HSE Mental Health Division

Delivering Specialist Mental Health Services **2016**

HSE Mental Health Services

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

ACKNOWLEDGEMENTS

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

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

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FOREWORD

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

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

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

The Department of Health & Children recently published the document 'Evidence Review to Inform the Parameters for a Refresh of a Vision for Change'. This document presents the results of an evidence review to inform the parameters of the planned refresh of mental health policy in Ireland ten years after the publication of the existing policy framework set out in VFC. The report presents a broad overview and mapping of evidence and developments in the mental health area that may be helpful in guiding policy development and practice in Ireland. The strategy for mental health services is also informed by more recent documents focused on the change agenda in health services particularly the recently published cross party strategy document "Report of the Oireachtas Committee on the Future of Healthcare, Sláintecare Report".

Service Framework

The spectrum of services provided through the Mental Health Division which has operational and financial authority and accountability for all mental health services, extends from promoting positive mental health through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness. The National Office for Suicide Prevention (NOSP) is a core part of the Mental Health Division and through its coordinating work will deliver on the actions arising from the Connecting for Life Policy 2015–2020.

Services are provided in a number of different settings including the service user's own home. 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 fully committed to and plays an active part in internal service improvement processes within the Division but also in the wider health system reform agenda.

Regionally the 9 Community Health Organisations (CHO's) have responsibility for the delivery of community health care services in their areas of responsibility. While the Chief Officer of the CHO has

overall responsibility, the Head of Service for Mental Health (in conjunction with the Executive Clinical Director), is responsible for the delivery of Mental Health Services in the CHO's. The Forensic Mental Health Service operates on a national basis. Details of CHO's, Heads of Service and area population are provided in Appendix 1.

EXECUTIVE SUMMARY

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

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

Building on the success of the annual reports which were published by the Child and Adolescent Mental Health Services up to 2013 and on the Delivering Specialist Mental Health Services Report 2014 - 2015, this 2016 report will provide an overview of the work of the specialist mental health services, describing the services delivered, detailing the resources available to the services and showing the activity of those services in 2016.

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

The term mental health describes a spectrum that extends from enjoying positive mental health through to severe and disabling illness. Over 90% of mental health needs can be successfully treated within a Primary Care setting, with less than 10% being referred to specialist community based mental health teams. Of this number approximately 10% are offered inpatient care with 8% of all admissions being of an involuntary nature. Specialist secondary care mental health services are provided to respond to the varied and complex clinical needs of those individuals with greater need.

The mental health services provided include Community Health Organisation (CHO) based Mental Health Services which comprise acute inpatient units, community based mental health teams (Child and Adolescent Mental Health, General Adult, MHID and Psychiatry of Old Age etc), day hospitals, out-patient clinics, continuing care settings and community residential services. There is also the National Forensic Mental Health Service. Within the main specialties, certain sub-specialities including rehabilitation and recovery, liaison psychiatry, and perinatal psychiatry are provided.

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

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

Workforce

- In December 2016 there was a total of 644 staff in the Child and Adolescent Community Mental Health Teams nationally (556 Clinical). This represents 53.1% of the clinical staffing levels recommended in A Vision for Change which is an increase of 3.4% nationally on the 2015 position.
- In December 2016 there was a total of 1,707 staff in the General Adult Community Mental Health Service (1,495 Clinical), which represents 74.8% of the clinical staffing levels recommended in a Vision for Change.
- In December 2016, there were 325 staff (clinical 287) working in 29 Psychiatry of Old Age Service teams, which represents 54.8% of the clinical staffing level as recommended in a Vision for Change.
- There are 500 Development posts in progress which will be filled across 2017 and 2018.

Child and Adolescent Mental Health Services

- In 2008 there were 49 CAMHS Community Mental Health Teams. This has increased to 66 in 2016.
- There has been a 26% increase in referrals accepted between 2012 and 2016.
- 14,193 new appointments were offered in 2016.
- 45% of new appointments were seen within 4 weeks.
- 20% of new cases seen are aged over 16 years.
- 12% of new patients did not attend their first appointment.
- In 2007, 3,609 individuals were waiting to be seen; in 2016, 2,513 were waiting to be seen.

General Adult Mental Health Services

- There are 114 Community General Adult Mental Health Teams.
- 1% increase in referrals accepted from 2015 to 2016.
- 37,536 new appointments offered in 2016.
- 23% new appointments seen within 1 week.
- Over 33% within 2 weeks & 51% seen within 4 weeks.
- Over 1 in 5 new patients did not attend their first appointment.

Psychiatry of Old Age Mental Health Services

- In 2013 there were 22 POA teams; there were 29 POA teams in place in 2016.
- 6% increase in referrals from 2014 to 2016.
- 9,012 new appointments offered in 2016.
- 40% new appointments seen within 1 week.
- 86% new appointments seen within 4 weeks.
- 2% 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 2016, there were 74 CAMHS Acute Inpatient beds.
- In 2008, 25% of admissions of children were to CAMHS acute inpatient beds. By the end of 2016, 82% of admissions of children were to CAMHS acute inpatient beds.
- 97% of the total bed days used by children who were admitted were in Child and Adolescent Acute Inpatient Units.
- Of the 18% (68) admitted to Adult Approved Centres, 88.2% (60) were 16/17 years old with 63.2% (43) of these discharged either the same day or within 3 days and 83.8% (57) within a week.

Adult Acute Inpatient Mental Health Services

- There are 29 Adult Acute Inpatient units.
- In line with national policy to enhance community services and reduce hospital admission in 2007, there were 16,293 admissions to acute units, in 2016, there were 12,590 admissions.
- In 2007, there was a 72% re- admission rate; and in 2016 this rate reduced to 65%.
- Average length of stay was 1018
- Median length of stay was 11 days

Chapter 1
Supporting the delivery of Quality Mental Health Services

Since its inception the Mental Health Division has developed and progressed programmes of work to deliver on its multi annual priorities. A key feature of this work included vesting the Mental Health Division with full financial, operational and strategic responsibility for mental health services nationally; supported by a performance framework to inform decision making.

The Mental Health Division places a major emphasis on the quality of services delivered and on the safety of those who use them. One of the key supports to the delivery of quality services is the provision of information about the mental health services to stakeholders. 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 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 Division is committed to providing ICT enabled solutions to meet its information and decision support requirements, and in the interim, it has established the Data Design and Optimisation Project to leverage the optimum information from the current information system.

Building on the success of the earlier reports which were published by the Child and Adolescent Mental Health Services up to 2013, the Division developed the reports, Delivering Specialist Mental Health Services 2014, 2015, 2016 and now, with the objective of providing on 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.

This Chapter and Chapter 2 of this report provide a context and describe the delivery of secondary care specialist mental health services, giving an overview of the components of service and how they are accessed by service users. Chapter 3 describes the investment made in mental health services including the Programme for Government funding available to mental health since 2012.

Chapter 4 outlines the Mental Health Workforce in the General Adult, Psychiatry of Old Age and Child and Adolescent Mental Health Services. The workforce data provided is an average of the staffing over the given year based on these returns.

Chapters 5 to 10 of the Report focus on the activity of the Child and Adolescent, General Adult, Psychiatry of Old Age and Forensic Mental Health Services respectively, including inpatient activity. This information is derived from the data collected as part of the national performance indicator suite. Data relating to the activity of community mental health teams in the adult mental health services is only being collected and reported since 2014. The limitation of the available data is acknowledged and it is an objective of the Division to incrementally expand the data collected and to develop its capacity for information analysis.

In that context, Chapter 11 of the Report provides an overview of the development of specialist and subspecialist mental health services including the National Forensic Mental Health Services, the development of Mental Health Intellectual Disability (MHID) services as well as Liaison Psychiatry and Rehabilitation services.

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

Overview

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

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 the most frequently seen.

Strategic Direction of Mental Health Services

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

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

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

Corey L. M. Keyes
Journal of Health and Social Behavior
Vol. 43, No. 2, Selecting Outcomes for the Sociology of Mental Health: Issues of Measurement and Dimensionality (Jun., 2002), pp. 207-222

Accessing specialist mental health services

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

The Report of the Expert Group on Mental Health Policy - A Vision for Change (2006) recognises a 'pivotal role' for primary care in providing mental health services. The policy assigns a key role to GPs as 'gatekeepers' to specialist mental health services who will detect and diagnose mental health difficulties and either treat the individual or refer them to specialist services.

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

Community Mental Health Teams

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

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

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

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

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

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

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

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

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

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

Chapter 2
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. The HSE (Clinical Strategy and Programmes Division and the Mental Health Division) in partnership with the College of Psychiatrists of Ireland have identified a number of Clinical Programmes, reflecting an on-going strategy to improve mental health services.

There are currently five Mental Health Clinical Programmes:

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

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

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

Impact of the clinical programme in 2016

- Over 6,000 presentations were assessed across 16 ED sites in 2016. 98% had a completed assessment.
- An additional 4 ED sites went live in quarter 3 and quarter 4 of 2016 bringing the total number to 21.
- Two national seminar days were held in 2016 for Clinical Nurse Specialist staff and Consultant leads for the programme. All sites were represented at the training.
- An education programme for staff working in ED – Changing Attitudes to Self-Harm was delivered to CNS staff delivering the programme for use in their daily work.
- A Clinical Lead was identified in September 2016, due to take up post in early 2017.

Assessment and Management of patients who present to ED following Self Harm

In 2016, 16 emergency departments reported data on this programme. The data indicates that

- 6,928 presentations were recorded in 16 ED's
- 90% of presentations received a bio psychosocial assessment
- 88% were seen within 6 hours of being fit to be assessed
- 67% of people had next of kin involved in the assessment process

B. Early Intervention in Psychosis

The key overall aims of the Early Intervention in Psychosis (EIP) Clinical Programme are:

- The early detection of psychosis (first episode and at risk mental state (ARMS)) through detailed assessment and engagement.
- The provision of standardised evidence based bio psychosocial interventions in a timely manner for the estimated 1500 individuals who develop psychosis and ARMS each year in Ireland.

The key interventions based on the best available clinical evidence are, detailed assessment within an agreed time, appropriate medication, physical health care monitoring, engagement by

key workers with service users, range of family intervention including Behavioural Family Therapy (BFT), Cognitive Behavioural Therapy for Psychosis (CBTp) and support to return to competitive employment using Individual Placement Support model (IPS).

In April 2016 a clinical Lead was appointed to the clinical programme and a review of services was completed. In September 2016 a National Working Group was established, comprising of various stakeholders in order to develop a model of care. The group meets monthly under agreed terms of reference.

Behavioural Family Therapy (BFT)

- In 2016 monthly data collection was commenced from individual services on the number of families offered Behavioural Family Therapy (BFT) and engaged in the process. Up to 40 families are offered BFT each month across the services
- There are 27 BFT trainers/supervisors in Ireland and 2 clinicians successfully completed accreditation of their clinical work by Meriden NHS UK in 2016.
- Four external BFT supervision workshops were provided for trainers/supervisors.

