HSE Mental Health Division

Delivering Specialist Mental Health Services 2014-2015

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Mental Health Services

CONTENTS

ACKNOWLEDGEMENT

The preparation of this Report would not have been possible without the mental health services nationally who ensure that the data provided on the activities of their services is provided in a timely fashion, while also delivering mental health services. They use the data to inform their work in delivering quality mental health services for their service users.

Thanks are also owed to the members of the Mental Health Data Design and Optimisation Group for their input, guidance and advice in the preparation of the Report and to the Planning and Business Information (PBI) Unit of the Deputy Director General's Office for supporting the Division in the production of the Report and in giving permission to Philip Flanagan, the Mental Health Information Analyst to work with the Division in the preparation of the report.

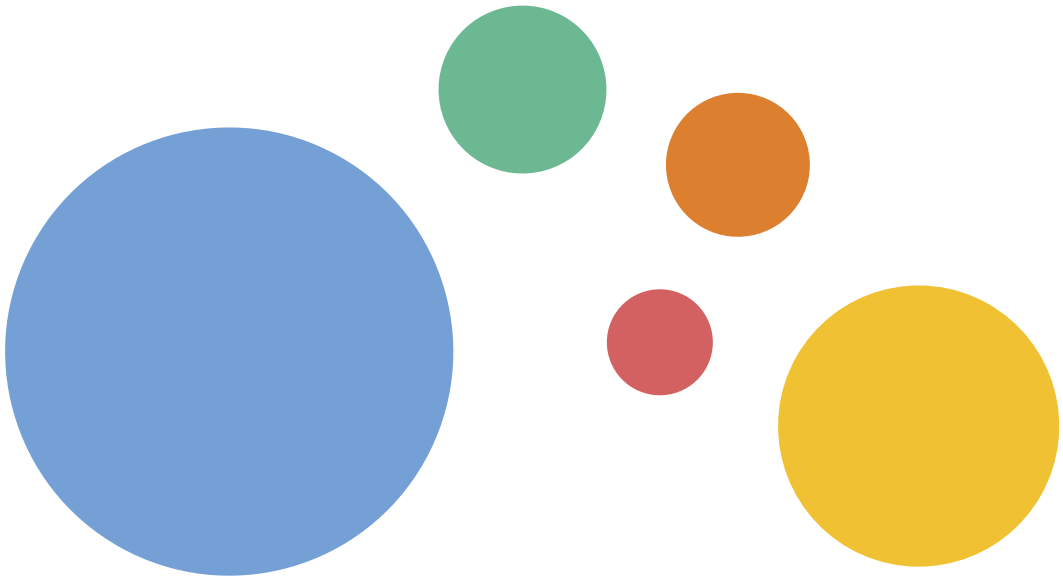
Finally, there were a number of individuals who gave their time to authoring sections of the Report and these include Philip Flanagan, Information Analyst, PBI; Dr Margo Wrigley, National Clinical Advisor and Group Lead for Mental Health; Professor Harry Kennedy, National Forensic Mental Health Services; Dr Matthew Sadlier, Consultant Psychiatrist, CHO 9 and Carol Ivory, Programme Manager, Information and Performance Management Programme, Mental Health Division. Your support for the project is much appreciated.

The Mental Health Division plan to continue to expand and enhance the information provided in this annual overview of the mental health services by including each year a qualitative assessment of a specific area or theme underpinning the mental health services.

Yvonne O'Neill

Head of Planning, Performance and Programme Management
Mental Health Division

September 2016



EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Context

One of the key supports to the delivery of quality services is the provision of information about the mental health services to stakeholders. Since the establishment of the Division, in the context of the Accountability Framework, there has been an increased focus on the development of performance metrics and in providing information on the work of the mental health services.
The Division is challenged in providing detailed information about its service provision as the information systems in place are reliant on largely 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.

Building on the success of the annual reports which were published by the Child and Adolescent Mental Health Services up to 2013, the Division has developed this report, Delivering Specialist Mental Health Services 2014-2015, with the objective of providing an overview of the work of the specialist mental health services.

The Report describes the secondary care specialist mental health services, giving an overview of the components of service and how they are accessed. It describes the Mental Health Workforce in the General Adult, Psychiatry of Old Age and Child and Adolescent Mental Health Services utilising the mental health performance indicator suite by providing an average of the staffing over the given year based on these returns. It also gives detail on the activity of the General Adult, Psychiatry of Old Age and Child and Adolescent Mental Health Services having regard to the limitation of the available data.

The collection of data and the development of data sets has been an evolving process for the mental health services. In preparing this Report, we have presented the available data while recognising and acknowledging that this is an ongoing and developmental process for the services.

It is an objective of the Division to incrementally expand the data collected and to develop its capacity for information analysis and, in that context, there is a section of the Report which 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 services as well as Liaison Psychiatry and Rehabilitation services.

It is planned 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.

Delivering Specialist Mental Health Services

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 services. Of this number, approximately 10% are offered inpatient care with 92% of all admissions being of a voluntary nature.

The specialist secondary care mental health service is provided to respond to the varied and complex clinical needs of those individuals for which it is required.

The Report of the Expert Group on Mental Health Policy - A Vision for Change (2006)(Vision) is a progressive, evidence-based document that proposed a new model of service delivery which would be service user-centred, flexible and community based. A Vision for Change remains the roadmap for the delivery of the mental health service. Many of the recommendations of Vision are made on the basis of quantum of service for a defined population and utilize the 2002 census of population of 3.9m. The most recent census in 2016 indicates a population of 4.7m. However, as the Report relates to the period 2014-2015, the census of population for comparison is the 2011 census of 4.5m.

The specialist 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, Psychiatry of Old Age etc), day hospitals, out-patient clinics, community residential settings, continuing care settings. 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 also provided.

The community-based mental health services 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 data presented in this Report shows, in summary:-

Workforce

- In December 2015, there was a total of 1,758 staff in the General Adult Community Mental Health Service (1,548 Clinical), which represents 80% of the staffing levels recommended in a Vision for Change.
- In the period from December 2014 to December 2015, the clinical staff of the General Adult Community Mental Health Teams increased by 70.
- In December 2015, there was a total of 604 staff in the Child and Adolescent Community Mental Health Teams nationally (521 Clinical). This represents 52% of the staffing levels recommended in A Vision for Change which is an increase of 2% nationally on the 2014 position.
- In December 2015, there were 303 staff (clinical 266) working in Psychiatry of Old Age Service teams, which represents 53% of the 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. This has increased to 63 in 2015.
- There has been a 25% increase in referrals between 2012 and 2015.
- 14,036 new appointments were offered in 2015.
- 45% new appointments were seen within 4 weeks.
- 1/5th of new cases seen are aged over 16 years.
- 14% of new patients did not attend their first appointment.
- In 2007, 3,609 individuals were waiting to be seen; in 2015, 2,319 were waiting to be seen, despite an increasing rate of referral.

General Adult Mental Health Services

- In 2015, there are 114 Community General Adult Mental Health teams, which is a reduction on the 123 Teams in 2008. This is in line with the Vision recommended configuration of teams per 50,000.
- 3% increase in referrals from 2013 to 2015.
- 37,091 new appointments offered in 2015.
- 23% new appointments seen within 1 week.
- Over 1/3rd within 2 weeks & 52% seen within 4 weeks.
- On average, 20% of new patients did not attend their first appointment.

Psychiatry of Old Age Mental Health Services

- In 2013, there were 22 POA teams; there were 26 POA teams in place in 2015.
- 7% increase in Referrals from 2013 to 2015.
- 9,386 new appointments offered in 2015.
- 41% new appointments Seen within 1 week.
- 85% seen within 4 weeks.
- 3% 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 2015, there were 74 CAMHS Acute Inpatient beds.
- In 2008, 25% of admissions of children were to CAMHS acute inpatient beds. By the end of 2015, 73% of admissions of children were to CAMHS acute inpatient beds.
- 94% of the total bed days used by children who were admitted were in Child and Adolescent Acute Inpatient Units.
- A new purpose built Child and Adolescent Mental Health Services Acute Inpatient unit of 22 beds opened in 2015 in Cherry Orchard Hospital Dublin 10.

Adult Acute Inpatient Mental Health Services

- There are 31 Adult Acute Inpatient units.
- In 2007, there were 16,293 admissions, in 2015, there were 13,096 admissions.
- In 2007, there was a 72% re- admission rate; and in 2015 this is now 66%.

INTRODUCTION

1

INTRODUCTION

Our 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 focussed 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 and fit for purpose infrastructure.

Service Framework

The spectrum of services provided through the Mental Health Division, which has 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. While the Division also includes the National Office for Suicide Prevention (NOSP) and the National Counselling Service/Counselling in Primary Care Service, the focus of this Report is on the specialist secondary care mental health services provided by the Division.

Services are provided in a number of different settings including the service user's own home. 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 non-health sector partners.

The Mental Health Division is part of the multi annual Future Health Reform Programme which is changing the structures within which public health services are delivered. The Community Health Organisations (CHO) which provide the mental health services for the population of each CHO were established in 2016.

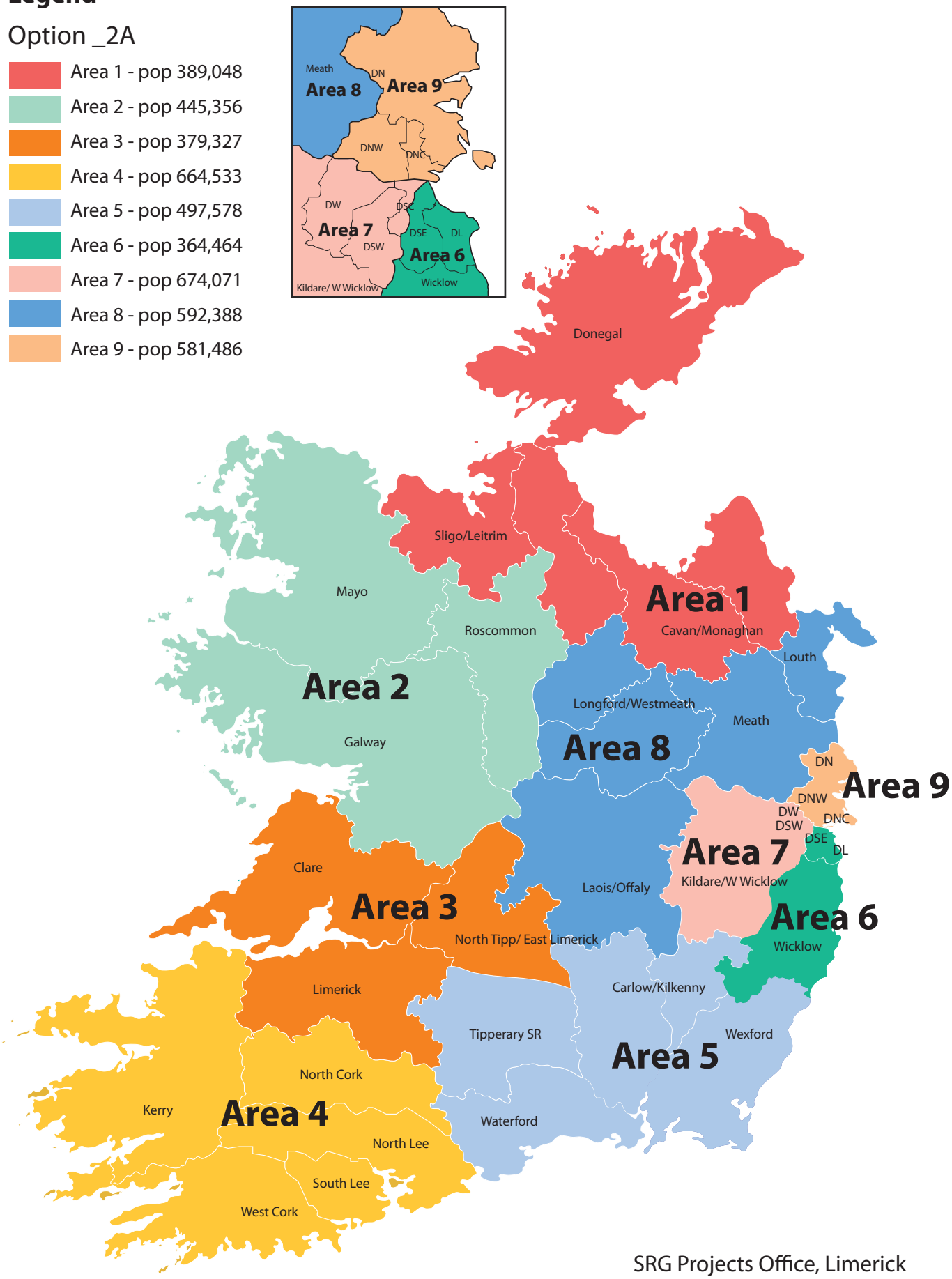
To ensure consistency, data is presented in this Report by CHO area for both 2014 and 2015. Details of the CHO Areas are provided in Figure 1 on page 8.

Supporting the delivery of Quality Mental Health Services – Providing Information

The Mental Health Division was established in 2013 and since then it has developed and progressed a range of programmes of work to deliver our multi-annual priorities. A key feature of this work included consolidating the new dedicated Mental Health Division with full financial, operational and strategic responsibility; supported by a performance framework to inform decision making.

The HSE places a significant emphasis on the quality of services delivered and on the safety of those who use and deliver them. One of the key supports to the delivery of quality services is the provision of information about the mental health services to stakeholders. Since the establishment of the Division, in the context of the Accountability Framework, there has been an increased focus on the development of performance metrics and in providing information on the work of the mental health services.

Figure 1 - Community Health Organisations (CHOs)



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The Division is challenged in providing detailed information about its service provision as the information systems in place are reliant on largely 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 data presented in this Report is the data which is collected and reported as part of the Key Performance Indicators (KPIs) and Performance Indicators (PIs) suite in the HSE's Service Plan and the Mental Health Division Operational Plan. The Metadata for the Suite is available on the HSE website www.hse.ie.

The Division is committed to providing ICT enabled solutions to meet its information and decision support requirements, and in the interim, it has established the Mental Health Data Design and Optimisation Governance Group to leverage the optimum information from the current information system.

Building on the success of the annual reports which were published by the Child and Adolescent Mental Health Services up to 2013, the Division has developed this report, Delivering Specialist Mental Health Services 2014-2015, with the objective of providing an overview of the work of the specialist mental health services, describing what the services do, detailing the resources available to the services and showing the activity of those services in 2014 and 2015.

The Report is structured as follows:-

- The Report is introduced by describing secondary care specialist mental health services, giving an overview of the components of service and how they are accessed. This introductory section also describes, in summary, the Programme for Government investment programme for Mental Health since 2012.

- This is followed by a chapter outlining the Mental Health Workforce in the General Adult, Psychiatry of Old Age and Child and Adolescent Mental Health Services utilising the mental health performance indicator suite provided by the mental health services nationally. The workforce data provided is an average of the staffing over the given year based on these returns.

- The next section presents the activity of the General Adult, Psychiatry of Old Age and Child and Adolescent Mental Health Services. This information is derived from the data collected as part of the 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 the Division to incrementally expand the data collected and to develop its capacity for information analysis.

- In that context, there is a section of the Report which 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 services as well as Liaison Psychiatry and Rehabilitation services. Although, the data which presented in the Report for General Adult, Psychiatry of Old Age and CAMHS services is not yet collected for these services, a broad description of the role and scope of these services, together with an update on progress in the development of the service is included in the Report.

It is planned 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.

DELIVERING SECONDARY CARE MENTAL HEALTH SERVICES

2

DELIVERING SECONDARY CARE MENTAL HEALTH SERVICES

Context

The World Health Organisation (August 2014) states that "Mental health can be conceptualized as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

The term mental health describes a spectrum that extends from enjoying positive mental health through to severe and disabling illness.

Professor Corey Keyes (2002) conducted wide-scale research in a number of diverse cultures which found that approximately 17.2% of a population enjoy good mental health, 56.6% report moderate mental health, a further 14.1% have a diagnosis and the remaining 12.1% are described as languishing.

Studies suggest that the lifetime incidence of mental illness in Ireland is 24% with Depression and Anxiety Disorders being most frequently seen. Severe mental illnesses such as schizophrenia which affects 1% of the population and major mood disorders, a similar proportion, may have a significant adverse effect on quality of life with reduced employment and early mortality due to natural and unnatural causes.

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 for assessment or treatment of a mental illness. Of this number approximately 10% experience acute phases of their illness and are offered acute inpatient care with 92% of all admissions being of a voluntary nature.

Specialist Mental Health Services

The Mental Health Division is accountable for the specialist secondary care mental health service for the population. This specialist secondary care mental health service is provided to respond to the varied and complex clinical needs of those individuals with a mental illness.

These 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, Psychiatry of Old Age etc.), day hospitals, out-patient clinics, community residential settings, continuing care settings. It also includes 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 Mental Health Division, together with the Social Care Division, has committed to developing specialist mental health services for those with a mental illness and an intellectual disability in the 2016 Service Plan.

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 port for professional support will be to the primary care system directly via GP or other health service professional.

The Report of the Expert Group on Metal Health Policy - A Vision for Change (2006) 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, through 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.

Each CMHT 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 inpatient unit. This would be in line with best practice and evidence based, 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 the individual's recovery.

NATIONAL MENTAL HEALTH CLINICAL PROGRAMMES

3

NATIONAL MENTAL HEALTH CLINICAL PROGRAMMES

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 who present to the mental health services. The HSE (Clinical Strategy and Programmes Division and the Mental Health Division) in partnership with the College of Psychiatrists of Ireland identified a number of Clinical Programmes.

There are currently three mental health clinical programmes:

- Management of Self Harm Presentations to Emergency Departments
- Early Intervention in First Episode Psychosis
- Eating Disorders

A Consultant Psychiatrist lead was appointed to the Self Harm and Eating Disorders Clinical Programmes in October 2015, completing the appointment of Leads to each of the Clinical Programmes.

Management of Self Harm Presentations to Emergency Departments

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 which is known to be associated with an increased risk of completed suicide.

In 2015, 25 Clinical Nurse Specialists in Self Harm were in post across 16 Emergency Departments. The nursing staff implemented an agreed standard operating procedure and data was collected from December 2015. The full range of resources is available on the HSE webpage including the Clinical Programme at www.hse.ie.

In tandem with the programme, a training plan has been developed to ensure that staff are skilled and have on-going opportunities to develop competencies and have access to supervision in this clinical area. Training has also been provided to emergency health care staff in working with self-harm or suicidal patients to foster improved knowledge of self-harm, more positive attitudes and increased confidence in assessing and managing people in the Emergency Department.

Early Intervention in First Episode Psychosis

This Clinical Programme has a number of evidenced based interventions; Behavioural Family Therapy (BFT), CBT for Psychosis, Individual Placement Support (IPS) and Physical Health Care. During 2015 the main focus was on BFT and in 2016 the focus is on Physical Health Care.

Behavioural Family Therapy (BFT)

As part of the development of this programme 19 staff were trained in May 2015 as trainers/supervisors in the delivery of Behavioural Family Therapy, bringing the total nationally to 26. There are now trainers/supervisors in most mental health areas allowing for local training and supervision. The new trainers rolled out training locally and over 180 staff were trained. BFT is now available for families/service users who access mental health services in all areas. Data is being collected since January 2016 on a monthly basis.

Eating Disorders:

Family Based Therapy (FBT)

In May and October 2015 Professor Jim Lock from Stanford University, California delivered training to named staff from each CAMHS team in Family Based Therapy (FBT). 73 staff in total attended the training. In additional a master class was facilitated for Consultant Psychiatrists working in CAMHS. FBT is the leading evidenced based intervention for young people with anorexia nervosa. This will be further developed in 2016.

Enhanced Cognitive Behavioural Therapy (CBTE)

Professor Christopher Fairburn facilitated a 2 day master class in May with staff who initially completed the online training in CBTE. A supervision structure to support staff is in development.

For 2016 the focus of the work of the Clinical Programmes will be on:-

- Implementation and collection of data from local areas to demonstrate that staff are using the new skills and service users are receiving the best care;
- Continued support by the Clinical Programmes Office to staff/services in the delivery of programmes by providing training and supervision structures;
- Design and implementation of the two further clinical programmes prioritising responses to children and adults with ADHD and those with Comorbid Mental Illness and Substance Misuse (Dual Diagnosis).

PROGRAMME FOR GOVERNMENT INVESTMENT IN MENTAL HEALTH SERVICES 2012 TO 2015

4

PROGRAMME FOR GOVERNMENT INVESTMENT IN MENTAL HEALTH SERVICES 2012 TO 2015

Between 2012 and 2016, €160m was allocated under the Programme for Government to invest in modern mental health services which are recovery focussed and community based.

- The investments in 2012 and 2013 largely prioritised the addition of health and social care professionals for General Adult and Child and Adolescent community mental health teams supporting the provision of multidisciplinary mental health care. It also provided investment for suicide prevention initiatives, the establishment of the Counselling in Primary Care service, and funded innovative projects to test models of care based on A Vision for Change.

- 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 as well as continuing investment in General Adult and Child and Adolescent Mental Health Services. It also included an additional focus on developing liaison psychiatry services in acute hospitals.

- The funding of €35m provided in 2015 has provided for continued investment in services aligned to our strategic priorities, providing potentially for another 390 staff to be funded in the Mental Health services over and above the 950 posts funded through 2012 to 2014.

There are other services which have been prioritised for development in the past three years through the Programme for Government investment, services for those with a mental illness and an intellectual disability; Liaison Psychiatry Services and Rehabilitation and Recovery Mental Health Services. Although, the data which presented in the Report for General Adult, Psychiatry of Old Age and CAMHS services is not yet collected for these services, a broad description of the role and scope of these services, together with an update on progress in the development of the service is included in the Report.

Table 1 shows the breakout of spend between 2012 and 2014 with almost 74m invested in staffing for the mental health services.

Table 1 – allocation of Programme for Government funding 2012 to 2014.

Funding Use	2012	2013	2014	2015	Total
Staff	22,838,338	31,129,426	20,000,000	21,520,000	95,487,764
Counselling in Primary Care	5,000,000	2,465,299			7,465,299
National Office for Suicide Prevention	3,000,000	1,000,000		2,750,000	6,750,000
Increase Ward Spaces/Placements				6,330,000	6,330,000
Jigsaw				3,200,000	3,200,000
Genio & Misc	2,102,662				2,102,662

Funding Use	2012	2013	2014	2015	Total
Enhanced Teamworking	1,547,000				1,547,000
ARI				1,000,000	1,000,000
Information System		405,275			405,275
Clinical Programs	402,000				402,000
Stigma				200,000	200,000
Advocacy	110,000				110,000
	35,000,000	**35,000,000**	**20,000,000**	**35,000,000**	**125,000,000**

2015 Programme for Government Investment

In addition to the continued delivery of existing services and the design and implementation of new models of care that are not dependent on new monies, the funding of €35m provided late in 2015 has provided for continued investment in services aligned to our strategic priorities, providing potentially for another 390 staff to be recruited to Mental Health services over and above the 1,143 posts funded through 2012 to 2014 PfG investment. Table 2 shows the detail of the posts allocated from 2012 to 2015.

Table 2 2012-2015 INVESTMENT IN POST SPECIFICALLY FOR COMMUNITY TEAMS

TEAMS	2012 WTE	2013 WTE	2014 WTE	2015 WTE	Total WTE
General Adult Community Mental Health Teams	254	180	38	76	548
Child and Adolescent Community Mental Health Teams	150	80	53	42	325
POA Community Mental Health Teams		100	25	34	159
MHID Community Mental Health Teams		40	24	41	105
Forensic Teams (In-reach, MHID and CAMHs)		28		1.5	29.5
Homeless MH Teams			7	TBA	7
Liaison Teams			10	7	17
Sub Total	**404**	**428**	**157**	**205.5**	**1,194.5**
Specialist/In-Pat/National Support/NOSP/Clinical Programmes/Traveller Health etc. *2015 some posts still to be agreed for Homeless, SSRU etc. but large number accounted for by Acute Units, Forensics etc.	10	49	95	184.5	338.5
TOTAL FUNDED POSTS	**414**	**477**	**252**	**390**	**1,533**

Development Posts:

At the end of June 2016, a total of 996.5 of the development posts had started and the breakdown per year is as follows:-

- 402.5 or 97% of the 416 development posts for 2012 have started.
- 440 or 92% of the 477.5 development posts for 2013 have started.
- 54 or 61% of the 251.1 development posts for 2014 have started.

