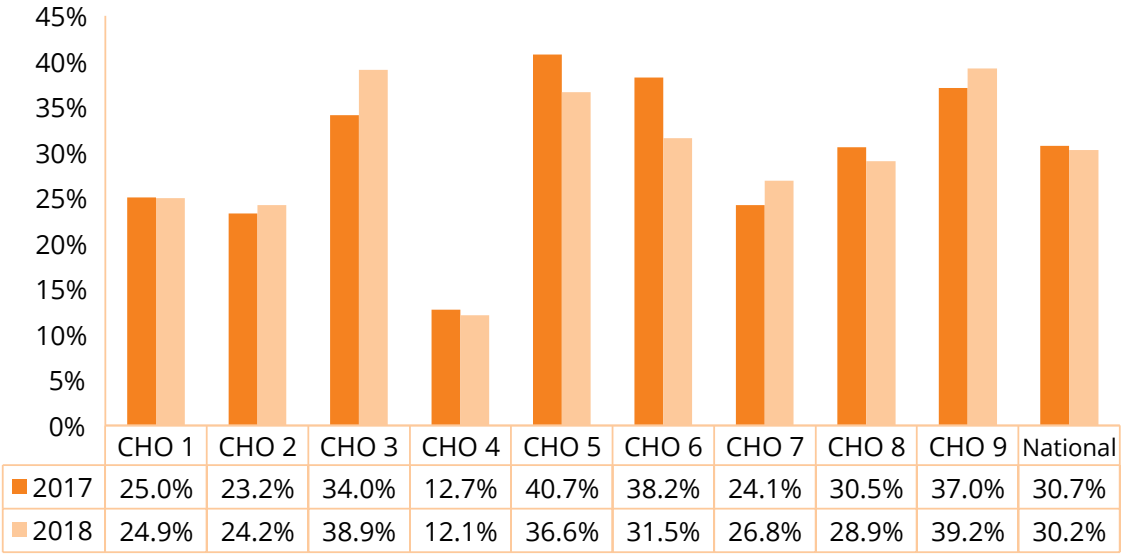
Breakdown of New Cases (New vs. Re-referred Cases)

A proportion of the new cases seen, will have previously attended the service and been discharged. In 2018, of the 8,553 cases seen, a total of 2,583 had been re-referred to the service. This represents a 30.2% re-referred rate.

In 2017, of the 8,614 cases seen, a total of 2,634 had been re-referred to the service. This represents a 30.7% re-referred rate.

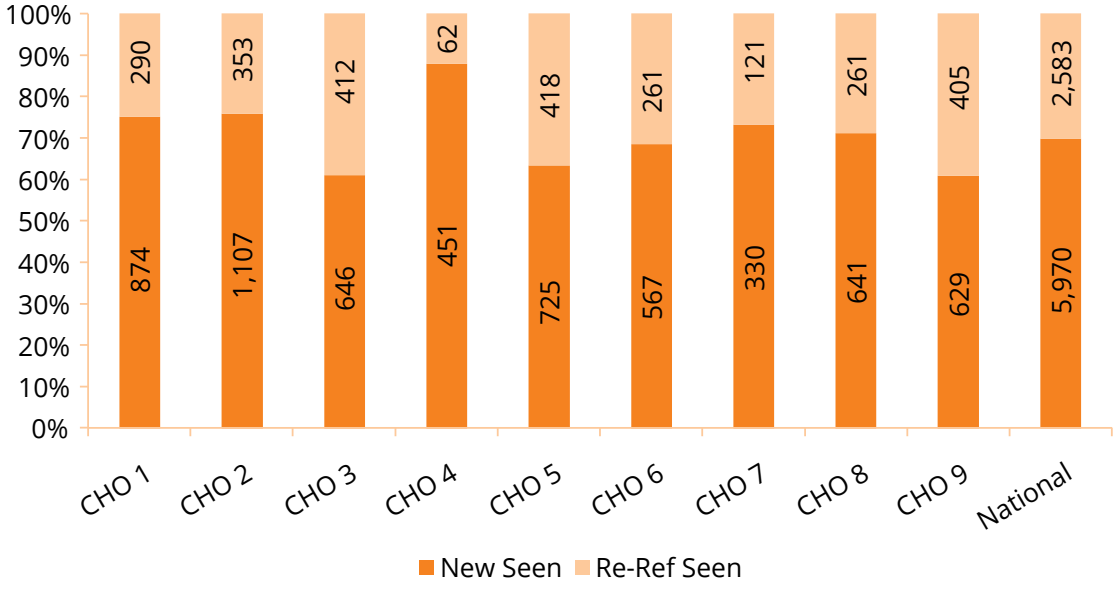
The proportion of re-referred cases varied in 2018 from 12.1% in CHO 4 to 39.2% in CHO 9 (in figure below).

Percentage of re-referred cases 2017 vs. 2018



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2017	25.0%	23.2%	34.0%	12.7%	40.7%	38.2%	24.1%	30.5%	37.0%	30.7%
2018	24.9%	24.2%	38.9%	12.1%	36.6%	31.5%	26.8%	28.9%	39.2%	30.2%

Breakdown of New Cases Seen (new vs. re-referred cases) 2018



Waiting Times for New Cases Seen

In 2018, a total number of 8,804 patients were offered an appointment, of which 8,553 new cases were seen by Psychiatry of Later Life Service.

The waiting time to be seen was recorded for each case over the 12 month period:

Length of wait to 1st appointment seen 2018 by CHO

	< 1 week	> 1 to 2 weeks	> 2 to 3 weeks	> 3 to 4 weeks	> 4 to 8 weeks	> 8 to 12 weeks	> 12 Weeks	DNA
CHO 1	64.4%	17.3%	6.2%	3.7%	3.4%	1.4%	2.0%	1.6%
CHO 2	36.3%	29.8%	15.1%	12.0%	5.5%	0.1%	0.0%	1.2%
CHO 3	36.8%	21.4%	16.1%	13.1%	7.5%	3.2%	1.0%	0.8%
CHO 4	34.3%	15.6%	13.3%	6.6%	12.6%	3.6%	5.2%	8.9%
CHO 5	41.8%	25.4%	14.4%	7.4%	5.8%	1.7%	1.4%	2.1%
CHO 6	34.9%	7.8%	15.8%	7.4%	21.7%	9.7%	1.8%	1.0%
CHO 7	28.4%	13.1%	10.1%	8.2%	20.6%	10.8%	5.8%	3.0%
CHO 8	23.6%	37.0%	11.5%	8.6%	10.5%	4.5%	2.8%	1.5%
CHO 9	33.7%	18.6%	13.5%	6.8%	11.7%	5.4%	2.0%	8.3%
National	38.5%	22.0%	13.0%	8.4%	9.6%	3.7%	1.9%	2.9%

Cases Closed or Discharged

In 2018, 7,019 cases were closed and discharged by Psychiatry of Later Life Service. This compares to 6,963 cases closed in 2017.

87.8% of the cases closed were discharged to the care of the General Practitioner or Primary Care Team (PCT) / Community Care Service and 12.2% due to death.

	Closed / Discharged to GP/ Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed due to Death	Total Closed Discharged
CHO 1	836	181	77	1,094
CHO 2	916	185	151	1,252
CHO 3	307	80	108	495
CHO 4	432	53	51	536
CHO 5	817	0	189	1,006
CHO 6	630	0	68	698
CHO 7	349	76	30	455
CHO 8	760	1	143	904
CHO 9	527	12	40	579
National	5,574	588	857	7,019

Percentage of Cases closed and discharged by CHO

	Closed / Discharged to GP/Primary Care Team / community care service	Closed due to Death
CHO 1	93.0%	7.0%
CHO 2	87.9%	12.1%
CHO 3	78.2%	21.8%
CHO 4	90.5%	9.5%
CHO 5	81.2%	18.8%
CHO 6	90.3%	9.7%
CHO 7	93.4%	6.6%
CHO 8	84.2%	15.8%
CHO 9	93.1%	6.9%
National	87.8%	12.2%

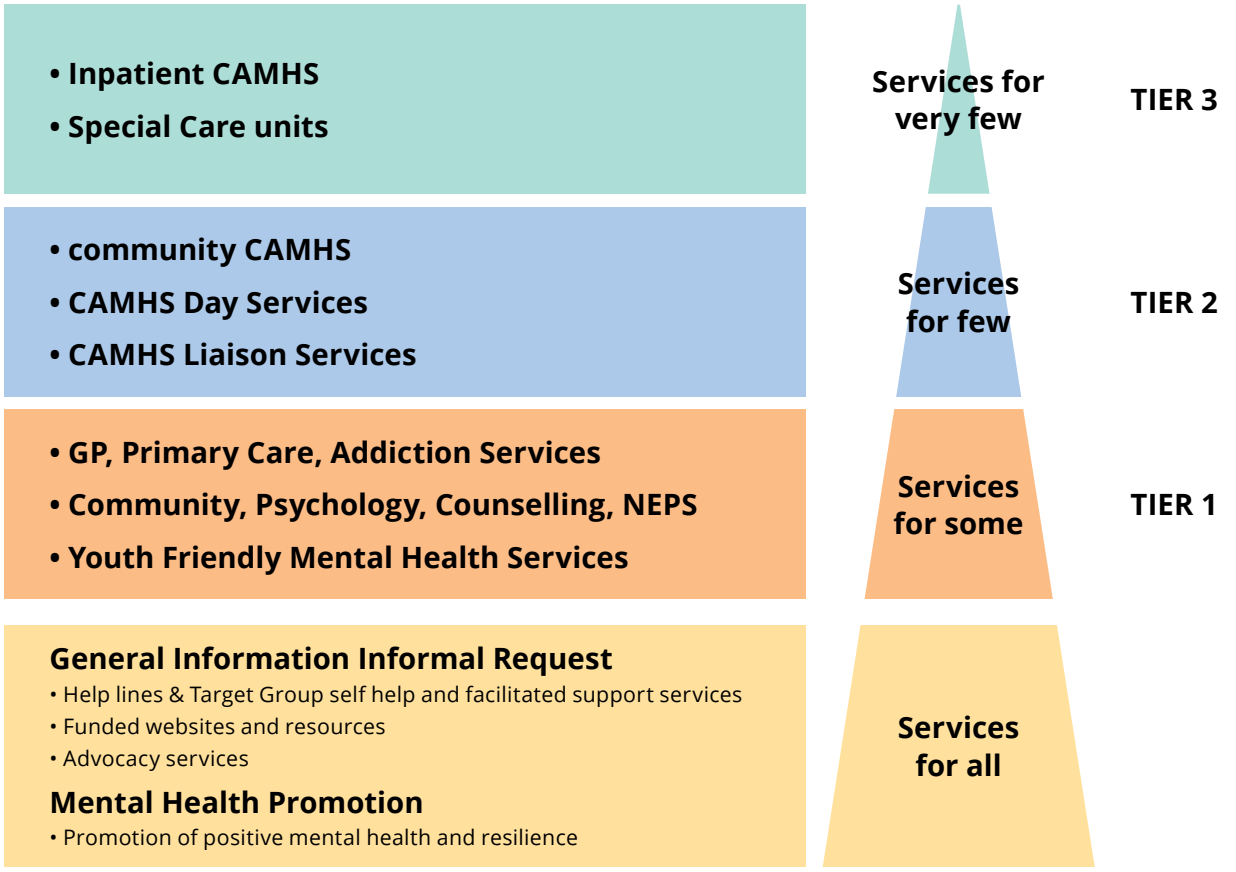
Chapter 8

Child and Adolescent Mental Health Acute Inpatient Services

Inpatient CAMHS

- CAMHS inpatient units offer assessment and treatment to children and adolescents up to the age of 18, with severe and often complex mental health difficulties.
- CAMHS inpatient units are known as "Approved Centres" and they are inspected by the Mental Health Commission. This means there are rules and codes of practice and legislation which must be followed by all CAMHS Inpatient Units. These regulations cover physical examination, physical restraint, risk assessment, admission, transfer and discharge from a CAMHS inpatient unit.
- Currently there are four HSE/HSE funded inpatient CAMHS units provided across the country.

The Graphic below shows where inpatient services fit within the Tiers of Mental Health Care



Inpatient CAMHS Units

Unit Name	Unit Location	Current Number of Registered beds with MHC	Primary Catchment Area
Eist Linn (HSE)	Cork CHO4	20	CHO 4 & CHO 5
Merlin Park (HSE)	Galway CHO2	20	CHO 1(a) Sligo/Leitrim/Donegal, CHO2, CHO3.
Linn Dara (HSE)	West Dublin CHO7	24 (22+2 High Observation Beds)	CHO6, CHO7, CHO8 (a) Laois/ Offaly/Longford/Westmeath.
St. Joseph's (HSE funded)	North Dublin CHO9	12	CHO9, CHO1 (b) (Cavan/ Monaghan), CHO8 (b) (Louth/Meath).
Total		74 (+2 high obs)	

Key Facts

- 2008 – 16 CAMHS Acute Inpatient beds; 2018 – 74 CAMHS Acute Inpatient beds
- 2008 – 25% admissions to CAMHS inpatient beds; 2018 – 70.7% admission to CAMHS inpatient beds
- 11% decrease in bed days used in 2018
- 92.7% bed days used in Child Adolescent Acute Inpatient Units as a total of bed days.

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 age appropriate 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, 74 CAMHS Acute Inpatient beds were funded at the end December 2018.