BFT 2016 Data

During 2016 data was collected from each CHO reflecting BFT activity within mental health services. In total for 2016 304 families were offered BFT intervention. 67% engaged in the process. On average 100 families a month are engaged in BFT approach. To date over 245 clinicians have been trained in BFT at the end of 2016 199 clinicians were on the National Register for BFT. 31 clinicians have trained to trainer/supervisor level and take a lead role in local mental health services. All clinicians delivery BFT must attend an agreed number of supervision sessions per year. There is a supervision structure in place.

Individual Placement Support (IPS)

- 210 Occupational Therapists received baseline training over 7 months in Model of Human Occupation vocational assessments in preparation of further work in implementing Individual Placement Support for first episode psychosis.
- A group was established to scope out the requirements to deliver IPS, meetings were also held with the Department of Employment Affairs and Social Protection to explore methods of working in partnership.

Cognitive Behavioural Therapy for Psychosis (CBTP)

A group was established in September 2016 to draft a Standard Operating Procedure for cognitive behavioural therapy for psychosis (CBTP). The group is chaired by a National Clinical Lead and membership of the group is comprised of clinicians from a range of disciplines with clinical expertise in the area.

Eating Disorders:

This clinical programme is in an early stage of development, and applies to service users across the age range (child and adult), and at all clinical stages of the disorder. It relates to care across community, day and inpatient mental health services, acute medical and primary care, collaborating with other relevant HSE clinical programmes. The aim of the programme is to provide the most effective treatment for each person with an eating disorder at the right time in the most effective setting.

- In April 2016 a national training day was held for all staff trained in Family Based Therapy (FBT). An electronic FBT peer supervision toolkit and resource pack was developed for clinical staff.

- In May 2016 a one day education day was provided for all trained staff in enhanced CBT. A supervision agreement for CBT -E was reached with an external provider to supervise 7 groups on a monthly basis across the country.
- In July 2016 a clinical lead was appointed to the programme, and a national working group for eating disorders was established. This group continued to meet monthly to design a model of care for eating disorders spanning adult and child services. The clinical lead established working relationships with a number of other HSE clinical programmes in developing integrated pathways of care from acute hospitals to outpatient care.

ADHD in Adults:

This clinical programme, also at an early stage of development applies to HSE Mental Health Services for adults with Attention Deficit Hyperactivity Disorder (ADHD). ADHD in adults is an impairing lifelong condition which is under-diagnosed in most European countries (including Ireland) leading to impaired quality of life following ineffective treatment thereby resulting in on-going distress and impairment. People with ADHD, once diagnosed, benefit from mental health treatment including psychosocial interventions.

The key aim of the clinical programme is to ensure adults with ADHD have access to assessment and treatment. The objectives of the programme include:

- Design a draft Model of Care for HSE ADHD adult services based on international best practice
- Establish links with other key clinical programmes
- Collaboration with the College's Clinical Advisory Group
- Identify HSE resource requirements
- Define HSE staff competencies - training and CPD requirements
- Define a core clinical outcome dataset

The national working group was established in October 2016, with key stakeholder representation and a programme manager was appointed in December 2016

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

The HSE Mental Health Division, along with the Clinical Strategy and Programmes Division and subsequently with the College of Psychiatrists of Ireland, and the Primary Care Division have recognised the need for a Clinical Programme for Dual Diagnosis to respond to people with substance misuse problems, both alcohol and/or drugs, as well as mental illness. These types of complex problems require a clinical programmatic response to ensure quality and access of service are enhanced.

This Clinical Programme was identified and developed in late 2016 and a programme manager commenced December 2016. A clinical lead was appointed in 2016 and will take up post in 2017.

Chapter 3
Investing in Mental Health Services

This Chapter will provide an overview of the investment in mental health services including the additional allocations under the Programme for Government. The HSE's Mental Health Division adopts a multi-year approach to budgeting with the key aim of which the delivery and development of safe and responsive services across the country, in line with the recommendations of VFC and with an increased use of an equitable evidence-based approach. The 2016 final budget for Mental Health, inclusive of 2012-2016 Programme for Government (PfG) funding was €826 million.

Between 2012 and 2016, €160m in ring-fenced new development funding was allocated under the PfG to invest in modern mental health services which are recovery focused and community-based. On a year-by-year basis, however, the HSE mental health budget has also been subject to restrictions which have applied to health expenditure generally, including downward adjustments for public service pay reductions and procurement savings similar to other HSE service areas. In addition, in 2013 and 2014 only, unspent development funds due to recruitment restrictions were used to meet unavoidable costs in other areas on a once-off basis only with all funds available on a recurring basis at the start of the next year. In total, taking account of the various movements, an additional €115.6million increase in the Mental Health budget is identified in the HSE Service Plans between 2012 and 2016 inclusive. It should be noted that minimal/no development funding has been re-directed to non-mental health services in 2015, 2016 and 2017 to date as underspends in PFG allocations were used towards other mental health related costs.

Net Mental Health Funding 2012 to 2018.

Heading	2012	2013	2014	2015	2016
NSP Budget (€m)	711.000	737.000	766.000	791.600	826.600
NSP Outturn (€m)		709.000	735.800	785.400	825.000

New Development Posts 2012 to 2016 (at October 2017)

Type of Post	2012	2013	2014	2015	2016	Total
New Development Posts (approx.):						
– Approved	416	477	251	350	317	1811
– Filled at Oct 2017	403	462	203	176	108.5	1352.5
– % Filled at Oct 2017	97%	96%	80%	47%	34%	75%

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

- 403 or 97% of the 416 development posts for 2012 have started where the remaining posts relate to largely Psychology and other specialist posts.
- 457 or 96% of the 477 development posts for 2013 have started where half of the remaining posts are medical and the other specialist posts as above.

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

- 203 or 80% of the 251.1 development posts for 2014 have started. Over one third of the remaining unfilled posts are medical and remain difficult to recruit.

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

- 176 or 47% of the approximate 350 development posts for 2015 have started

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

- 109 or 34% of the approximate 319 development posts for 2016 have started.
- A further 134 posts relate to the Assistant Psychology in Primary Care initiative.
- A further approximate 120 posts for Eating Disorders, the opening of new units, enhanced perinatal mental health services and specialist rehabilitation services have also been approved.

Allocation of Programme for Government Funding 2012 to 2016

Funding Use	2012	2013	2014	2015	2016	Total
Service Staff for Community Teams, Specialist services and supports (in-patient below)	22,838,338	31,129,426	20,000,000	21,520,000	12,710,000	108,197,764
Counselling in Primary Care (CIPC)	5,000,000	2,465,299				7,465,299
National Office for Suicide Prevention & CFL	3,000,000	1,000,000		2,750,000	550,000	7,300,000
In Patient Capacity/Placements				6,330,000	8,970,000	15,300,000
Jigsaw & Limerick Youth Service & SHIP Counselling				3,200,000	5,300,000	8,500,000
Genio & Misc	2,102,662					2,102,662
Enhanced Teamworking	1,547,000					1,547,000
Advancing Recovery				1,000,000		1,000,000
Information Systems		405,275			1,5000,000	1,905,275
Clinical Programs	402,000				270,000	672,000
Specialist Rehabilitation Services					3,000,000	3,000,000
Primary CAre Homeless					2,000,000	2,000,000
Stigma Reduction				200,000		200,000
Advocacy in Mental Health	110,000					110,000
Clinical Psychology Training & Post Graduate Nursing					700,000	700,000
	35,000,000	**35,000,000**	**35,000,000**	**35,000,000**	**35,000,000**	**35,000,000**

2012–2016 Investment In Posts Specifically For Community Teams

Teams	2012 WTE	2012 WTE	2012 WTE	2012 WTE	2012 WTE	2012 WTE
General Adult Community Mental Health Teams	254	180	38	88	4	564
Child and Adolescent Community Mental Health Teams	150	80	53	42	18	343
POA Community Mental Health Teams	0	100	25	30	0	155
MHID Community Mental Health Teams	0	40	24	41	0	105
Forensic Teams (In-reach, MHID and CAMHS)	0	28	0	39	18	85
Homeless MH Teams	0	0	7	0	0	7
Liasion Teams	0	0	10	5	0	15
In-Patiens & Continuing Care	0	0	0	31	101	132
Primary Care Assistant Psychology Under 18s	0	0	0	0	134	134
Mental Health Engagement	0	0	0	0	18	18
Physical Health	0	0	0	8	0	8
Traveller Mental Health	0	0	0	9	0	9
Peer Support	0	0	0	0	20	20
Clinical Programmes	0	0	0	32	0	32
ICT/E-Rostering	0	0	0	23	0	23
Sub Total	**404**	**428**	**157**	**348**	**313**	**1650**
National Support/NOSP/CFL	12	49	94	37	4	196

Chapter 4
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 the 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 staff.

The composition of each Child and Adolescent Community Mental Health Teams should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions.

A survey of the staffing of the Child and Adolescent Mental Health Services including Community CAMHS teams, Day service programmes, Hospital Liaison teams, and Inpatient services was carried out at various stages in 2016. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in CAMHS services in 2016 was 900.86.

Vision for Change Recommendations v. Actual Staffing (2016)

CAMHS Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2016
Staff Community MHTs	1 : 50,000	79	66	1,238	643.50
Adolescent Day Service teams		16	4		26.43
Hospital Liaison MHTs	1 : 300,000	16	3	208	31.63
Total		111	73	1,446	701.56
Inpatient Services			4 Units		199.30
			Total Staff		900.86

Staffing of CAMHS Acute Inpatient Units

The total number of staff at the four inpatient units was 199.3 (December 2016). The table below shows the breakdown of the inpatient staffing by profession between 2013 and 2016.