The allocation of the posts from the 2015 Programme for Government €35m has been finalised. Approximately 390 posts have been funded from the €35m in 2015 including 60 previously unfunded posts already in place.

13 new development posts have started with the majority of remainder notified to NRS.

Planned Programme for Government Investment 2016

In addition to consolidation and on-going development of services arising from this previous investment, the Programme for Government Funding (PfG) of €35m in 2016 will provide for:-

- the development, by Primary Care, of counselling services for children;
- the allocation of funding to embed the Jigsaw service in the current 10 sites and the expansion of the services to Cork, Dublin and Limerick.
- Provision of posts for Heads of Service User, Family Member and Carer engagement in each CHO and the development of the Peer Support Worker role.
- Further investment in low secure acute care and high dependency rehabilitation services for service user with complex needs
- The development of the Clinical Care programmes for ADHD and Dual Diagnosis.

MENTAL HEALTH WORKFORCE

5

MENTAL HEALTH WORKFORCE

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 Child and Adolescent Mental Health Services, General Adult Mental Health Services and Psychiatry of Old Age 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

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 2015. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 842.48

Table 3 Vision for Change recommendations – actual staffing (2015)

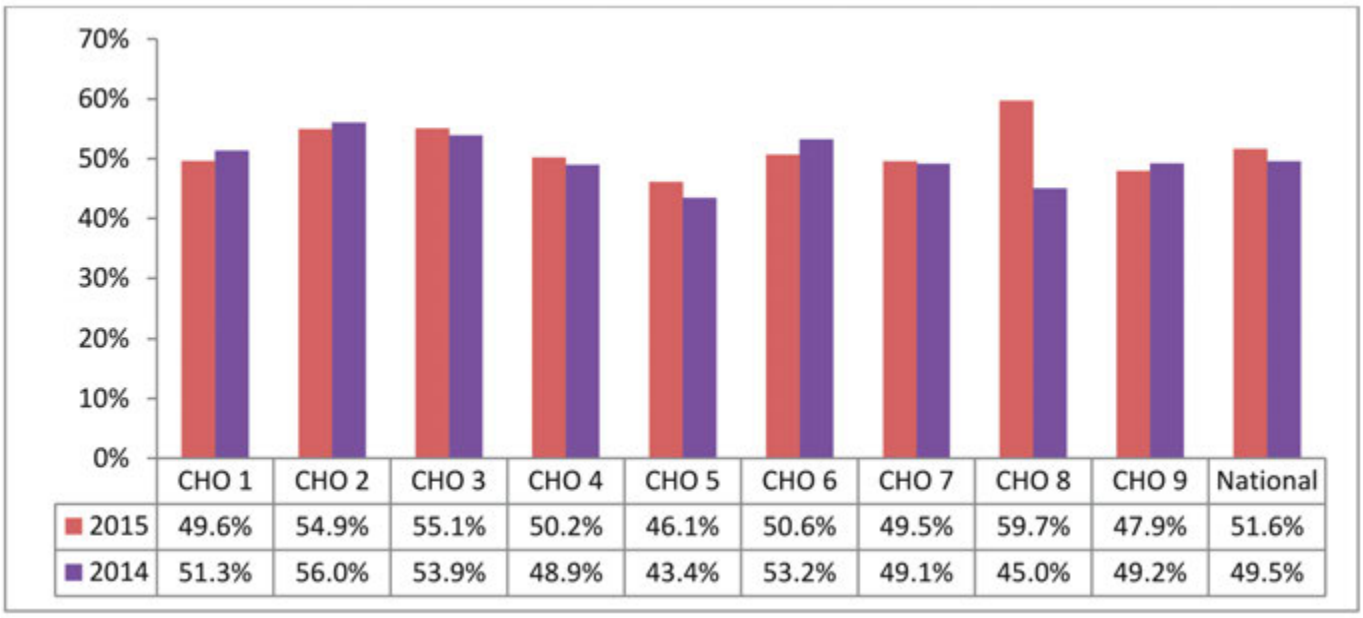
Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2015
Staff Community MHTs	1 : 50,000	77	63	1,196	603.95
Adolescent Day Service teams		15	4		27.18
Hospital Liaison MHTs	1 : 300,000	15	4	195	30
Total	**1 : 42,857**	**107**	**71**	**1,391**	**661.13**
Inpatient Services			4 Units		181.35
			Total Staff		842.48

Staffing of CAMHS Community Mental Health Teams

In Ireland, 25% of the population is under 18 years of age and in December 2015, there was a total of 603.95 staff in the Child and Adolescent Community Mental Health Teams nationally (521.41 Clinical). This represents 51.6% of the staffing levels recommended in A Vision for Change which is an increase of 2.1% nationally on the 2014 position. The largest increase was in CHO 8 at 14.7%

In the period from 2011 to 2015, arising from the Programme for Government investment in CAMHs services from 2012, staffing in the community CAMHS teams had a net gain of 139.71 whole time equivalents over this period, exclusive of staff leaving and retiring etc. over the period 2011 to 2015.

Figure 2 Community CAMHS Teams Staffing vs. VFC recommendations in 2014 - 2015



In December 2015, there was 603.95 staff (clinical 521.41) working in 63 Community CAMHS teams, with an average of 9.58 staff of which 8.27 were clinical staff per team. The range of team size varies from the smallest team of 5.3 (4.5 clinical) to the largest which comprises of 16.8 (15.80 clinical). The variation in team size can arise due to team development or population size etc.

Table 4 Growth in Community CAMHS Teams Staffing by profession - 2011 to 2015

	2011	2012	2013	2014	2015	Change +/-
Consultant Psychiatrist	57.69	60.44	60.37	65.39	64.15	6.46
Senior Registrar	19.8	20.6	10.4	13.30	10.70	-9.10
Registrar/SHO	43.49	45.2	47.03	48.58	59.52	16.03
Social Worker	68.01	67.29	72.09	76.47	77.60	9.59
Clinical Psychologist	57.78	57.78	55.75	61.61	66.54	8.76
Nurse	61.33	59.64	68.77	88.37	98.27	36.94
Occupational Therapist	26.7	25.72	50.53	47.99	52.19	25.49
Speech & Language Therapist	29.22	29.72	46.14	51.61	42.61	13.39
Child/Social Care Worker	15.74	12.74	33.54	41.35	41.13	25.39
Other Therapist	9	6.45	6.6	5.70	8.70	-0.30
Administrative Support Staff	75.48	76.36	80.54	79.83	82.54	7.06
	464.24	461.94	531.76	580.20	603.95	139.71

Staffing of CAMHs Day Services and CAMHS Liaison Teams

Each of the three Dublin paediatric hospitals has a liaison team and the total number of staff on these teams is 28.73 (clinical 22.53)

There are three Day services in Dublin and one in Galway providing a service to adolescents only with a total staff of 27.18 (clinical 21.35). Dunfillan Young Person's Unit is located at the St. John of God Lucena clinic in Rathgar, St. Joseph's Adolescent and Family Service at St. Vincent's Hospital, Fairview, the Linn Dara Adolescent Day Programme at CAMHS facility in Cherry Orchard Hospital, Ballyfermot and the Merlin Park Adolescent Day Programme Galway.

Table 5 Staffing of Day Services and Liaison Teams

Sep-15	Day Service	Paediatric Hospital Liaison	Total
Medical	4.85	7.63	12.48
Nursing	10.6	5.4	16
Health Care Professional	5.9	9.5	15.4
Support Staff	5.83	6.2	12.03
Total	27.18	28.73	55.91

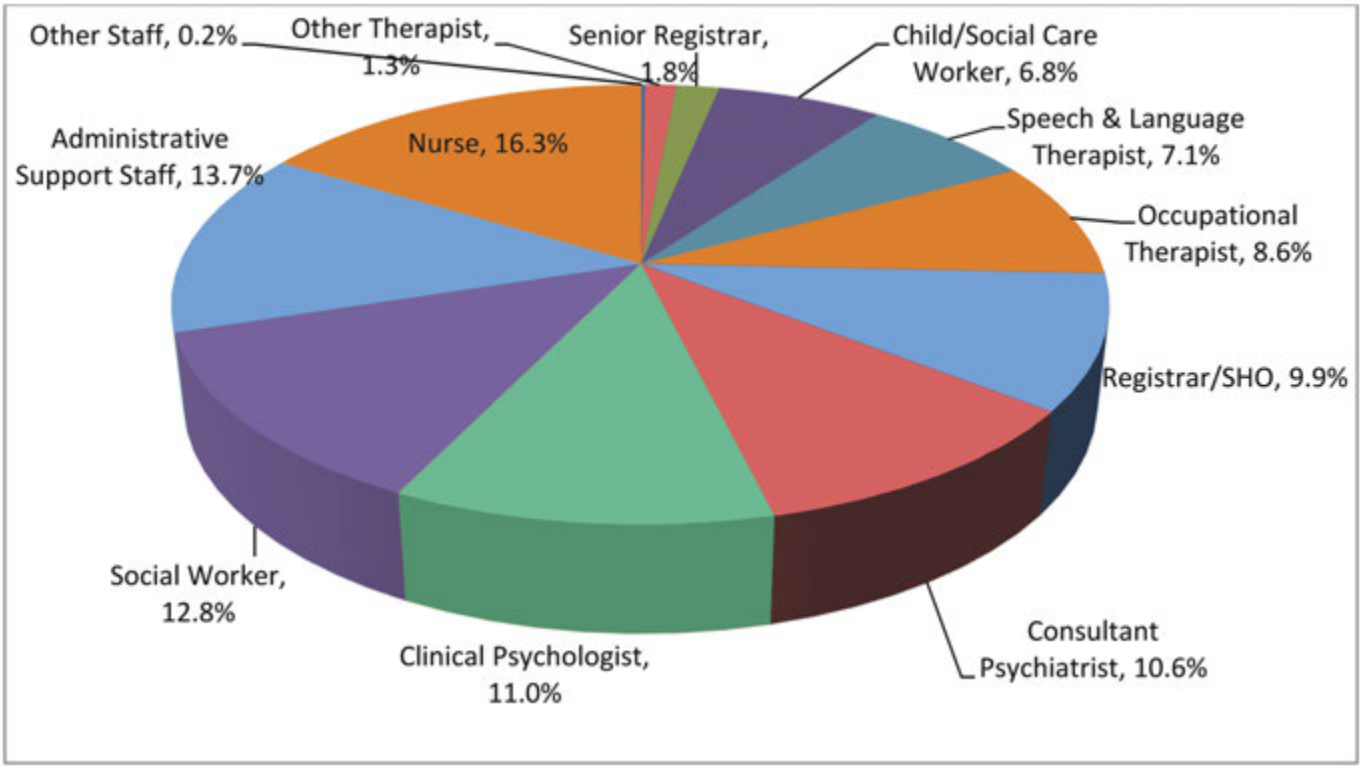
Staffing of CAMHs Acute Inpatient Units

The total number of staff at the four inpatient units was 181.35 (September 2015). Table 4 shows the breakout of the staffing by profession between September 2013 and September 2015.

Table 6 Staffing of Child and Adolescent Inpatient Units by profession 2013-2015

	Sep-13	Sep-14	Sep-15
Consultant Psychiatrist	5.75	5.10	6.00
Senior registrar	4.00	3.00	4.00
Registrar/SHO	3.80	3.00	4.00
Director of Nursing	2.00	1.00	1.00
Assistant Director of Nursing / CNM III	5.70	2.70	4.70
CNM II	6.90	6.00	12.00
CNM I	8.50	7.50	7.50
Clinical Nurse Specialist	2.00	2.00	2.50
Staff Nurse	78.08	94.00	84.50
Clinical Psychologist	4.50	4.00	3.81
Occupational Therapist	2.90	4.30	2.80
Speech and Language Therapist	3.00	2.70	2.90
Social Worker	4.31	6.30	6.20
Childcare Worker	2.00	1.00	1.00
Dietician	0.80	1.70	1.20
Physiotherapy	0.00	0.00	0.30
Other Therapist	0.00	0.00	0.00
Administrative Support staff	7.60	7.75	7.75
Non-Nursing Care Assistant/Multi Task Attendant	7.50	9.00	9.00
Non-Nursing Chef (Household)	1.00	1.00	1.00
Non-Nursing Catering Assistant	4.19	2.50	5.19

Figure 3 Community CAMHS workforce by profession (2015)



General Adult Mental Health Services Workforce

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 2015. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 1,758.38.

Table 7 Vision for Change recommendations – actual staffing (2015)

Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2015
Staff Community MHTs	1 : 50,000	92	114	2,116	1,758.38

Community GAMHT staffing compared against Vision for Change recommendations

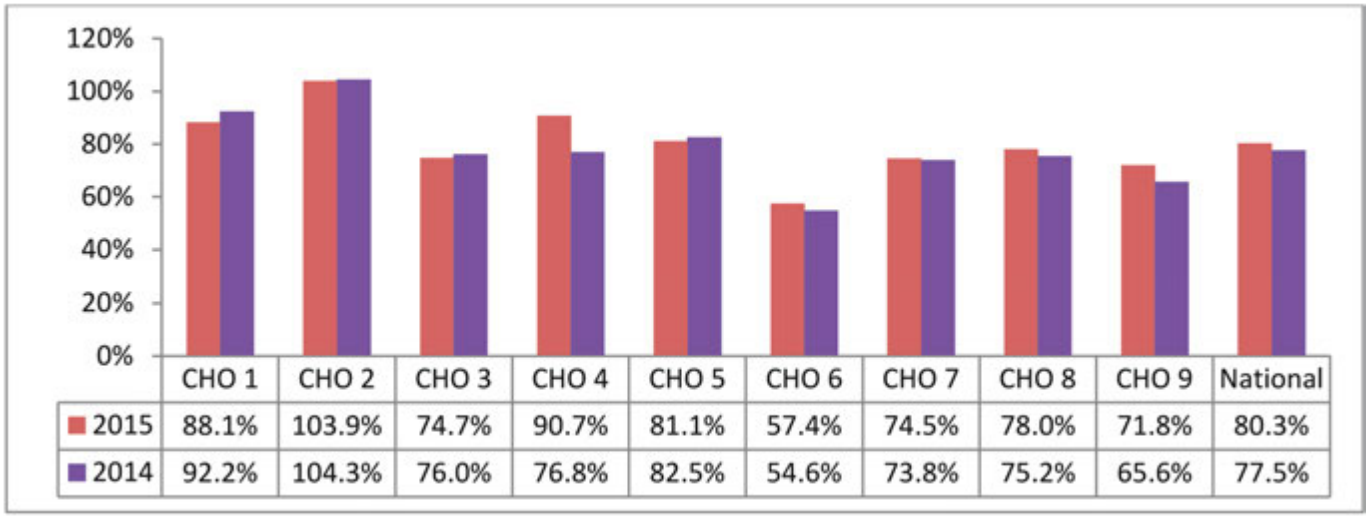
Vision for Change (2006) recommends that there should be one General Adult community mental health team for each sector of 50,000 population with individual General Adult community mental health team comprising of the following:

- 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 2015 there was a total of 1,758.38 staff in situ (1,547.79 Clinical), which represents 80.3% of the staffing levels recommended in a Vision for Change.

Figure 4 Community GAMHS Teams Staffing vs. VFC recommendations for 2014 - 2015



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	88.1%	103.9%	74.7%	90.7%	81.1%	57.4%	74.5%	78.0%	71.8%	80.3%
2014	92.2%	104.3%	76.0%	76.8%	82.5%	54.6%	73.8%	75.2%	65.6%	77.5%

In 2015 the staffing level as recommended in a Vision for Change had increased by 2.8% nationally on the 2014 position. The largest increase was in the CHO 4 which was 13.9%

Community General Adult Mental Health teams

In the period from December 2014 to December 2015, the clinical staff of the Community General Adult Mental Health Teams increased by 70.04.

Table 8 Community General Adult Mental Health Teams (2014 to 2015)

	Clinical Staff 2015	Clinical Staff 2014	Change +/-
CHO 1	145.00	151.83	-6.83
CHO 2	194.26	195.10	-0.84
CHO 3	118.98	121.15	-2.17
CHO 4	253.28	214.30	38.98
CHO 5	169.52	172.46	-2.94
CHO 6	90.02	85.57	4.45
CHO 7	208.20	206.20	2.00
CHO 8	193.10	186.29	6.81
CHO 9	175.43	160.13	15.30
Admin/support	210.59	195.32	15.27
	1,758.38	1,688.35	70.04

In December 2015 there was 1,758.38 staff (clinical 1,547.79) working in 114 Community General Adult Mental Health teams, with an average of 15.42 staff per team, of which 13.58 were clinical staff.

The General Adult Community Mental Health Teams as shown in table 9, had a net gain of 123.41 whole time equivalents over this period, exclusive of staff leaving and retiring etc. over the period 2013 to 2015

Table 9 Community GAMH Teams Staffing by discipline 2013 to 2015

	2013	2014	2015	Change +/-
Consultant Psychiatrist	157.34	157.92	159.97	2.63
Senior Registrar	35.40	35.30	30.43	-4.97
Registrar/SHO	203.60	208.31	217.60	14.00
Social Worker	138.11	132.99	148.73	10.62
Clinical Psychologist	110.72	126.26	132.39	21.67
Nurse	604.21	613.13	648.92	44.71
Occupational Therapist	116.05	123.76	124.48	8.43
Other Therapist e.g. SLT Creative/Recreational	12.98	14.58	15.92	2.94
Other Staff	14.28	17.78	16.33	2.05
Mental Health Support Worker	15.30	17.00	7.00	-8.30
Addiction Counsellor	48.58	46.00	46.02	-2.56
Non-Nursing	32.32	35.61	43.80	11.48
Administrative Support Staff	146.08	159.71	166.79	20.71
	1,634.97	1,688.35	1,758.38	123.41

Figure 5 Community GAMHT workforce by profession (2015)

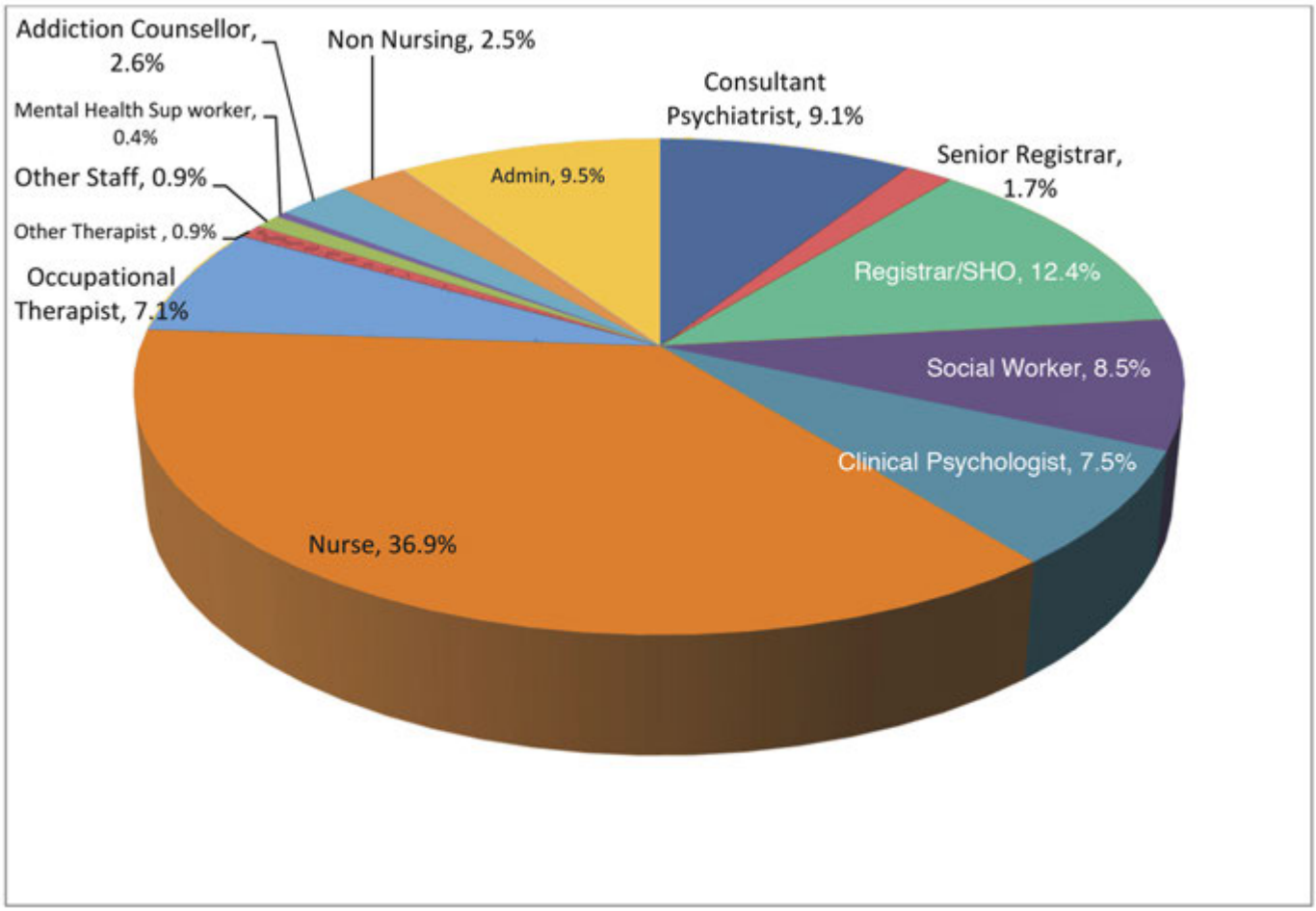


Table 10 Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2014-2015

	Population	Clinical Staff 2015	% of VFC rec 2015	Clinical Staff 2014	% of VFC rec 2014
CHO 1	**391,994**	145.00	88.1%	151.83	92.2%
CHO 2	**445,356**	194.26	103.9%	195.10	104.3%
CHO 3	**379,327**	118.98	74.7%	121.15	76.0%
CHO 4	**664,534**	253.28	90.7%	214.30	76.8%
CHO 5	**497,578**	169.52	81.1%	172.46	82.5%
CHO 6	**373,092**	90.02	57.4%	85.57	54.6%
CHO 7	**665,443**	208.20	74.5%	206.20	73.8%
CHO 8	**589,442**	193.10	78.0%	186.29	75.2%
CHO 9	**581,486**	175.43	71.8%	160.13	65.6%
National	**4,588,252**	1,547.79	80.3%	1,493.03	77.5%

Psychiatry of Old Age Workforce

Staffing of Community Psychiatry of Old Age Services

A survey of the staffing of Psychiatry of Old Age Service (POA) was carried out in December 2015. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 302.54.

Table 11 Vision for Change recommendations – actual staffing (2015)

Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2015
Staff POA service	1 : 100,000*	46	26**	552	302.54

*Equates to 1 : 11,700 over 65 year old population

**This figure includes Teams serving larger populations which are operating as double or triple teams.

Currently there are 26 POA community teams with a number of teams in development which have been resourced from the Programme for Government investments in recent years. However, in some areas, Teams serving larger populations are operating as double or triple teams, so the resource equates to 36 of the 46 teams recommended in Vision. When all recruitment completed, POA services will be available nationally.