HSE inpatient services and bed capacity (2008 to 2018)

Child & Adolescent Inpatient Units	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
St. Anne's Inpatient Unit, Galway	10	10	10								
New Unit, Merlin Park Hospital, Galway				20	20	20	20	20	20	20	20
Warrenstown Inpatient Unit, Dublin	6	6	6	6							
Interim Linn Dara Unit, Palmerstown, Dublin (May 2012*)					8	8	14				
Linn Dara Inpatient Unit, Cherry Orchard Hospital, Dublin (Dec 2015†)								22‡	22‡	22‡	22‡
St. Vincent's Hospital, Fairview, Dublin		6	6	6	12	12	12	12	12	12	12
Interim Eist Linn Unit, St. Stephen's Hospital, Cork		8	8								
Eist Linn Unit, Bessboro, Cork				20	20	20	20	20	20	20	20
Total No. of Beds	16	30	30	52	60	60	66	74	74	74	74

**Transfer from Warrenstown to Interim Linn Dara Unit May 2012*
† Partial opening of new unit

‡ 22 plus 2 additional high observation beds.

Maximising the admission of children to age appropriate CAMHS Acute Inpatient Units

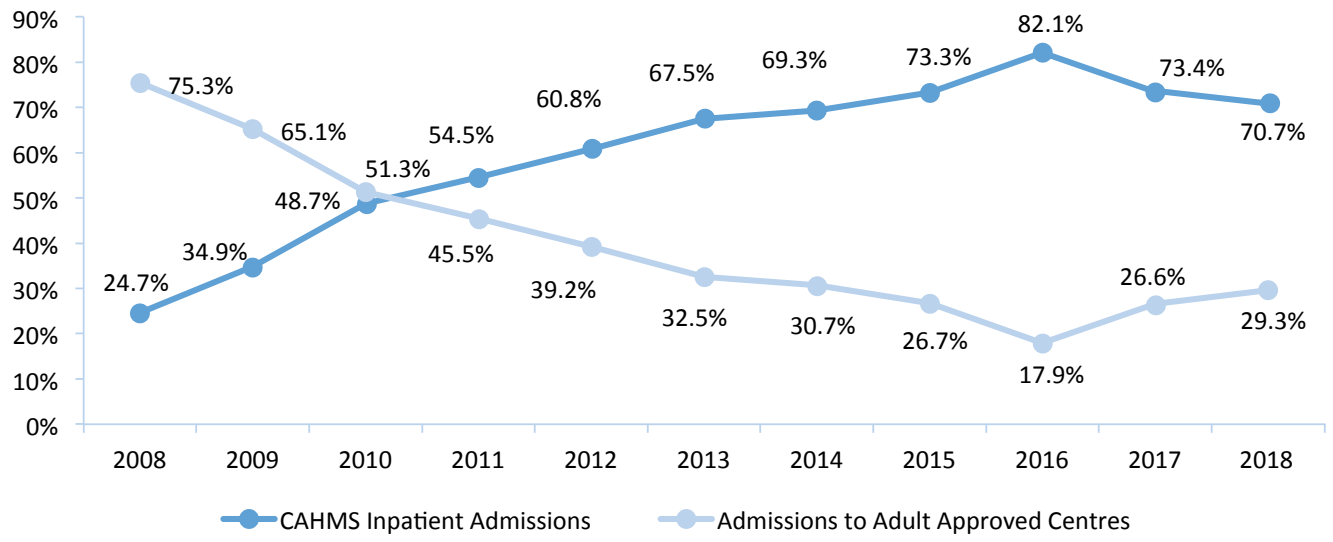
The increase in the availability of age appropriate CAMHS acute inpatient facilities has enabled the CAMHS service to ensure, as much as possible, that when a child is admitted, that admission is to age appropriate inpatient facilities.

In 2018, there were 287 children and adolescents admitted and of these, 203 (70.7%) were admitted to child and adolescent inpatient units and 84 (29.3%) to adult approved centres.

Of these 287 admissions, 93% (267) were voluntary admissions with parental consent with a very small number under Section 25 of the Mental Health Act 2001. Of the 84 admitted to Adult Approved Centres, 77 or 92% were 16/17 years old with 38.1% (32) of these discharged either the same day or within 3 days and 61.9% (52) within a week.

Admissions of children to Acute Inpatient Units 2008-2018

Figure below shows the increase in the percentage of admissions of children to age appropriate units in the period from 2008 to 2018.



Number of admissions by Unit/Unit Type*

Child and Adolescent Units	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
St. Anne's, Galway	32	31	29	33								
Merlin Park Inpatient Unit, Galway					38	71	70	68	85	95	60	35
St. Joseph's, Fairview, Dublin			29	34	42	36	38	33	54	67	44	52
Warrenstown Unit, Blanchardstown, Dublin	46	42	37	37	39							
Interim Linn Dara Unit, Palmerstown, Dublin						24†	30	46	83	110	66	69
Eist Linn, St. Stephen's Hospital, Cork			4	44	5							
Eist Linn, Bessboro, Cork					32	38	49	54	39	40	56	47
Total Child	78	73	99	148	156	145	187	201	261	312	226	203
Adult Units	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
HSE Adult Units	190	223	185	155	129	109	91	89	95	68	82	84
Central Mental Hospital				1	1							
Total Adult	190	223	185	156	130	109	91	89	95	68	82	84
Total	268	296	284	304	286	254	278	290	356	380	308	287

† 6 of these admissions were to Warrenstown House before its closure

* *N.B Admission data does not include admission of Children to Private Units.*

How long are children staying in Acute Inpatient Units?

The length of stay of child admissions is longer than adults due to the greater complexity in assessing and treating the clinical presentations of children. In 2018, the total number of bed days used by the admission of children was 18,431, a decrease of -11% (-2,215) on the 2017 position of 20,646.

In 2018, 92.7% (17,093) of bed days used were in the age appropriate Child and Adolescent Acute Inpatient Units with 7.3% (1,338) used in adult approved centres. These figures are comparable with 2017 position of 96.9% (20,013) in CAMHS inpatient and 3.1% (633) in adult approved centres.

The following table provides a detailed breakdown of bed usage in CAMHS and adult units by each CHO.

In interpreting the data it should be noted that a small number of individuals having an unusually long length of stay can impact the statistics.

Bed Days used by CHO

Bed Days Used	2017					2018				
	Total Days Used	CAMHS	IP	Adult	IP	Total Days Used	CAMHS	IP	Adult	IP
CHO 1	1,569	1,547	98.6%	22	1.4%	904	773	85.5%	131	14.5%
CHO 2	3,396	3,379	99.5%	17	0.5%	2,339	2,339	100.0%	0	0.0%
CHO 3	2,899	2,754	95.0%	145	5.0%	2,245	2,218	98.8%	27	1.2%
CHO 4	3,705	3,656	98.7%	49	1.3%	3,211	2,461	76.6%	750	23.4%
CHO 5	1,370	1,162	84.8%	208	15.2%	1,667	1,469	88.1%	198	11.9%
CHO 6	1,474	1,474	100.0%	0	0.0%	1,058	1,058	100.0%	0	0.0%
CHO 7	1,879	1,807	96.2%	72	3.8%	2,414	2,383	98.7%	31	1.3%
CHO 8	2,810	2,763	98.3%	47	1.7%	2,787	2,707	97.1%	80	2.9%
CHO 9	1,544	1,471	95.3%	73	4.7%	1,806	1,685	93.3%	121	6.7%
National	20,646	20,013	96.9%	633	3.1%	18,431	17,093	92.7%	1338	7.3%

The following table compares the percentage of admissions of children by length of stay in the Adult Approved Centres between 2014 and 2018.

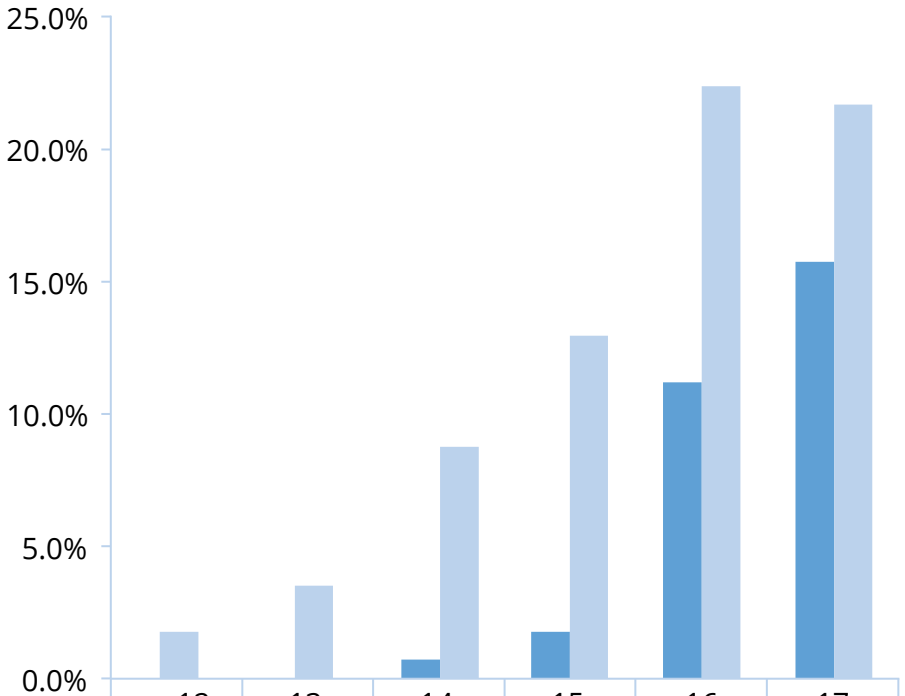
Percentage of admissions by Length of Stay in Adult Approved Centres

	2014	2015	2016	2017	2018
Same day discharged	1.1%	6.3%	14.7%	6.1%	2.4%
1-3 days	33.7%	34.7%	48.5%	39.0%	35.7%
3-5 days	14.6%	14.7%	13.2%	17.1%	10.7%
5-7 days	12.4%	10.5%	7.4%	12.2%	13.1%
>7 <=14	21.4%	13.7%	10.3%	14.6%	15.5%
2-3 weeks	6.7%	8.4%	2.9%	2.4%	8.3%
3-4 weeks	2.3%	3.2%	0.0%	4.9%	6.0%
4-8 weeks	6.7%	6.3%	1.5%	2.4%	3.6%
8-12 weeks	0.0%	1.1%	1.5%	0.0%	1.2%
12-16 weeks	1.1%	0.0%	0.0%	0.0%	1.2%
>16 weeks	0.0%	1.1%	0.0%	1.2%	2.4%
Admissions	89	95	68	82	84

Age of admissions (2018)

Of the 287 admissions of children and adolescents in 2018, 37.3% were aged 17 years or over on admission, 33.4% were aged 16 years, 14.6% were aged 15 years, 9.4% were aged 14 years, 3.5% were aged 13 years, and 1.8% were aged 12 years or under.

Age of admissions (2018)



	=<12	13	14	15	16	17
Adult Units	0.0%	0.0%	0.7%	1.7%	11.1%	15.7%
Child & Adolescent Units	1.7%	3.5%	8.7%	12.9%	22.3%	21.6%

Planned Development for Child and Adolescent Mental Health Services

New Children's Hospital of Ireland

Construction started at the end of 2016 on the New Children's Hospital which 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. Completion of the new children's hospital is planned for 2021.

New 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. Design of the Hospital is well advanced, contractors have been engaged and construction has commenced.

Chapter 9

Adult Acute Inpatient Services

Key Facts

- 29 Acute Inpatients units
- 2007 – 16,293 admissions;- 2018 – 12,106 admissions
- 2007 – 72% re- admission rate;- 2018 – 62.8% re- admission rate

Mental Health Adult Acute Inpatient Services

The aim of an admission to an Adult Acute Inpatient Unit is to:

- Provide 24/7 care and treatment of those with the most severe mental illness.
- Implement specific treatment programmes.
- Achieve the earliest possible discharge of the individual back to their family and on-going care of the Community Mental Health team.

Inpatient psychiatric treatment, where clinically indicated, is usually only for individuals with severe psychiatric disorders such as schizophrenia, depression, and mania. Other presentations include severe and/or complex medical-psychiatric disorders such as anorexia / bulimia. Admission may occasionally also be required for clarification of diagnosis and appropriate treatment or for the commencement and monitoring of specific medication.

Individuals may be admitted voluntarily, or as an involuntary patient within the provisions of the Mental Health Act, 2001. In 2018 83.9% of admissions were voluntary admissions.

All Adult Acute Inpatient Units are required to be registered as Approved Centres under the Mental Health Act 2001 and this Register is maintained by the Mental Health Commission and the centres listed below are the centres currently on the Register. Subject to the provisions of the Mental Health Act 2001, each centre's registration lasts for three years from the date of registration.

2018 Adult Acute Inpatient Units by CHO

CHO 1	CHO 6
Letterkenny General - Unit	St. John of Gods Private Hospital
Sligo Mental Health Services	St. Vincent's University Hospital, Elm Park Unit
Cavan General - Unit	Newcastle Hospital
CHO 2	**CHO 7**
UCHG - Unit	Tallaght Hospital - Unit
Mayo General Hospital - Unit	St. James Hospital - Unit
Roscommon General Hospital - Unit	Lakeview Unit, Naas General Hospital - Unit
CHO 3	**CHO 8**
Ennis General Hospital - Unit	St. Loman's Hospital, Mullingar
Mid-Western Regional Hospital, Limerick - Unit	Midlands Regional Hospital PL - Unit
CHO 4	Cluain Lir Care Centre, Mullingar
Cork University Hospital - Unit	Drogheda Department of Psychiatry, Crosslanes, Drogheda, Co Louth
St. Stephen's Hospital, Glanmire	
Kerry General Hospital - Unit	**CHO 9**
Mercy University Hospital - Unit	Mater Hospital - St. Aloysius Unit
Bantry General - Unit	Ashlin Centre - Joyce Unit & Sheehan Unit
CHO 5	St. Vincent's Hospital Fairview
St. Luke's Hospital Kilkenny - Unit	Connolly Hospital - Unit
Waterford General Hospital - Unit	

Under the Mental Health Act 2001, people who receive treatment in approved centres (that is, psychiatric hospitals or inpatient units); should be included in discussions on their care and treatment and in the care planning process for their treatment. Patients have the right to be treated with dignity and respect and the right to be listened to by all those working on their care team. They are entitled to take part in decisions that affect their health and their care team should consider their views carefully. They have the right to be fully informed about their legal rights, their admission and treatment.