Staffing of Child and Adolescent Inpatient Units by profession 2013-2016

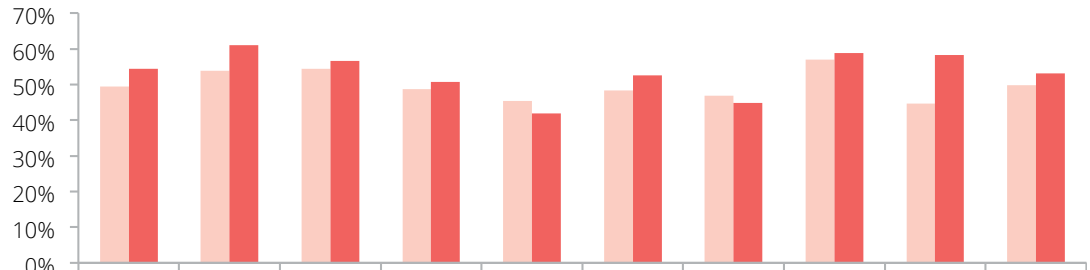
	2013	2014	2015	2016
Consultant Psychiatrist	5.75	5.10	6.00	6.40
Senior Registrar	4.00	3.00	4.00	2.50
Registrar/SHO	3.80	3.00	4.00	9.50
Director of Nursing	2.00	1.00	1.00	1.50
Assistant Director of Nursing / CNM III	5.70	2.70	4.70	4.20
CNM II	6.90	6.00	12.00	11.00
CNM I	8.50	7.50	7.50	7.50
Clinical Nurse Specialist	2.00	2.00	2.50	3.50
Staff Nurse	78.08	94.00	84.50	84.50
Clinical Psychologist	4.50	4.00	3.81	6.61
Occupational Therapist	2.90	4.30	2.80	4.30
Speech and Language Therapist	3.00	2.70	2.90	2.30
Social Worker	4.31	6.30	6.20	6.30
Childcare Worker	2.00	1.00	1.00	2.00
Dietician	0.80	1.70	1.20	1.70
Physiotherapy	0.00	0.00	0.30	0.00
Other Therapist	0.00	0.00	0.00	0.00
Administrative Support staff	7.60	7.75	7.75	6.50
Non-Nursing Care Assistant/Multi Task Attendant	7.50	9.00	9.00	11.00
Non-Nursing Chef (Household)	1.00	1.00	1.00	1.00
Non-Nursing Catering Assistant	4.19	2.50	5.19	5.69
Non-Nursing Driver/Porter	2.00	2.00	2.00	4.00
Teaching Staff	7.00	4.00	10.00	11.30
Teaching Support Staff	2.00	2.00	2.00	3.60
Other Staff	0.40	0.00	2.00	2.40
Total	165.93	172.55	183.35	199.30

Staffing of CAMHS Community Mental Health Teams

In Ireland, 25% of the population is under 18 years of age and in December 2016 there was a total of 643.5 staff in the Child and Adolescent Community Mental Health Teams nationally (555.87 Clinical). This represents 53.1% of the clinical staffing levels recommended in A Vision for Change which is an increase of 3% nationally on the 2015 position. The largest increase was in CHO 9 at 13.5%

In the period from 2011 to 2016, arising from the Programme for Government investment in CAMHS services from 2012, staffing in the community CAMHS teams had a net gain of 179.26 whole time equivalents over this period, exclusive of staff leaving and retiring etc.

Community CAMHS Teams Staffing vs. VFC recommendations in 2015 – 2016

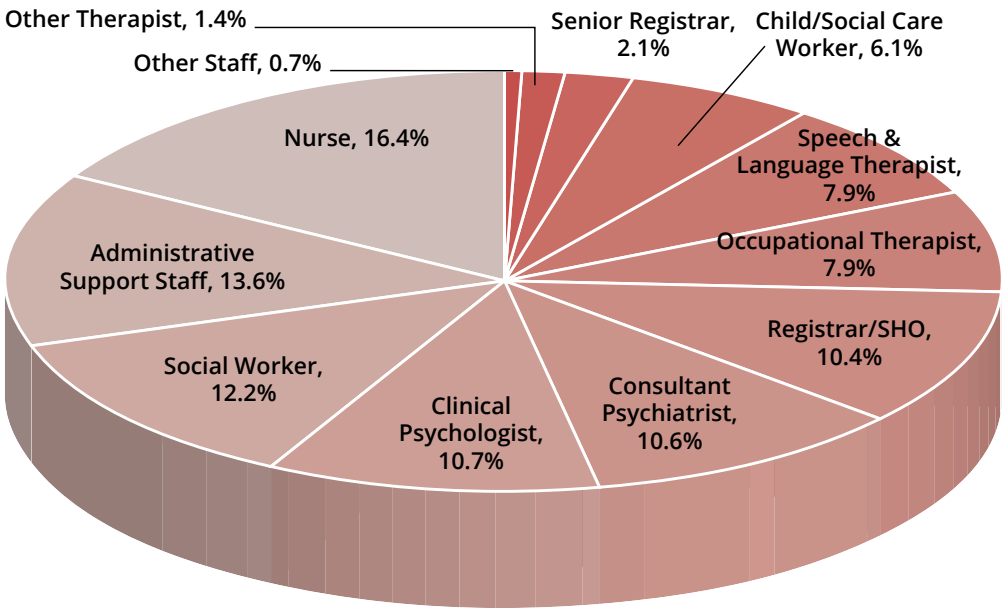


	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	49.5%	53.9%	54.3%	48.7%	45.4%	48.3%	46.8%	56.9%	44.7%	49.8%
2016	54.4%	61.0%	56.7%	50.7%	41.9%	52.6%	44.8%	58.8%	58.2%	53.1%

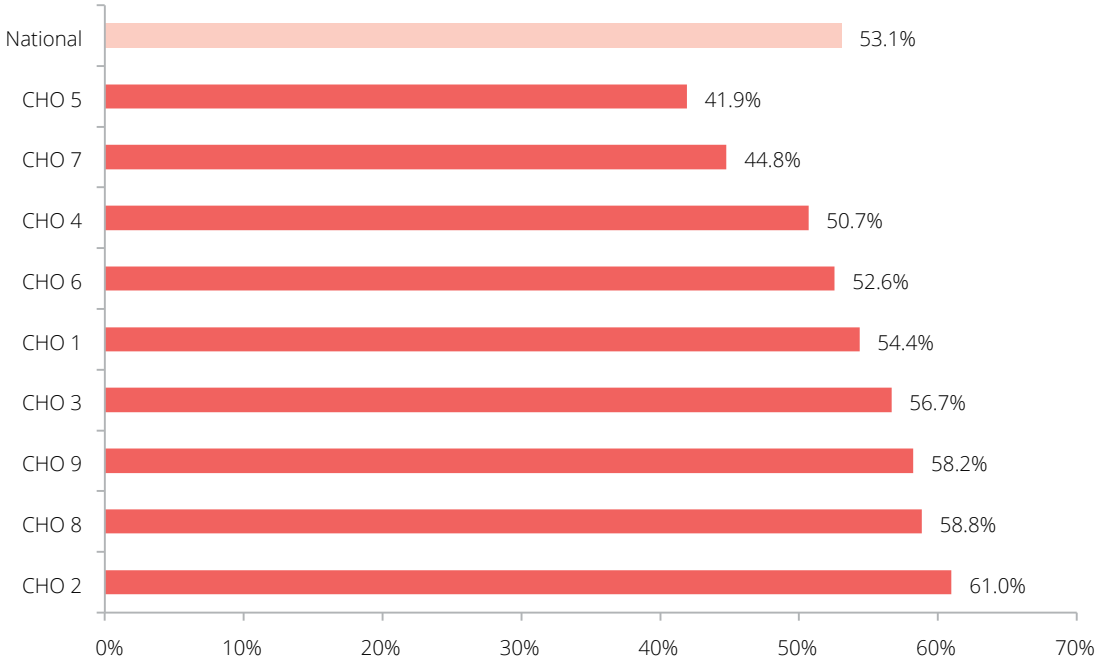
In December 2016, there was 643.5 staff (clinical 555.87) working in 66 Community CAMHS teams, with an average of 9.75 staff, 8.35 of which were clinical staff. The range of team size varies from the smallest team of 4.96 (3.76 clinical) to the largest which comprises of 22.23 (19.83 clinical). The variation in team size can arise due to team development or population size etc.

	2011	2012	2013	2014	2015	2016	Change +/-
Consultant Psychiatrist	57.69	60.44	60.37	65.39	**64.15**	**68.2**	**10.53**
Senior Registrar	19.8	20.6	10.4	13.30	**10.70**	**13.2**	**-6.58**
Registrar/SHO	43.49	45.2	47.03	48.58	**59.52**	**67.0**	**23.50**
Social Worker	68.01	67.29	72.09	76.47	**77.60**	**78.5**	**10.53**
Clinical Psychologist	57.78	57.78	55.75	61.61	**66.54**	**68.8**	**11.03**
Nurse	61.33	59.64	68.77	88.37	**98.27**	**105.4**	**44.08**
Occupational Therapist	26.7	25.72	50.53	47.99	**52.19**	**50.9**	**24.22**
Speech & Language Therapist	29.22	29.72	46.14	51.61	**42.61**	**50.6**	**21.35**
Child/Social Care Worker	15.74	12.74	33.54	41.35	**41.13**	**39.5**	**23.73**
Other Therapist/Staff	9	6.45	6.6	5.70	**8.70**	**13.7**	**4.72**
Administrative Support Staff	75.48	76.36	80.54	79.83	**82.54**	**87.6**	**12.15**
Total	464.24	461.94	531.76	580.20	**603.95**	**643.50**	**179.26**

Staffing of Child and Adolescent Inpatient Units by profession 2013-2016



Community CAMHS Teams Staffing vs. VFC recommendation by Community Healthcare Organisations 2016



Staffing of CAMHS Day Services and CAMHS Liaison Teams

Each of the three Dublin paediatric hospitals have a liaison team and the total number of staff on these teams is 31.63 (clinical 26.13)

There are three adolescent day services in Dublin and one in Galway with a total staff of 26.43 (clinical 22.85).

1. Dunfillan Young Person's Unit is located at the St. John of God Lucena clinic in Rathgar,
2. St. Joseph's Adolescent and Family Service at St. Vincent's Hospital, Fairview,
3. Linn Dara Adolescent Day Programme at CAMHS facility in Ballyfermot and the
4. Merlin Park Adolescent Day Programme is located in Galway.

Staffing of Day Services and Liaison Teams

Dec-16	Day Service	Paediatric Hospital Liaison	Total
Medical	4.45	9.93	14.38
Nursing	11.70	5.30	17.00
Health Care Professional	6.60	10.90	17.50
Support Staff	3.68	5.50	9.18
Total	26.43	31.63	58.06

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 2016. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 1,706.77

Vision for Change recommendations – actual staffing (2016)

Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2016
Staff Community MHTs	1 : 50,000	95	114	2,185	1,706

Community GAMHT staffing compared against Vision for Change recommendations

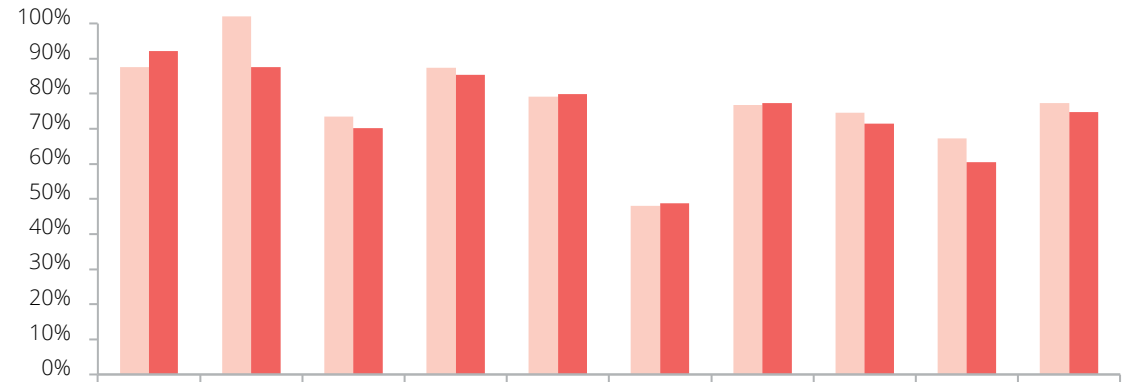
Vision for Change (2006) recommends that there should be one General Adult Community Mental Health Team for each sector of 50,000 population with individual General Adult Community Mental Health Team comprising of the following:

- 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 2016 there was a total of 1,706.76 staff in situ (1,495.27 Clinical), which represents 77.9% (74.8% clinical) of the staffing levels recommended in a Vision for Change.