Table 12 Number of POA Community Teams and Teams in Development by CHO 2015

CHO	MHA	TEAM	S/D/T	Developments from PfG
1	Donegal	1	S	1 cons 2015
	Sligo/Leitrim	1	S	0.5 con 2015
	Cavan/Monaghan	1	S	0.5 cons 2014
2	Mayo North	1	S	
	Mayo South			New Team 2014
	Roscommon[2]	1	S	New Team 2014
	Galway West	1	S	
	Galway East	1	S	
3	Limerick	1	D	
	Clare	1	S	
	NTipp[2]			New Team 2014
4	Kerry[2]	1	S	New Team 2014
	South Lee	1	S	
	West Cork[2]	1	S	New Team 2015
	North Lee[2]	1	S	New Team 2014
	North Cork			New Team 2014
5	Wexford	1	S	
	Wex/Waterford[2]	1	S	1 cons 2015
	Waterford	1	S	
	Carlow/Kilkenny		S	1 cons 2015
	S Tipp	1	S	
6	Elm Park	1	T	
	Wicklow[2]	1	S	New Team 2015
7	SC Dublin	1	D	
	SW Dublin	1	D	
	Kildare/WWicklow[2]	1	D	New Team 2014
8	Louth	1	S	
	Louth/Meath[2]	1	S	New Team 2014
	Meath	1	S	
9	North Dublin	1	D	1 cons 2015
	Dublin North City	1	T	1 cons 2014

[1]S/D/T: single/double/triple team

[2] PFG teams

Psychiatry of Old Age Service staffing compared against Vision for Change recommendations

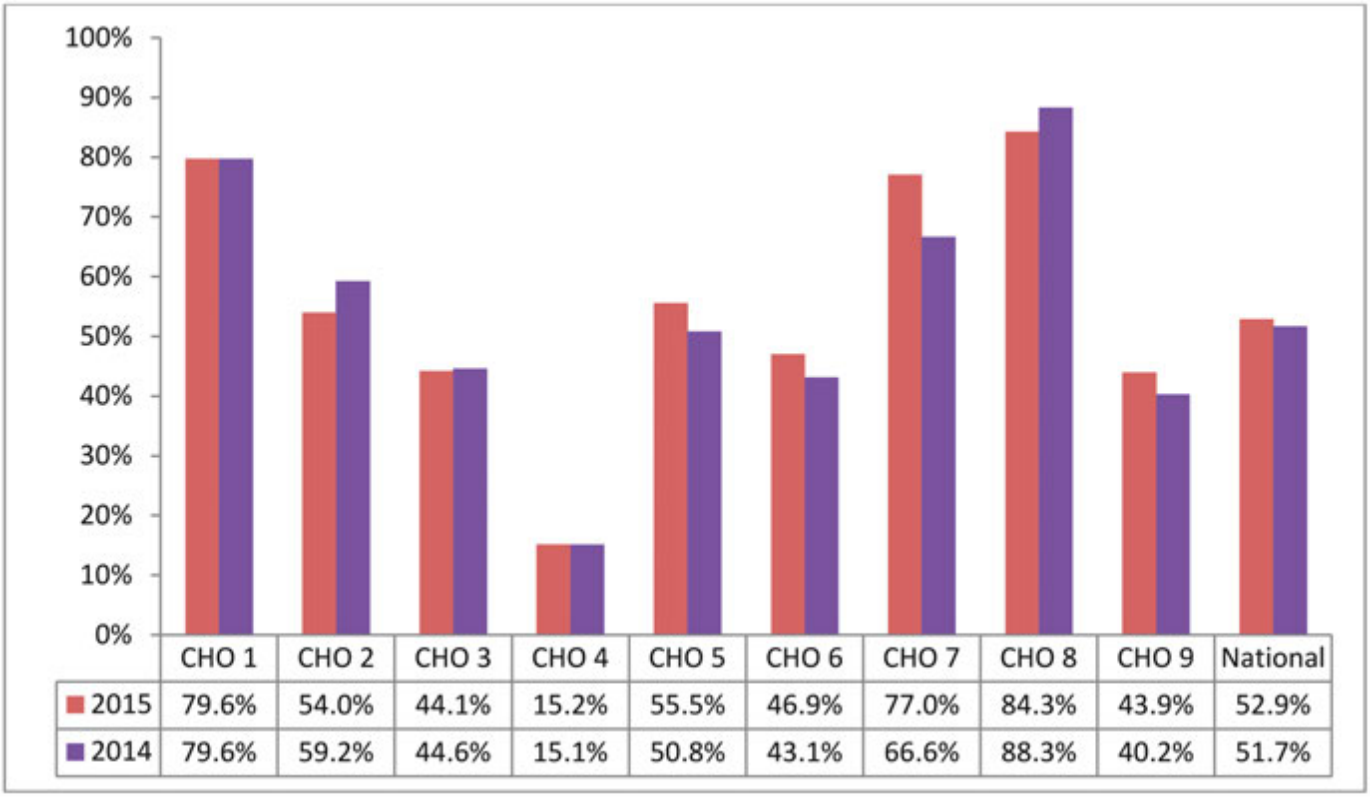
Vision for Change (2006) recommends that there should be one General Adult community mental health team for each sector of 50,000 population with individual General Adult community mental health team comprising of the following:

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

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

In December 2015, there were 302.54 staff (clinical 266.22) working in 26 Psychiatry of Old Age Service teams, with an average of 15.42 staff (of which 13.58 were clinical staff) per team. This represents 52.9% of the staffing level as recommended in a Vision for Change. Figure 6 illustrates the regional staffing levels from 2014 to 2015.

Figure 6 Community POA Team Staffing vs. VFC recommendations in 2014 - 2015



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	79.6%	54.0%	44.1%	15.2%	55.5%	46.9%	77.0%	84.3%	43.9%	52.9%
2014	79.6%	59.2%	44.6%	15.1%	50.8%	43.1%	66.6%	88.3%	40.2%	51.7%

Psychiatry of Old Age Service Teams

In the period from 2013 to 2015, Community Psychiatry of Old Age Service had a net gain of 44.75 whole time equivalents over this period, exclusive of staff leaving and retiring etc. over the period 2013 to 2015 (Table 14)

Figure 7 Psychiatry of Old Age Service workforce by profession (2015)

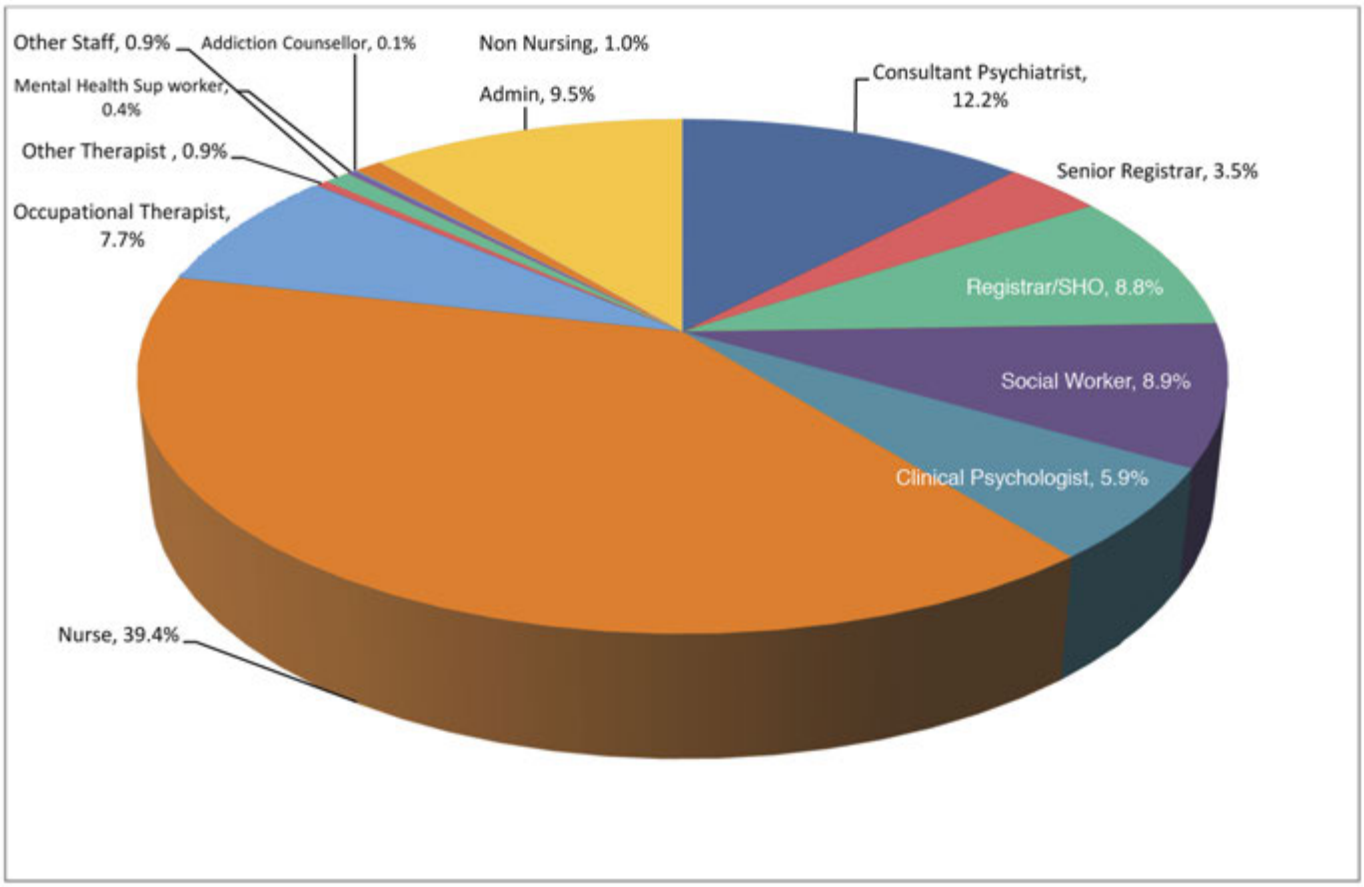
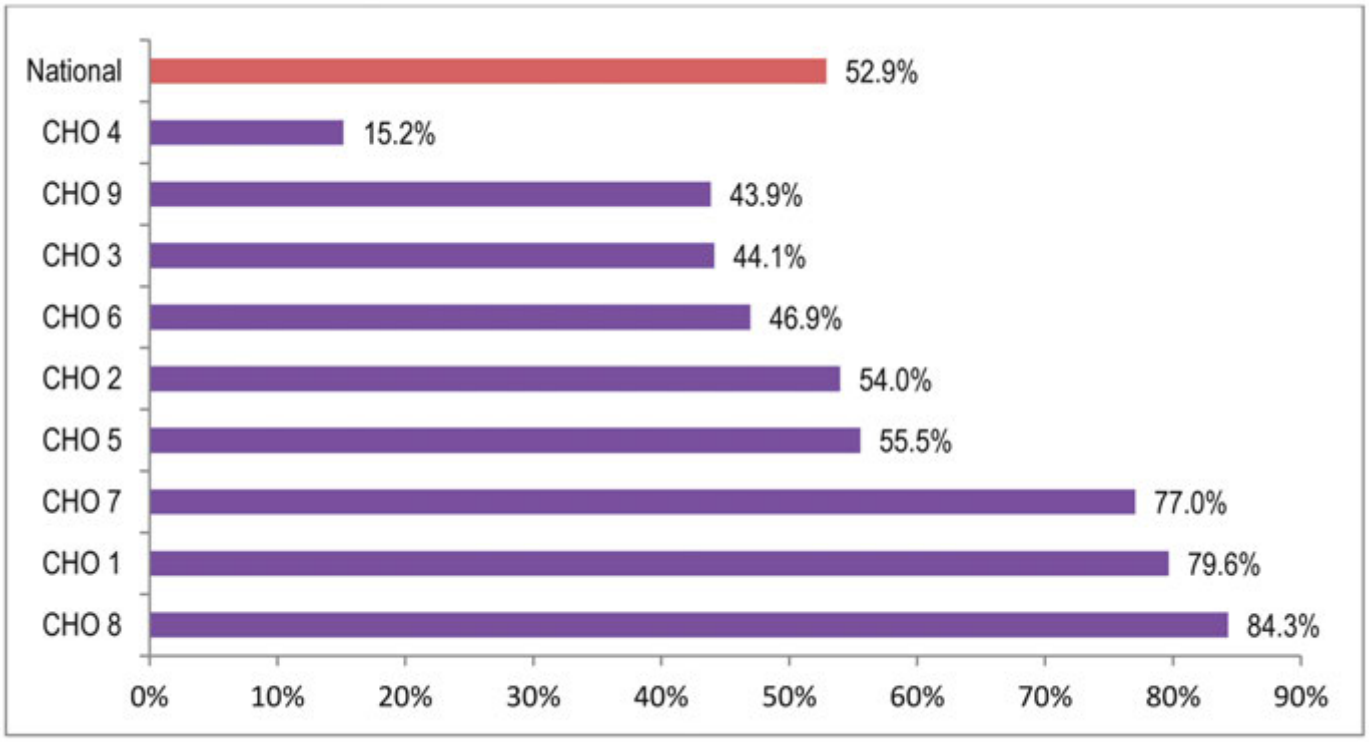


Table 13 Psychiatry of Old Age Service Staffing by discipline 2013 to 2015

	2013	2014	2015	Change +/-
Consultant Psychiatrist	32.30	36.30	36.95	4.65
Senior Registrar	10.00	11.00	10.55	0.55
Registrar/SHO	27.00	26.00	26.50	-0.50
Social Worker	16.00	25.00	26.90	10.90
Clinical Psychologist	10.85	16.50	17.80	6.95
Nurse	102.12	114.83	119.12	17.00
Occupational Therapist	20.32	24.22	23.27	2.95
Other Therapist e.g. SLT Creative/Recreational	1.20	2.00	1.30	0.10
Other Staff	1.00	0.88	2.63	1.63
Mental Health Support Worker	3.00	3.00	1.00	-2.00
Addiction Counsellor	0.40	0.40	0.20	-0.20
Non-Nursing	3.29	6.32	2.91	-0.38
Administrative Support Staff	30.31	35.24	33.41	3.10
	257.79	301.69	302.54	44.75

In 2015 the staffing level as recommended in a Vision for Change had increased by 1.2% nationally on the 2014 position. The largest increase was in the CHO 7 10.4%

Figure 8 POA Teams Staffing vs. VFC recommendation by Community Healthcare Organisations 2015



CHILD AND ADOLESCENT COMMUNITY MENTAL HEALTH SERVICES

6

CHILD AND ADOLESCENT COMMUNITY MENTAL HEALTH SERVICES

KEY FACTS

- 2008 - 49 CAMHS teams; 2015 – 63 CAMHS Teams
- 2008 – 351.63 Clinical WTE's; 2015 – 521.41 Clinical WTE's
- 51.6% of the Clinical staffing levels recommended in A Vision for Change
- 25% increase in Referrals from 2012 to 2015
- 14,036 new appointments offered in 2015
- 45.1% new appointments Seen within 4 weeks
- 1/5th of new cases seen are aged over 16 years.
- 13.7% of New patients did not attend their first appointment
- 2007 – 3,609 were waiting to be seen; 2015 – 2,319 were waiting to be seen

Children and Adolescents in the Population

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

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

Figure 9 2011 & 2006 Census by Age

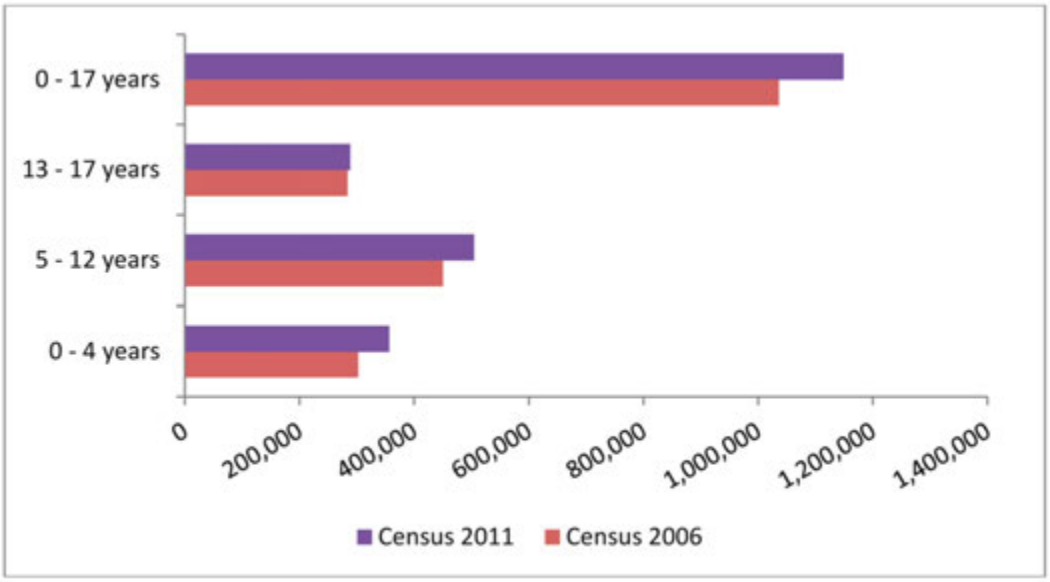


Table 14 2011 & 2006 census by Age

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

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

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

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

Table 15 2011 census by Age 0 – 17 years by CHO Area

CHO Areas	Total	0-17 yrs.	%
CHO 1	391,994	103,549	26.42%
CHO 2	445,356	109,784	24.65%
CHO 3	379,327	94,989	25.04%
CHO 4	664,534	163,388	24.59%
CHO 5	497,578	129,408	26.01%
CHO 6	526,157	110,895	21.08%
CHO 7	512,378	136,334	26.61%
CHO 8	589,442	164,418	27.89%
CHO 9	581,486	135,922	23.37%
National	4,588,252	1,148,687	25.04%

Prevalence of childhood psychiatric disorders

The majority of illness burden in childhood and more so in adolescence, is caused by mental disorders and the majority of adult mental disorders have their onset in adolescence.

The World Health Organisation (2003) in its report "Caring for children and adolescents with mental disorders: Setting WHO direction" states that: "The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive."

- **1 in 10** children and adolescents suffer from mental 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.[1,6]

- A study to determine the prevalence rates of psychiatric disorders, suicidal ideation and intent, and parasuicide in population of Irish adolescents aged 12-15 years in a defined geographical area found that 15.6% of the total population met the criteria for a current psychiatric disorder, including 2.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide.[2]

- The prevalence of mental disorders in young people is increasing over time.[3]
- 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.[4]
- A range of efficacious psychosocial and pharmacological treatments exists for many mental disorders in children and adolescents.[5,7]
- 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). [8]

(references for this section in appendix 1)

Children attending CAMHs

The total population under 18 years in the 2011 census was 1,148,687 and in Quarter 3 of 2015 the number of active open cases recorded by CAMHs community mental health teams was 18,581 or 1.6% of the child population nationally. Data is collected twice a year in respect of active open cases.

Table 16 Number of children attending CAMHS by year and CHO

	2015		2014	
	Q1	Q3	Q1	Q3
CHO 1	2,109	1,947	1,870	2,020
CHO 2	2,324	2,232	2,108	2,197
CHO 3	2,351	2,399	2,238	2,371
CHO 4	2,266	2,208	2,174	2,208
CHO 5	1,572	1,544	1,390	1,432
CHO 6	3,363	2,801	3,094	3,154
CHO 7	2,408	2,106	2,609	2,397
CHO 8	1,657	1,760	1,301	1,398
CHO 9	1,711	1,584	1,725	1,689
National	**19,761**	**18,581**	**18,509**	**18,866**

Table 17 Percentage of CHO Population under 18 years old attending CAMHS

	<18 years Population	Average Caseload 2015	Percentage
CHO 1	103,549	2,028	***2.0%***
CHO 2	109,784	2,278	***2.1%***
CHO 3	94,989	2,375	***2.5%***
CHO 4	163,388	2,237	***1.4%***
CHO 5	129,408	1,558	***1.2%***
CHO 6	110,895	3,082	***2.8%***
CHO 7	136,334	2,257	***1.7%***
CHO 8	164,418	1,709	***1.0%***
CHO 9	135,922	1,648	***1.2%***
National	**1,148,687**	**19,171**	***1.7%***

Referral Process and Criteria for Child and Adolescent Mental Health Services

Community child and adolescent 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 Standard Operating Procedure sets out the referrals process as follows:

The referral criteria to Community CAMHS are as follows:

- Age up to 18 years old.
- The severity and complexity of the presenting mental health disorder is such that treatment at primary care service level has been unsuccessful.
- Community CAMHS accepts referrals for the assessment and treatment of disorders such as:
- Moderate to severe depression;
- Mood disorders;
- Psychosis;
- Anxiety disorders;
- Attention Deficit Hyperactive Disorder (ADHD/ADD);
- Moderate/Severe Eating Disorder; and
- Suicidal behaviours and ideation where intent is present.
- The needs of 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 Referral Agents are:

a) GPs are 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).

* 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 2015, there were 13,356 referrals accepted by the Community Child and Adolescent Mental Health service which is a 2% increase on 2014. In the period from 2012, the number of referrals accepted has increased overall by 25% nationally.

Table 18 Referrals accepted 2015 vs. 2014

	Population	2015	2014	+/- Variance	2013	+/- Variance	2012	+/- Variance
CHO 1	103,549	1,026	1,005	2%				
CHO 2	109,784	1,064	1,035	3%				
CHO 3	94,989	1,813	1,866	-3%				
CHO 4	163,388	1,578	1,539	3%				
CHO 5	129,408	1,502	1,283	17%				
CHO 6	110,895	1,625	1,670	-3%				
CHO 7	136,334	1,694	1,955	-13%				
CHO 8	164,418	1,881	1,642	15%				
CHO 9	135,922	1,173	1,067	10%				
National	1,148,687	13,356	13,062	2%	12,319	8%	10,705	25%

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 see the individual within three months. 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 2015, there were 1,187 individuals to be seen within three months and a further 1,132 individuals were on the waiting list. This represented a decrease of 550 (19.1%) from the total number of 2,869 waiting at the end of 2014.

In the context of an overall 25% increase in the number of referrals accepted, between 2012 and 2015, the Child and Adolescent Mental Health Service waiting list decreased by 103 cases since 2012, an overall decrease of 4% (see Table 21 below).

In March 2015 the numbers waiting to be seen peaked at 3,206, with 56 % (1,801) waiting greater than 3 months.

In 2015, the CAMHs Service Improvement Project, in consultation with the CHOs locally, completed an analysis of those on the waiting list. A targeted approach to addressing the needs of those waiting over 12 months, combined with maintaining the objective of offering first appointments and seeing individuals within three months was adopted. This focussed approach ensured that the waiting list decreased by 550 when compared with the figures at the end of December 2014.