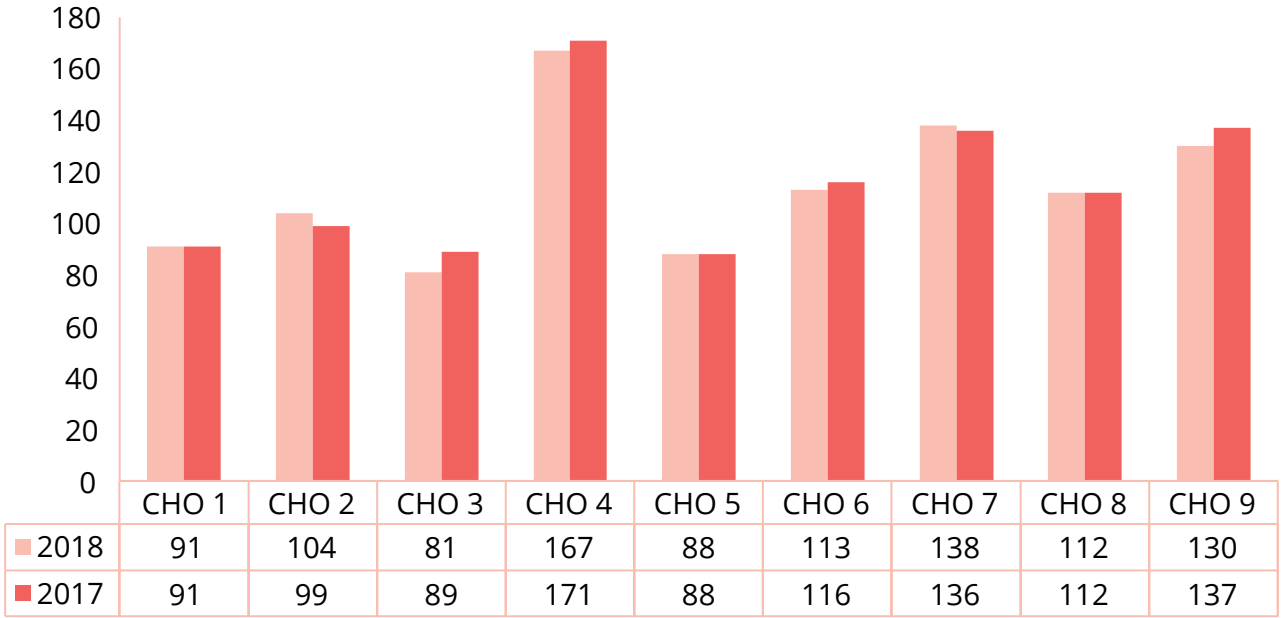
Adult Mental Health Acute inpatient Beds

There are 29 adult acute inpatient units nationally. At the end of 2018, the number of adult acute inpatient places was 1,024 (1,039 at the end of 2017) or 21.5 beds per 100,000 population. The information provided below includes General Adult Psychiatry acute admissions and Psychiatry of Later Life acute admissions.

Adult Acute Inpatient Units, Beds & Bed Rate per 100,000 by CHO

	2018				2017			
	Total Population	**Units**	**Beds**	**Bed Rate per 100,000**		**Units**	**Beds**	**Bed Rate per 100,000**
CHO 1	394,333	3	91	23.1	CHO 1	3	91	23.1
CHO 2	453,109	3	104	23.0	CHO 2	3	99	21.8
CHO 3	384,998	2	81	21.0	CHO 3	2	89	23.1
CHO 4	690,575	5	167	24.2	CHO 4	5	171	24.8
CHO 5	510,333	2	88	17.2	CHO 5	2	88	18.3
CHO 6	549,531	3	113	20.6	CHO 6	3	116	25.9
CHO 7	541,352	3	138	25.5	CHO 7	3	136	20.2
CHO 8	616,229	4	112	18.2	CHO 8	4	112	18.2
CHO 9	621,405	4	130	20.9	CHO 9	4	137	22.0
National	4,761,865	29	1,024	21.5	National	29	1,039	21.8

Adult Acute Inpatient Beds 2017/2018 by CHO



Vision for Change recommends a separate 8 bed acute Psychiatry of Later Life unit per 300,000 population. Current provision of POLL units nationally is shown in the table below which also indicates POLL units which are due to open as part of the commissioning of a new adult unit. All new adult units now and in the future will include a dedicated POLL unit. Admission activity provided by the Health Research Board does not distinguish between General Adult and Psychiatry of Later Life patients.

Adult Acute Inpatient Units with separate POLL Provision

CHO	Approved Centre	POLL Unit	Comment
CHO3	Acute Psychiatric Unit 5B, University Hospital Limerick	•	New and being commissioned
CHO3	Acute Psychiatric Unit, Ennis, Co Clare	•	
CHO4	Acute Mental Health Unit, Kerry General Hospital, Tralee	•	When unit fully commissioned
CHO4	South Lee Mental Health Unit, CH	•	
CHO6	Elm Mount Unit, St Vincent's	•	
CHO7	Jonathan Swift Clinic, St James's, Dublin 8	•	
CHO8	Crosslanes Drogheda	•	
CHO9	Ashlin Centre, Beaumont, Dublin 9	•	
CHO9	St Vincent's Hospital, Richmond Road, Fairview, Dublin 3	•	Serves all of Dublin North City

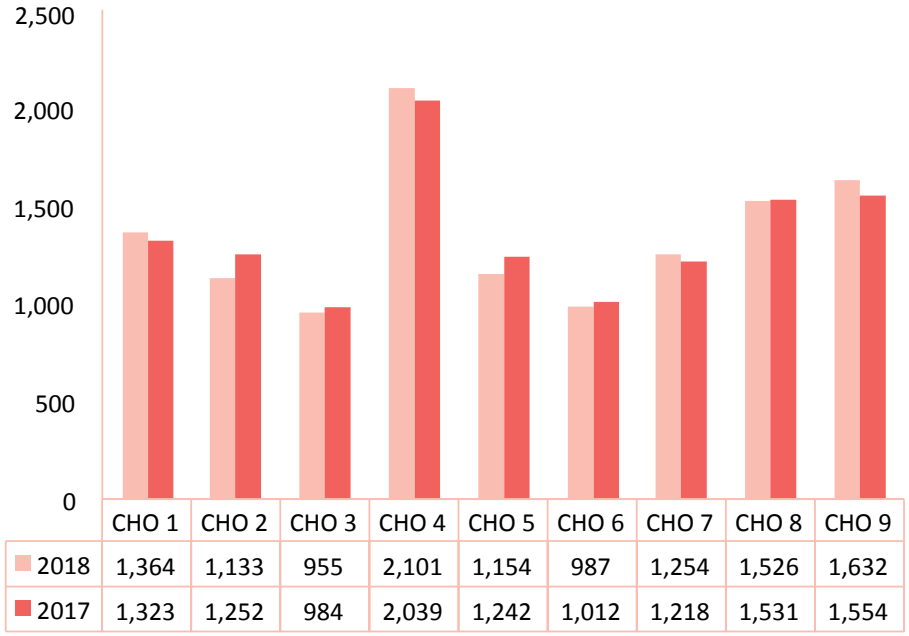
Admissions to Adult Acute Inpatient Units

Admissions refer to all admissions of individuals to adult acute psychiatric units/hospitals during the year. Therefore there can be a number of admissions by one individual. The activity presented for each CHO includes both first admissions and re-admissions.

At the end of 2018 the number of admissions was 12,106 compared to 12,155 at the end of 2017.

	Admissions				
	2014	2015	2016	2017	2018
CHO 1	1,212	1,254	1,299	1,323	1,364
CHO 2	1,487	1,510	1,300	1,252	1,133
CHO 3	1,005	1,024	1,026	984	955
CHO 4	2,120	2,127	1,997	2,039	2,101
CHO 5	1,355	1,366	1,327	1,242	1,154
CHO 6	1,076	1,172	1,156	1,012	987
CHO 7	1,486	1,369	1,356	1,218	1,254
CHO 8	1,607	1,675	1,621	1,531	1,526
CHO 9	1,632	1,626	1,508	1,554	1,632
National	12,980	13,123	12,590	12,155	12,106

Adult Acute Admissions 2017 - 2018 by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2018	1,364	1,133	955	2,101	1,154	987	1,254	1,526	1,632
2017	1,323	1,252	984	2,039	1,242	1,012	1,218	1,531	1,554

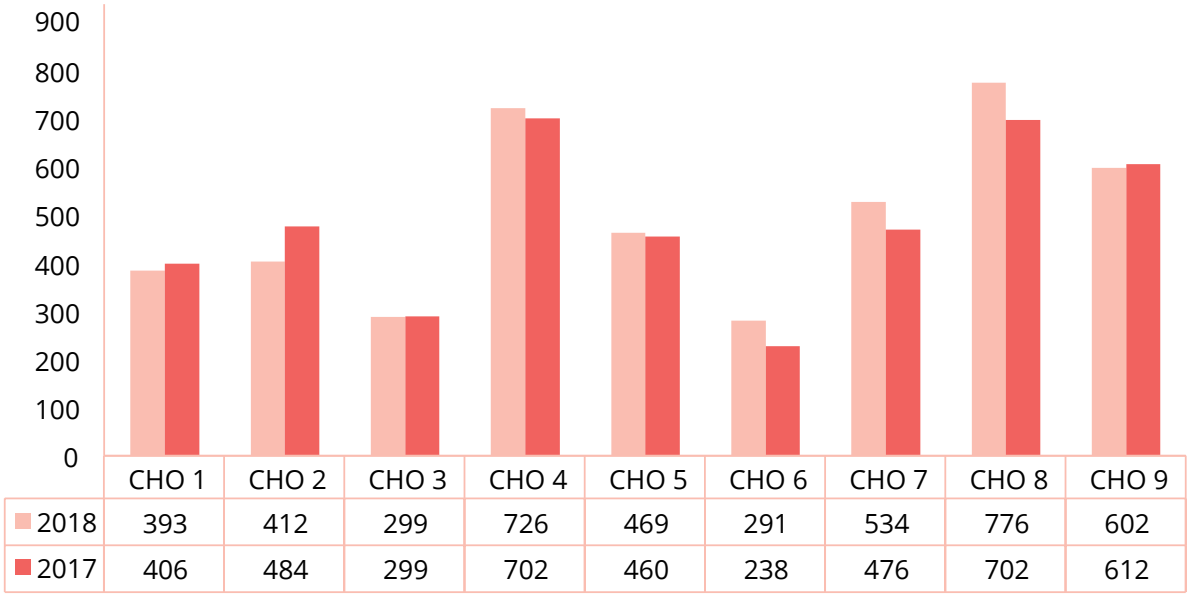
Adult Acute First Admissions

First admissions are admissions of persons who were not previously admitted to the receiving hospital or unit or to any other psychiatric inpatient facility.

At the end of 2018 the number of First admissions was 4,502, compared to 4,379 at the end of 2017. First admissions accounted for 37% of admissions in 2018.

	First time admissions				
	2014	**2015**	**2016**	**2017**	**2018**
CHO 1	333	352	373	406	393
CHO 2	557	584	527	484	412
CHO 3	290	324	311	299	299
CHO 4	691	724	715	702	726
CHO 5	487	509	516	460	469
CHO 6	335	357	293	238	291
CHO 7	519	542	510	476	534
CHO 8	518	586	727	702	776
CHO 9	539	545	499	612	602
National	4,269	4,523	4,471	4,379	4,502

Adult Acute First admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2018	393	412	299	726	469	291	534	776	602
2017	406	484	299	702	460	238	476	702	612

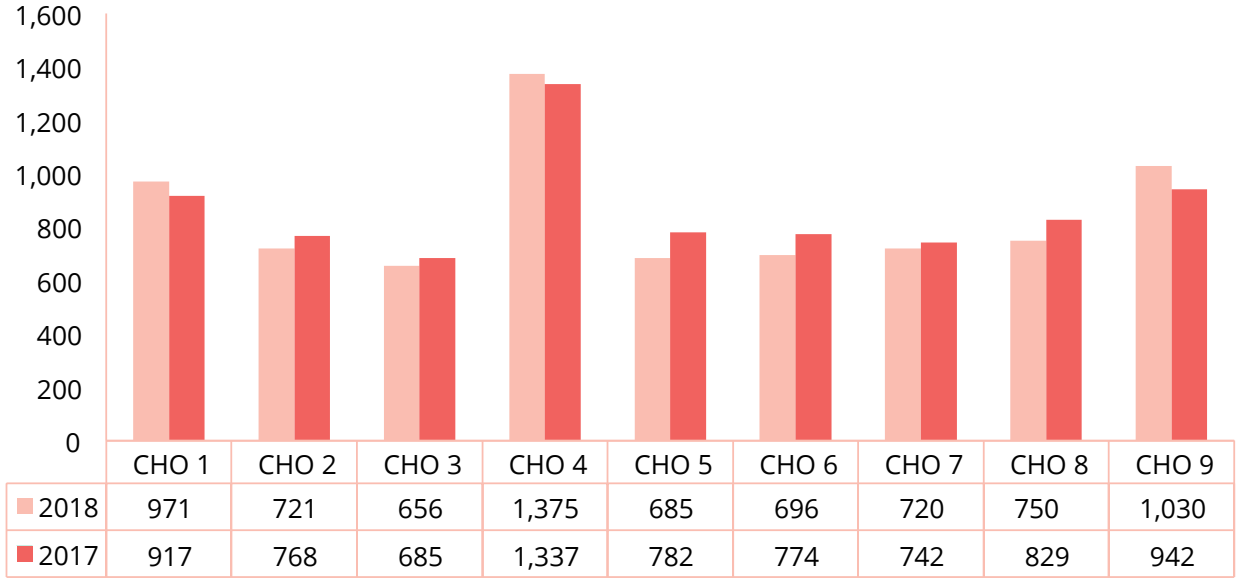
Adult Acute Re-admissions

Re-admissions are admissions of persons who were either previously admitted to the receiving hospital or unit or to any other psychiatric acute inpatient facility.