Community GAMHS Teams Staffing vs. VFC recommendations for 2015 - 2016



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	87.5%	102.1%	73.6%	87.3%	79.1%	48.1%	76.8%	74.6%	67.2%	77.4%
2016	92.1%	87.5%	70.1%	85.4%	79.9%	48.8%	77.3%	71.5%	60.4%	74.8%

In 2016 the staffing level as recommended in a Vision for Change had decreased by 2.6% nationally on the 2015 position. The largest decrease was in the CHO 2 which was 14.6%

Community General Adult Mental Health teams

In the period from December 2015 to December 2016, the clinical staff of the Community General Adult Mental Health Teams decreased by 51.63. Decreases in staffing numbers can occur due to staff retiring and or changing role and the posts can remain unfilled due to various factors including shortage of qualified applications etc.

Community General Adult Mental Health Teams (2015 to 2016)

	Clinical Staff 2016	Clinical Staff 2015	Change +/-
CHO 1	152.58	145.00	7.57
CHO 2	166.52	194.26	-27.74
CHO 3	113.37	118.98	-5.61
CHO 4	247.75	253.28	-5.53
CHO 5	171.25	169.52	1.73
CHO 6	91.42	90.02	1.40
CHO 7	209.5	208.20	1.30
CHO 8	185.18	193.10	-7.92
CHO 9	157.7	175.43	-17.73
Total Clinical	1,495.27	1,547.79	-52.53
Admin/support	211.49	210.59	0.90
Total Staff	1,706.76	1,758.38	-51.63

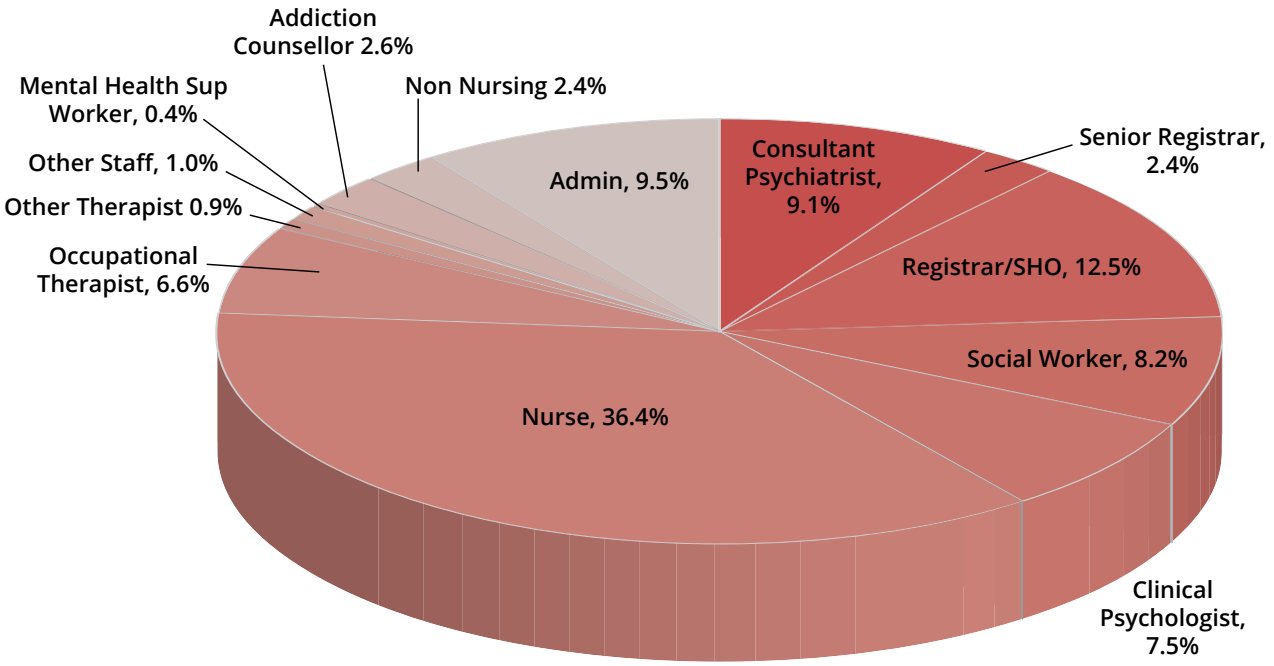
In December 2016 there was 1,706.76 staff (clinical 1,495.27) working in 114 Community General Adult Mental Health teams, with an average of 14.97 staff per team, of which 13.12 were clinical staff.

The General Adult Community Mental Health Teams as shown in the table below, had a net gain of 71.80 whole time equivalents over the period 2013 to 2016, exclusive of staff leaving and retiring etc.

Community GAMH Teams Staffing by discipline 2013 to 2016

	2013	2014	2015	2016	Change +/-
Consultant Psychiatrist	157.34	157.92	159.97	155.64	-1.70
Senior Registrar	35.40	35.30	30.43	41.23	5.83
Registrar/SHO	203.60	208.31	217.60	212.6	9.00
Social Worker	138.11	132.99	148.73	139.18	1.07
Clinical Psychologist	110.72	126.26	132.39	128.75	18.03
Nurse	604.21	613.13	648.92	621.58	17.37
Occupational Therapist	116.05	123.76	124.48	112.55	-3.50
Other Therapist e.g. SLT Creative/Recreational	12.98	14.58	15.92	14.69	1.71
Other Staff	14.28	17.78	16.33	16.43	2.15
Mental Health Support Worker	15.30	17.00	7.00	9	-6.30
Addiction Counsellor	48.58	46.00	46.02	43.62	-4.96
Non Nursing	32.32	35.61	43.80	40.5	8.18
Administrative Support Staff	146.08	159.71	166.79	170.99	24.91
Total	1,634.97	1,688.35	1,758.38	1706.76	71.79

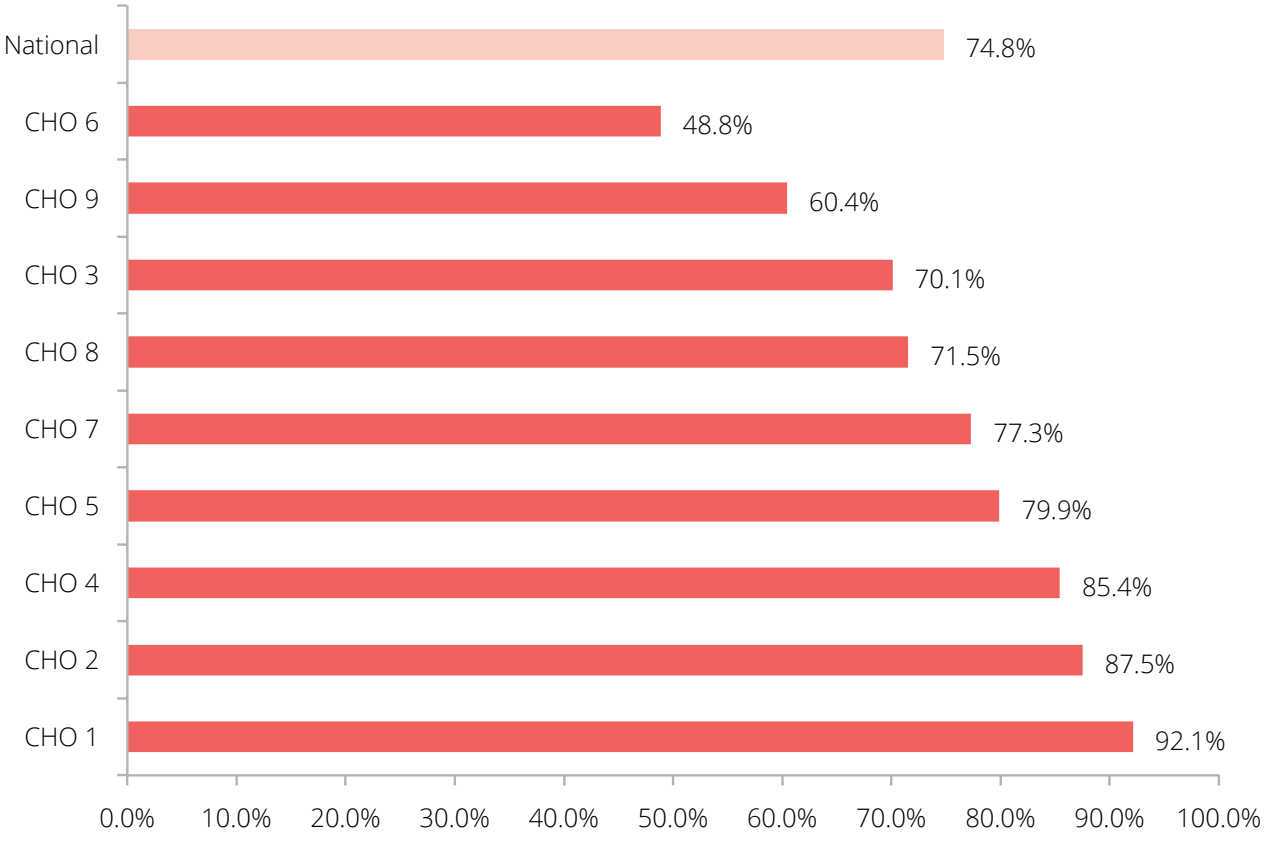
Community GAMHT work force by profession (2016)



Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2015-2016

	Population Census 2016	Clinical Staff 2016	% of VFC rec 2016	Clinical Staff 2015	% of VFC rec 2015
CHO 1	394,333	152.58	92.1%	145.00	87.5%
CHO 2	453,109	166.52	87.5%	194.26	102.1%
CHO 3	384,998	113.37	70.1%	118.98	73.6%
CHO 4	690,575	247.75	85.4%	253.28	87.3%
CHO 5	510,333	171.25	79.9%	169.52	79.1%
CHO 6	445,590	91.42	48.8%	90.02	48.1%
CHO 7	645,293	209.5	77.3%	208.20	76.8%
CHO 8	616,229	185.18	71.5%	193.10	74.6%
CHO 9	621,405	157.7	60.4%	175.43	67.2%
National	4,761,865	1,495.27	74.8%	1,547.79	77.4%

Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2015-2016



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 2016. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 324.70

Vision for Change recommendations – actual staffing (2016)

Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2016
Staff POA service	1 : 100,000*	48	29	571	324.70

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

Currently there are 29 POA community teams (December 2016) with a number of teams in development which have been resourced from the Programme for Government investments in recent years. The plan is to move to full resourcing of POA services which will ensure national coverage.