Table 19 Length of Wait time by CHO - December 2015 vs. December 2014

	Dec- 2015						Dec- 2014					
	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	146	76	69	83	28	**402**	148	58	51	61	42	**360**
CHO 2	33	3	0	0	2	**38**	19	7	10	2	8	**46**
CHO 3	99	45	61	52	22	**279**	128	63	67	60	76	**394**
CHO 4	200	83	75	70	94	**522**	170	85	75	65	104	**499**
CHO 5	90	22	13	2	0	**127**	80	45	32	24	80	**261**
CHO 6	259	53	51	13	0	**376**	253	105	54	35	12	**459**
CHO 7	129	9	3	5	9	**155**	160	61	63	33	52	**369**
CHO 8	142	52	21	4	0	**219**	121	72	61	24	0	**278**
CHO 9	89	44	28	14	26	**201**	79	40	34	19	31	**203**
National	**1,187**	**387**	**321**	**243**	**181**	2,319	**1,158**	**536**	**447**	**323**	**405**	2,869

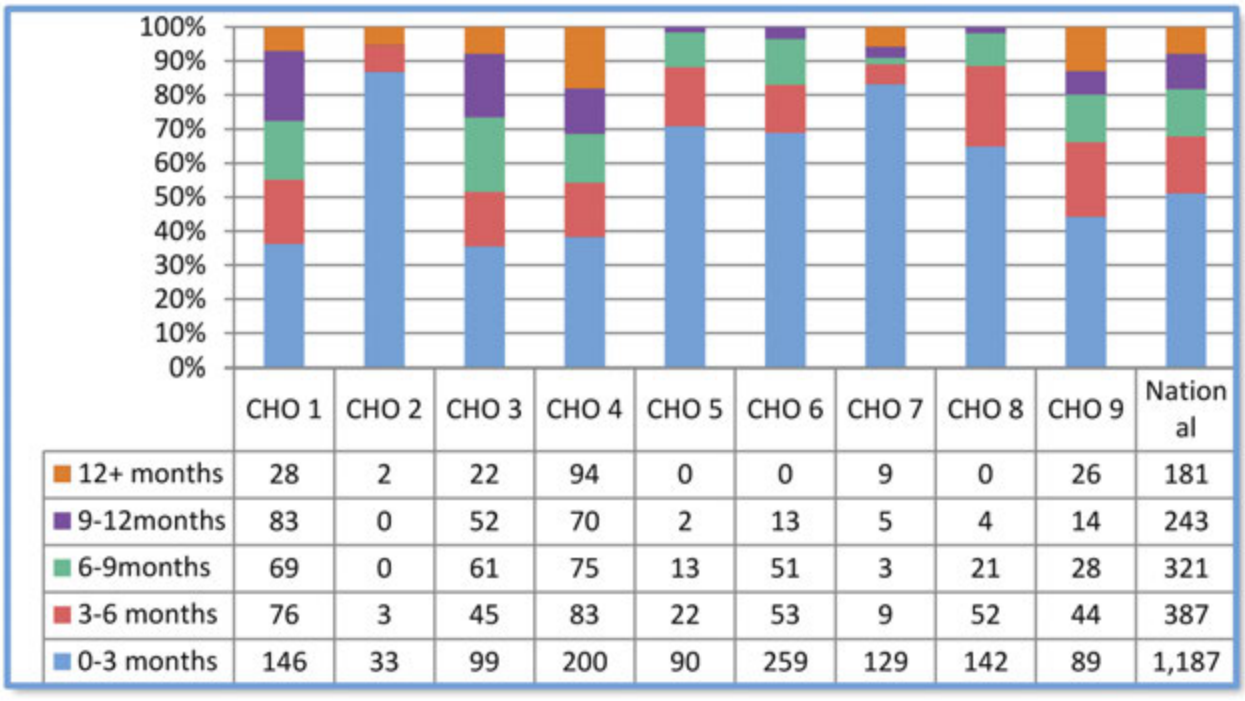
Table 20 Referrals accepted trend vs. Waiting List trend

	Referrals	+/- 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%
12 vs. 15	***2,651***	***25%***	***-103***	***-4%***

Numbers waiting by length of time per CHO

The numbers waiting to be seen varied by Child and Adolescent Community Mental Health Team and 71% (45) of Teams had less than 50 on the waiting list.

Figure 10 Breakdown of Waiting Lists by CHO Area 2015



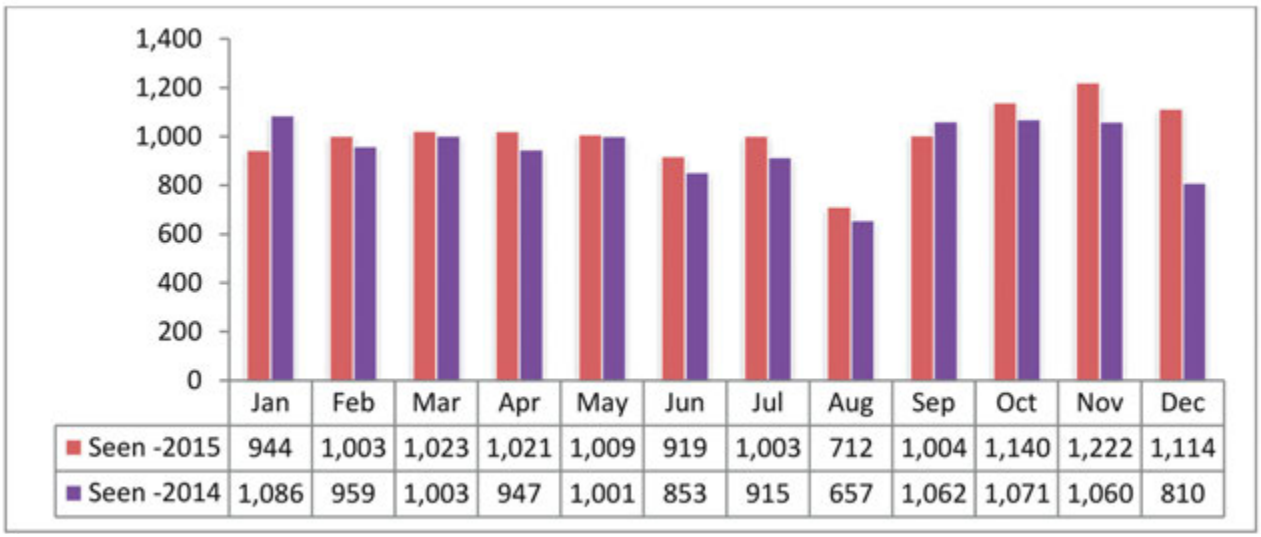
	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
12+ months	28	2	22	94	0	0	9	0	26	181
9-12months	83	0	52	70	2	13	5	4	14	243
6-9months	69	0	61	75	13	51	3	21	28	321
3-6 months	76	3	45	83	22	53	9	52	44	387
0-3 months	146	33	99	200	90	259	129	142	89	1,187

New (including re-referred) cases seen by Community CAMHS teams in 2015

In 2015, 14,036 new cases were offered an appointment by Community CAMHS teams compared to 13,189 cases in 2014.

Of these, 12,114 (11,424 in 2014) were seen and 1,922 (1,765 in 2014) did not attend (DNA). This gives a consistent non-attendance rate of 13% nationally in both years.

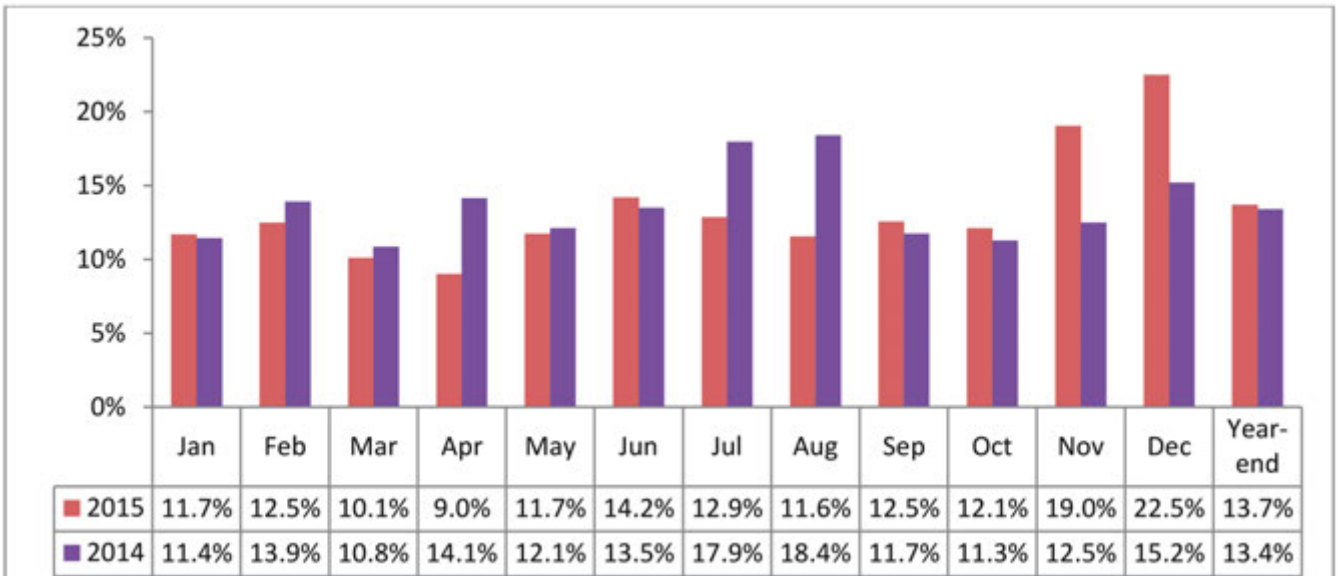
Figure 11 Number of New (including re-referred) cases Seen 2015 vs. 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen -2015	944	1,003	1,023	1,021	1,009	919	1,003	712	1,004	1,140	1,222	1,114
Seen -2014	1,086	959	1,003	947	1,001	853	915	657	1,062	1,071	1,060	810

Figure 12 shows the variation by month in the DNA rates, reflecting the seasonal impact on attendance, as the rates range from 22.5% (December) to 9% (April) across 2015. This compares to 18.4% (August) & 10.8% (March) in 2014.

Figure 12 DNA Rate by month 2015 vs. 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
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%
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%

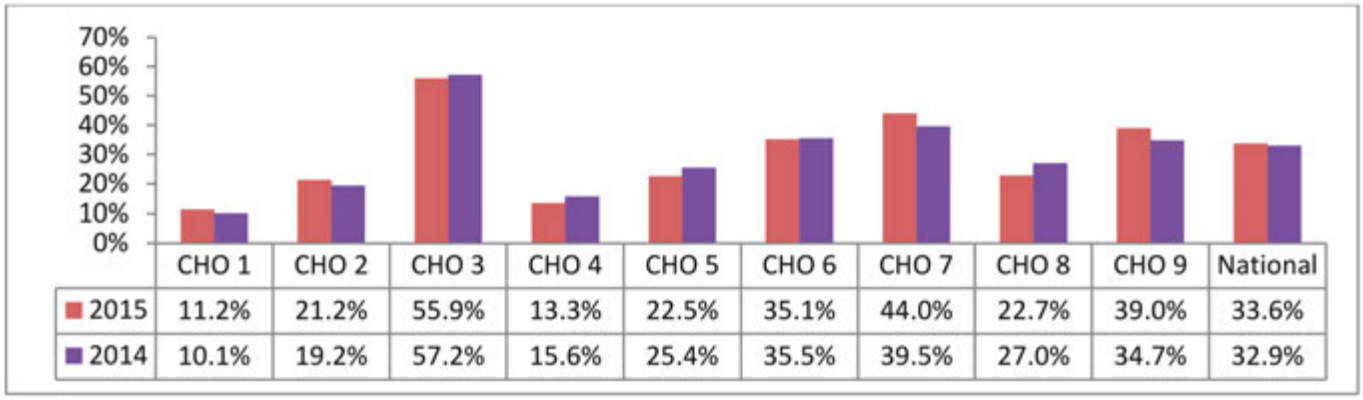
Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen, a proportion will have previously attended the service and been discharged.

In 2015, of the 12,114 cases seen, a total of 4,074 had been re-referred to the service. In 2014, of the 11,424 cases seen, a total of 3,755 had been re-referred to the service. This reflects a consistent re-referral rate of approximately 33%.

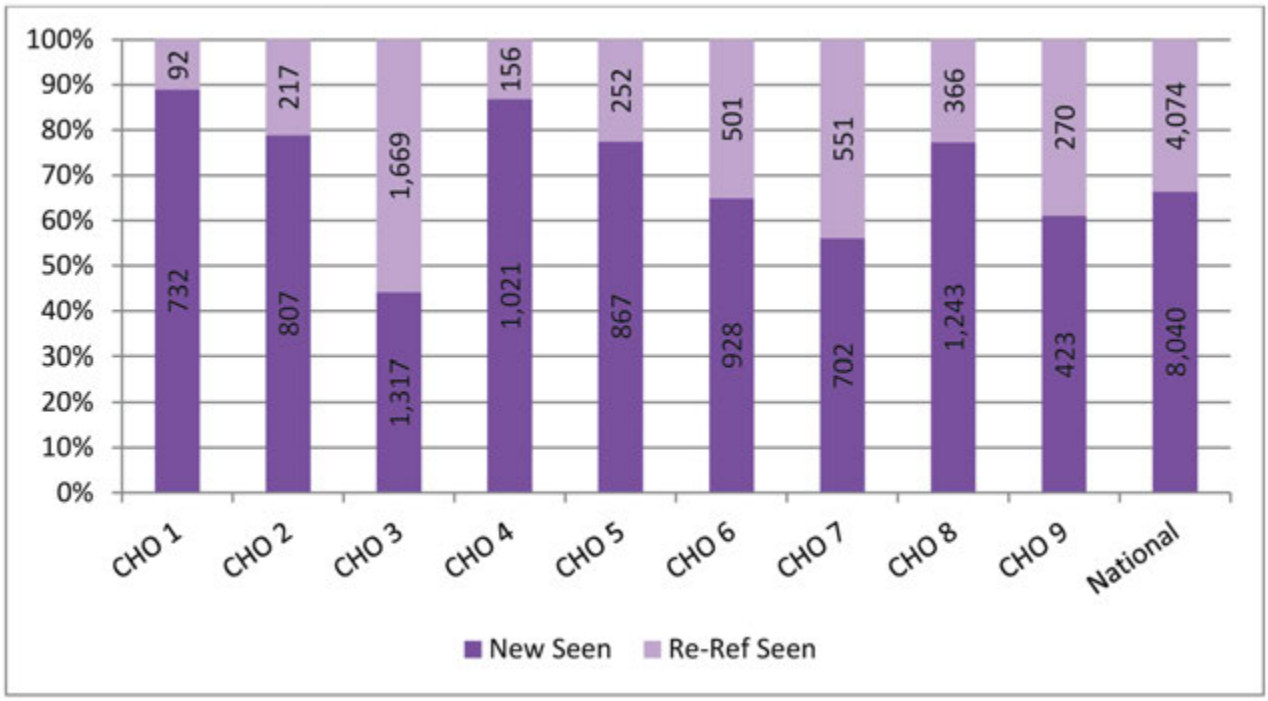
The proportion of re-referred cases seen in the CHOs over the two years varied from 11.2% in CHO 1 to 55.9% in CHO 3 (Figure 13).

Figure 13 Percentage of Re-referred cases 2015 vs. 2014



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	11.2%	21.2%	55.9%	13.3%	22.5%	35.1%	44.0%	22.7%	39.0%	33.6%
2014	10.1%	19.2%	57.2%	15.6%	25.4%	35.5%	39.5%	27.0%	34.7%	32.9%

Figure 14 Breakdown of new cases (New vs. Re-referred cases) 2015



New and re-referred Cases seen by age profile

In 2015, a total number of 12,114 new and re-referred cases were seen by Community CAMHS teams. Of these, 78.4% (9,502) were under 16 years of age and 21.6% (2,612) were over 16 years of age.

In 2014 a total number of 11,424 new and re-referred cases were seen by Community CAMHS teams. Of these, 80% (9,130) were under 16 years of age and 20% (2,294) 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.

Table 21 Number of new (including referred) cases seen aged 16 years and over 2015

2015	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	824	139	16.9%
CHO 2	1,024	289	28.2%
CHO 3	2,986	578	19.4%
CHO 4	1,177	256	21.8%
CHO 5	1,119	349	31.2%
CHO 6	1,429	306	21.4%
CHO 7	1,253	208	16.6%
CHO 8	1,609	372	23.1%
CHO 9	693	115	16.6%
National	12,114	2,612	21.6%

Table 22 Number of new (including referred) cases seen aged 16 years and over 2014

2014	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	819	131	16.0%
CHO 2	917	230	25.1%
CHO 3	2,109	390	18.5%
CHO 4	1,530	352	23.0%
CHO 5	1,321	349	26.4%
CHO 6	987	197	20.0%
CHO 7	1,622	277	17.1%
CHO 8	1,335	290	21.7%
CHO 9	784	78	9.9%
National	11,424	2,294	20.1%

Timeliness of access to CAMHs Community Mental Health Teams

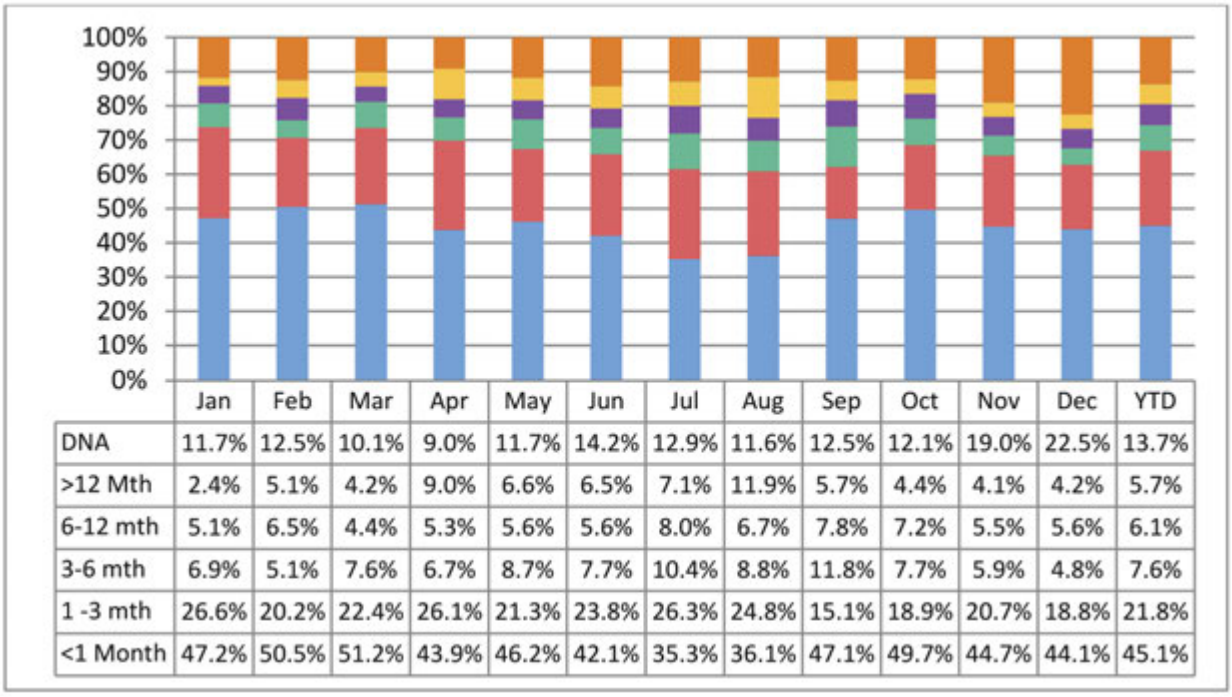
In 2015, a total number of 14,036 were offered an appointment of which 12,114 new cases were seen by Community CAMHS teams.

The expectation is that the CAMHs Community Mental Health Teams will offer an appointment and see an individual within three months. In 2015, 67% of new cases were seen within three months and of these, 45% were seen within one month.

The breakdown is as follows:-

- 45.1% of new cases were seen within 1 month of referral.
- 66.9% were seen within 3 months.
- 7.6% of new cases had waited between 3 to 6 months.
- 6.1% had waited between 6 and 12 months.
- 5.7% had waited more than 1 year.
- 13.7% did not attend their appointment.

Figure 15 Timeframe for 1st appointment to be seen in 2015



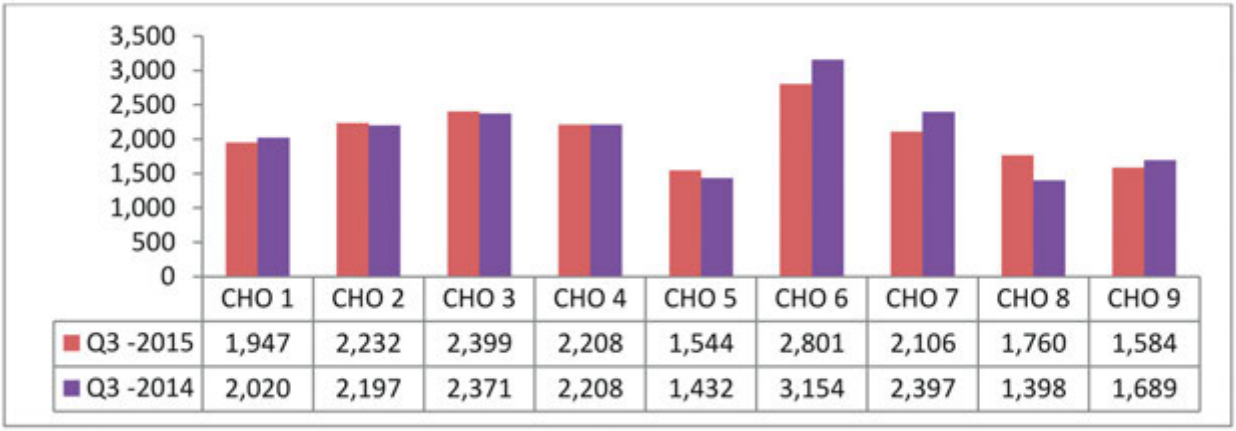
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DNA	11.7%	12.5%	10.1%	9.0%	11.7%	14.2%	12.9%	11.6%	12.5%	12.1%	19.0%	22.5%	13.7%
>12 Mth	2.4%	5.1%	4.2%	9.0%	6.6%	6.5%	7.1%	11.9%	5.7%	4.4%	4.1%	4.2%	5.7%
6-12 mth	5.1%	6.5%	4.4%	5.3%	5.6%	5.6%	8.0%	6.7%	7.8%	7.2%	5.5%	5.6%	6.1%
3-6 mth	6.9%	5.1%	7.6%	6.7%	8.7%	7.7%	10.4%	8.8%	11.8%	7.7%	5.9%	4.8%	7.6%
1 -3 mth	26.6%	20.2%	22.4%	26.1%	21.3%	23.8%	26.3%	24.8%	15.1%	18.9%	20.7%	18.8%	21.8%
<1 Month	47.2%	50.5%	51.2%	43.9%	46.2%	42.1%	35.3%	36.1%	47.1%	49.7%	44.7%	44.1%	45.1%

Table 23 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	36.8%	17.4%	10.8%	8.9%	17.9%	8.1%
CHO 2	77.5%	11.4%	1.9%	0.7%	0.8%	7.7%
CHO 3	62.7%	24.1%	2.2%	2.8%	8.0%	0.2%
CHO 4	37.3%	22.7%	8.9%	8.2%	9.5%	13.3%
CHO 5	45.1%	22.4%	8.3%	2.6%	4.7%	16.9%
CHO 6	25.8%	24.9%	8.6%	12.0%	0.8%	27.9%
CHO 7	31.7%	26.3%	9.1%	6.3%	7.1%	19.4%
CHO 8	45.1%	17.2%	9.8%	7.9%	1.3%	18.7%
CHO 9	31.0%	25.7%	16.5%	5.5%	6.1%	15.1%
National	**45.1%**	**21.8%**	**7.6%**	**6.1%**	**5.7%**	**13.7%**

Community CAMHS Caseload

Figure 16 The number of Active open cases in Q3 2014 vs. Q3 2015 for the Community CAMHS Service by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
Q3 -2015	1,947	2,232	2,399	2,208	1,544	2,801	2,106	1,760	1,584
Q3 -2014	2,020	2,197	2,371	2,208	1,432	3,154	2,397	1,398	1,689

Discharge from the CAMHs Community Mental Health Teams

In 2015, 12,955 individuals were discharged by Community CAMHS teams compared to 11,199 cases in 2014.

87.3% (84.7% in 2014) of the individuals were discharged to care of the General Practitioner or Primary Care Team (PCT), 6.5% (8.6% in 2014) to a Community Based Service, 43.6% (4.1% in 2014) to another CAMHS service, and 2.6% (2.6% in 2014) to an Adult Mental Health Service.