At the end of 2018 the number of re-admissions was 7,604, compared to 7,776 at the end of 2017. Re-admissions accounted for 62.8% of admissions in 2018.

	Re-admissions				
	2014	**2015**	**2016**	**2017**	**2018**
CHO 1	879	902	926	917	971
CHO 2	930	926	773	768	721
CHO 3	715	700	715	685	656
CHO 4	1,429	1,403	1,282	1,337	1,375
CHO 5	868	857	811	782	685
CHO 6	741	815	863	774	696
CHO 7	967	827	846	742	720
CHO 8	1,089	1,089	887	829	750
CHO 9	1,093	1,081	1,008	942	1,030
National	8,711	8,600	8,111	7,776	7,604

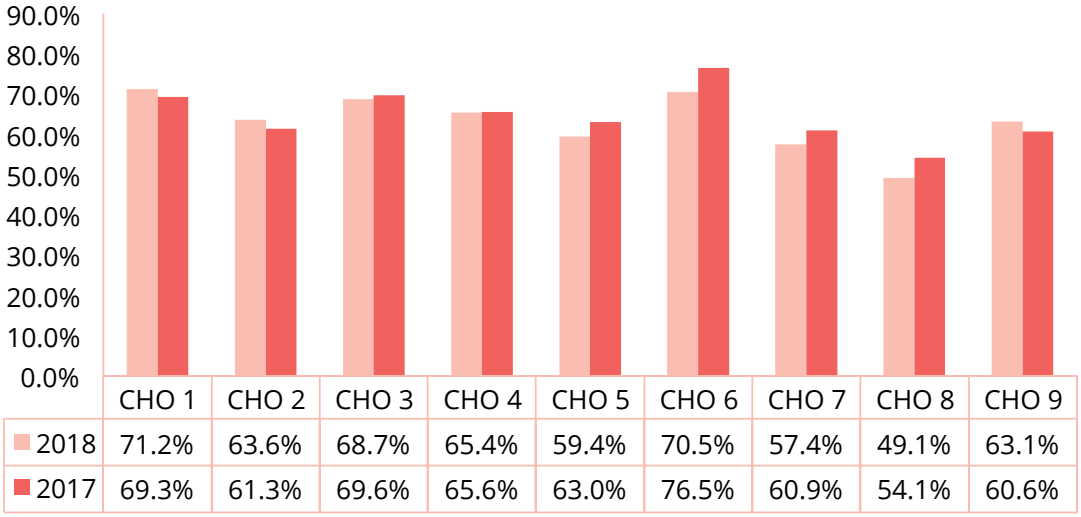
Adult Acute Re-Admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2018	971	721	656	1,375	685	696	720	750	1,030
2017	917	768	685	1,337	782	774	742	829	942

Percentage of Re-admissions						
	2016		2017		2018	
CHO 1	926	71.3%	917	69.3%	971	71.2%
CHO 2	773	59.5%	768	61.3%	721	63.6%
CHO 3	715	69.7%	685	69.6%	656	68.7%
CHO 4	1,282	64.2%	1,337	65.6%	1,375	65.4%
CHO 5	811	61.1%	782	63.0%	685	59.4%
CHO 6	863	74.7%	774	76.5%	696	70.5%
CHO 7	846	62.4%	742	60.9%	720	57.4%
CHO 8	887	54.7%	829	54.1%	750	49.1%
CHO 9	1,008	66.8%	942	60.6%	1,030	63.1%
National	8,111	64.4%	7,776	64.0%	7,604	62.8%

Percentage of Adult Acute Re-Admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2018	71.2%	63.6%	68.7%	65.4%	59.4%	70.5%	57.4%	49.1%	63.1%
2017	69.3%	61.3%	69.6%	65.6%	63.0%	76.5%	60.9%	54.1%	60.6%

Length of Stay

Length of stay is the amount of time, counted in days, spent in adult acute inpatient units by an individual from the date of admission to the date of discharge. The date of admission and the date of discharge figures are calculated for those who were discharged during the reporting year. The length of stay calculation excludes those with a length of stay greater than one year. This practice reflects the fact that measures of length of stay such as the mean and range would be heavily skewed towards larger values by including these outliers.

Median length of stay is the middle number in the sequence of numbers created by listing all of the figures for length of stay during the period of less than one year. Where such a sequence has an even amount of numbers, the median is the average of the two middle numbers.

At the end of 2018 the median length of stay was 11.5 days.

Median Length of stay

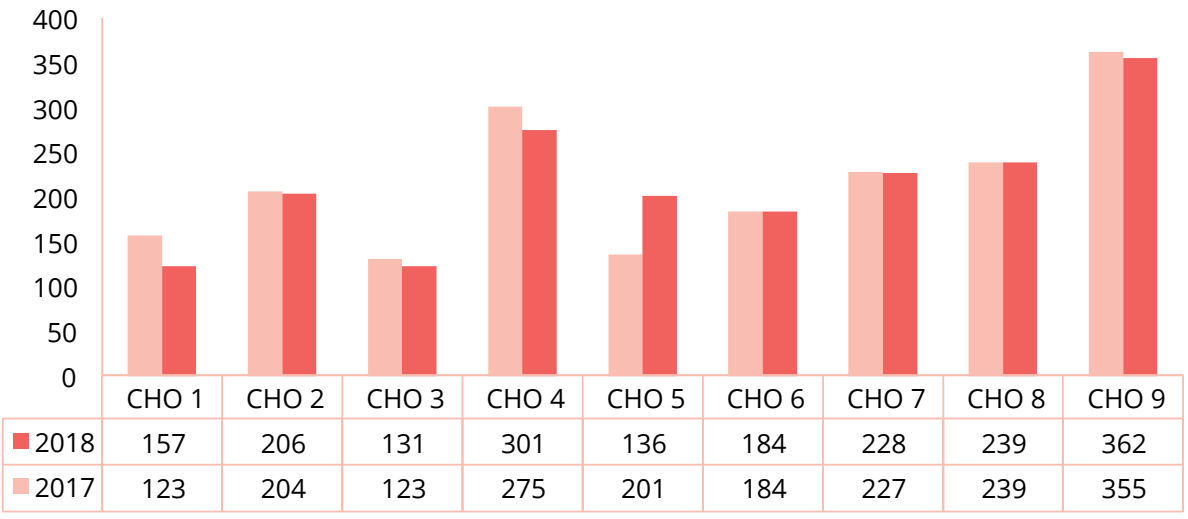
	2014	2015	2016	2017	2018
CHO 1	10.4	9.8	8.3	9.0	8.6
CHO 2	12.7	11.1	11.1	10.0	14.3
CHO 3	13.3	12.9	14.8	14.0	13.5
CHO 4	13.5	13.4	14.5	12.0	13.3
CHO 5	9.8	9.3	9.5	10.0	8.6
CHO 6	14.0	14.3	11.5	14.0	14.3
CHO 7	9.3	11.2	10.3	14.0	11.8
CHO 8	11.7	11.4	9.3	11.0	9.8
CHO 9	23.9	16.1	10.3	11.0	10.3
National	13.2	12.2	11.0	12.0	11.5

Involuntary Admissions to Adult Acute Inpatient Units

An involuntary admission refers to the legal status of each admission as recorded at the time of admission to acute units/hospitals in each CHO. At the end of 2018 the number of involuntary admissions was 1,944 (1,931 at the end of 2017). Involuntary admissions accounted for 16.1% of both first and re-admissions to adult acute inpatient units in 2018.

	Involuntary admission				
	2014	**2015**	**2016**	**2017**	**2018**
CHO 1	208	187	167	123	157
CHO 2	175	215	194	204	206
CHO 3	150	114	132	123	131
CHO 4	228	277	279	275	301
CHO 5	206	194	241	201	136
CHO 6	187	228	219	184	184
CHO 7	188	204	256	227	228
CHO 8	165	235	209	239	239
CHO 9	286	246	286	355	362
National	1,793	1,900	1,958	1,931	1,944

Involuntary admissions by CHO



Data Notes

The Health Research Board (HRB) provides Performance Indicator (PI) reports each quarter for the Health Service Executive from which the activity in acute mental health inpatient units is prepared. In utilising the information it is important to note a number of limitations of the data.

Data related to transfers to general hospitals for medical, surgical or other treatments, are not included in HRB reporting, as it would lead to the loss of data on length of stay. Patients in general hospitals, for any of the above treatments, often return to acute psychiatric units following the completion of treatment.

The figures presented for admissions represent events rather than persons. Therefore, one person may have more than one admission during any three month period, meaning that each admission is recorded separately. As such, the PI reports are reporting on the activity in acute inpatient services and do not necessarily represent the prevalence of mental illness.

Chapter 10

National Forensic
Mental Health Service

The National Forensic Mental Health Service (NFMHS) is a national tertiary mental health service and an integral part of the HSE's Mental Health Service, reporting centrally. The NFMHS is the only forensic mental health service for the population of Ireland. It works with local mental health services in every part of the country. The NFMHS is a national resource for teaching and training in all disciplines, driven by excellence in research and development, rights and recovery.

It provides a therapeutically safe and secure hospital setting where specialist treatments can be provided, as defined in the Mental Health Act 2010 Sections 10 and 21(2). It also provides such a service in accordance with the Criminal Law (Insanity) Acts 2006 & 2010.

Overview of the National Service

Definition of the specialty:

The National Forensic Mental Health Service (NFMHS) is the only forensic mental health service for the population of Ireland. It is currently located in Dundrum, Dublin, in the original building which was built in 1850. The Central Mental Hospital (CMH) provides secure hospital services at high, medium and pre-discharge levels. It is an Approved Centre with special status under the Mental Health Act 2001 and the only designated centre under the Criminal Law (Insanity) Act 2006. The National Forensic Mental Health Service also provides forensic rehabilitation and recovery teams that meet the requirements of Section 13A of the Criminal Law (Insanity) Act 2010 concerning the supervision of patients found not guilty by reason of insanity who are conditionally discharged. The National Forensic Mental Health Service and Central Mental Hospital is therefore subject to all the protections, rules and regulations that follow, including inspection by the Inspectorate of Mental Health Services. In 2018 the hospital commenced the process of opening 10 additional beds, increasing from 93 to 97 inpatient beds in 2018 and a number of community supported residences. The NFMHS also provides in-reach clinics at Cloverhill, Mountjoy, Dochas Centre, Wheatfield, the Midlands, Portlaoise, and Arbour Hill Prisons. It also provides a highly specialised in-reach forensic mental health service to Oberstown Children Detention Centre. The prison in-reach clinics are provided in close cooperation with the Irish Prison Service primary care teams so that a system of two stage reception screening is used to ensure early intervention. Weekly multi- disciplinary multi-agency meetings are held to ensure continuity of care and monitoring across prisons and through-care pathways back to community services. The construction of the new Central Mental Hospital on the Portrane site in North Dublin is continuing at an intense pace. The task of relocating to a new hospital is formidable but progressing well. It is expected to be completed and the service to transition in 2020. This new facility will increase the current bed capacity from 97 inpatient beds (103 in 2019) to 170.

The 170 beds include 10 specialist FMHID beds, 10 Forensic Child and Adolescent (FCAMHS) beds and a 30 bedded ICRU and additional bed capacity for women which will allow for the development of a care pathway for women. The transition programme is being actively developed so that modern, intensive services for the most severely mentally disordered patients will be delivered to international standards of quality and excellence.

Who is referred?

The National Forensic Mental Health Service provides mental health services for persons who require treatment in conditions of special therapeutic safety and security. Typically patients present a risk of serious harm to others. Seriousness is clinically assessed by Consultant Forensic Psychiatrists according to history of serious violence (homicide or potentially fatal assaults), complex needs (dual and triple diagnosis relevant to violence), institutional behaviour and other criteria. Specialist treatment needs are important and include the provision of specialised treatment programmes to reduce risk and to reduce the seriousness of risk. Highly specialised services are also provided in the high risk environments of prisons and to supervise those found not guilty by reason of insanity who have been conditionally discharged to the community.

Referred by whom

The NFMHS receives referrals from primary care teams in prisons and criminal justice agencies, from community mental health teams and from other agencies including An Garda Siochana, the courts and from psychiatrists working in the disabilities services. Typically those referred have a severe, enduring and disabling mental illness or mental disorder and are thought to represent a risk of harm to others.