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

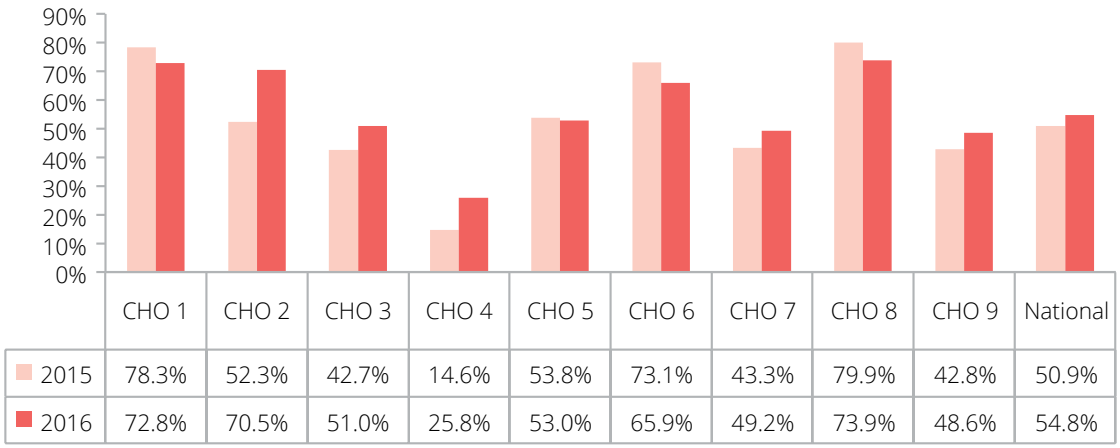
A Vision for Change (2006) recommends that there should be one Psychiatry of Old Age Service team for each sector of 100,000 population. The staff complement for a Psychiatry of Old Age team is 12 per 100,000 head of population, (11 clinical and 1 administrative support staff) and is comprised of:

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

The composition of each Psychiatry of 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 2016, there were 321.70 staff (clinical 286.90) working in 29 Psychiatry of Old Age Service teams, with an average of 11.09 staff (of which 9.89 were clinical staff) per team. This represents 56.9% (54.8% clinical) of the staffing level as recommended in a Vision for Change.

Community POA Team Staffing vs. VFC recommendations in 2015 - 2016



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	78.3%	52.3%	42.7%	14.6%	53.8%	73.1%	43.3%	79.9%	42.8%	50.9%
2016	72.8%	70.5%	51.0%	25.8%	53.0%	65.9%	49.2%	73.9%	48.6%	54.8%

In 2016 the staffing level as recommended in a Vision for Change had increased by 3.9% nationally on the 2015 position. The largest increase was in the CHO 2 which saw an increase of 18.2%

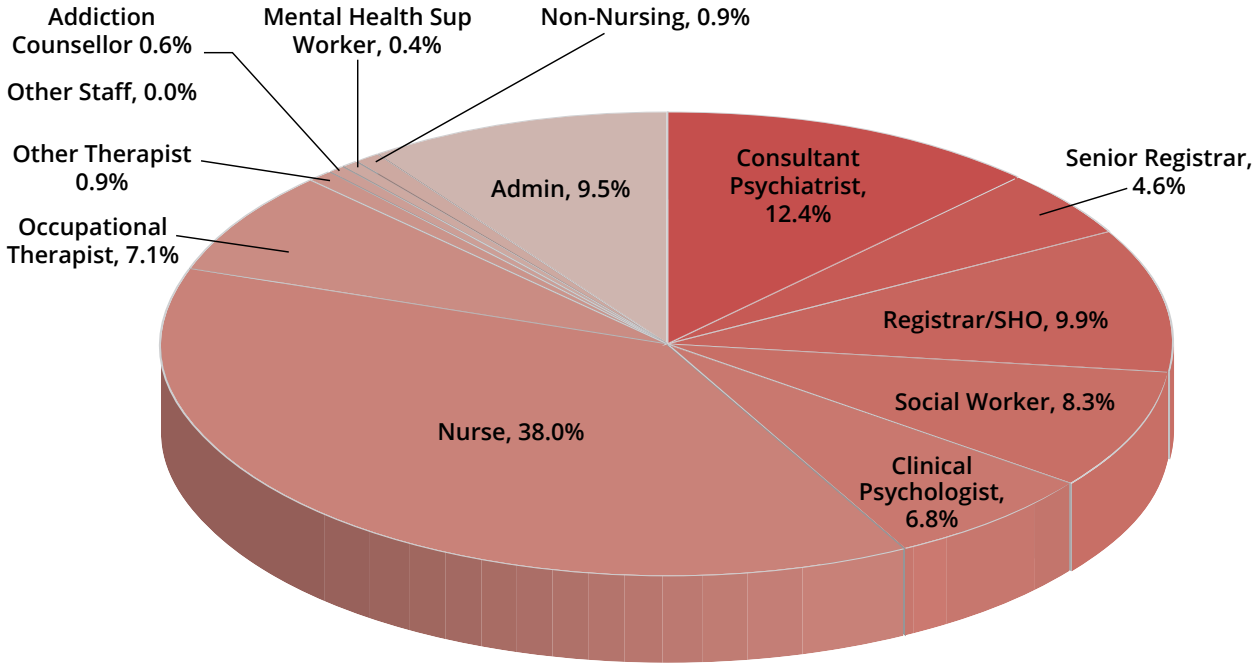
Psychiatry of Old Age Service Teams

The staffing of Psychiatry of Old Age Service increased by 20.68 WTE's in the period from December 2015 to December 2016. In the period from 2013 to 2016, Community Psychiatry of Old Age Service had a net gain of 66.91 whole time equivalents over this period, exclusive of staff leaving and retiring etc.

Psychiatry of Old Age Service Teams (2015 to 2016)

	Clinical Staff 2016	Clinical Staff 2015	Change +/- 2015/2016
CHO 1	35.90	38.60	-2.70
CHO 2	39.70	29.42	10.28
CHO 3	23.40	19.60	3.80
CHO 4	20.90	11.88	9.02
CHO 5	32.40	32.80	-0.40
CHO 6	27.50	30.50	-3.00
CHO 7	33.50	29.50	4.00
CHO 8	45.00	48.72	-3.72
CHO 9	28.60	25.20	3.40
Total Clinical	286.90	266.22	20.68
Admin/support	37.8	36.32	1.48
Total	324.70	302.54	22.16

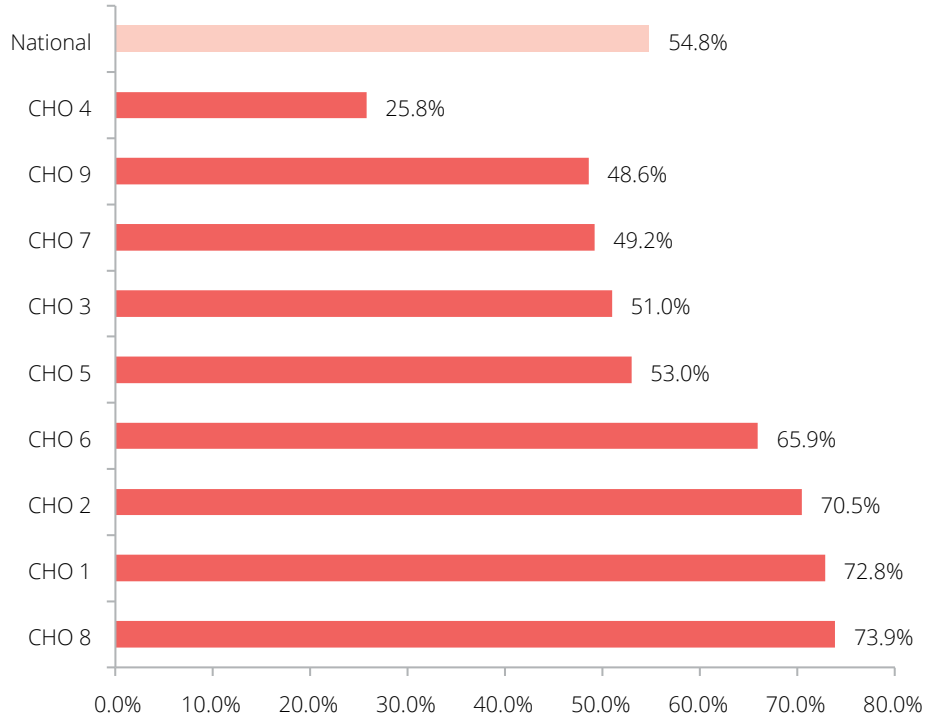
Psychiatry of Old Age Service Workforce by profession (2016)



Psychiatry of Old Age Service Staffing by discipline 2013 to 2016

	2013	2014	2015	2016	Change +/-
Consultant Psychiatrist	32.30	36.30	36.95	40.2	7.90
Senior Registrar	10.00	11.00	10.55	15	5.00
Registrar/SHO	27.00	26.00	26.50	32	5.00
Social Worker	16.00	25.00	26.90	26.8	10.80
Clinical Psychologist	10.85	16.50	17.80	22.1	11.25
Nurse	102.12	114.83	119.12	123.3	21.18
Occupational Therapist	20.32	24.22	23.27	23	2.68
Other Therapist e.g. SLT Creative/Recreational	1.20	2.00	1.30	1.6	0.40
Other Staff	1.00	0.88	2.63	1.9	0.90
Mental Health Support Worker	3.00	3.00	1.00	1	-2.00
Addiction Counsellor	0.40	0.40	0.20	0	-0.40
Non Nursing	3.29	6.32	2.91	2.9	-0.39
Administrative Support Staff	30.31	35.24	33.41	34.9	4.59
Total	257.79	301.69	302.54	324.70	66.91

POA Team Staffing vs. VFC recommendation by Community Healthcare Organisations 2016