Table 24 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	85.8%	9.5%	1.9%	2.8%
CHO 2	92.4%	2.4%	2.0%	3.2%
CHO 3	93.2%	1.0%	1.8%	4.0%
CHO 4	89.6%	3.8%	2.6%	4.0%
CHO 5	84.3%	6.9%	6.1%	2.8%
CHO 6	94.1%	0.7%	3.9%	1.3%
CHO 7	80.5%	11.7%	5.7%	2.2%
CHO 8	89.3%	5.7%	3.6%	1.4%
CHO 9	86.5%	8.3%	1.9%	3.4%
National	87.3%	6.5%	3.6%	2.6%

Table 25 Destination of those discharged from CAMHs Community Mental Health Team by CHO

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service	Total
CHO 1	863	96	19	28	1,006
CHO 2	865	22	19	30	936
CHO 3	558	6	11	24	599
CHO 4	1,254	53	36	56	1,399
CHO 5	1,066	87	77	35	1,265
CHO 6	1,548	11	64	22	1,645
CHO 7	2,227	324	157	60	2,768
CHO 8	1,253	80	51	19	1,403
CHO 9	1,672	161	36	65	1,934
National	**11,306**	**840**	**470**	**339**	**12,955**

GENERAL ADULT COMMUNITY MENTAL HEALTH SERVICES

7

GENERAL ADULT COMMUNITY MENTAL HEALTH SERVICES

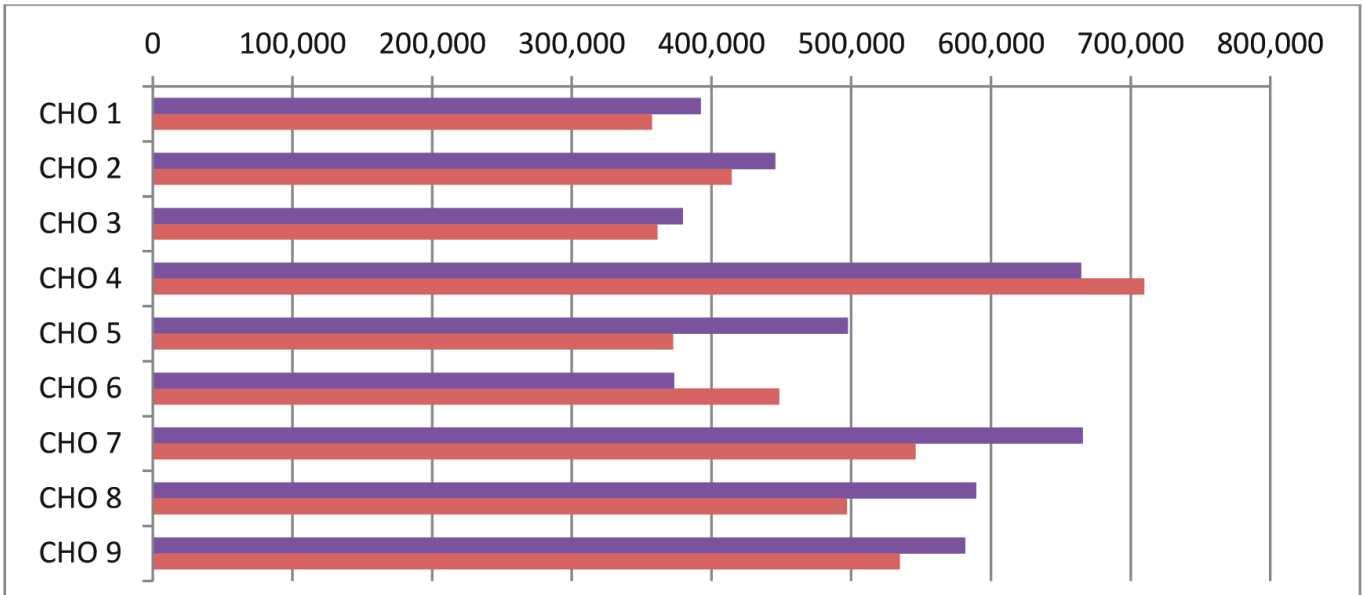
KEY FACTS

- 114 Community General Adult Mental Health teams
- 2013 – 1,456.57 Clinical WTE's; 2015 – 1,547.79 Clinical WTE's
- 80.3% of the Clinical staffing levels recommended in a Vision for Change
- 3% increase in referrals from 2013 to 2015
- 37,091 new appointments offered in 2015
- 22.5% new appointments seen within 1 week
- Over 1/3 within 2 weeks & 52.4% seen within 4 weeks
- 1 in 5 new patients did not attend their first appointment

Adults in the Population

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

Figure 17 - 2011 & 2006 Census by CHO*

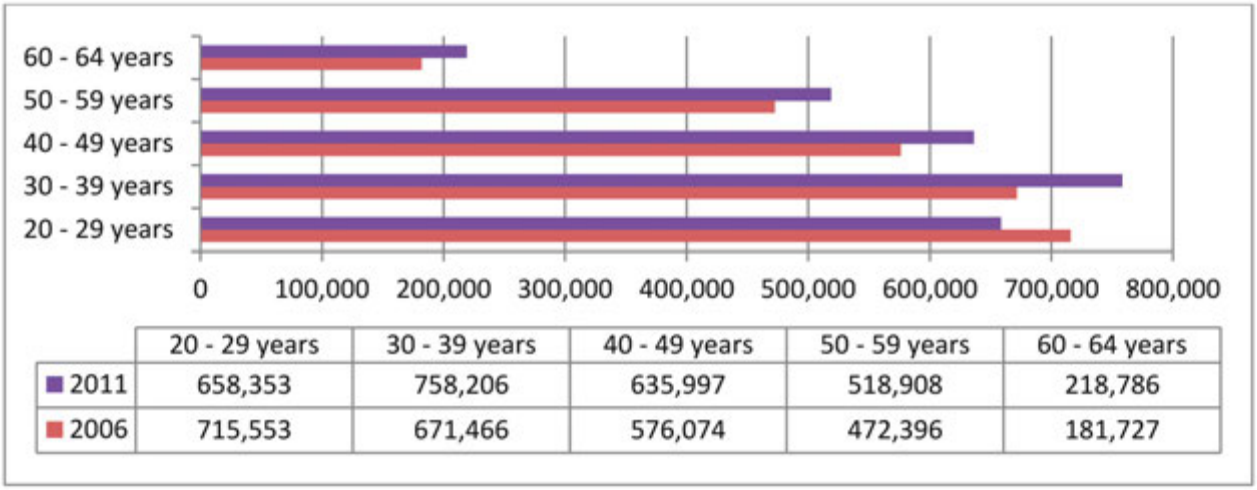


	CHO 9	CHO 8	CHO 7	CHO 6	CHO 5	CHO 4	CHO 3	CHO 2	CHO 1
2011	581,486	589,442	665,443	373,092	497,578	664,534	379,327	445,356	391,994
2006	534,521	497,037	545,751	448,158	372,397	709,571	361,028	414,277	357,108

* NB CHO Areas not in place until 2014

Community CAMHS Caseload

Figure 18 - 2011 census by Age



	20 - 29 years	30 - 39 years	40 - 49 years	50 - 59 years	60 - 64 years
2011	658,353	758,206	635,997	518,908	218,786
2006	715,553	671,466	576,074	472,396	181,727

Access to Community General Adult Mental Health Teams

Referrals

Between 2013 and 2015, there has been an increase of 3% nationally in the number of referrals accepted by the Community General Adult Mental Health service; however from 2014 to 2015 there was a 1% decrease as outlined in Table 27.

Table 26 Referrals accepted 2015 vs. 2013

	2015	2014	+/- Variance	2013	+/- Variance
CHO 1	3,264	3,889	-16%		
CHO 2	6,551	6,537	0%		
CHO 3	3,738	3,523	6%		
CHO 4	6,202	5,906	5%		
CHO 5	3,917	3,984	-2%		
CHO 6	2,240	2,275	-2%		
CHO 7	3,745	3,967	-6%		
CHO 8	5,417	5,118	6%		
CHO 9	3,678	3,828	-4%		
National	**38,752**	**39,027**	-1%	**37,672**	3%

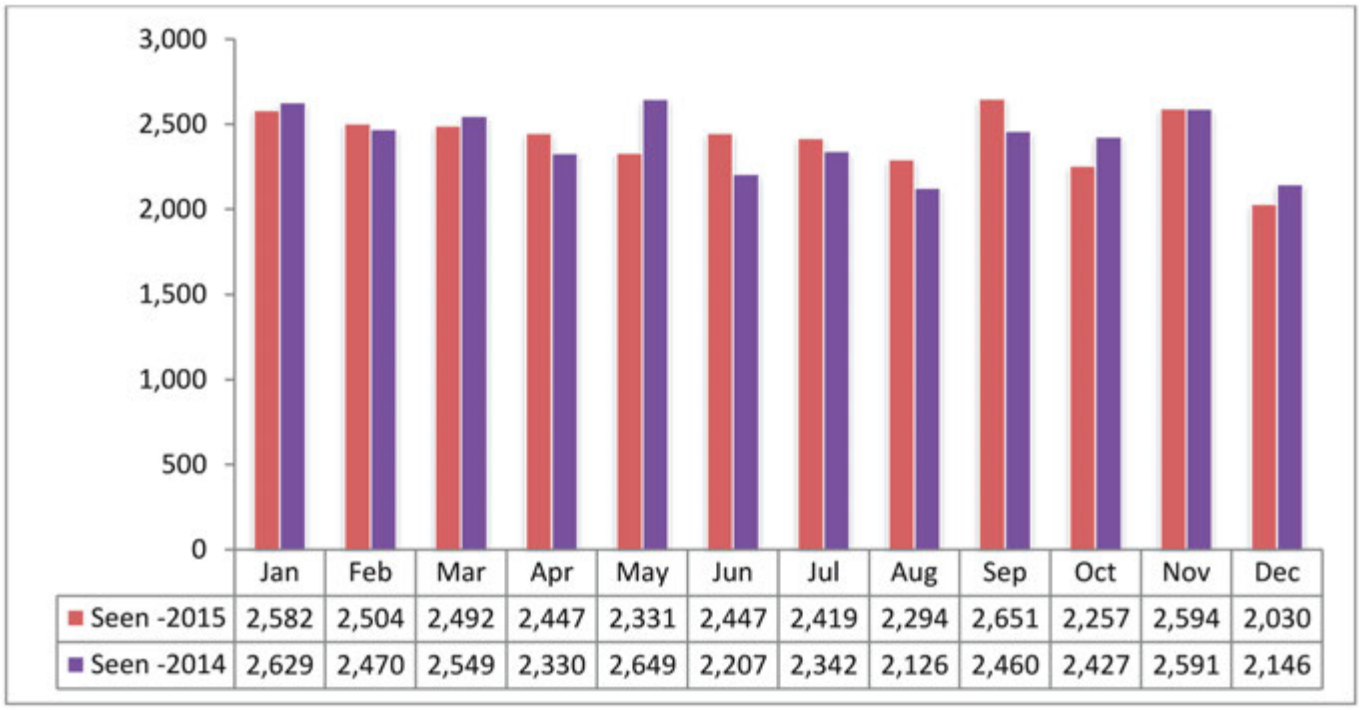
New cases seen by Community general adult mental health teams 2015

In 2015 a total number of 37,091 new cases were offered an appointment by Community general adult mental health teams which compares to 37,183 cases in 2014.

A total of 29,048 (28,926 in 2014) were seen and 8,043 (8,257 in 2014) did not attend (DNA).
This gives a non-attendance rate of 21.7% compared with 22.4% in 2014.

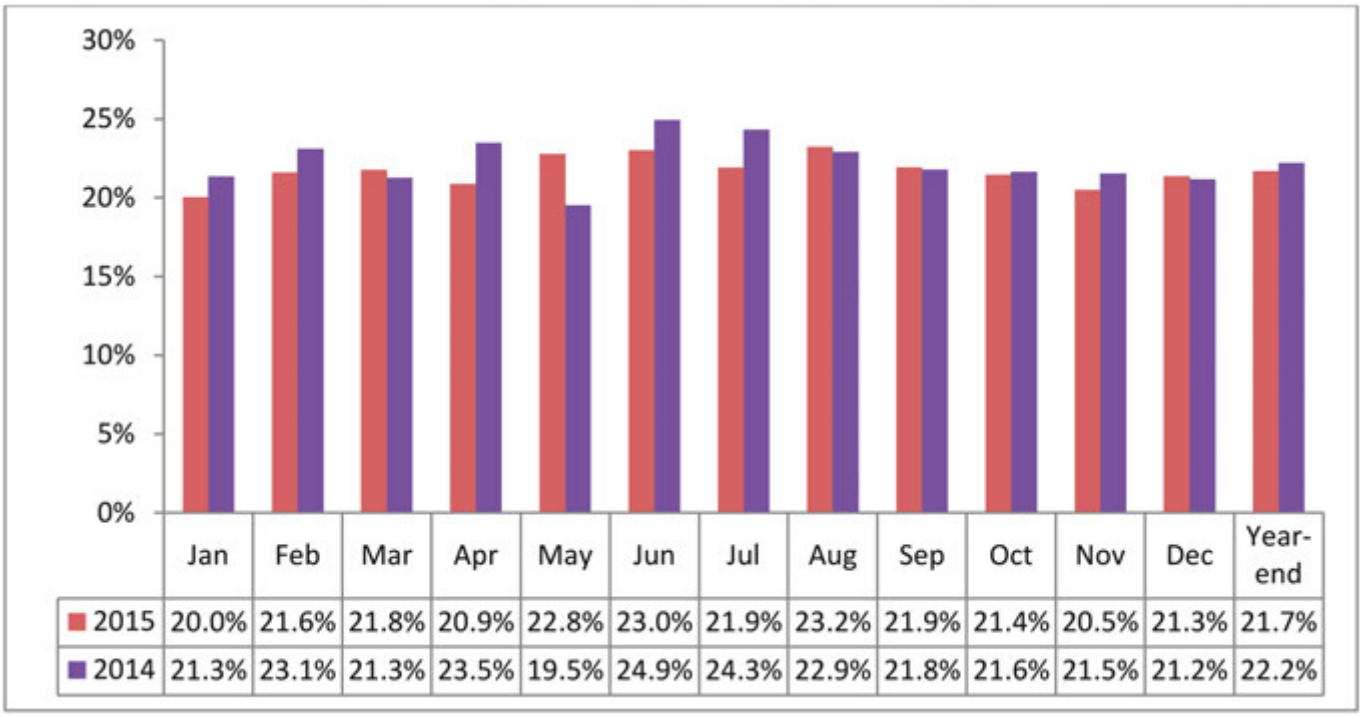
Figure 20 shows the DNA rates range from 23.2 % (August) to 20% (January) across 2015. In 2014, the range was from 24.9% (June) to 19.5% (May) in 2014.

Figure 19 New (including re-referred) cases Seen and DNAs 2015 vs. 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen -2015	2,582	2,504	2,492	2,447	2,331	2,447	2,419	2,294	2,651	2,257	2,594	2,030
Seen -2014	2,629	2,470	2,549	2,330	2,649	2,207	2,342	2,126	2,460	2,427	2,591	2,146

Figure 20 DNA Rate 2015 vs. 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2015	20.0%	21.6%	21.8%	20.9%	22.8%	23.0%	21.9%	23.2%	21.9%	21.4%	20.5%	21.3%	21.7%
2014	21.3%	23.1%	21.3%	23.5%	19.5%	24.9%	24.3%	22.9%	21.8%	21.6%	21.5%	21.2%	22.2%

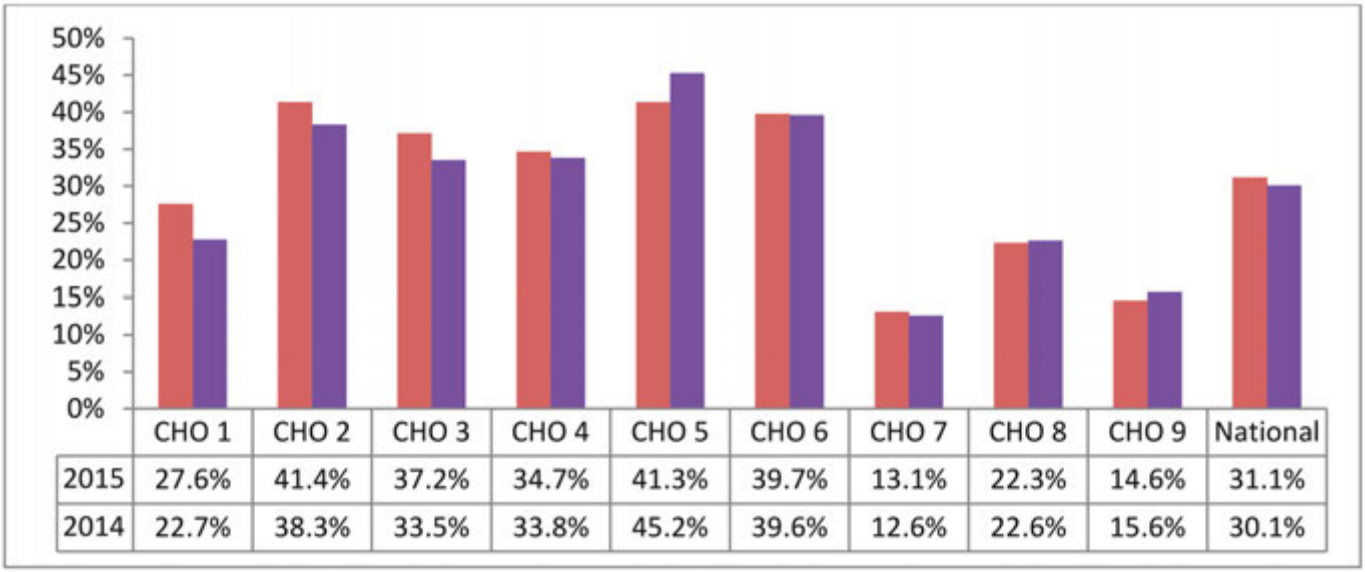
Breakdown of New Cases (New vs. Re-referred Cases)

Of new cases seen in a service, a proportion will have previously attended the service and been discharged. In 2015, of the 29,048 cases seen, a total of 9,047 had been re-referred to the service. This represents a 31.1% re-referred rate.

In 2014, of the 28,926 cases seen, a total of 8,698 had been re-referred to the service representing a 30.1% re-referred rate.

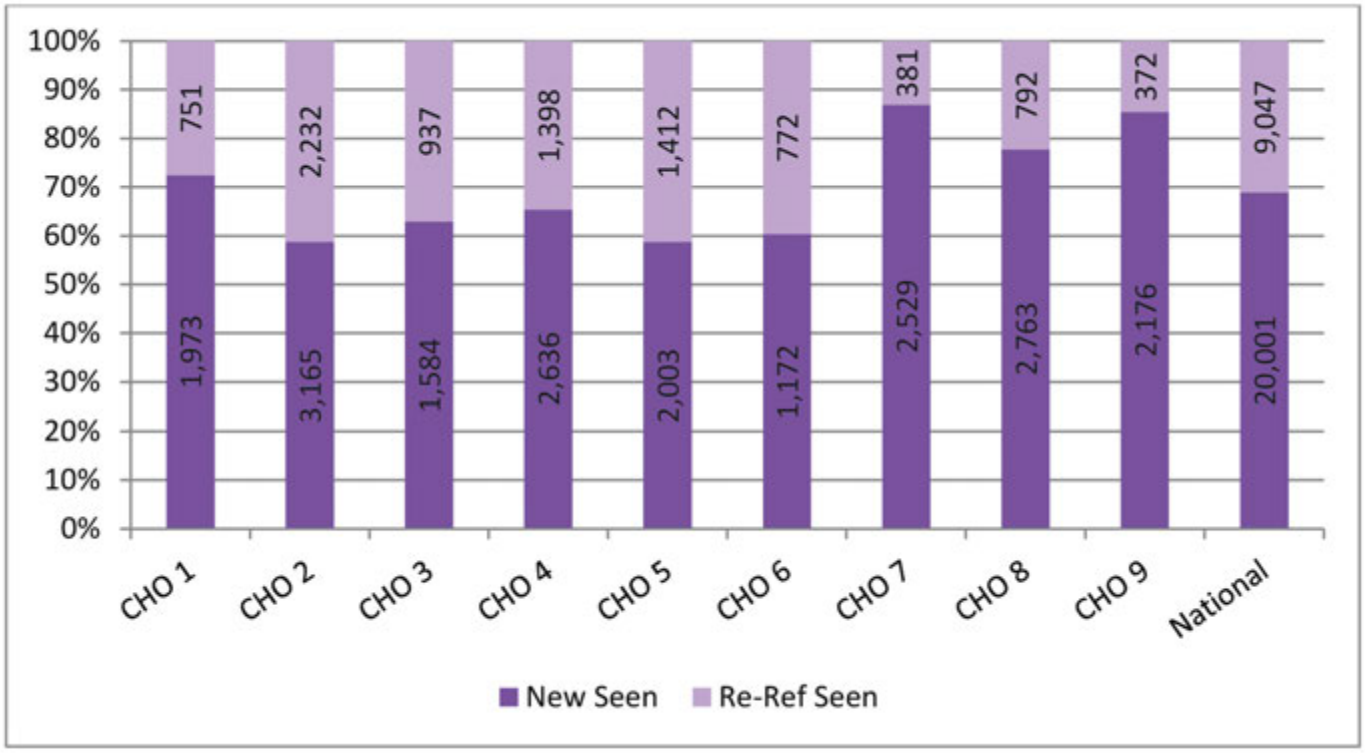
The proportion of re-referred cases varied from 13.1% in CHO 7 to 41.4% in CHO 2 (Figure 21).

Figure 21 Percentage of Re-referred cases 2015 vs. 2014



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	27.6%	41.4%	37.2%	34.7%	41.3%	39.7%	13.1%	22.3%	14.6%	31.1%
2014	22.7%	38.3%	33.5%	33.8%	45.2%	39.6%	12.6%	22.6%	15.6%	30.1%

Figure 22 Breakdown of new cases (New vs. Re-referred cases) 2015



Waiting Times for New Cases Seen

In 2015, a total number of 37,091 were offered an appointment, of which 29,048 new cases were seen by Community general adult mental health teams. The waiting time to be seen was recorded for each case.

Table 27 Length of wait to 1st appointment by CHO

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	26.8%	10.8%	9.2%	7.0%	13.5%	5.2%	8.9%	18.6%
CHO 2	32.0%	12.5%	16.8%	8.7%	10.6%	5.3%	2.2%	11.9%
CHO 3	25.1%	15.1%	8.3%	5.4%	11.3%	5.5%	1.8%	27.5%
CHO 4	18.0%	8.9%	9.7%	9.7%	16.3%	5.3%	3.9%	28.3%
CHO 5	26.5%	10.9%	15.3%	11.1%	17.3%	8.9%	2.4%	7.6%
CHO 6	30.2%	13.0%	11.7%	9.1%	11.4%	3.8%	1.3%	19.4%
CHO 7	16.6%	8.3%	7.3%	7.4%	20.1%	11.8%	8.3%	20.0%
CHO 8	15.5%	10.6%	8.6%	7.3%	16.2%	9.5%	3.5%	28.8%
CHO 9	14.1%	9.9%	7.6%	6.0%	11.5%	7.2%	11.2%	32.6%
National	22.5%	11.0%	10.8%	8.1%	14.3%	7.0%	4.7%	21.7%

Cases Closed or Discharged

In 2015, 22,837 cases were closed and discharged by Community general adult mental health teams, this compares to 23,970 cases closed in 2014.

Of these, 94% of the cases closed were discharged to care of the General Practitioner or Primary Care service, 4% to another Adult Mental Health Service, 1% to other Service and 1% were due to Death.