Where assessed

The NFMHS provides in-reach clinics at Cloverhill, Mountjoy, Dochas Centre, Wheatfield, the Midlands, Portlaoise and Arbour Hill Prisons and also at Oberstown Children's Detention Centre. These prison in-reach clinics are equivalent to community out-patient clinics. This includes a psychiatric in-reach and court liaison service in Cloverhill, the largest remand prison, for diversion from the criminal justice system where possible. Outpatient assessments are also carried out at the NFMHS outpatient/ day centre at Ushers Island.

Recovery

The NFMHS ensures a recovery orientation in a forensic context. All patients are fully involved in the drafting of their individual care plans. The extent of change, engagement and growth through treatment programmes is assessed every six months through a system of routine outcome measures in which patients are also fully involved in setting their personal goals.

Special Needs Groups

The National Forensic Mental Health Service provides five specialist care and treatment pathways through conditions of therapeutic security: for men with severe, enduring and disabling mental illnesses detained under the Criminal Law (Insanity) Act, the Mental Health Act and sometimes Wardship; similarly for women in need of care and treatment in conditions of therapeutic security, for people with mental health intellectual disability and developmental needs, and for young people with severe mental health needs who are in contact with the youth justice system.

Service Activity Levels of Prison In-Reach Teams

Trends in committals to Irish prisons by gender and total, 2007-2018 as per Irish Prison Service Annual Report 2018.

Year	Total	Change from previous year - %	Persons	Change from previous year - %	Male	Female
2018	8,071	- 13.1	6,490	-13.3	7,066	1,005
2017	9,287	-38.5	7,484	-40.5	7,943	2,918
2016	15,099	-12.2	12,579	-11.3	10,033	2,546
2015	17,206	6.5	14,182	5.8	11,264	2,918
2014	16,155	2.7	13,408	2.7	10,723	2,685
2013	15,735	-7.6	13,055	-5.8	10,729	2,326
2012	17,026	-1.7	13,860	-0.7	11,709	2,151
2011	17,318	0.8	13,952	1.4	12,050	1,902
2010	17,179	11.4	13,758	11.5	12,057	1,701
2009	15,425	13.8	12,339	12.9	10,880	1,459
2008	13,557	13.6	10,928	12.5	9,703	1,225
2007	11,934	-1.8	9,711	0.1	8,556	1,155

The population served in prisons is better guided by the number of committals to each prison. A two stage screening system is being introduced in each prison and is already in operation in Cloverhill and Mountjoy. Currently 15% of all committals are seen by the psychiatric in-reach team at Cloverhill.

Prison In-reach Service 2018

Prison	New Referrals	Patient Reviews	Transfer to other In-reach teams	Transfer from other In-reach teams	Total discharges
Arbour Hill	19	214	6	8	18
Cork	191	1,036	44	6	103
Clover Hill	308	1,134	89	9	216
Castlerea	52	181	12	2	30
Dochas	81	540	4	5	82
Midlands	141	721	21	8	99
Mountjoy	110	1,131	23	28	102
Portlaoise					
Shelton Abbey					
Wheatfield Place of Detention	86	563	28	47	52
Oberstown Children Detention Campus	38	108	0	0	44
Total	1025	5628	227	113	746

Service Activity Levels of Central Mental Hospital

The number of persons found not guilty by reason of insanity has increased year on year since the law reforms of 2006 and 2010. The obligation on the Mental Health (Criminal Law) Review Board and on clinicians to act in the best interests of the patient and in the public interest means that length of stay is no longer falling.

Admissions and Discharges 2007 to 2018

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
TOTAL Admissions	41	50	61	56	52	57	74	52	45	30	27	23
TOTAL Discharges	33	41	52	55	62	61	76	52	47	30	26	18

Waiting List

The numbers admitted and discharged each year are therefore falling while demand from the prison population and local approved centres is increasing. There has been a large increase in the number of patients found Not Guilty for Reason of Insanity (NGRI) (see table below). The waiting list for admission to the Central Mental Hospital is therefore an increasingly prolonged one. For 'legacy' reasons the NFMHS has 2 secure forensic beds per 100,000 population while most modern European states have in excess of 7 secure forensic beds per 100,000. It is intended to open 6 additional beds at the Central Mental Hospital in 2019 as part of the transition to the new Central Mental Hospital in Portrane in 2020.

NGRI Verdicts

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
NGRI	7	4	3	1	2	5	6	5	16	7	6	62

Length of Stay

Cross-sectional length of stay (years), Central Mental Hospital, September of each year.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
N	75	83	83	83	93	92	94	92	91	92	94	92	91	97
Mean (s.d.) years	9.3 (11.2)	8.0 (10.4)	7.2 (10.4)	6.4 (9.7)	6.4 (9.3)	6.6 (9.3)	7.5 (9.8)	7.2 (9.8)	7.1 (9.3)	7.2 (9.7)	7.1 (8.9)	6.9 (8.8)	6.9 (8.7)	6.8 (8.7)
Median (years)	5.0	3.5	2.3	2.1	2.6	3.3	4.4	4.8	4.9	3.1	3.7	3.5	3.8	4.1

Cross-sectional length of stay in bands.

Length of stay	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
N	93	92	94	92	91	92	94	92	91	97
<12 months	29	19	16	22	22	26	18	20	16	17
12 to 60 months	31	46	40	28	24	24	35	34	37	44
60 + months	38	31	38	42	45	42	41	38	38	36

Service Activity Levels of Forensic Rehabilitation and Recovery Teams

Patient Numbers 2018

	Start Jan 2014	End Dec 2014	2015	2016	2017	2018
Inpatients on pre-discharge wards	24	23	24	24	23	23
Patients in supported community living	13	16	16	16	6	18
Patients in independent living	7	9	9	11	11	14
Patients living in other community services residences	3	2	4	6	17	5
TOTAL	46	50	53	57	57	60

Community Consultation and Liaison Work

These referrals represent a range of sources including referrals from HSE Community Mental Health Teams in all parts of Ireland and criminal justice agencies such as the Director of Public Prosecutions and Chief State Solicitor. Each of these assessments is time intensive, involving from three to ten hours of work in the assessment and preparation of written expert advice by Consultant Forensic Psychiatrists and doctors in training.

Community Consultation and Liaison Clinics 2018

	Referrals
Referrals received from HSE Community Mental Health Teams conducted in our outpatient clinic in Usher's Island and Approved Centres nationally	93
Referrals seen for the purpose of reports at request of Judges of District and Circuit Courts, DPP, Solicitors, and Prison Referrals from prison with no inreach	322
Prison in-reach team Cloverhill Prison Voluntary & Requested reports to District & Circuit Courts & High Court	164
Requests for psychiatric reports for inpatients.	12
Total	591

Teaching, Training, Research and Development

As a national tier three and tier four highly specialised service, the National Forensic Mental Health Service has an essential role in relation to teaching and training in all mental health disciplines including undergraduate and postgraduate medicine / psychiatry, nursing, clinical psychology, occupational therapy and mental health social work. There are close ties with Trinity College Dublin and with all relevant training schools and universities. This reflects an essential national role as the source of research and development, teaching and training in this area of specialist practice. Structured professional judgement tools for use by clinicians in forensic mental health practice (the DUNDRUM toolkit) are now in use in many countries, including translations into French and Dutch / Flemish. The National Forensic Mental Health Service aspires to university hospital status.

Chapter 11

Other Specialty and Subspecialty Mental Health Services

Mental Health Intellectual Disability

People of all ages and with all levels of intellectual disabilities can be affected by mental health problems and it is recognised that people with an intellectual disability are actually more likely to develop mental health problems in comparison with the general population .If a person has an ID they are at least two to three times more likely to have a mental illness than the general population, with 4 in every 10 people with ID experiencing a mental illness in their lifetime (Cooper et al., 2007). Psychosis, bipolar disorder and neurodevelopmental conditions such as attention deficit hyperactivity disorder are all more common than in people without intellectual disability, and emotional disorders are at least as common.

A Vision for Change recommends that specialist Mental Health Intellectual Disability (MHID) services are required for those with moderate or greater degrees of intellectual disability and co-morbid mental illness/behavioural problems.

Special expertise is required for a number of reasons which include:

- An accurate diagnosis related to atypical presentations of mental illness, communication difficulties and often an inability to make a subjective complaint
- The provision of appropriate multidisciplinary care and treatment for mental illnesses, and, in some cases, chronic and persistent behavioural problems. Behavioural issues in those with an intellectual disability can be particularly challenging where individuals may have reduced verbal capacity.
- Complicated psychotropic drug therapies are associated with an increased frequency of side effects in the intellectual disability population and equal difficulty in recognising response to treatment which is more by way of behaviour than subjective report.
- Co-existing epilepsy and medical conditions.
- Particular ethical issues related to capacity and consent in this population.

Mental Health Service provision is more complicated for people with intellectual disability as many MHID services are provided directly by the HSE and also by voluntary agencies. These agencies are funded by the HSE through annually negotiated Service Level Agreements.

There have been major advances in the development of MHID services across the country. In 2013, investment in the provision of MHID services began with the allocation of Programme for Government development posts. Since then the Mental Health Services have allocated further posts specifically for the development of multi-disciplinary teams, initially for adults and latterly for children. Approximately 102 posts in total have been allocated.

In July 2016, a Developmental Clinical Lead was appointed to work with Mental Health's National Clinical Advisor and Clinical Programmes Group Lead and Head of Operations to oversee the development of MHID services within each CHO. In addition in late 2016, MHID was prioritised by Mental Health Services as a Service Improvement project and the "National MHID Service Development Programme" was developed.

This programme of work is supported by a dedicated project manager and through close partnership with the HSE's Social Care Service and relevant voluntary agencies. These partnerships are vital to ensure there is an integrated service to respond to the mental health needs of the Irish ID population.

The National MHID Service Development programme's aim is to operationalise Vision for Change and provide specialist, multi-disciplinary, community MHID services for adults and children, across Ireland.

The workforce data used in this section is based on the returns from the Mental Health Services to the National MHID Service Development programme as part of the mapping exercise. The figures relate to CAMHS-ID Mental Health Services and Adult MHID services and reflect staffing across both the HSE and voluntary agencies.

Mental Health and Intellectual Disability Services Workforce

A Vision for Change (2006) recommends that there should be one Adult Community Mental Health and Intellectual Disability (MHID) team for each 150,000 population and one Child and Adolescent Community Mental Health Team Intellectual Disability (CAMHS-ID) team for each 300,000 population. With each team the staff complement is 10, including the following:

- One consultant psychiatrist
- One doctor in training
- Two clinical nurse specialists
- Two clinical psychologists
- Two social workers
- One occupational therapist
- One administrative staff.

Vision for Change Recommendations v. Actual Staffing (2018)

MHID Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2018
Adult MHID teams	1 : 150,000	31	17	310	100.6
CAMHS-ID	1 : 300,000	16	3	160	12.1
Total		47	20	470	112.7

Based on the mapping exercise, there is a detailed understanding of actual staffing levels across both HSE and voluntary agencies and unfilled posts provided by the Programme for Government investment. The plan is to move towards full national coverage of both adult and CAMHS-ID services through further team development. This will be achieved by strategically targeting areas with coverage gaps and augmenting existing posts with additional resources needed to ensure services users across the country have equal access to MHID services.

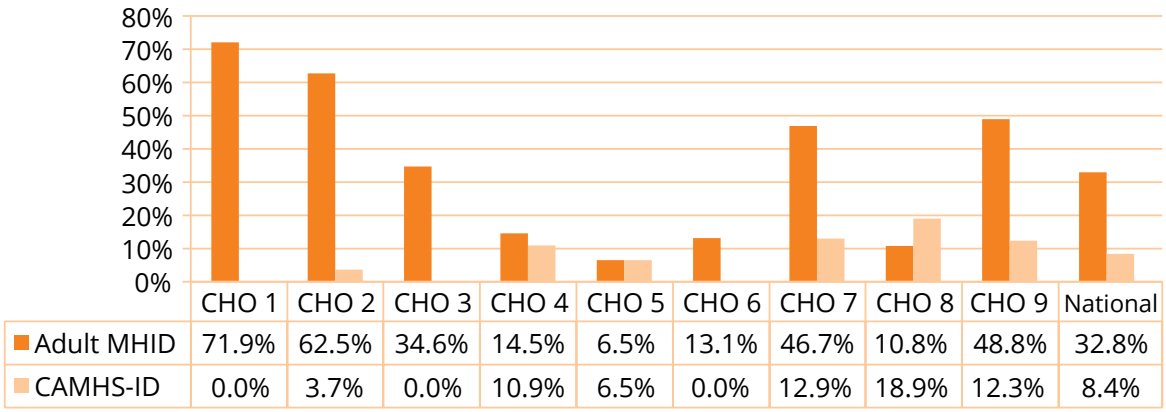
Staffing of Mental Health and Intellectual Disability Teams

The composition of each MHID teams should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions.

A mapping exercise of the staffing of Mental Health and Intellectual Disability Services including CAMHS –ID teams, was carried out in stages in 2018. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in MHID services in 2018 was 112.7.

In December 2018 there was a total of 100.6 staff in Adult MHID Teams nationally (93.8 Clinical). This represents 33% of the clinical staffing levels recommended in *A Vision for Change*. CAMHS-ID had a total of 12 staff nationally, all clinical. This represents 8.4% of the clinical staffing levels recommended in *A Vision for Change*.