Chapter 5
Child and Adolescent Mental Health Services

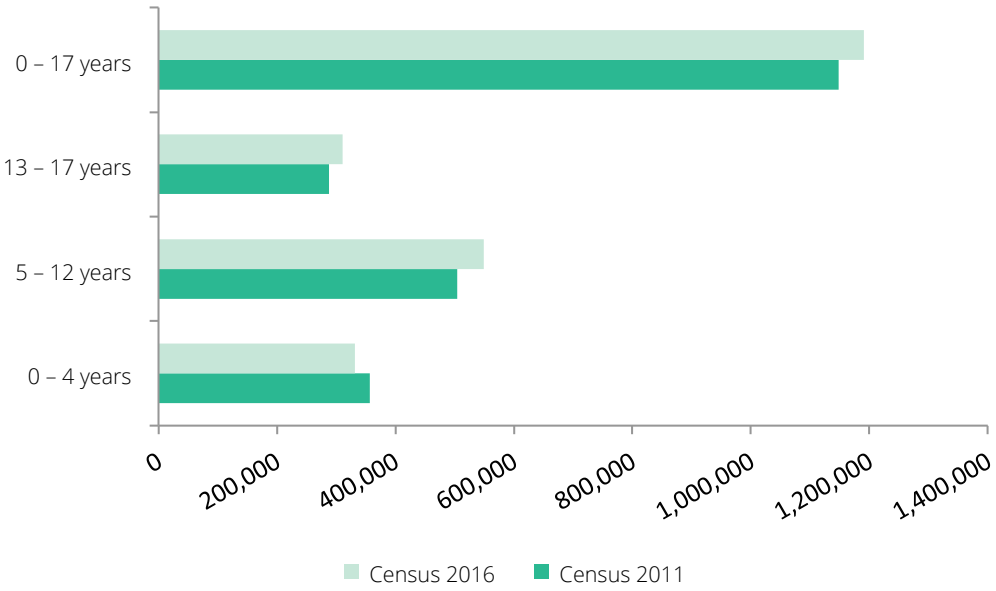
- 2008 - 49 CAMHS teams; 2016 – 66 CAMHS Teams
- 2008 – 351.63 Clinical WTE's; 2016 – 555.87 Clinical WTE's
- 53.1% of the Clinical staffing levels recommended in A Vision for Change
- 26% increase in referrals from 2012 to 2016
- 14,193 new appointments offered in 2016
- 45.2% new appointments seen within 4 weeks
- A quarter of new cases seen are aged over 16 years.
- 12.3% of new patients did not attend their first appointment
- 2007 – 3,609 individuals were waiting to be seen; 2016 – 2,513 individuals were waiting to be seen

Children in the Population

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

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

2016 & 2011 Census by Age



2016–2011 Census by Age

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

The population of pre-school children (aged 0-4 years) of 331,515, showed a decrease of 24.814 (-7%) since 2011. The greatest decrease in pre-school children was in CHO 1 at -10.4%, followed by CHO 8 (-9.3%) and CHO 5 (-9.1%), while the slowest reduction was recorded in CHO 6 (-0.9%). Given the low level of referral of this age range to CAMHS services in general, the impact of this demographic change on CAMHS referral patterns is likely to be minimal.

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

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

2016 Census by Age 0 – 17 years by CHO Area

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

Prevalence of Childhood Psychiatric Disorders

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

The World Health Organisation (2003) "Caring for children and adolescents with mental disorders: Setting WHO direction" states that: "The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, 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.

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.

- The prevalence of mental disorders in young people is increasing over time.
- 74% of 26 year olds with mental illness were found to have experienced mental illness prior to the age of 18 years and 50% prior to the age of 15 years in a large birth cohort study.
- A range of efficacious psychosocial and pharmacological treatments exists for many mental disorders in children and adolescents.
- The long-term consequences of untreated childhood disorders are costly, in both human and fiscal terms (Mental Health: Report of the US Surgeon General, 2001).

Children Attending CAMHS

The total population under 18 years in the 2016 census was 1,190,502 and in Quarter 3 of 2016 the number of active open cases recorded by CAMHS Community Mental Health Teams was 18,888 or 1.6% of the child population nationally.

Number of children attending CAMHS by year and CHO

	2016		2015		2014	
	Q1	Q3	Q1	Q3	Q1	Q3
CHO 1	1,973	1,842	2,109	1,947	1,870	2,020
CHO 2	2,328	2,291	2,324	2,232	2,108	2,197
CHO 3	2,380	2,366	2,351	2,399	2,238	2,371
CHO 4	2,412	2,447	2,266	2,208	2,174	2,208
CHO 5	1,538	1,562	1,572	1,544	1,390	1,432
CHO 6	3,274	3,150	3,363	2,801	3,094	3,154
CHO 7	1,870	1,955	2,408	2,106	2,609	2,397
CHO 8	1,905	1,814	1,657	1,760	1,301	1,398
CHO 9	1,518	1,461	1,711	1,584	1,725	1,689
National	19,198	18,888	19,761	18,581	18,509	18,866

Percentage of CHO Population under 18 years old attending CAMHS 2016

	<18 years Population	Caseload 2016	Percentage
CHO 1	103,778	1,842	1.8%
CHO 2	111,880	2,291	2.0%
CHO 3	96,266	2,366	2.5%
CHO 4	168,542	2,447	1.5%
CHO 5	131,522	1,562	1.2%
CHO 6	116,264	3,150	2.7%
CHO 7	144,296	1,955	1.4%
CHO 8	172,373	1,814	1.1%
CHO 9	145,581	1,461	1.0%
National	1,190,502	18,888	1.6%

Referral Process and Criteria for Child and Adolescent Mental Health Services

CAMHS Community Mental Health Teams are the first line of specialist mental health services for children and young people who are directly referred to the Community CAMHS team from a number of sources. The Child and Adolescent Mental Health Services Standard Operating Procedure sets out the referrals process as follows:

The referral criteria to Community CAMHS are as follows:

- Children aged up to their 18th Birthday.
- 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 Referring 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 2016, there were 13,499 referrals accepted by the Community Child and Adolescent Mental Health service which is a 1% increase on 2015. In the period from 2012, the number of referrals accepted has increased overall by 26% nationally.

Referrals accepted 2012 - 2016

	2016	2015	+/- Variance 15 vs. 16	2014	+/- Variance 14 vs. 16	2013	+/- Variance 13 vs. 16	2012	+/- Variance 12 vs. 16
CHO 1	957	1,026	-7%	1,005	-5%				
CHO 2	1,049	1,064	-1%	1,035	1%				
CHO 3	1,941	1,813	7%	1,866	4%				
CHO 4	1,566	1,578	-1%	1,539	2%				
CHO 5	1,458	1,502	-3%	1,283	14%				
CHO 6	1,639	1,625	1%	1,670	-2%				
CHO 7	1,688	1,694	0%	1,955	-14%				
CHO 8	2,094	1,881	11%	1,642	28%				
CHO 9	1,107	1,173	-6%	1,067	4%				
National	13,499	13,356	1%	13,062	3%	12,319	10%	10,705	26%

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 12 weeks. All CAMHS Community Mental Health Teams screen the referrals received and those deemed to be urgent are seen as a priority which can impact on seeing individuals within three months.

At the end of December 2016, 1,234 individuals were expected to be seen within three months and a further 1,279 individuals were on the waiting list. This represented an increase of 194 (8%) from the total number of 2,319 waiting at the end of 2015.

In the context of an overall 26% increase in the number of referrals accepted, between 2012 and 2016, the Child and Adolescent Mental Health Service waiting list has increased by 91 cases since 2012, an overall increase of 4%.

At the end of 2016 there were 2,513 cases waiting to be seen. This is an increase of 194 cases on the same period in 2015. Those waiting over 12 months rose by 37 to 218 in 2016. The Mental Health Division set up a CAMHS Waiting List Initiative to focus on reducing waiting lists with a particular focus on those waiting >12 months. The CHOs with individuals waiting over 12 months are taking focused actions to ensure no child is waiting more than 12 months. However these increases are attributed to the challenges presented by the increase in population, increase in referrals, staffing retention and challenges in recruiting.

Length of Wait time by CHO - December 2015 vs. December 2016

	2016						2015					
	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	123	73	72	61	93	422	146	76	69	83	28	402
CHO 2	23	5	3	2	2	35	33	3	0	0	2	38
CHO 3	120	53	50	31	30	284	99	45	61	52	22	279
CHO 4	231	112	110	70	75	598	200	83	75	70	94	522
CHO 5	87	46	11	1	0	145	90	22	13	2	0	127
CHO 6	236	81	48	1	0	366	259	53	51	13	0	376
CHO 7	170	34	6	0	0	210	129	9	3	5	9	155
CHO 8	144	70	40	9	1	264	142	52	21	4	0	219
CHO 9	100	38	19	15	17	189	89	44	28	14	26	201
National	1,234	512	359	190	218	2,513	1,187	387	321	243	181	2,319

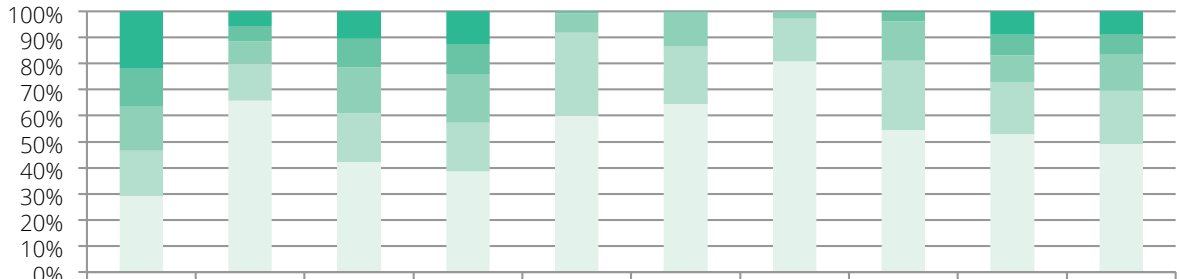
Referrals Accepted Trend vs. Waiting List trend

	Referrals accepted	+/- Trend on previous year	Wait List	+/- Trend on previous year
2011	8,663		1,983	
2012	10,705	24%	2,422	22%
2013	12,319	15%	2,602	7%
2014	13,062	6%	2,869	10%
2015	13,356	2%	2,319	-19%
2016	13,499	1%	2,513	8%
2012 v 2016	2,794	26%	91	4%

Numbers waiting by length of time per CHO in 2016

The numbers waiting to be seen varied by Child and Adolescent Community Mental Health Team and 74% (49) of teams had less than 50 on the waiting list with 92% (61) having waiting lists below 100.

Breakdown of Waiting Lists by CHO Area 2016



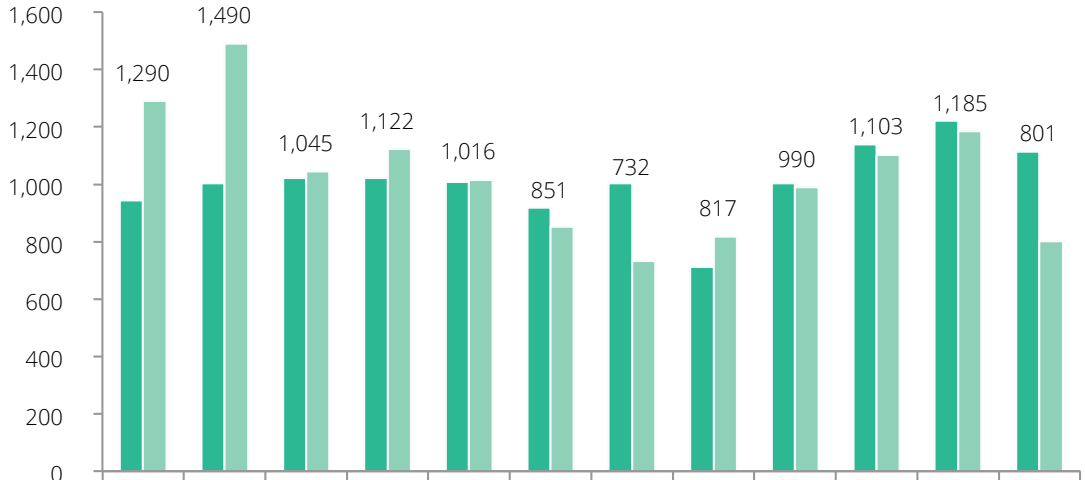
	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
12+ Months	93	2	30	75	0	0	0	1	17	218
9–12 Months	61	2	31	70	1	1	0	9	15	190
6–9 Months	72	3	50	110	11	48	6	40	19	359
3–6 Months	73	5	53	112	46	81	34	70	38	512
0–3 Months	123	23	120	231	87	236	170	144	100	1,234

New (including re-referred) cases seen by Community CAMHS teams in 2016

In 2016, 14,193 new cases were offered an appointment by Community CAMHS Teams compared to 14,036 cases in 2015.