Table 28 No. of Cases closed and discharged by Community General Adult teams in 2015

	Closed / Discharged to GP/Primary Care service	Closed / Discharged to other Adult Mental Health Service	Closed / Discharged to other Service	Closed due to Death	Total Closed Discharged
CHO 1	2713	248	19	32	3,012
CHO 2	2151	282	49	19	2,501
CHO 3	2144	77	69	58	2,348
CHO 4	3240	113	9	65	3,427
CHO 5	2103	12	60	9	2,184
CHO 6	1783	95	10	31	1,919
CHO 7	1978	19	2	12	2,011
CHO 8	2945	29	3	32	3,009
CHO 9	2311	69	10	36	2,426
National	21368	944	231	294	22,837

PSYCHIATRY OF OLD AGE COMMUNITY MENTAL HEALTH SERVICES

8

PSYCHIATRY OF OLD AGE COMMUNITY MENTAL HEALTH SERVICES

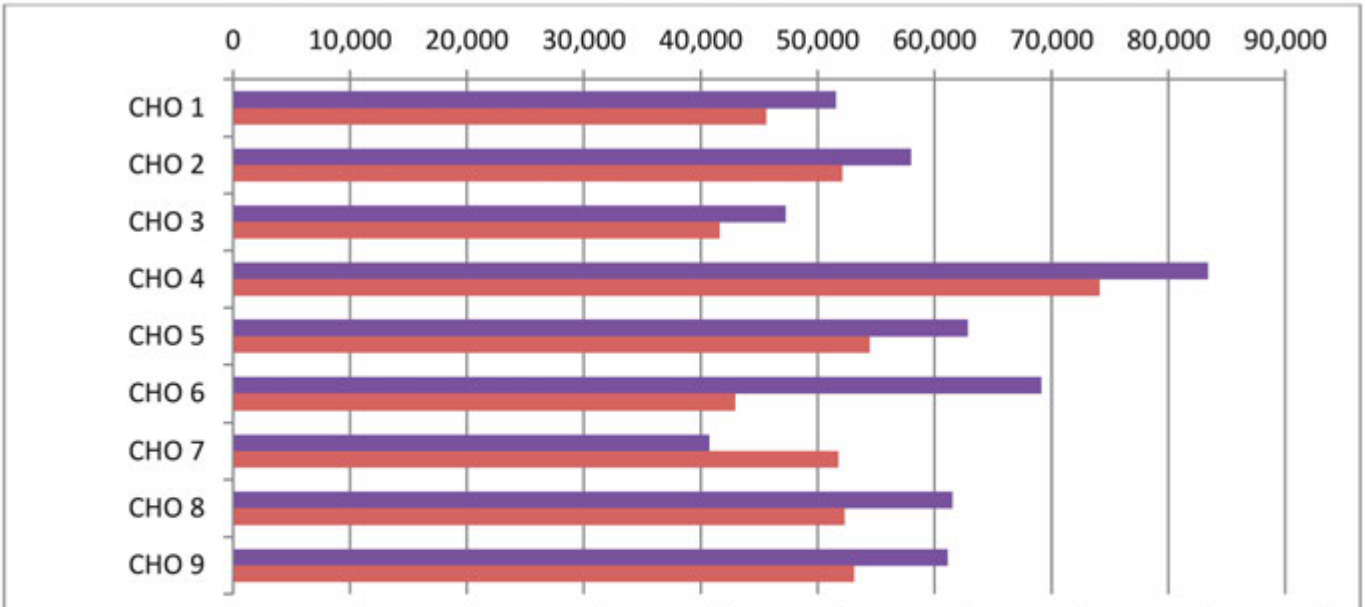
KEY FACTS

- 2013 – 22 POA teams; 2015 – 26 POA teams
- 2013 – 224.19 Clinical WTE's; 2015 – 266.22 Clinical WTE's
- 59.2% of the Clinical staffing levels recommended in a Vision for Change
- 7% increase in Referrals from 2013 to 2015
- 9,386 new appointments offered in 2015
- 40.8% new appointments Seen within 1 week
- 85% seen within 4 weeks
- 2.7% New patients did not attend their first appointment

Older Adults in the Population

In line with other European countries, the population over 65 years is increasing in Ireland and now forms 11.7% of the total population. There is a notable increase in those aged over 85 years (1.3%) and 80 - 84 years (1.5%). These two age brackets are associated with the highest rates of frailty both physical and cognitive. From 2006 to 2011 there was a 14% increase in the over 65 years population.

Figure 23 - 2011 & 2006 Census – Number over 65



	CHO 9	CHO 8	CHO 7	CHO 6	CHO 5	CHO 4	CHO 3	CHO 2	CHO 1
Census 2011	61,100	61,487	40,729	69,104	62,821	83,368	47,254	57,984	51,546
Census 2006	53,101	52,292	51,771	42,935	54,439	74,106	41,611	52,085	45,586

Figure 24 - 2011 census by Age

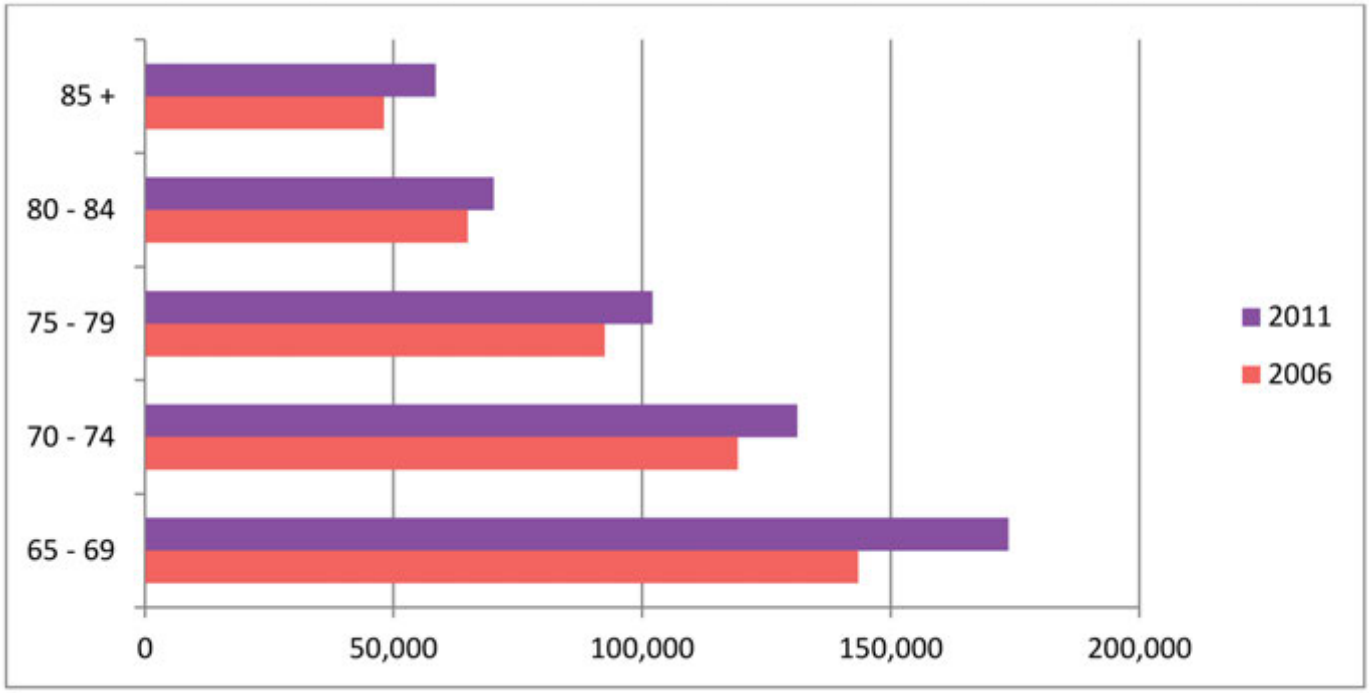


Table 29 2011 census by Age 65 + years by CHO

	Total Pop	*65 +*	% of Population
CHO 1	391,994	51,546	13.1%
CHO 2	445,356	57,984	13.0%
CHO 3	379,327	47,254	12.5%
CHO 4	664,534	83,368	12.5%
CHO 5	497,578	62,821	12.6%
CHO 6	526,157	69,104	13.1%
CHO 7	512,378	40,729	7.9%
CHO 8	589,442	61,487	10.4%
CHO 9	581,486	61,100	10.5%
National	**4,588,252**	**535,393**	11.7%

Prevalence of mental disorders in later life

Mental disorders in later life 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 commonest 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 commonest 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 comorbidly 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 Old Age Services

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 special 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.

Table 30 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 Old Age Services

Between 2013 and 2015, there was an increase of 7% nationally in the number of referrals accepted by the Psychiatry of Old Age Service as outlined in Table 32.

Table 31 Referrals accepted 2015 vs. 2014

	2015	2014	+/- Variance	2013	+/- Variance
CHO 1	1,380	1,494	-8%		
CHO 2	1,807	1,375	31%		
CHO 3	965	989	-2%		
CHO 4	339	454	-25%		
CHO 5	1,487	1,439	3%		
CHO 6	1,031	957	8%		
CHO 7	839	980	-14%		
CHO 8	1,523	1,514	1%		
CHO 9	1,073	1,046	3%		
National	**10,444**	**10,248**	2%	**9,761**	7%

Access to Psychiatry of Old Age Services

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CHO 5	1,487	1,439	3%		
CHO 6	1,031	957	8%		
CHO 7	839	980	-14%		
CHO 8	1,523	1,514	1%		
CHO 9	1,073	1,046	3%		
National	**10,444**	**10,248**	2%	**9,761**	7%

New cases seen by Psychiatry of Old Age Service 2015

In 2015 a total number of 9,386 new cases were offered an appointment by Psychiatry of Old Age Service this compares to 9,314 cases in 2014.

A total of 9,128 (9,022 in 2014) were seen and 258 (292 in 2014) did not attend (DNA).

This gives a non-attendance rate of 2.7%, ranging from 1.5% to 3.7% 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 expected improvement in 2016.

Figure 25 New (including re-referred) cases 2015 vs. 2014

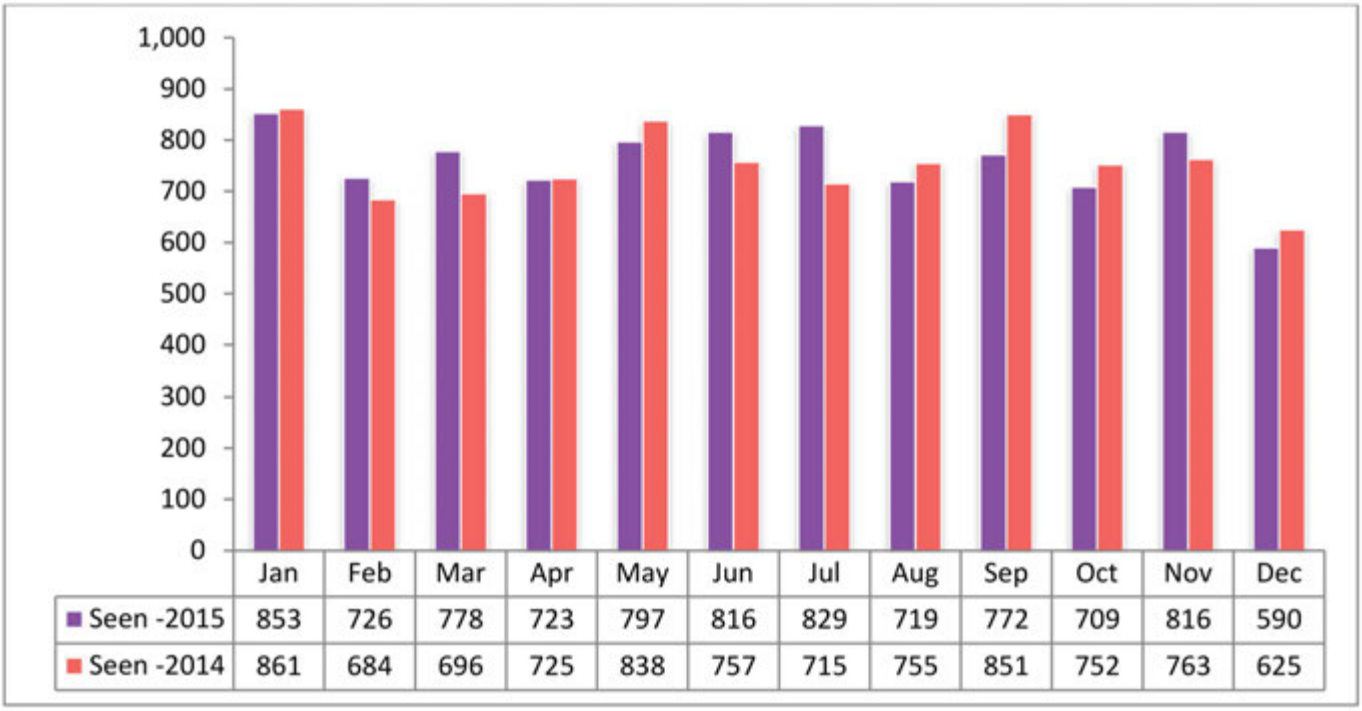
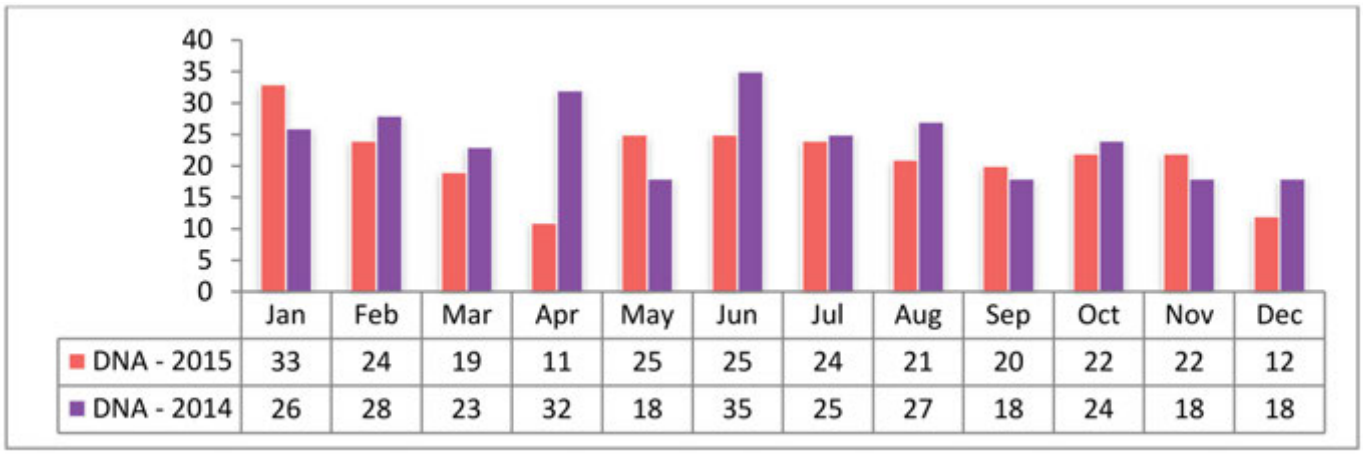
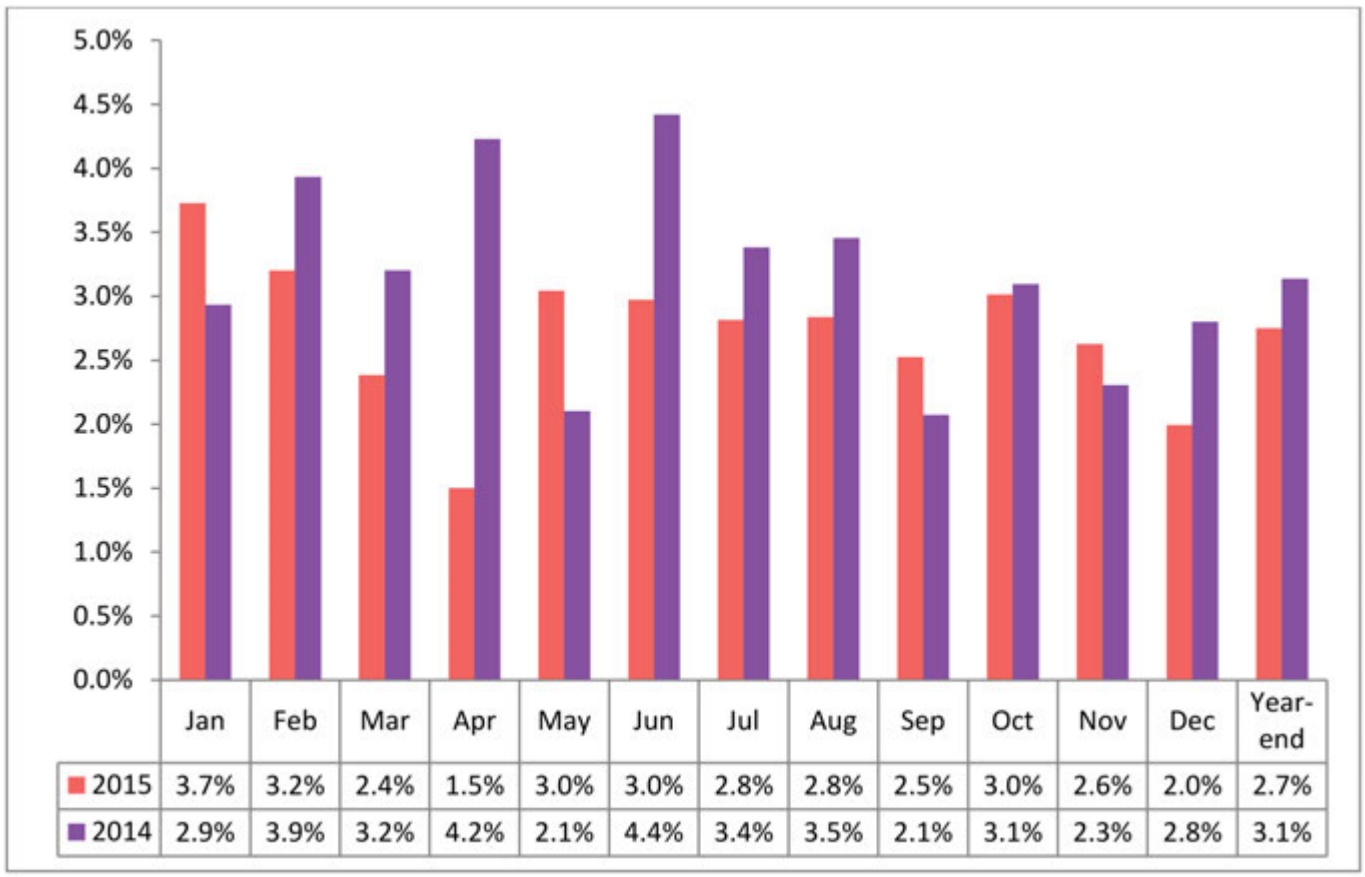


Figure 26 New (including re-referred) cases 2015 vs. 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
DNA - 2015	33	24	19	11	25	25	24	21	20	22	22	12
DNA - 2014	26	28	23	32	18	35	25	27	18	24	18	18

Figure 27 DNA Rate2015 vs. 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2015	3.7%	3.2%	2.4%	1.5%	3.0%	3.0%	2.8%	2.8%	2.5%	3.0%	2.6%	2.0%	2.7%
2014	2.9%	3.9%	3.2%	4.2%	2.1%	4.4%	3.4%	3.5%	2.1%	3.1%	2.3%	2.8%	3.1%

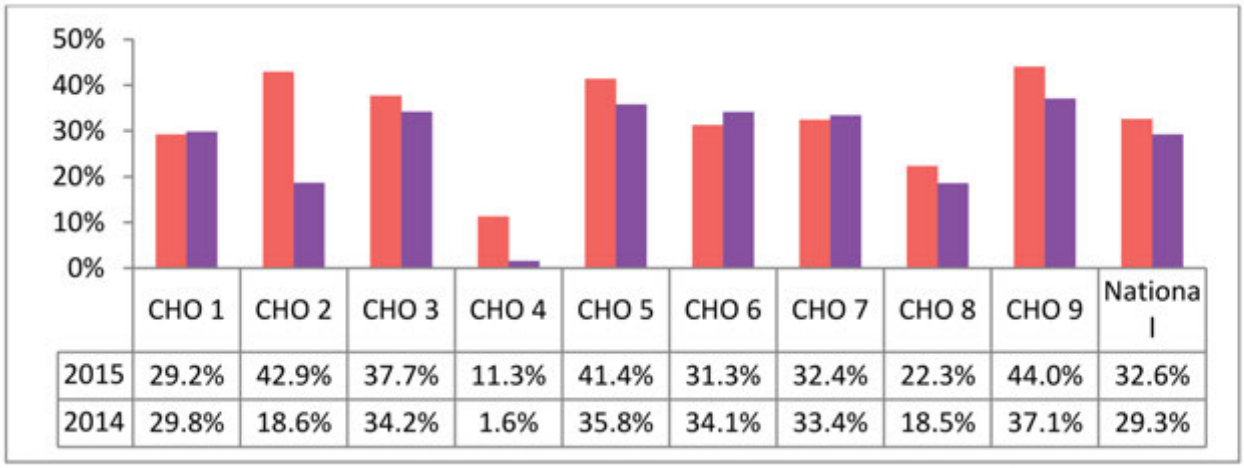
Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen a proportion will have previously attended the service and been discharged. In 2015 of the 9,128 cases seen a total of 3,834 had been re-referred to the service. This represents a 32.6% re-referred rate.

In 2014 of the 9,022 cases seen a total of 2,641 had been re-referred to the service representing a 29.3% re-referred rate.

The proportion of re-referred cases varied from 11.3% in CHO 4 to 44% in CHO 9 (Figure 28).

Figure 28 Percentage of Re-referred cases 2015 vs. 2014



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	29.2%	42.9%	37.7%	11.3%	41.4%	31.3%	32.4%	22.3%	44.0%	32.6%
2014	29.8%	18.6%	34.2%	1.6%	35.8%	34.1%	33.4%	18.5%	37.1%	29.3%

Figure 29 Breakdown of new cases (New vs. Re-referred cases) 2015

Waiting Times for New Cases Seen

In 2015, a total number of 9,386 patients were offered an appointment, of which 9,128 new cases were seen by Psychiatry of Old Age Service.

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

Table 32 Length of wait to 1st appointment seen 2015 by CHO

	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	64.9%	12.7%	7.9%	2.2%	2.1%	2.0%	6.2%	2.0%
CHO 2	28.8%	17.6%	24.0%	17.3%	7.8%	0.2%	0.0%	4.4%
CHO 3	54.2%	24.5%	15.3%	4.3%	1.1%	0.0%	0.0%	0.6%
CHO 4	17.3%	10.1%	9.5%	6.7%	17.3%	7.8%	10.6%	20.7%
CHO 5	43.5%	22.6%	17.6%	9.7%	5.6%	0.1%	0.0%	0.8%
CHO 6	27.6%	16.4%	10.7%	11.1%	23.4%	8.5%	1.8%	0.6%
CHO 7	49.7%	13.9%	9.3%	6.9%	11.0%	6.2%	2.2%	0.7%
CHO 8	32.8%	25.1%	13.3%	12.7%	7.1%	1.3%	1.9%	5.8%
CHO 9	31.2%	27.1%	15.6%	9.3%	11.7%	1.3%	1.1%	2.8%
National	40.8%	19.6%	15.0%	9.6%	8.4%	2.1%	1.8%	2.7%

Cases Closed or Discharged

In 2015, 6,883 cases were closed and discharged by Psychiatry of Old Age Service, this compares to 6,697 cases closed in 2014.

88.6% of the cases closed were discharged to care of the General Practitioner or Primary Care Team (PCT / community care service and 11.4% due to death.

Table 33 Cases closed and discharged by CHO

	Closed / Discharged to GP/Primary Care Team /community care service	Closed due to Death	Total Closed Discharged
CHO 1	1,161	89	1,250
CHO 2	874	92	966
CHO 3	468	115	583
CHO 4	165	0	165
CHO 5	974	222	1,196
CHO 6	536	45	581
CHO 7	333	11	344
CHO 8	807	166	973
CHO 9	777	48	825
National	**6,095**	**788**	**6,883**

Table 34 Percentage of Cases closed and discharged by CHO

	Closed / Discharged to GP/Primary Care Team /community care service	Closed due to Death
CHO 1	92.9%	7.1%
CHO 2	90.5%	9.5%
CHO 3	80.3%	19.7%
CHO 4	100.0%	0.0%
CHO 5	81.4%	18.6%
CHO 6	92.3%	7.7%
CHO 7	96.8%	3.2%
CHO 8	82.9%	17.1%
CHO 9	94.2%	5.8%
National	**88.6%**	**11.4%**

CHILD AND ADOLESCENT MENTAL HEALTH ACUTE INPATIENT SERVICES

9

CHILD AND ADOLESCENT MENTAL HEALTH ACUTE INPATIENT SERVICES

KEY FACTS

- 2008 – 16 CAMHS Acute Inpatient beds; 2015 – 74 CAMHS Acute Inpatient beds
- 2008 – 25% admissions to CAMHS inpatient beds; 2015 - 73% admission to CAMHS inpatient beds
- 94% bed days used in Child Adolescent Acute Inpatient Units as a total of bed days.
- New 22 bedded unit opened in 2015 in Cherry Orchard Hospital Dublin 10

Introduction

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

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

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

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 bespoke age appropriate inpatient facilities has resulted in significant progress being made in achieving the targets set out in A Vision for Change (2006), with 74 CAMHs Acute Inpatient beds provided at end December 2015.