Adult MHID and CAMHS-ID Teams Staffing vs. VFC recommendations in 2018



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
Adult MHID	71.9%	62.5%	34.6%	14.5%	6.5%	13.1%	46.7%	10.8%	48.8%	32.8%
CAMHS-ID	0.0%	3.7%	0.0%	10.9%	6.5%	0.0%	12.9%	18.9%	12.3%	8.4%

Adult MHID and CAMHS-ID Teams Staffing and VFC recommendations per CHO in 2018

	Population Census 2016	Adult MHID Staffing 2018	% of VFC rec 2018	CAHMS-ID Staffing 2018	% of VFC rec
CHO 1	394,333	19.8	75.3%	0.0	0.0%
CHO 2	453,109	19	62.9%	0.5	3.3%
CHO 3	384,998	8	31.2%	0.0	0.0%
CHO 4	690,575	7	15.2%	2.3	9.8%
CHO 5	510,333	2	5.9%	1.0	5.9%
CHO 6	445,590	3.5	11.8%	0.0	0.0%
CHO 7	645,293	18.1	42.1%	2.5	11.6%
CHO 8*	616,229	5	12.2%	3.5	17.0%
CHO 9	621,405	18.2	43.9%	2.3	11.1%
National	4,761,865	100.6	31.7%	12.1	7.6%

**Midlands only (Louth and Meath resources shared with CHO1)*

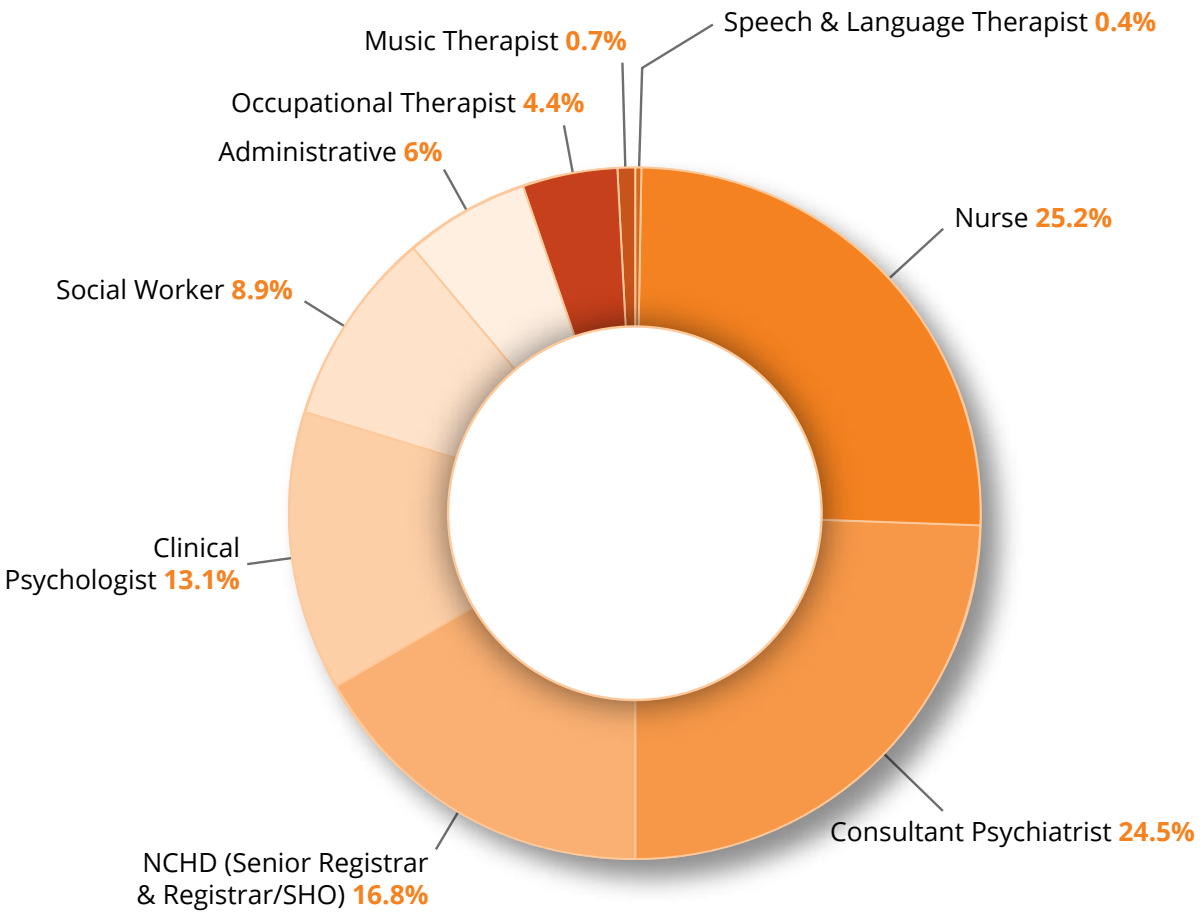
MHID Teams Staffing by discipline 2018

2018	Adult	CAMHS-ID
Consultant Psychiatrist	20.3	7.25
NCHD(Senior Registrar & Registrar/SHO	17.1	1.8
Social Worker	10	0
Clinical Psychologist	12.8	2
Nurse	27.4	1
Occupational Therapist	5	0
Speech & Language Therapist	0.4	0
Music Therapist	0.8	0
Administrative Support Staff	6.8	0
Total	100.6	12.1

Workforce of Adult MHID and CAMHS-ID Teams by profession 2018

A characteristic of MHID 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 a person and their family or carers.

The largest professional group was psychiatry making up 41.3% of the workforce (consultant psychiatrists (24.5%), and doctors in training (16.8%).



Liaison Psychiatry

Liaison psychiatry, also known as Psychological Medicine, is the medical specialty concerned with the care of people with both mental and physical health symptoms regardless of presumed cause. The specialty uses the biopsychosocial model and is concerned with the inter-relationship between the physiology, psychology and sociology of human ill health.

These services are operate in the Acute Hospital setting, see people in the Emergency Departments and on medical and surgical wards, as well as seeing people in the outpatients. Liaison psychiatry teams span the generations, seeing children in the paediatric hospitals and there are both adult and older persons teams in many acute hospitals. The teams are multidisciplinary and clinically led by a consultant liaison psychiatrist who will have higher specialty training in General Adult Psychiatry with subspecialty endorsement in Liaison Psychiatry. Many liaison psychiatrists will also have spent some time training in General Medicine.

The multidisciplinary team should include specialist Mental Health Nurses, Clinical Psychologists, Occupational Therapists and Social Workers together with high quality administrative support.
The rationale for developing the subspecialty is as follows:

- It is estimated that 5% of all Emergency Department attendances are due to mental disorders. Within the ED group, self-harm is a prominent presenting symptom. Chronic and repeat attenders to ED may also benefit from liaison psychiatry input and typically count for 8% of all ED attendances. The most common reason for frequent attendance is an untreated mental health problem.
- 25% - 33% of people with long-term physical health problems also have a concurrent mental illness. This increases the risk of physical health complications together with the costs of treating the physical illness and is associated with an increased length of stay and worse outcome.
- It is estimated that approximately 60% of those over the age of 65 admitted to a general hospital have a concurrent mental health disorder; this includes depression, dementia and delirium, the three commonest conditions seen by older persons liaison teams.
- There is a clear evidence base demonstrating the increased cost of mental health problems generally and in particular their impact on physical health conditions.

Hence, liaison psychiatry provides a key link between physical and mental health care providers thereby ensuring people using acute hospitals have access to mental health services. An important task of hospital based liaison psychiatry services is to have strong links with their local community mental health teams, enabling easy referral to these teams if people require more mental health care after leaving hospital.

When full recruitment has been completed, all Level 3 and Level 4 hospitals i.e. those with a 24 hour Emergency Department will have a liaison psychiatry service except for the three Level 3 hospitals in the Midlands (Portlaoise, Tullamore and Mullingar). Clarification on the future roles of these hospitals, i.e. whether they are at Level 2 or Level 3 will determine whether a liaison psychiatry service will be funded and developed by the Mental Health Service in these sites.

Specialist Perinatal Mental Health Service

Background

Perinatal Mental Health Disorders are those which complicate pregnancy and the first year post-partum. They can be new onset, re-occurrence or relapse of pre-existing disorder. Their unique aspect is the potential negative impact on mother/child relationship, which can lead to significant emotional, behavioural and cognitive problems in the child. A Working Group which was multidisciplinary with service user input from AIMs Ireland was established to develop a national Model of Care. Up to this, the only specific services available were a part-time service in the three Dublin maternity hospitals. The HSE's Specialist Perinatal Mental Health Services Model of Care was launched on 30.11.2017. Its

implementation began in 2018 overseen by the Clinical Lead and Programme Manager through the National Oversight Implementation Group (NOIG).

Specialist Perinatal Mental Health Multidisciplinary Teams are being recruited for the maternity hospital/service hub in each of the six hospital groups/maternity networks. Three of the teams were operational by Q4 2018 with a fourth perinatal psychiatrist identified to start early 2019. As part of this implementation a mental health midwife is also being recruited for each of the 18 maternity hospitals/ units with two mental health midwives for the four larger services, those with over 8,000 deliveries per year. These were already in place in the Rotunda Hospital.

The specific circumstances of pregnancy, birth and early mother/infant bonding requires staff who are knowledgeable, skilled, sensitive and experienced. Therefore the philosophy underpinning the national Model of Care is its focus on: the mother, the baby, their relationship in the context of the family. Hence specialist perinatal mental health services are vital because of the very negative consequences of perinatal mental health disorders for the mother, the baby, their relationship and that with the partner and other children. The specialist teams and mental health midwives work jointly to ensure all women attending the maternity service will have information on positive mental health and standard questions on mental health as well as physical health are routinely asked of each woman attending both booking and review clinics. They also provide a triage system so that women with mental health problems are assessed by the appropriate team member: that is mental health midwife for milder problems with those with severer problems being seen by the specialist team in the hub maternity hospitals and liaison psychiatry team in the spoke maternity services in each hospital group/maternity network.

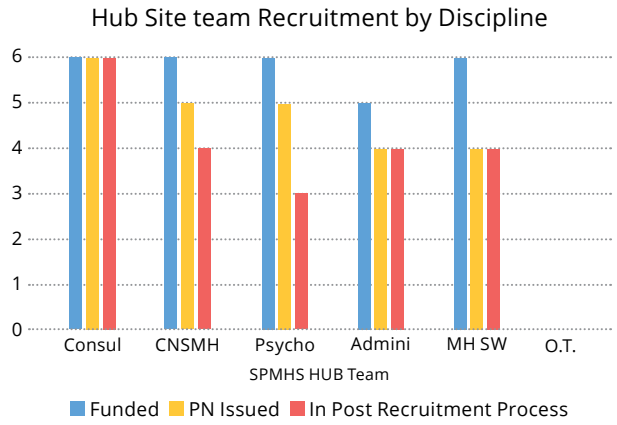
SPMHS Staffing update 2018

In 2018 the focus of the Programme Manager and National Clinical Lead was to recruit key staff in 6 hub sites. By December 2018 4.0WTE of the 6.0WTE Consultant Psychiatrists for SPMHS were appointed. The first ever services outside of Dublin beginning in University Maternity Hospital Limerick in April 2018, and in Cork University Maternity Hospital in December 2018.

The National Maternity Hospital increased their consultant provision to 1.0WTE and the Rotunda Hospital successfully recruited the additional 0.6WTE to start early 2019.

Table 1: SPMHS staff recruitment update

Staffing the SPMHS hub teams



Six Hub Sites

- Hub Site teams funded through PFG 2017 & 2018 (€3m)
- 6WTE f/t Perinatal Psychiatrists- 4 in place
- Perinatal CNSMH panel in place - in recruitment
- UMHL first Psychologist for SPMHS - due to start Jan '19
- 6 O.T.s & 1 Psychologist - WTEs requested through 2019 estimates process.

Growing awareness of PMH problems

During 2018 a number of conferences and seminars took place for hospital and community staff. They highlighted that perinatal mental health problems occur in 10 to 15% of women in the perinatal period, ranging from mild to severe. Staff were also updated on the new services and pathways in place now for women which as outlined in the SPMHS MOC, operate through the national hub and spoke services in development. These conferences took place in:

- Galway
- Wexford
- Waterford
- At the annual Perinatal Mental Health Conference in UH Limerick

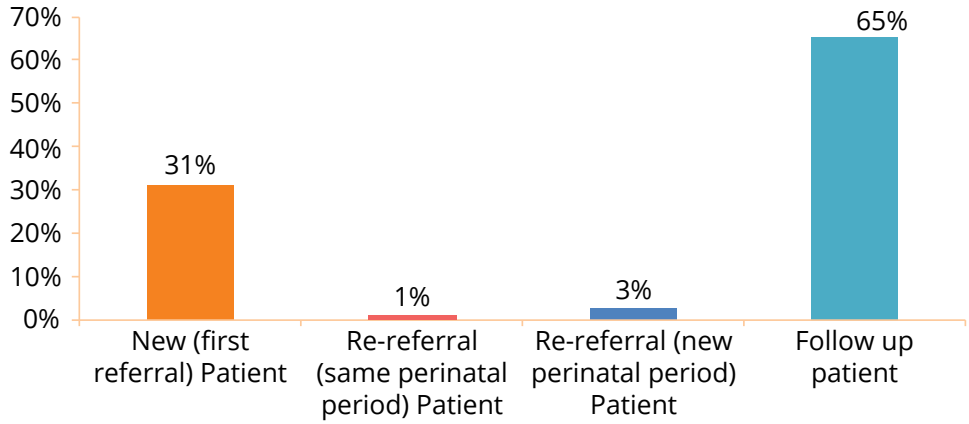
Presentations on the Model of Care were also delivered to senior nursing and midwifery management groups nationally, providing managers with an update on the implementation of services. Since the MOC launch in November 2017 and up to November 2018 over 6,000 page views of the HSE's Specialist Perinatal Mental Health Service have taken place. The HSE website and the most searched for information in Google related to perinatal mental health and perinatal mental health Ireland. Work is underway to provide additional information specifically on perinatal mental health problems for patients and service providers such as General Practitioners and Public Health Nursing staff.