Of these, 12,442 (12,114 in 2015) were seen and 1,751 (1,922 in 2015) did not attend (DNA). This gives slight decrease in the non-attendance rate to 12.3% nationally from 13.7% in 2015.

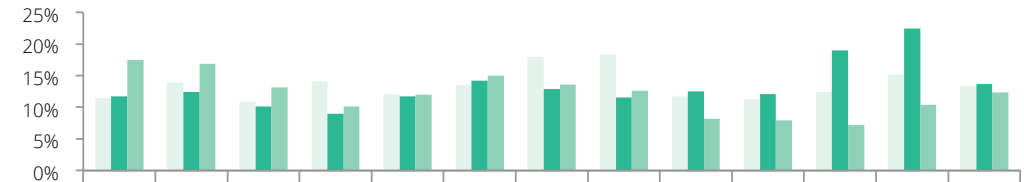
Number of New (including re-referred) cases seen 2016 vs. 2015



	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 – 2016	1,290	1,490	1,045	1,122	1,016	851	732	817	990	1,103	1,185	801

Figure 12 shows the variation by month in the DNA rates, reflecting the seasonal impact on attendance, as the rates range from 17.5 % (January) to 7.2% (November) across 2015. This compares to 22.5 % (December) to 9% (April) in 2015 and 18.4% (August) & 10.8% (March) in 2014.

DNA Rate by month 2016 vs. 2015



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-End
2014	11.4%	13.9%	10.8%	14.1%	12.1%	13.5%	17.9%	18.4%	11.7%	11.3%	12.5%	15.2%	13.4%
2015	11.7%	12.5%	10.1%	9.0%	11.7%	14.2%	12.9%	11.6%	12.5%	12.1%	19.0%	22.5%	13.7%
2016	17.5%	16.9%	13.1%	10.2%	12.0%	15.0%	13.6%	12.6%	8.2%	7.9%	7.2%	10.4%	12.3%

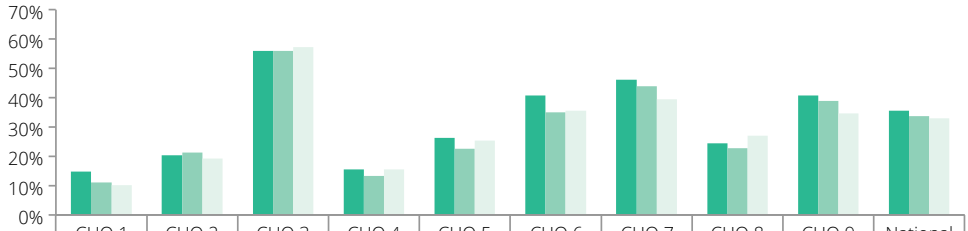
Breakdown of New Cases (New vs. Re-referred Cases)

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

In 2016, of the 12,442 cases seen, a total of 4,417 had been re-referred to the service. In 2015, of the 12,114 cases seen, a total of 4,074 had been re-referred to the service. This reflects an increase in re-referral rate from 33.6% in 2015 to 35.6%.

The proportion of re-referred cases seen in the CHOs over the two years varied from 14.8% in CHO 1 to 56% in CHO 3 (see figures below).

Percentage of Re-referred cases 2016 vs. 2014



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2016	14.8%	20.3%	56.0%	15.6%	26.3%	40.8%	46.0%	24.3%	40.8%	35.5%
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%

Breakdown of new cases (New vs. Re-referred cases) 2016

New and re-referred Cases seen by age profile

In 2016, a total number of 12,442 new and re-referred cases were seen by Community CAMHS teams. Of these, 75% (9,333) were under 16 years of age and 25% (3,109) were over 16 years of age.

In 2015 a total number of 12,114 new and re-referred cases were seen by Community CAMHS teams.

Of these, 78% (9,502) were under 16 years of age and 22% (2,612) were over 16 years of age.

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

Number of new (including re-referred) cases seen aged 16 years and over 2016

2016	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	817	177	21.7%
CHO 2	989	272	27.5%
CHO 3	2,731	601	22.0%
CHO 4	1,176	258	21.9%
CHO 5	1,169	380	32.5%
CHO 6	1,813	481	26.5%
CHO 7	1,349	256	19.0%
CHO 8	1,614	500	31.0%
CHO 9	784	184	23.5%
National	12,442	3,109	25.0%

Number of new (including re-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%

Timeliness of access to CAMHS Community Mental Health Teams

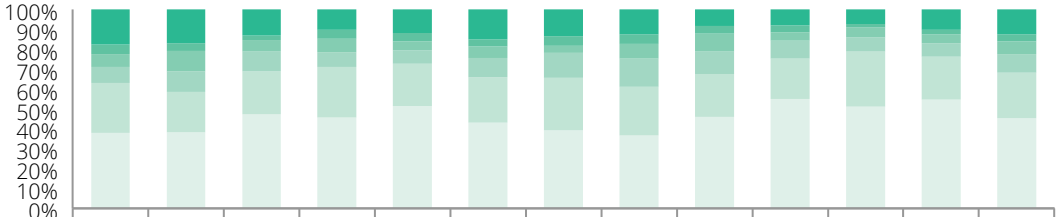
In 2016, a total of 14,193 individuals were offered an appointment of which 12,442 new cases were seen by Community CAMHS teams.

The expectation is that the CAMHS Community Mental Health Teams will offer an appointment and see an individual within three months. In 2016, 68% of new cases were seen within three months and of these, 45% were seen within one month.

The breakdown is as follows:-

- 45.2% of new cases were seen within 1 month of referral.
- 68.4% seen within 3 months.
- 9.3% of new cases had waited between 3 to 6 months.
- 6.3% had waited between 6 and 12 months.
- 3.7% had waited more than 1 year.
- 12.3% did not attend their appointment.

Timeframe for 1st appointment to be seen in 2016



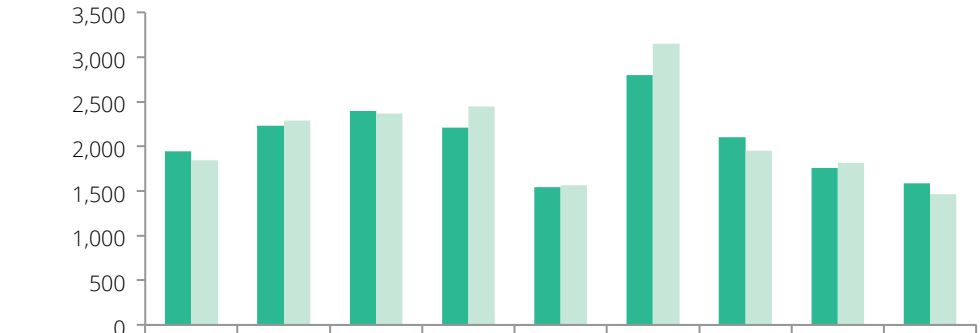
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DNA	17.5%	16.9%	13.1%	10.2%	12.0%	15.0%	13.6%	12.6%	8.2%	7.9%	7.2%	10.4%	12.3%
>12 Mth	4.9%	3.9%	2.3%	4.6%	4.0%	3.5%	4.8%	4.8%	4.1%	3.6%	1.9%	2.1%	3.7%
6–12 Mth	6.5%	10.3%	5.7%	6.6%	4.6%	5.8%	3.4%	7.2%	9.0%	4.1%	5.0%	4.6%	6.3%
3 – 6 Mth	8.0%	10.4%	9.8%	7.5%	6.8%	9.9%	12.5%	14.3%	11.1%	9.2%	7.0%	6.6%	9.3%
1 – 3 Mth	25.2%	20.3%	21.8%	25.3%	21.1%	22.8%	26.6%	24.3%	21.7%	20.4%	27.6%	21.6%	23.1%
<1 Month	37.9%	38.2%	47.2%	45.8%	51.6%	43.1%	39.1%	36.8%	45.9%	54.8%	51.3%	54.7%	45.2%

Timeframe for 1st appointment by CHO

	Length of wait to 1st appointment by CHO					
	<1 Month	1 -3 months	3-6 months	6-12 months	>12 months	DNA
CHO 1	42.3%	17.7%	9.9%	13.2%	12.1%	4.9%
CHO 2	86.3%	5.9%	1.4%	0.5%	0.0%	5.9%
CHO 3	57.3%	26.0%	5.3%	3.3%	5.3%	2.7%
CHO 4	34.3%	22.8%	11.6%	7.8%	11.0%	12.5%
CHO 5	44.1%	24.8%	13.0%	4.9%	0.1%	13.0%
CHO 6	34.3%	26.9%	10.5%	9.8%	0.4%	18.1%
CHO 7	30.2%	26.9%	13.0%	6.3%	3.2%	20.4%
CHO 8	47.6%	19.2%	8.7%	6.4%	0.2%	17.9%
CHO 9	29.8%	29.5%	12.8%	7.0%	6.6%	14.3%
National	45.2%	23.2%	9.3%	6.3%	3.7%	12.3%

Community CAMHS Caseload

The number of active open cases in Q3 2016 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 – 2016	1,842	2,291	2,366	2,447	1,562	3,150	1,955	1,814	1,461

Discharge from the CAMHS Community Mental Health Teams

In 2016, 13,284 individuals were discharged by Community CAMHS Teams compared to 12,955 cases in 2015.

88.8% (87.3% in 2015) of the individuals were discharged to the care of the General Practitioner or Primary Care Team (PCT), 5.1% (6.5% in 2015) to a Community Based Service, 3.1% (3.6% in 2014) to another CAMHS service, and 3% (2.6% in 2015) to an Adult Mental Health Service.