Table 35 HSE inpatient services and bed capacity (2008 to 2015)

Child & Adolescent Inpatient Units	2008	2009	2010	2011	2012	2013	2014	2015
St. Anne's Inpatient Unit, Galway	10	10	10					
New Unit, Merlin Park Hospital, Galway				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‡
St. Vincent's Hospital, Fairview, Dublin		6	6	6	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
Total No. of Beds	**16**	**30**	**30**	**52**	**60**	**60**	**66**	**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, in so far as possible, that when a child is admitted, that admission is to age appropriate inpatient facilities.

In 2015, there were 356 children and adolescents admitted and of these, 261 (73.3%) were admitted to child and adolescent inpatient units and 95 (26.7%) to adult units. Of these 95 admissions, 85.2% (81) of these were voluntary admissions with parental consent with a very small number under Section 25 of the Mental Health Act 2001. Of the 95 admitted to Adult Approved Centres, 86 or 90.5% were 16/17 years old with 41% (39) of these discharged either the same day or within 3 days and 66.3% (63) within a week.

In 2014, 201 (69%) admissions were to child and adolescent inpatient units and 89 (31%) to adult units. Figure 30 shows the increase in the percentage of admissions of children to age appropriate units in the period from 2008 to 2015.

Figure 30 Admissions of children to Acute Inpatient Units 2008-2015

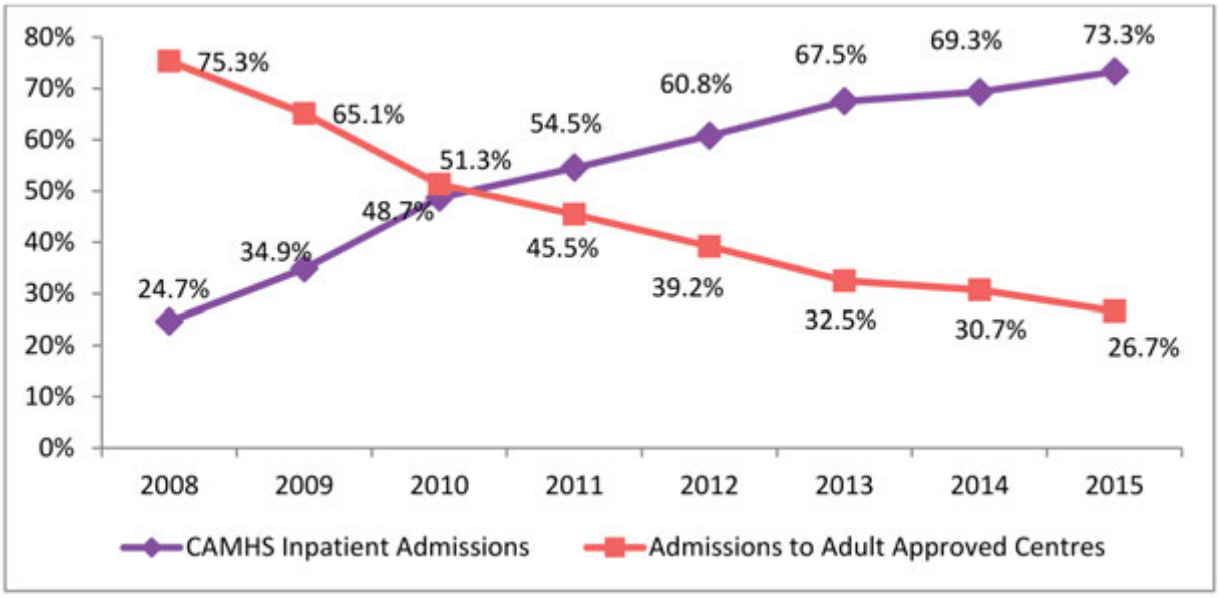


Table 36 Number of admissions by Unit/Unit Type

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

† 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 2015, the total number of bed days used by the admission of children was 18,936, an increase of 9.1% (1,581) on the 2014 position of 17,355.

In 2015, 94.3% (17,858) of bed days used were in the age appropriate Child and Adolescent Acute Inpatient Units with 5.7% (1,078) used in adult approved centres. These figures are comparable with 2014 position of 94.9% (16,462) in CAMHS inpatient and 5.1% (893) 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.

Table 37 Bed Days used by CHO

Bed days used	2014					2015				
	Total days Used	CAMHS IP		Adult IP		Total days Used	CAMHS IP		Adult IP	
CHO 1	1,639	1,605	97.9%	34	2.1%	2,043	1,958	95.8%	85	4.2%
CHO 2	2,439	2,398	98.3%	41	1.7%	2,583	2,582	100.0%	1	0.0%
CHO 3	2,246	2,188	97.4%	58	2.6%	1,920	1,913	99.6%	7	0.4%
CHO 4	3,136	3,069	97.9%	67	2.1%	2,909	2,840	97.6%	69	2.4%
CHO 5	1,876	1,781	94.9%	95	5.1%	2,224	2,040	91.7%	184	8.3%
CHO 6	828	815	98.4%	13	1.6%	874	846	96.8%	28	3.2%
CHO 7	1,718	1,572	91.5%	146	8.5%	1,897	1,835	96.7%	62	3.3%
CHO 8	1,827	1,553	85.0%	274	15.0%	1,736	1,256	72.4%	480	27.6%
CHO 9	1,646	1,481	90.0%	165	10.0%	2,750	2,588	94.1%	162	5.9%
National	17,355	16,462	94.9%	893	5.1%	18,936	17,858	94.3%	1,078	5.7%

The following table 38 compares the percentage of admissions of children by Length of Stay in the Adult Approved Centres between 2014 and 2015.

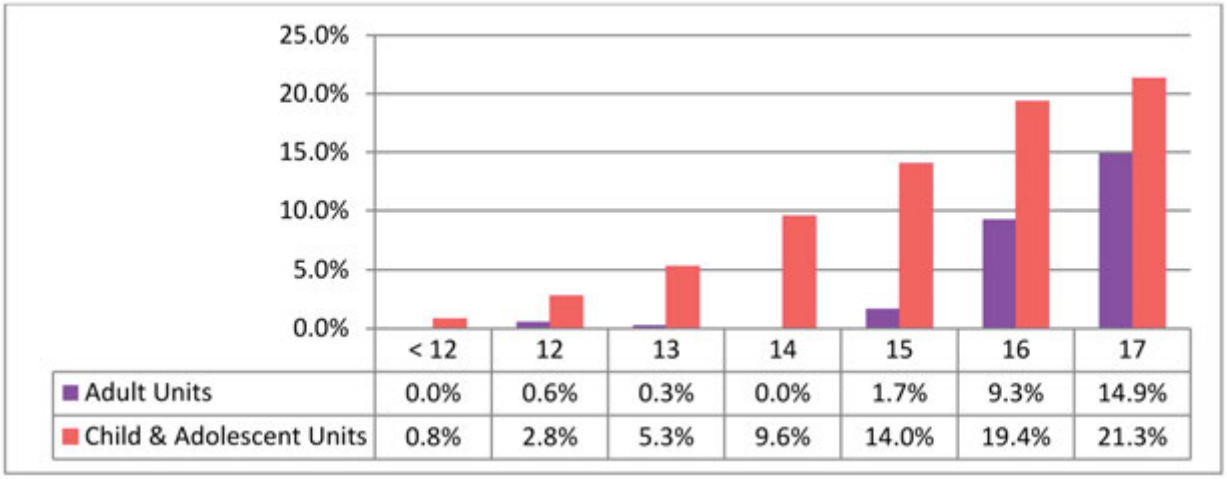
Table 38 Percentage of admissions by Length of Stay in Adult Approved Centres

	2014	2015
Same day discharged	1.1%	6.3%
1-3 days	33.7%	34.7%
3-5 days	14.6%	14.7%
5-7 days	12.4%	10.5%
>7 <=14	21.4%	13.7%
2-3 week	6.7%	8.4%
3-4 weeks	2.3%	3.2%
4-8 weeks	6.7%	6.3%
8-12 weeks	0.0%	1.1%
12-16 weeks	1.1%	0.0%
>16 weeks	0.0%	1.1%
Admissions	**89**	**95**

Age of admissions (2015)

Of the 356 admissions of children and adolescents in 2015, 36 % were aged 17 years or over on admission, 28.7% were aged 16 years, 15.7% were aged 15 years, 9.6% were aged 14 years, 5.6% were aged 13 years, 3.4% aged 12 years and 0.8% less than 12 years of age.

Figure 31 Age of admissions (2015)



	< 12	12	13	14	15	16	17
Adult Units	0.0%	0.6%	0.3%	0.0%	1.7%	9.3%	14.9%
Child & Adolescent Units	0.8%	2.8%	5.3%	9.6%	14.0%	19.4%	21.3%

Planned Development for Child and Adolescent Mental Health Services

New Children's Hospital of Ireland

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

National Forensic Hospital

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

ADULT ACUTE INPATIENT MENTAL HEALTH SERVICES

10

ADULT ACUTE INPATIENT MENTAL HEALTH SERVICES

KEY FACTS

- 31 Acute Inpatients units
- 2007 – 16,293 admissions;- 2015 - 13,096 admissions
- 2007 – 72% re- admission rate;- 2015 – 66% re- admission rate

Mental Health Adult Acute Inpatient Services

Introduction

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 ongoing care of the Community Mental Health team.

Inpatient psychiatric treatment is usually indicated 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.On average 86%of admissions are 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.

Table 39 2015 Adult Acute Inpatient Units by CHO

CHO 1	CHO 6
Letterkenny General - Unit	Cluain Mhuire
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 - DOP Unit

CHO 4	Cluain Lir Care Centre, Mullingar
Cork University Hospital - Unit	St Brigids Hospital, Ardee
St Stephen's Hospital, Glanmire	Our Lady's Navan - Unit
Kerry General Hospital - Unit	**CHO 9**
Mercy University Hospital - Unit	Mater Hospital - St Aloysius Unit
Bantry General - Unit	Ashlin Centre - Joyce Unit
CHO 5	Ashlin Centre - Sheehan Unit
St Luke's Hospital Kilkenny - Unit	St Vincent's Hospital Fairview
Waterford General Hospital - DOP	Connolly Hospital - DOP

*Department of Psychiatry (DOP)

Under the Mental Health Act 2001, when people are receiving treatment in approved centres (that is, psychiatric hospitals or inpatient units), they should be included in discussions on their care and treatment and to help them with their recovery. 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.

Access to Adult Acute Inpatient Services

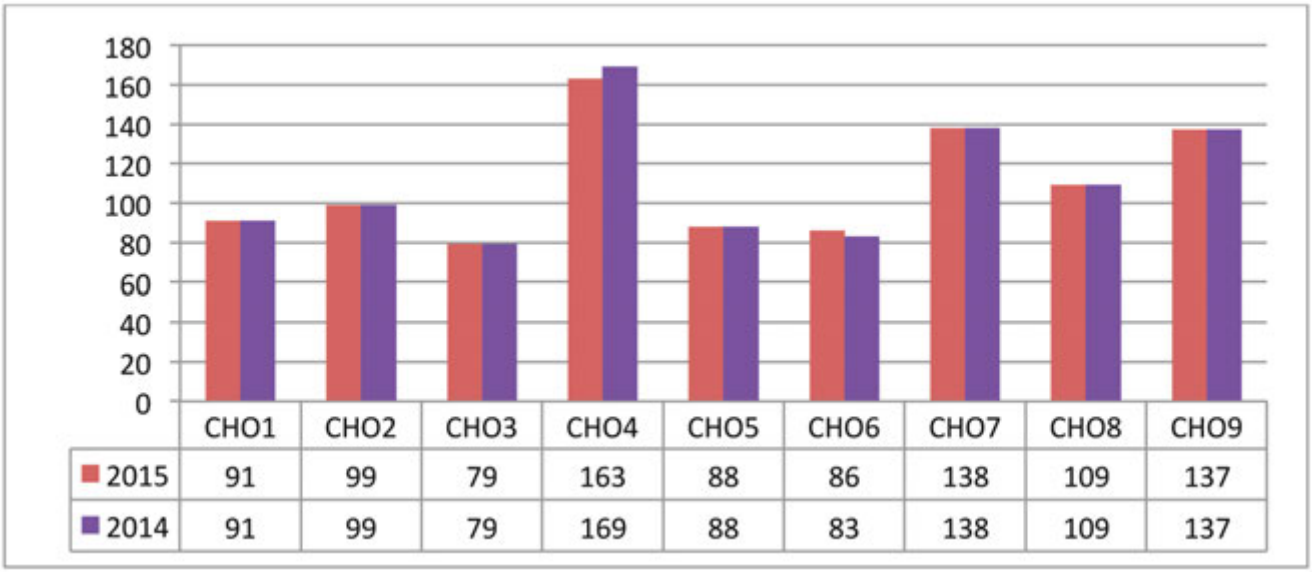
Adult Mental Health Acute inpatient Beds

There are 31 adult acute inpatient units nationally. At the end of 2015, the number of adult acute inpatient places was 990 (993 at the end of 2014) or 21.6 beds per 100,000 population. The information provided below includes General Adult Psychiatry acute admissions and Psychiatry of Old Age acute admissions.

Table 40 Adult Acute Inpatient Units, Beds & Bed Rate per 100,000 by CHO

	Total Population	*Units*	*Beds*	*Bed Rate per 100,000*
CHO 1	391,994	3	91	23.2
CHO 2	445,356	3	99	22.2
CHO 3	379,327	2	79	20.8
CHO 4	664,534	5	163	24.5
CHO 5	497,578	2	88	18.8
CHO 6	373,092	3	86	20.1
CHO 7	665,443	3	138	21.5
CHO 8	589,442	5	109	18.5
CHO 9	581,486	5	137	23.6
National	**4,588,252**	**31**	**990**	**21.6**

Figure 32 Adult Acute Inpatient Beds 2014/2015 by CHO



	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
2015	91	99	79	163	88	86	138	109	137
2014	91	99	79	169	88	83	138	109	137

A Vision for Change recommends a separate 8 bedded acute Psychiatry of Old Age unit per 300,000 population. Current provision of POA units nationally is shown in Table 42 below which also indicates POA 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 POA unit. Admission activity provided by the Health Research Board does not distinguish between General Adult and Psychiatry of Old Age patients.

Table 41 - Adult Acute Inpatient Units with separate POA provision

CHO	Approved Centre	POA 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	DOP, Navan Hospital	✓	When new Drogheda unit opens
CHO9	Ashlin Centre, Beaumont, Dublin 9	✓	
CHO9	St Vincent's Hospital, Richmond Road, Fairview, Dublin 3	✓	Serves all of Dublin North City

✓ Unit in place

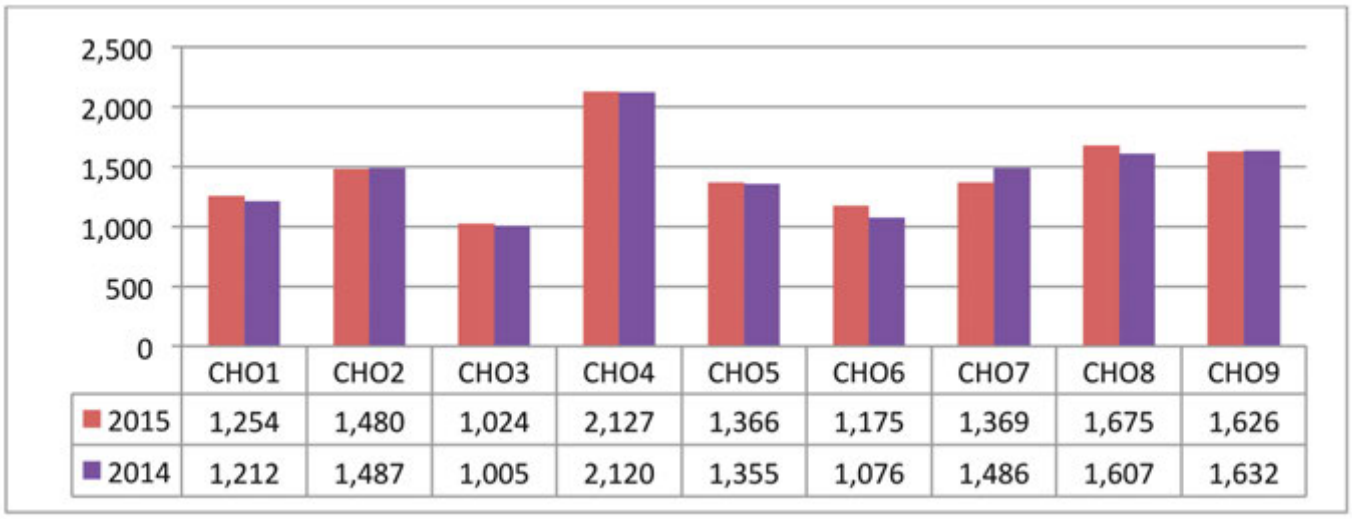
✓ POA unit due to open

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 2015 the number of admission was 13,096 compared to 12, 980 at the end of 2014.

Figure 33 Adult Acute Admissions 2014/2015 by CHO



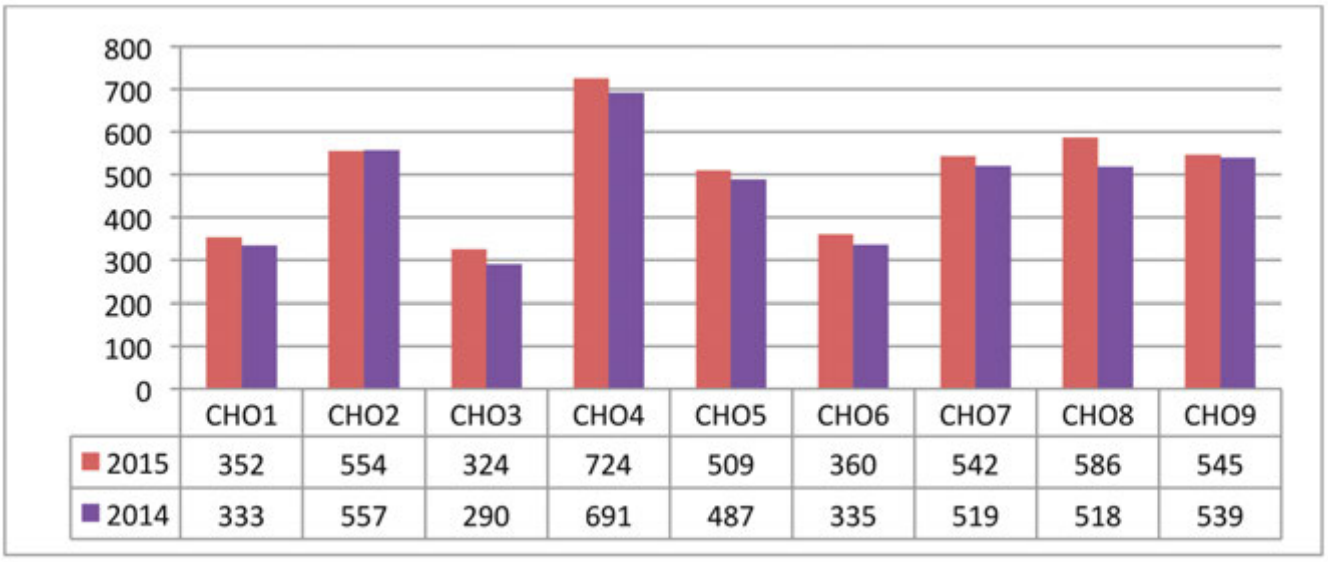
	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
2015	1,254	1,480	1,024	2,127	1,366	1,175	1,369	1,675	1,626
2014	1,212	1,487	1,005	2,120	1,355	1,076	1,486	1,607	1,632

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 in-patient facility.

At the end of 2015 the number of First admissions was 4,496 this is compared to 4,269 at the end of 2014. First admissions accounted for 34% of admissions in 2015.

Figure 34 Adult Acute First admissions by CHO



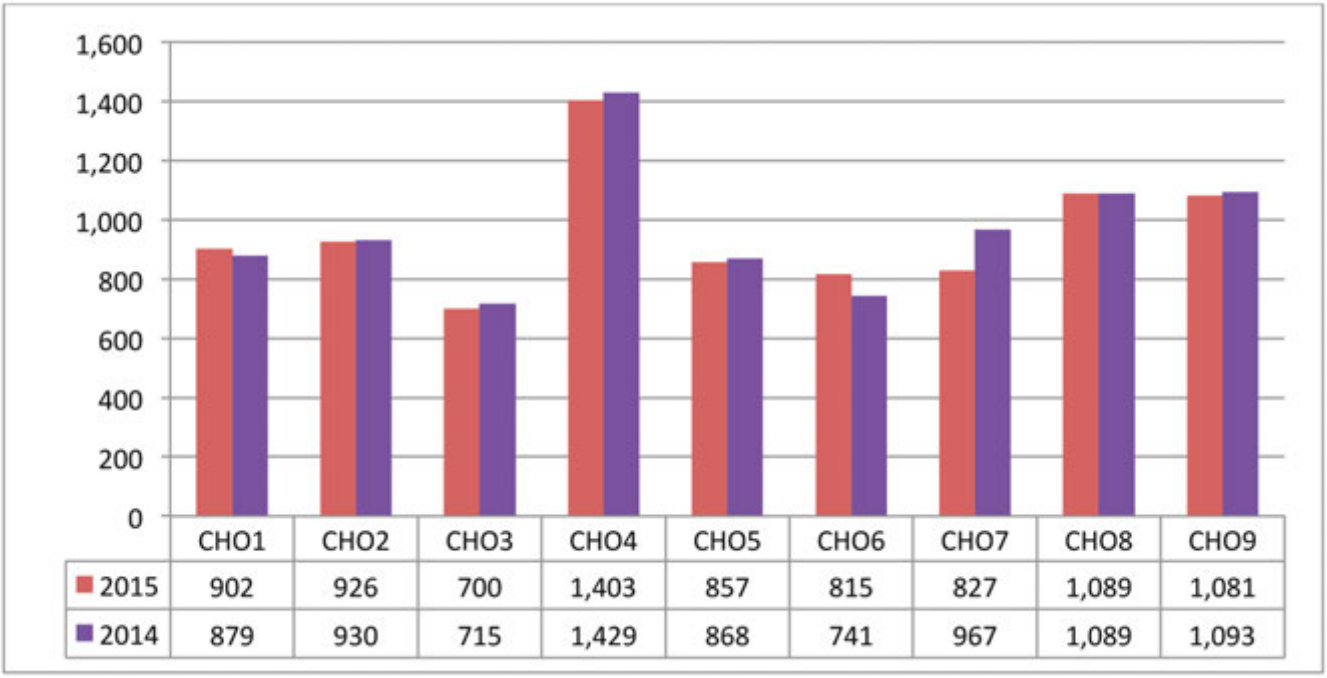
	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
2015	352	554	324	724	509	360	542	586	545
2014	333	557	290	691	487	335	519	518	539

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 in-patient facility.