Data for SPMHS

Data for two hub sites showed that from May-Dec 2018 almost 2,000 patient contacts took place with over one quarter of those seen as inpatients in maternity hospitals. Just over 30% of these patient contacts were first referrals with 65% of patient contacts receiving follow up appointments, see table 2 below.

Table 2: New Patient/Referred/Follow up Pt.'s

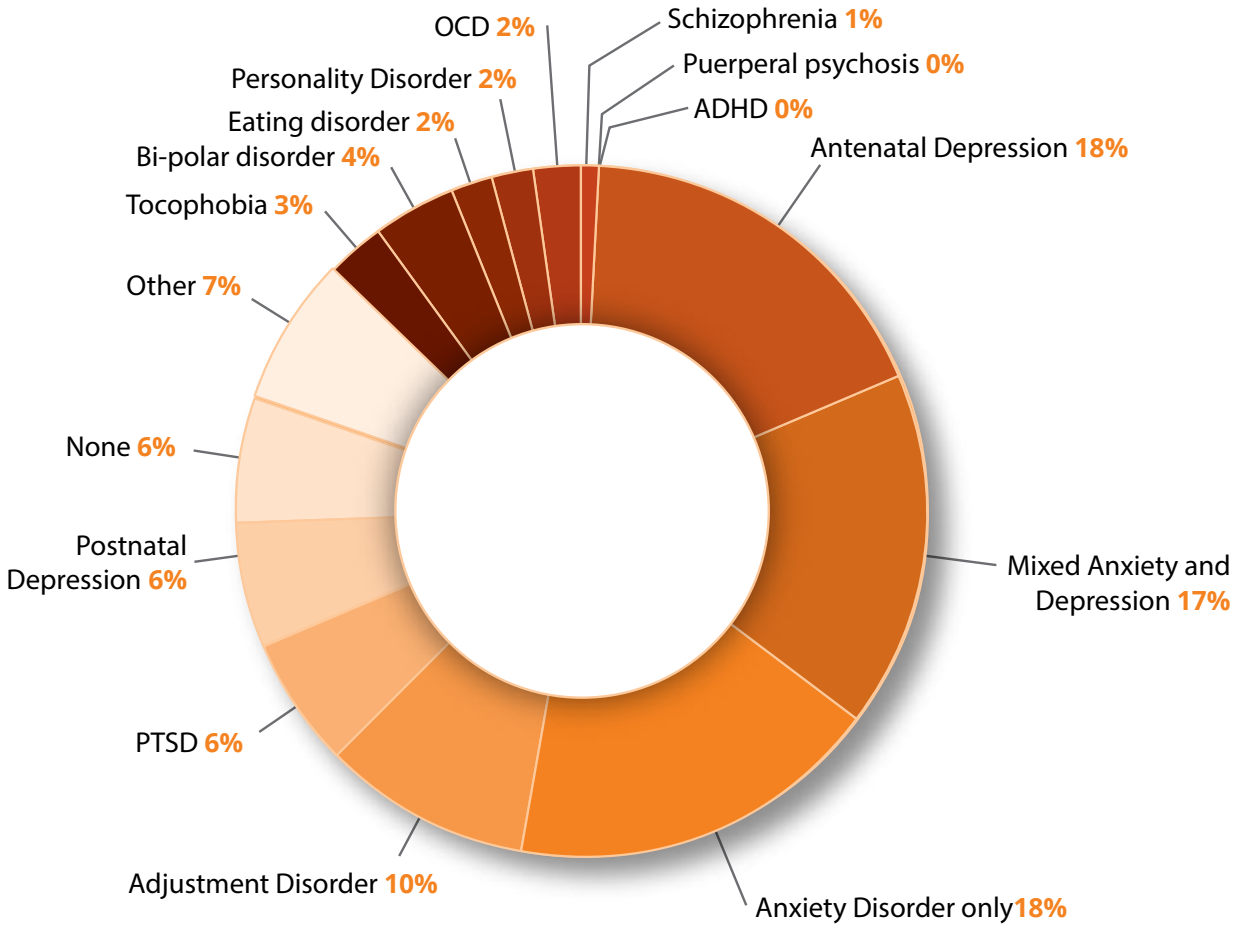
New Patient/Re-referred and Follow up May - December 2018 (two hub sites)



The most common diagnoses were anxiety and depression with 61% of patient contacts diagnosed with anxiety, depression or a combination of both.

Table 3: Primary Diagnosis from 2 hub sites

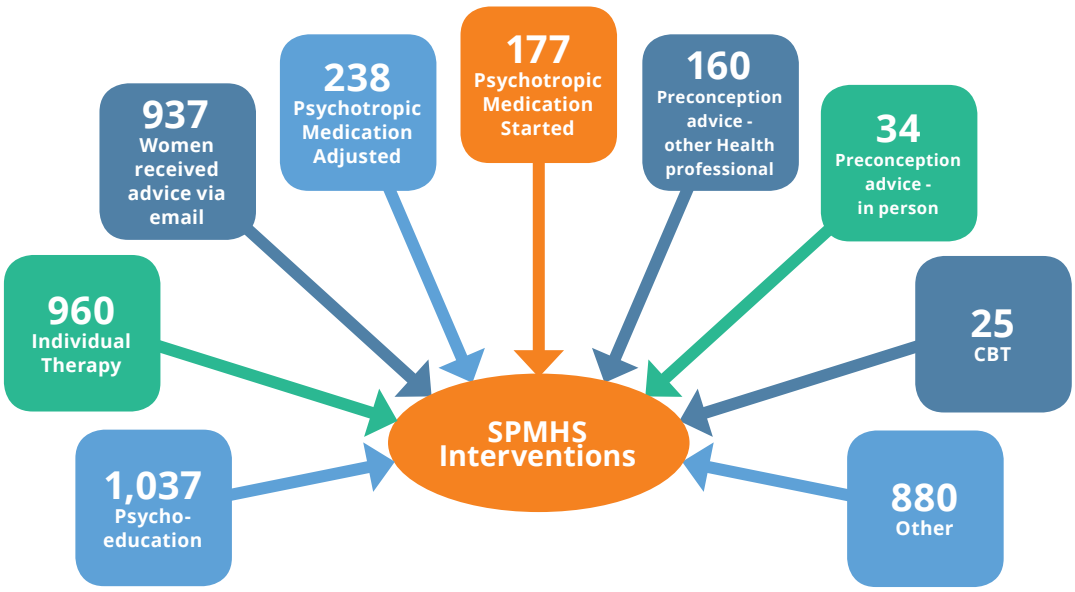
SPMHS Primary Diagnosis May - Dec 6mths (2 hub sites)



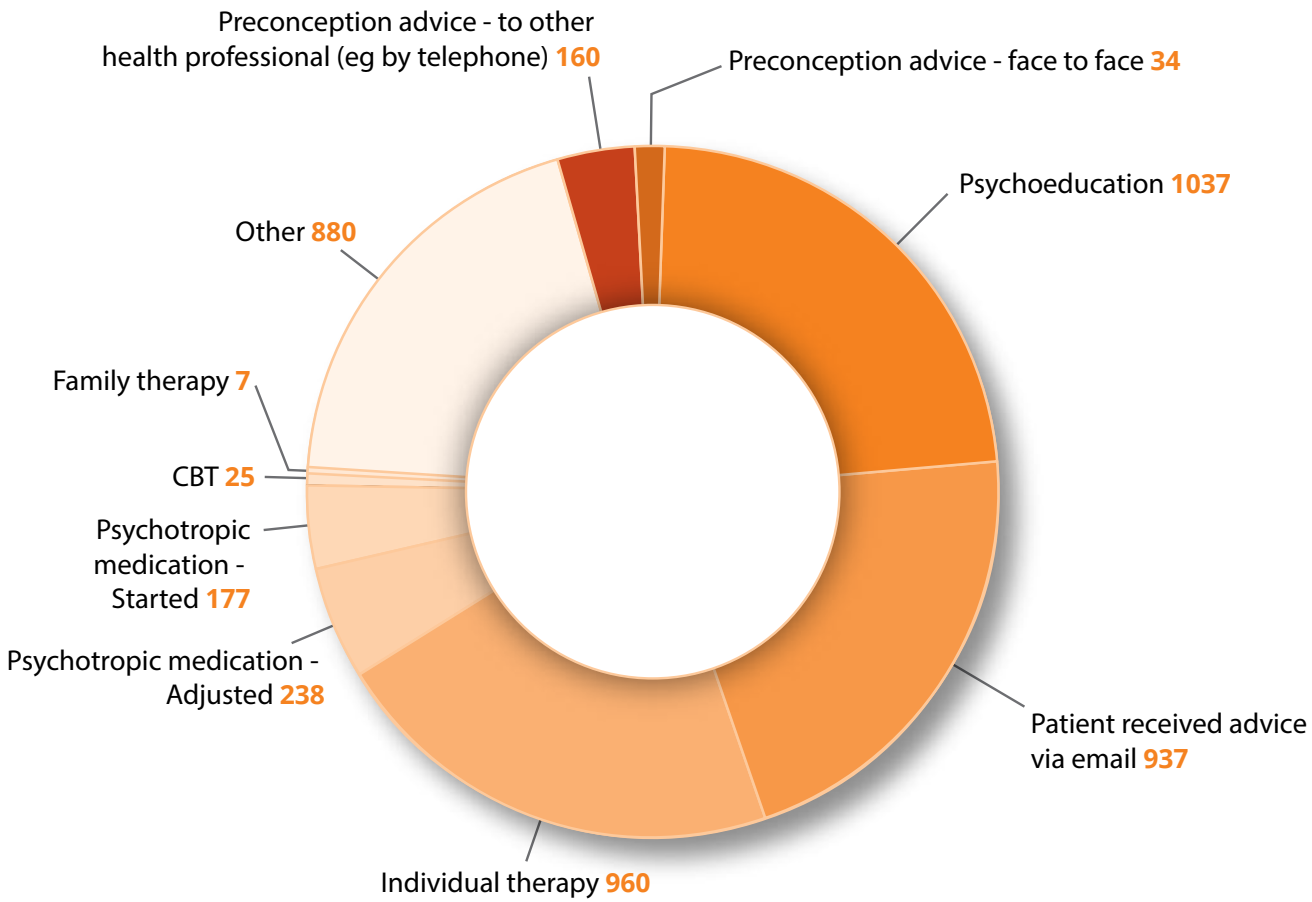
544 women were seen by two or more of the SPMHS multidisciplinary team with 320 women seen by the mental health midwife only. The largest age cohort are women aged between 30-39yrs. Psycho-education was the most common intervention with 1,037 patient contacts and a further 960 receiving individual therapy, (Table 4).

Table 4: Interventions provided by SPMHS

SPMHS Interventions provided (6 mnths) in 2 Hub sites



Interventions provided by SPMHS May - Dec (2 hub sites)



Rehabilitation and Recovery Mental Health Services

Killaspy et al., 2005 defines this area of practice as "a whole systems approach to recovery from mental illness that maximises a known individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future leading to successful community living through appropriate support".

This definition applies equally to people with severe and enduring mental illnesses who have both active symptomology and impaired social functioning. Hence, rehabilitation and recovery mental health services should have the joint aims of minimising the symptoms of illness and promoting the person's social inclusion.

It is known that approximately 10% of people referred to mental health services have particularly complex needs that require rehabilitation and intensive support over many years. Most have a diagnosis of psychosis complicated by prominent negative symptoms that impair their motivational and organisational skills to manage everyday activities. These deficits may place them at risk of self-neglect. Many have so called positive symptoms of delusions and hallucinations that have not responded fully to medication and these can contribute to making communication and engagement difficult. Many also have co-existing mental health problems such as depression and anxiety, long- term physical issues and an increased risk to developing same. Many have other problems such as substance misuse or may be on the autism spectrum.

The HSE National Mental Health Service has provided for the development of rehabilitation services by allocating investment funding for the development of these services where they have not existed to date.

Since 2014 the HSE has developed a number of processes and structures to support the delivery of services in a recovery oriented way.

Key achievement in 2018 in rehabilitation and recovery include:

- Publication of a National Framework for Recovery in Mental Health 2018 – 2020 – this document sets out a framework and pathway to ensure the delivery of recovery focused treatment services nationally.
- The continued recruitment of peer support workers onto mental health teams, peer support workers provide direct supports to service users and act as advocates for service users on the mental health teams in which they are employed.
- 2018 saw further development of Recovery Education and Recovery College structures nationally.

Chapter 12

Conclusion

As can be seen from the foregoing, Mental Health Services have continued the journey of transformation from primarily hospital focused to community based services, and in many areas have gone further in developing multi-disciplinary, community-based alternatives to hospital than any other part of the health system.

This transformation of services has been guided by the Mental Treatment Act 2001 and the associated regulations and the Government Policy document *"A Vision for Change" Repo*rt of the Expert group on Mental health Policy (Government of Ireland 2006).

The strategic direction of mental health policy will be further informed by the 'Evidence Review to Inform the Parameters for a Refresh of *A Vision for Change'* report published in February 2017 and by the implementation of the Slaintecare Report.

As stated earlier in this report Mental Health Services and mental health staff nationwide are fully committed to the provision of high quality evidence based mental health services. One of the key supports to the delivery of quality services is the provision of information about the mental health services to stakeholders.

This Report is one strand in ensuring that activity data is disseminated as widely as possible and that information on the good work, and the challenges, in mental health services is collected and the data used to inform improved service delivery. The Report has demonstrated the considerable achievements of mental health staff in delivering high quality, evidence based mental health services.

The Report has provided up to date information on activities in Acute Inpatient Units, Child and Adolescent Mental Health, General Adult, Psychiatry of Old Age and the National Forensic Mental Health Service. Information on sub-specialities including MHID, Liaison Psychiatry, and other specialist mental health services has been provided.

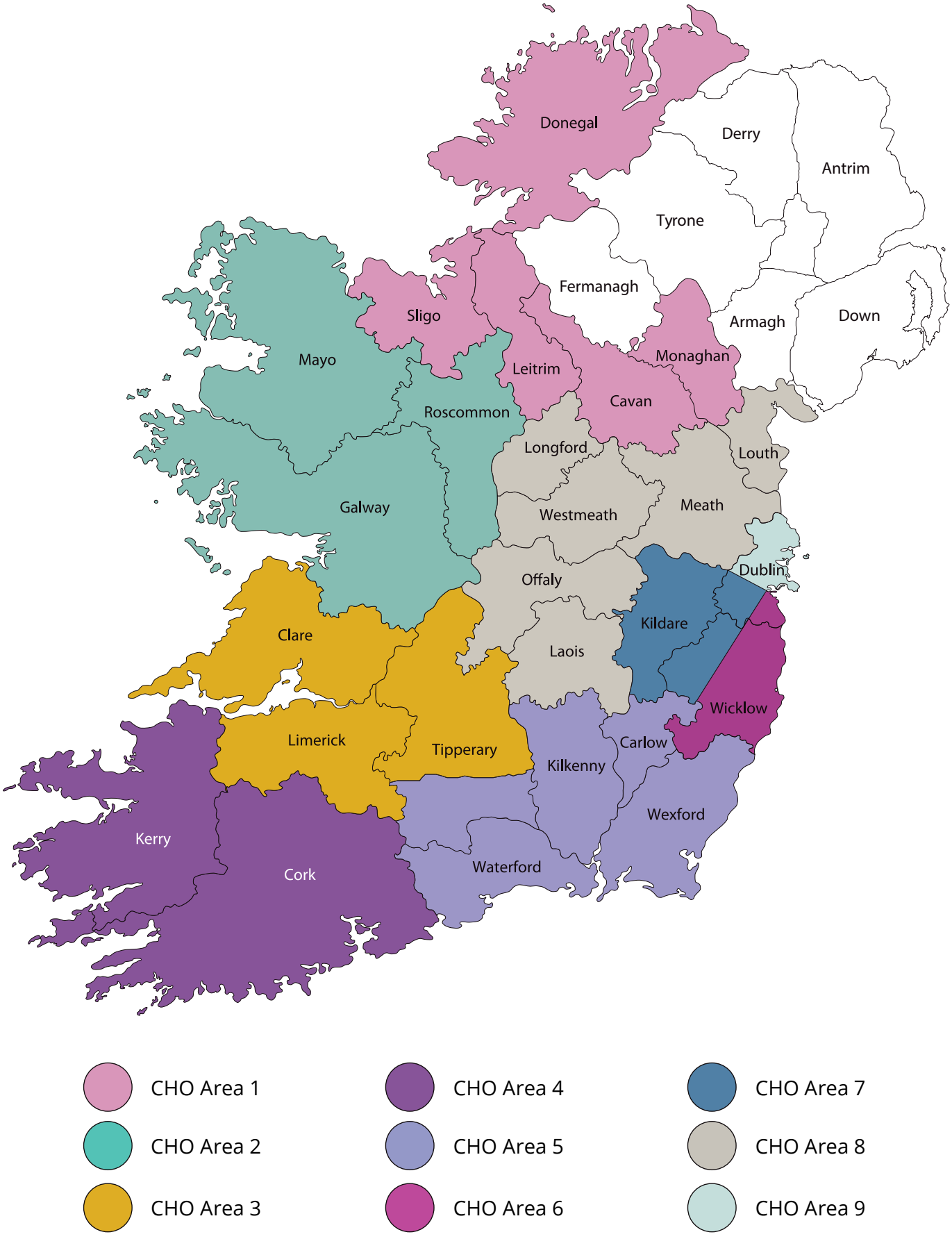
In reporting on activity in 2018, Mental Health Services are cognisant and supportive of the planned changes in the wider health service. Mental Health Services are fully committed to the implementation of the Slaintecare report and to the delivery of integrated services.

Significant work has been undertaken in Mental Health Services in 2018 to plan for the changes required. Our objective is to maintain quality, deliver good outcomes and recognise that there are opportunities, even in a constrained financial environment, to provide excellent health and social care services to the population. Mental Health Services will ensure that the resources available to health and social care are targeted towards providing care and support for those patients and clients most in need, and ensuring that these services are delivered efficiently and effectively, consistent with best available evidence.

It is the intention of the Mental Health Services to continue to publish this Delivering Specialist Mental Health Report annually to ensure the widest dissemination possible of the activities, challenges and the on-going work in developing and improving Mental Health services nationally.

Appendix 1

Community Health Organisations (CHOs)



Community mental health service populations by CHO

	CAMHS		GAMHT		POLL	
CHO Areas	0 - < 18 years	Total pop	>=18 years to <64 years	Total pop	> = 65 years	Total pop
CHO 1	103,778	394,333	2 30,492	394,333	60,063	394,333
CHO 2	111,880	453,109	272,671	453,109	68,558	453,109
CHO 3	96,266	384,998	232,797	384,998	55,935	384,998
CHO 4	168,542	690,575	423,156	690,575	98,877	690,575
CHO 5	131,522	510,333	304,509	510,333	74,302	510,333
CHO 6	116,264	549,531	274,412	424,772	59,799	424,772
CHO 7	144,296	541,352	422,098	666,111	74,014	666,111
CHO 8	172,373	616,229	369,598	616,229	74,258	616,229
CHO 9	145,581	621,405	404,063	621,405	71,761	621,405
Total	1,190,502	4,761,865	2,933,796	4,761,865	637,567	4,761,865
Percentage	**25.00%**		**61.60%**		**13.40%**	

Child and Adolescent Mental Health Service (CAMHS) cover 25% of the population (Census 2016) who are less than 18 years of age.

Psychiatry of Later Life (POLL) services covers the 13.4% who are over the age of 65 with the remaining 61.4% of the population covered by the General Adult Mental Health Teams (GAMHT).

Appendix 2 Mental Health Service Improvement Projects 2018

2018 Service Improvement Projects

RAG	Project ID	Projects	Stage	Executive Sponsor	Head of Service	Project Closure Date
Red	AOE002	National Mental Health e-Rostering Project	Implementation	Yvonne O'Neill	Kevin Brady	Jul-20
Amber	AOE003	MHD ICT Infrastructure Improvement Project (Phase 1)	Implementation	Yvonne O'Neill	Kevin Brady	Jun-20
Green	AOE007	Standardised process for Service User Journey within General Adult Community Mental Health Teams	Implementation	Yvonne O'Neill	Dave Dooley	Apr-19
Green	AOE010	Developing Digital Mental Health Supports in Ireland	Implementation	Yvonne O'Neill	N/A	Dec-19
Red	SIQ006	Implementation of Team Coordinators for Community Mental Health Teams	Implementation	Jim Ryan	Sinead Glennon	Dec-19
Green	SIQ007	Develop a Stepped Model of Mental Health Care for the Homeless Population in Dublin (CHO 6,7,9)	Initiation	Jim Ryan	Angela Walsh	TBD

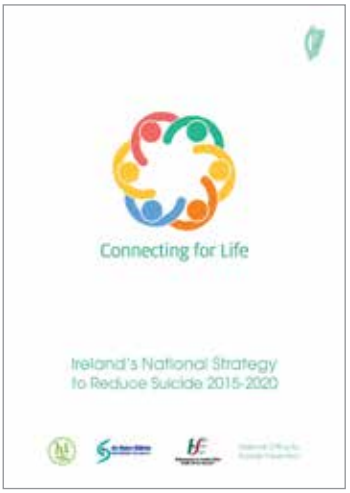
Green	SIQ008	Review of the CAMHS SOP	Closure	Jim Ryan	N/A	Mar-19
On Hold	SIQ009	Choice and Partnership Approach CAPA	Discovery	Jim Ryan	Sinead Glennon	TBD
Green	SIQ012	Integration of Peer support working onto Multi-disciplinary teams	Discovery	Jim Ryan		TBD
Green	SIQ013	Implementation of Revised CAMHS SOP	Discovery	Jim Ryan		TBD
Green	SIQ014	Design of a revised Care & Recovery planning process	Discovery	Yvonne O'Neill		TBD
Green	IAD001	Develop a model of care for people with Severe and Enduring Mental Health Illnesses and Challenging Behaviours	Implementation	Jim Ryan	Antoinette Barry	Jun-19
Green	IAD002	MHID	Implementation	Dr. Philip Dodd/ Jim Ryan	Leo Kinsella	Dec-19
Green	IAD003	Standard Availability of talking therapies in mental health services	Implementation	Siobhan Ní Bhriain	Sinead Glennon	Dec-19
Red	SUE004	Formalization of Service User, Family Member and Carer Engagement Recognition and Reward Procedures	Implementation	Liam Hennessy	Leo Kinsella	Mar-19
Green	SUE005	Development of an Independent Advocacy service in CAMHS	Implementation	Liam Hennessy	Charlie Meehan	Mar-19
Green	SUE006	Implementation of the National Recovery Framework in Mental Health 2018-2020	Planning	Yvonne O'Neill	Charlie Meehan	Jul-19
Green	PWB002	Suicide and Self-Harm Awareness, Assessment and Response Project (SSHAARP)	Initiation	Jim Ryan	Angela Walsh	TBD
Green	PWB003	Deliver enhanced bereavement support services to families and communities affected by suicide of those people known to mental health services	Initiation	Jim Ryan	Siobhan McArdle	TBD
Green	PWB005	Physical Health Needs of Mental Health Service Users	Implementation	Jim Ryan & Dr. Philip Dodd	Angela Walsh	Oct-19
Green	PWB006	HSE Best Practice Guidance for Suicide Prevention Services	Implementation	John Meehan	NOSP Project (Mary O Sullivan ROSP CHO2)	Mar-19
Green	PWB007	Future of Mental Health Stigma Reduction Campaign	Implementation	John Meehan	NOSP Delivered Project	Mar-19
*Subject to receipt of required documentation and project level approval						

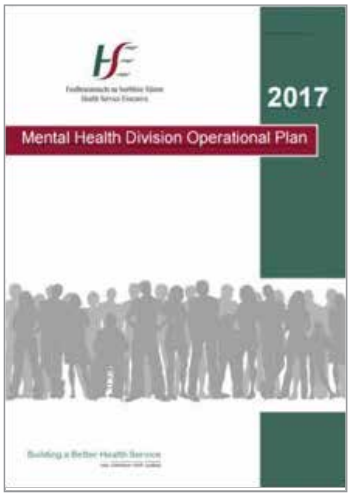
Other publications which provide information on Mental Health can also be found on the HSE website.

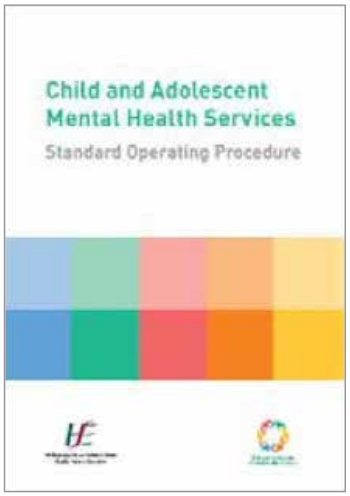
http://www.hse.ie/eng/services/publications/

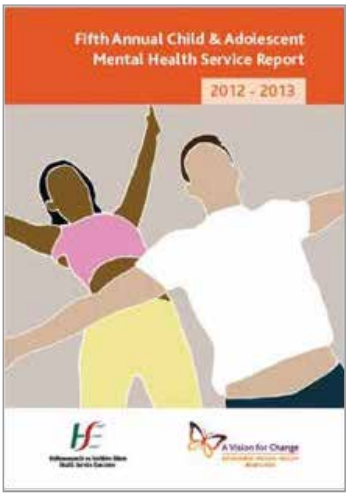
Mental Health Performance Reports can be found at

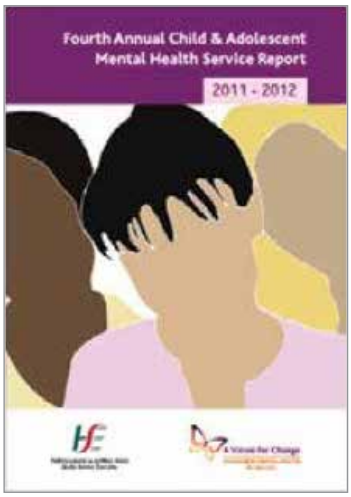
http://www.hse.ie/eng/services/publications/performancereports/

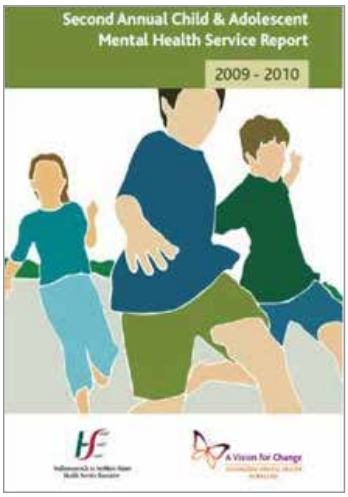












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