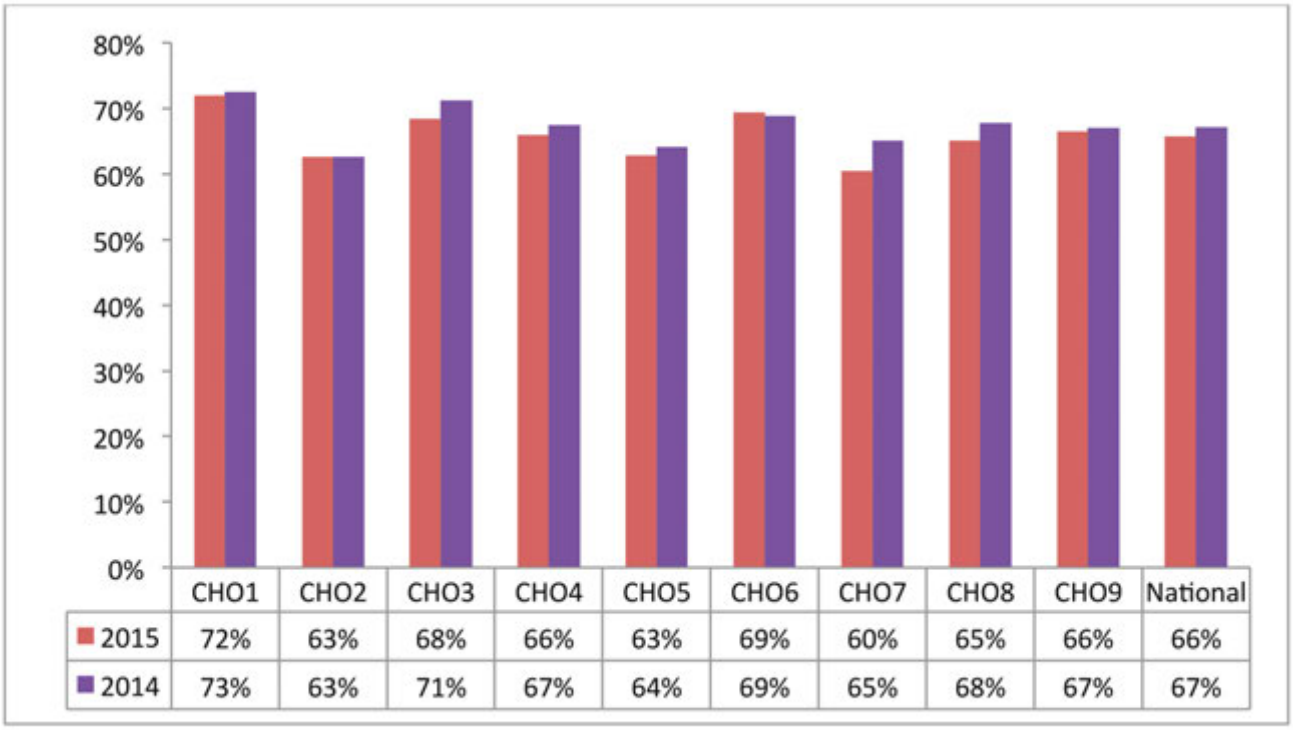
At the end of 2015 the number of re-admissions was 8,600. This is compared to 8,711 at the end of 2014. Re-admissions accounted for 66% of admissions in 2015.

Figure 35 Adult Acute Re-admissions by CHO



	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
2015	902	926	700	1,403	857	815	827	1,089	1,081
2014	879	930	715	1,429	868	741	967	1,089	1,093

Figure 36 Percentage of Adult Acute Re-admissions by CHO



	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9	National
2015	72%	63%	68%	66%	63%	69%	60%	65%	66%	66%
2014	73%	63%	71%	67%	64%	69%	65%	68%	67%	67%

Length of Stay

Length of stay is the amount of time 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 in-patient stay of 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 2015 the Median length of stay was 12.2.

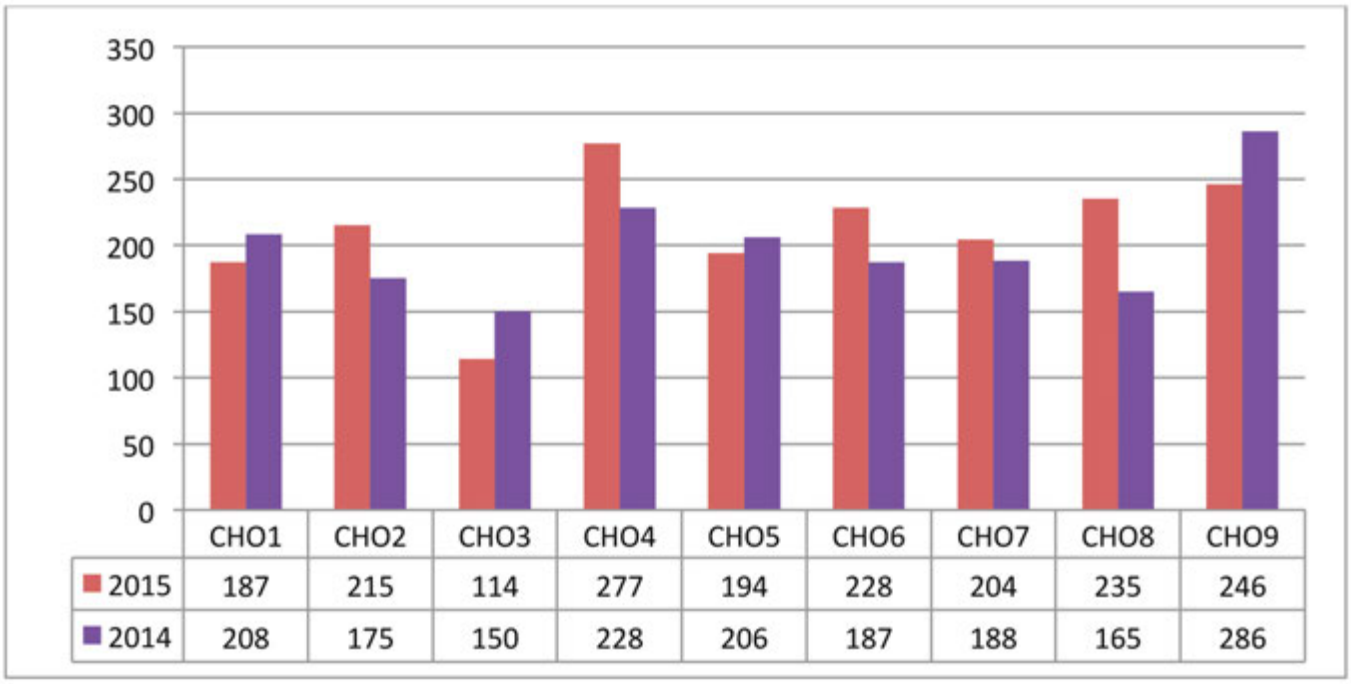
Table 42 Median length of stay by CHO

	2013	2014	2015
CHO 1	12.0	10.4	9.8
CHO 2	13.2	12.7	11.1
CHO 3	12.3	13.3	12.9
CHO 4	13.2	13.5	13.4
CHO 5	10.1	9.8	9.3
CHO 6	16.5	14.0	14.3
CHO 7	8.1	9.3	11.2
CHO 8	14.7	11.7	11.4
CHO 9	17.3	23.9	16.1
National	**13.0**	**13.2**	**12.2**

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 2015 the number of involuntary admissions was 1,900 (1, 793 at the end of 2014). Involuntary admissions accounted for 15% of both first and re-admissions to adult acute inpatient units in 2015.

Figure 37 Involuntary admission by CHO



Data Notes

The Health Research Board (HRB) provides Performance Indicator Reports each quarter to 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 relating to transfers to general hospitals for medical, surgical or other treatment 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 in-patient services and do not necessarily represent the prevalence of mental illness.

NATIONAL FORENSIC MENTAL HEALTH SERVICES

11

NATIONAL FORENSIC MENTAL HEALTH SERVICES

Definition of the specialty:

The National Forensic Mental Health Service (NFMHS) is a national tertiary mental health service and an integral part of the HSE's Mental Health Division, 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.

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

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 in the community those found not guilty by reason of insanity who have been conditionally discharged.

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 prison in-reach clinics at Cloverhill, Mountjoy, Dochas Centre, Wheatfield, the Midlands, Portlaoise and Arbour Hill Prisons and St Patrick's Young Offender's Institution. These prison in-reach clinics are equivalent to community out-patient clinics. 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 of through care pathways back to community services. This includes a psychiatric in-reach and court liaison service in the largest remand prison, for diversion from the criminal justice system where possible.

The Central Mental Hospital (CMH) provides secure hospital services at high, medium and pre-discharge levels, and is an Approved Centre under the Mental Health Act 2001. The National Forensic Mental Health Service also provides a forensic rehabilitation and recovery team that meets the requirements of section 13A of the Criminal Law (Insanity) Act 2010 concerning the supervision of conditionally discharged patients found not guilty by reason of insanity. 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. The CMH is also a designated centre under the Criminal Law (Insanity) Act 2006, the only designated centre under the 2006 Act.

Recovery

The National Forensic Mental Health Service aims to support service users as they work to achieve their optimum level of physical and mental health and independence. Central to this is the involvement of service users and carers in all aspects of care and treatment.

Integrated Care Pathways

Drawing on best international practice, the NFMHS has developed a system for linking assessed risks to treatment needs for those who need treatment in conditions of special therapeutic safety due to mental disorder – the DUNDRUM toolkit. The operations of the NFMHS form a care and treatment pathway, from the prison in-reach clinics through court diversion or admission, to the high security wards of the Central Mental Hospital, and onwards through the medium secure wards to the pre-discharge units and community forensic mental health team. This pathway is transparent to service users and their families. It is designed to engage them in the recovery process. It is also transparent to the courts, Mental Health Tribunals and Mental Health Review Boards and other interested parties.

Special Needs Groups

In 2014 the NFMHS has initiated a Forensic Mental Health Intellectual Disabilities service. This is initially providing specialist treatment and rehabilitation for those with both mental health and intellectual disability needs in the Central Mental Hospital.

Service Activity Levels of Prison In-Reach Teams

The activity of the new prison in-reach teams is not fully reflected in activity levels for 2014 because of delays in recruitment external to the NFMHS.

Based on Irish Prison Service statistics, trends in numbers committed to prisons in Ireland are complex, with some declines in numbers of men committed since 2012 but a continuing rise in women committed to prison.

Table 43 Trends in committals to Irish prisons by gender and total, 2007-2015

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Men	8,556	9,703	10,880	12,057	12,050	11,709	10,729	13,064	*Not yet published*
Women	1,155	1,225	1,459	1,701	1,902	2,151	2,326	3,091	
Total	9,711	10,928	12,339	13,758	13,952	13,860	13,055	16,155	

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 9.9% of all committals are seen by the psychiatric in-reach teams.

Table 44 Prison In-reach Service 2015

Prison	Number of:		Transfers		Discharges	Avg. % Met Clinics
	New Referrals	Patient Reviews	To other in-reach teams	From other in-reach teams (Mar – Dec)	Total discharges	
Portlaoise	67	100	10	3	42	91%
Midlands	205	608	31	35	142	93%
Clover Hill	392	1,315	44	1	317	95%
Wheatfield	82	473	16	18	73	90%
Arbour Hill	29	369	5	2	11	98%
Dochas	66	441	1	0	55	100%
Mountjoy	101	942	19	37	112	82%
Castlerea *Jun-Dec ×Sept-Dec	65*	127*	3×	8×	16×	100%*
Total	1,007	4,375	129	104	768	Total Avg 94%

The number successfully transferred between in-reach forensic teams across prisons and successfully discharged to CMHTs/Prison GP's/Community GP's/Homeless Services represents the desired goal.
There are very few DNAs in prison and all those referred are seen, always within a week. The practice of documenting the tracking of prisoner patients as they move between prisons was commenced in 2014 and by 2015 was well established, meeting standards equivalent to these required for community mental health services in other jurisdictions such as the Care Programme Approach in the UK
The cancelling of clinics due to the unavailability of prison officers was a problem in 2014 but has been much less of a problem in 2015.

Service Activity Levels of Central Mental Hospital

For the year 2015, there were 37 admissions from prisons. This represents a decrease year on year which is a trend that arises from the accumulation of longer stay patients. There were 45 admissions in all.

The number of patients detained under MHA Section 21(2) is now 19, including 4 out of 6 in the Selective Adaptive Behaviour Unit (SABU, intensive care unit) and 3 out of 6 women patients.

There were eight new moves out of the hospital to the forensic rehabilitation and recovery team, but this was offset by two recalls and six new NGRIs. There are in addition at least eleven of the patients already the in hospital while on remand who are likely to be found NGRI in the course of 2016 and 2017.

Table 45 Admissions 2007 to 2015

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015
Admissions from prison	34	47	53	50	50	55	62	44	**37**
Admissions from approved centres	1	2	3	2	0	2	4	1	**0**
Admitted as NGRI	0	0	1	3	1	0	3	4	**5**
Admitted as UTP	6	1	4	1	1	1	5	3	**0**
Changed Status									**1**
Recalled Conditional Discharge/Sec 14									**2**
TOTAL ADMISSIONS	**41**	**50**	**61**	**56**	**52**	**57**	**74**	**52**	**45**
Discharges 2007 – 2015									
Discharges to prison or courts (section 15)	25	37	46	50	48	48	58	36	**34**
Discharges to courts (UTP or temporary NGRI)	6	2	1	4	1	0	7	4	**2**
Discharges of MHA section 21(2) to approved centres or nursing homes	0	1	3	0	0	2	1	0	**3**
Moves from CMH to F-R&R community	1	0	2	0	6	3	5	8	**1**
Conditional and unconditional discharges to forensic R&R team	1	1	0	1	7	9	5	4	**7**
Total	**33**	**41**	**52**	**55**	**62**	**61**	**76**	**52**	**47**

Note that the numbers of admissions and discharges do not balance because of additional numbers moved from the CMH to community places under section 14 leave, supervised by the forensic rehabilitation and recovery team. Conditional and unconditional discharges often overlap with these.

Waiting List

The time spent on the waiting list prior to admission, and the numbers released from custody while on the waiting list should be taken as indicators of uncontrolled or poorly controlled risk.

Length of Stay

Length of stay is often regarded as a key performance indicator. In forensic psychiatry this is often controlled by non-clinical factors. Those on fixed sentences must be released whether clinically ready or not. Those found not guilty by reason of insanity can only be conditionally discharged by the Mental Health Review Board. Those admitted on transfer from approved centres around the country can only be discharged in most cases if accepted back to the approved centre that referred them. In many cases the approved centres have closed and the successor centres refuse to accept patients back on the grounds that they cannot provide longer term in-patient care.

In practice, although mean and median length of stay had been falling at the Central Mental Hospital fell from 2005 to 2010, since then length of stay has changed little.

Table 46 Cross-sectional length of stay (years), Central Mental Hospital, November of each year

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
N	75	83	83	83	93	92	94	92	91	92	94
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)
Median (years)	5.0	3.5	2.3	2.1	2.6	3.3	4.4	4.8	4.9	3.1	3.7

This appears to be because longer term patients are accumulating as a percentage of the total. Medium term patients are more easily discharged as a result of law reform in 2010. However the figures for 2015 show that the availability of short term beds declined in 2015 as the proportion of beds occupied by medium term patients increased.

Table 47 Cross-sectional length of stay in bands

Length of stay	2009	2010	2011	2012	2013	2014	2015
N	93	92	94	92	91	92	94
<12 months	29	19	16	22	22	26	18
12 to 60 months	31	46	40	28	24	24	35
60 + months	38	31	38	42	45	42	41

Service Activity Levels of Forensic Rehabilitation and Recovery Teams

The Forensic Recovery and Rehabilitation cluster consists of two consultant forensic psychiatrists who lead a joint multi-disciplinary team. The team is responsible for a rehabilitation ward and pre-discharge house within the CMH secure campus and the team is responsible for the community supervision of a growing number of NGRI and UTP patients who have been granted overnight leave under section 14 Criminal Law (Insanity) Act 2006 or who have been conditionally discharged under section 13A Criminal Law (Insanity) Act 2010. The community patients in the community are accommodated and supervised in a variety of settings are varying levels of relational support according to their needs.

Table 48 Patient Numbers 2015

	Start Jan 2014	End Dec 2014	End Dec 2015
Inpatients on pre-discharge wards	24	23	24
Patients in Supported community living	13	16	16
Patients in independent living	7	9	9
Patients living in other community services residences	3	2	4
TOTAL	**46**	**50**	**53**

These figures include an increasing number of moves along the recovery pathway from rehabilitation to pre-discharge to supported community living, independent living and other moves including some recalls to the hospital.

Out-patient activity, Forensic Rehabilitation and Recovery Team

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.

Table 49 Community Clinics 2015

	Referrals	New referrals seen
Referrals received from HSE Community Mental Health Teams conducted in our outpatient clinic in Usher's Island and Approved Centres nationally	177	151*
Reports at request of Judges of District and Circuit Courts	134	134
Voluntary reports to courts from prison in-reach team Cloverhill Prison		128

*26 were deemed inappropriate by the referrals meeting.

OTHER SPECIALTY AND SUBSPECIALTY MENTAL HEALTH SERVICES

12

OTHER SPECIALTY AND SUBSPECIALTY MENTAL HEALTH SERVICES

In this report, the Mental Health Division has focused on the four specialist mental health services for which service activity is available.

There are other services which have been prioritised for development in the past three years through the Programme for Government investment.

- The specialty of Mental Health Intellectual Disability (MHID). This is known by the Medical Council as Psychiatry of Learning Disability (PLD).
- Two subspecialties:
- Liaison Psychiatry
- Rehabilitation and Recovery Mental Health Services

Although, the data which is available for General Adult, Psychiatry of Old Age and CAMHS services is not yet collected for these services, this section provides a broad definition of the role and scope of each service together with an update on progress in the development of the service.

Mental Health Intellectual Disability

3.8% of the population have an intellectual disability (ID) of which 3% have mild and 0.8% have moderate or greater degrees. The number of people with co-existing/comorbid mental illness is 25% of those with mild or moderate and if those with behavioural problems are included, which includes those with a severe learning disability, this means that up to 50% may have a comorbid illness and/or behavioural problems.

A Vision for Change recommends that those individuals with mild learning disability who develop a comorbid mental illness will be responded to by the generic age related mental health service i.e. CAMHS, General Adult and Psychiatry of Old Age. However, on an individual basis some individuals with mild MHID and comorbid complex mental health needs may be better served by MHID services

However, specialist mental health intellectual disability services are required for those with moderate or greater degrees of intellectual disability and comorbid mental illness/behavioural problems. In addition, approximately a third of those with mild ID may be better served by specialist MHID services.

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 both mental illness, certain chronic and persistent behavioural problems. The latter, in particular, includes those with an intellectual disability, autism spectrum disorder and a comorbid mental illness.
- 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.

Ethical issues related to capacity and consent requiring universal consideration in this population.

The model of the service is the same format as in the other specialties i.e. by means of multidisciplinary teams led by specialist consultant psychiatrists.

As investment in the provision of MHID services began in 2013, there are relatively few complete MHID teams in place for either adults or children.

Service provision is more complicated for people with intellectual disability as many ID services are provided through voluntary agencies which provide holistic services for people encompassing physical, social and psychological issues amorphously, funded on a per capita basis. This differs from HSE provided services which are delivered on the basis of catchment area responsibility.

There are a number of consultant psychiatrists specialising in this area working in these voluntary providers but without the specialist multi-disciplinary team. The agencies are funded by the HSE through annually negotiated Service Agreements.

In other parts of the country, ID services are provided by the HSE. Again, some of these services have consultant psychiatrists working within them but the teams are incomplete. In general, whilst there are some services for adults, there are relatively few available for children.

The following table shows the consultant manpower available specifically for MHID services by CHO. In most voluntary agencies there is no defined multidisciplinary team working with a consultant as previously outlined.

Table 50 MENTAL HEALTH INTELLECTUAL DISABILITY: Consultant Manpower October 15

CHO	Area	Pop	Adult MHID Consultant	CAMHS MHID Consultant	2013 Alloc (38.5)[1]	2014 Alloc (26)[1]
Area 1	Donegal	389, 048	1	0	2	2
	Sligo/Leitrim		1	0	2	2
	Cav/Mon		(2)	(1)[2]	5	2
Area 2	Galway/Rosc	445, 356	1 (0.8 + 0.2)	(1)[1]	1	2
	Mayo		0.8	0.8	1	1
Area 3	Limerick/Clare/NTipp	379, 327	1	0.7	2	1
Area 4	Cork	664, 533	1 + 1.5	see comment	5.5	1.5
	Kerry		(1)	0.1	0	3
Area 5	CKST	497, 578	1.5	1	0	
	Waterford/Wex				5	2
Area 6	Wicklow/DSE	364, 464	1 0.5 0.5		2.5	
Area 7	DSCW[3]	647, 071	0.5 1.3 0.65	0.4		
	Kildare		1 + 0.4	0.5	0	0

Area 8	L/O	592, 388				
	Long/W'meath		1		4	1
	Louth/Meath		See Cav/Mon	See Cav/Mon	5	2
Area 9	Dublin N City	581, 486	4.65	0.5	0	4
	North Dublin		2	1	0	2
Forensic Service		National	(1)	0		

( ) Number in brackets indicates posts allocated 13/14 and awaiting appointment

[1] Includes all disciplines

NB In calculating manpower requirement must take account of large residential ID populations of national origin in voluntary organisations

Since 2013, the Mental Health Division has allocated posts specifically for the development of these services, initially for adults and latterly for children. Approximately 100 posts in total have been allocated. However, in addition to the difficulties in recruitment particularly at consultant level, local areas without experience of such services are unclear as to how to set up the services and train personnel. The Mental Health Division has provided guidance in the context of a brief document on the development of mental health services for people with intellectual disability focusing on planning and overseeing the implementation of a national model.

To progress the development of the services, in late 2015, it was agreed to appoint a Developmental Clinical Lead who will work with the National Clinical Advisor and Head of Operations to oversee the development of these services within each CHO Area.

An important part of this work will include working with the Social Care Division to provide an integrated service to respond to the mental health needs of this group.

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 designed to operate away from traditional mental health settings in Acute Hospital Emergency Departments and wards and medical and surgical outpatients. The teams are multidisciplinary, 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 Higher Specialty Training in General Medicine or General Practice.

The multidisciplinary team should include specialist mental health nurses, clinical psychologists, occupational therapists and social workers together with good 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.
- 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 ensure that there are strong links with other mental health services particularly those based in the community.

The Mental Health Division has prioritised the development of liaison psychiatry services for the past two years. The following table is a summary of the current position:

Table 51 Liaison Psychiatry Services

CHO	Hospital	In Place 2014/15	Liaison Services in Development
1	Letterkenny		2015 PfG allocation
	Sligo		2014 PfG allocation
	Cavan		2014 f PfG allocation
2	Mayo		2015 f PfG allocation
	Galway	✓	
	Portiuncula	With Galway	
3	Limerick	✓	
4	CUH	✓	
	Mercy	✓[1]	
5	Kilkenny		Local reconfiguration
	Waterford		2014 PfG allocation
6	St Vincent's	✓	
	Loughlinstown/St Michaels	✓	Hospital now Level 2
7	St James's	✓	
	Tallaght	✓	
	Naas		2015 PfG allocation
8	Portaloise		Reconfiguration discussions in train
	Mullingar		Reconfiguration discussions in train
	Tullamore		Reconfiguration discussions in train
	Drogheda	✓	2013 PfG allocation
9	Beaumont	✓	
	Connolly	✓	
	Mater	✓	

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 Division in these sites.

In addition, perinatal liaison psychiatry services are provided in the three Dublin Maternity Hospitals (Rotunda, Holles Street, Coombe). Two are provided by a consultant liaison psychiatrist working in an adjacent hospital who has a special interest in perinatal psychiatry. Each has four clinical sessions per week for this work. The third hospital has a half time General Adult Psychiatrist providing the service. The Mental Health Division has committed in the Service Plan 2016 to review the need for further development of perinatal psychiatry services nationally.

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 Mental Health Division 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.

The current provision of Rehabilitation and Recovery Services in Ireland is shown by CHO/Area in the table below:

Table 52 Rehabilitation and Recovery Mental Health Services

CHO	MHS	Rehab Service in Place 2014/2015	Services in Development
1	Donegal	X	Development of service under discussion
	Sligo	✓	
	Cavan/Monaghan	✓	
2	Mayo	✓	
	Galway	✓	
	Roscommon		Funded 2015
3	Limerick	✓	
	Clare	✓	
4	Kerry	✓	
	South Lee		Funded 2015
	North Lee	X	
	West Cork	X	
	North Cork	✓	
5	Wexford	✓	
	Waterford	✓	
	Carlow/Kilkenny	✓	
	South Tipp	✓	
6	Wicklow		Funded 2015
	Elm Park		Funded 2015
	Cluain Mhuire	X	
7	DSC		
7	DS West	✓	
	Kildare	✓	
8	Longford/Westmeath	✓	Funded 2014
	Laois/Offaly	✓	
	Louth/Meath		Funded 2014
9	North Dublin	✓	
	Dublin North City	✓	3 Services

When full recruitment of the 2015 allocation of services has been completed, all the country should have access to such services.

APPENDIX

13

APPENDIX

Appendix 1

References for Chapter on Child and Adolescent Mental Health Services

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8. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

APPENDIX

Appendix 2

Other publications which provide information on Mental Health can also be found on the HSE website.
http://www.hse.ie/eng/services/publications/

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