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

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service
CHO 1	90.4%	5.5%	2.1%	2.0%
CHO 2	93.8%	2.1%	1.3%	2.7%
CHO 3	90.3%	3.1%	2.2%	4.5%
CHO 4	88.8%	2.4%	3.0%	5.8%
CHO 5	84.7%	7.9%	4.3%	3.0%
CHO 6	93.2%	1.7%	3.1%	2.1%
CHO 7	84.1%	8.3%	5.5%	2.2%
CHO 8	88.7%	6.1%	2.5%	2.7%
CHO 9	88.6%	6.2%	1.7%	3.6%
National	88.8%	5.1%	3.1%	3.0%

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

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service	Total
CHO 1	833	51	19	18	921
CHO 2	923	21	13	27	984
CHO 3	706	24	17	35	782
CHO 4	1,252	34	42	82	1,410
CHO 5	1,150	107	59	41	1,357
CHO 6	1,982	36	65	44	2,127
CHO 7	1,973	195	128	51	2,347
CHO 8	1,430	98	41	43	1,612
CHO 9	1,545	108	29	62	1,744
National	11,794	674	413	403	13,284

Chapter 6
General Adult Mental Health Services

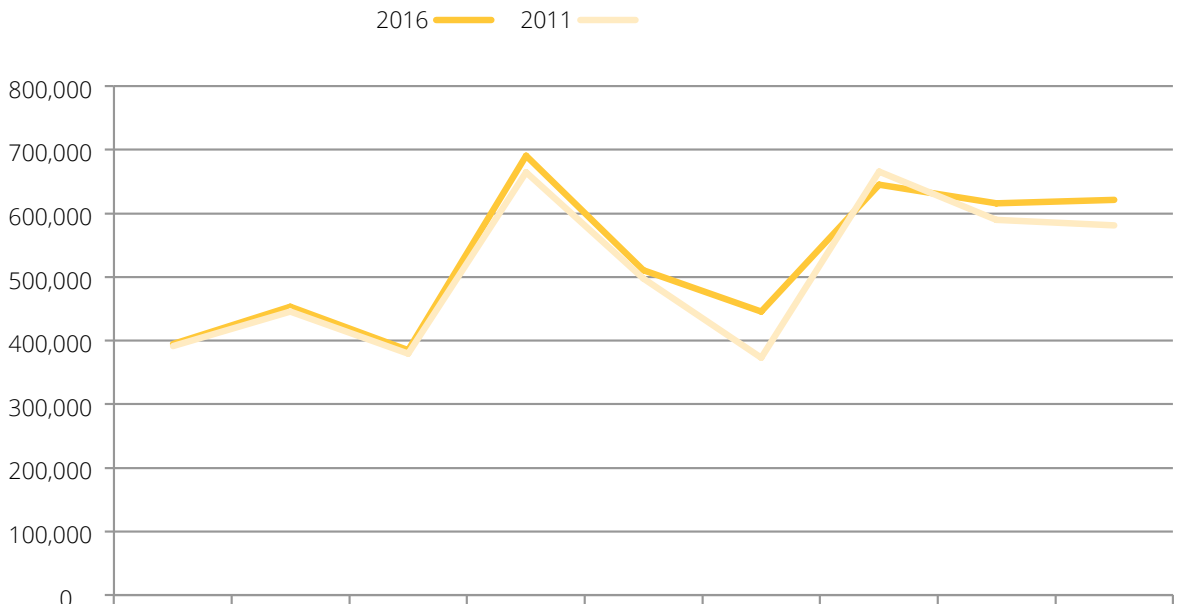
Key Facts

- 114 Community General Adult Mental Health Teams
- 2013 – 1,456.57 Clinical WTE's; 2016 – 1,495.27 Clinical WTE's
- 74.8% of the Clinical staffing levels recommended in a Vision for Change
- 1.1% increase in referrals accepted from 2015 to 2016
- 37,536 new appointments offered in 2016
- 23% new appointments seen within 1 week
- Over one third are seen within 2 weeks & 51.5% seen within 4 weeks
- Over 1 in 5 new patients did not attend their first appointment

Adults in the Population

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

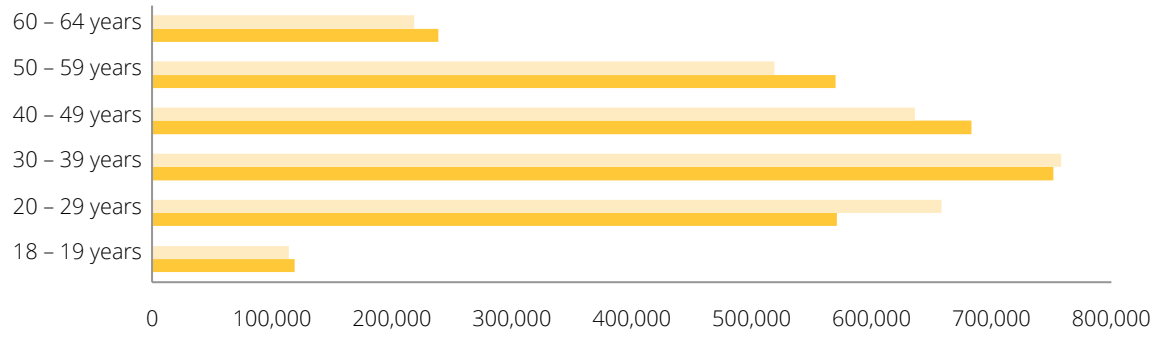
2016 & 2011 Census by CHO*



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2016	394,333	453,109	384,998	690,575	510,333	445,590	645,293	616,229	621,405
2011	391,994	445,356	379,327	664,534	497,578	373,092	665,443	589,442	581,486

**** NB CHO Areas not in place until 2014***

2016 census by Age



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

Access to Community General Adult Mental Health Teams

Referrals

Between 2014 and 2016, there has been a slight increase of 0.3% nationally in the number of referrals accepted by the community general adult mental health service. From 2015 to 2016 there was a 1% increase as outlined in the table below.

Referrals accepted 2014 vs. 2016

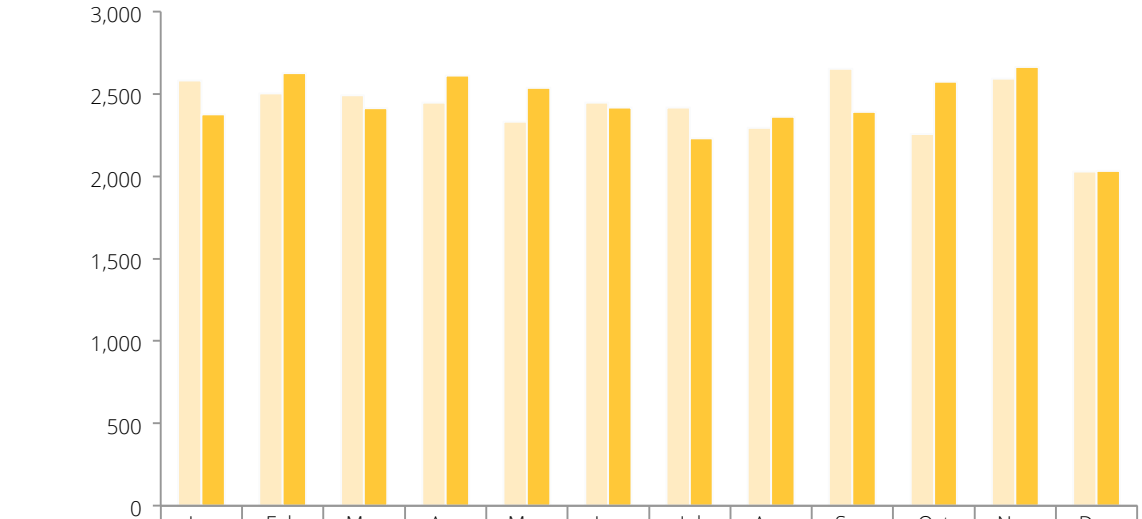
	Referrals Accepted				
	2016	2015	+/- Variance 2015/2016	2014	+/- Variance 2014/2016
CHO 1	3,334	3,264	2.1%	3,889	-16.1%
CHO 2	6,463	6,551	-1.3%	6,537	0.2%
CHO 3	3,701	3,738	-1.0%	3,523	6.1%
CHO 4	6,471	6,202	4.3%	5,906	5.0%
CHO 5	4,078	3,917	4.1%	3,984	-1.7%
CHO 6	2,214	2,240	-1.2%	2,275	-1.5%
CHO 7	4,033	3,745	7.7%	3,967	-5.6%
CHO 8	5,278	5,417	-2.6%	5,118	5.8%
CHO 9	3,591	3,678	-2.4%	3,828	-3.9%
National	39,163	38,752	1.1%	39,027	0.3%

New cases seen by Community General Adult Mental Health Teams 2016

In 2016 a total number of 37,536 new cases were offered an appointment by community general adult mental health teams which compares to 37,091 cases in 2015.

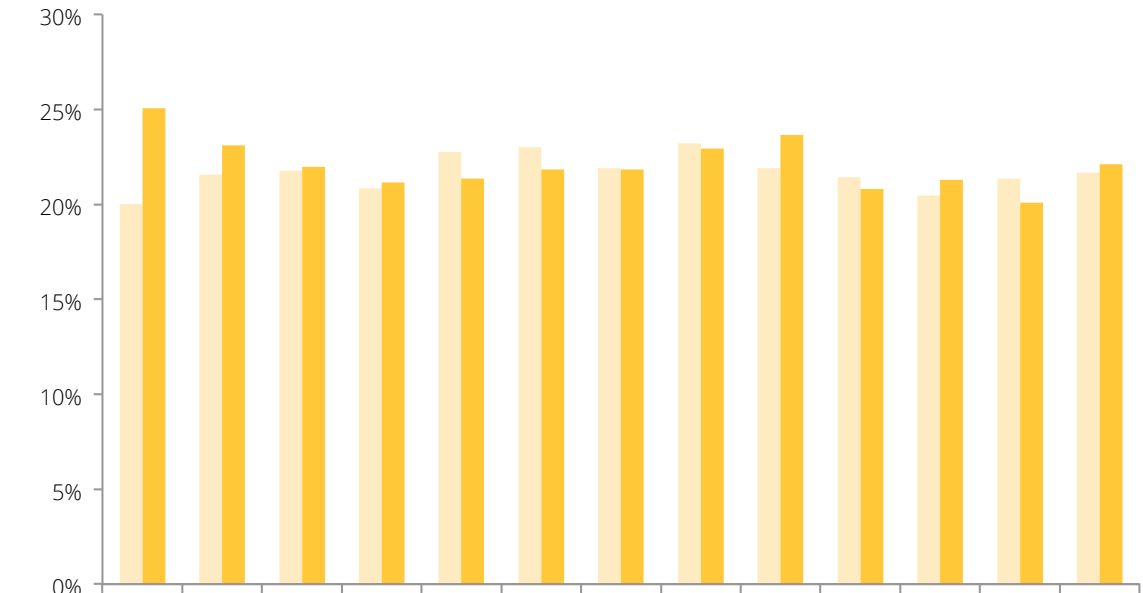
A total of 29,235 (29,048 in 2015) were seen and 8,301 (8,043 in 2015) did not attend (DNA). This gives a non-attendance rate of 22.1% compared with 21.7% in 2015.

New (including re-referred) cases seen and DNAs 2016 vs. 2015



	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 – 2016	2,378	2,625	2,413	2,611	2,537	2,417	2,229	2,363	2,393	2,574	2,663	2,032

DNA Rate 2016 vs. 2015



	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%
2016	25.1%	23.1%	22.0%	21.1%	21.4%	21.8%	21.8%	22.9%	23.6%	20.8%	21.3%	20.1%	22.1%

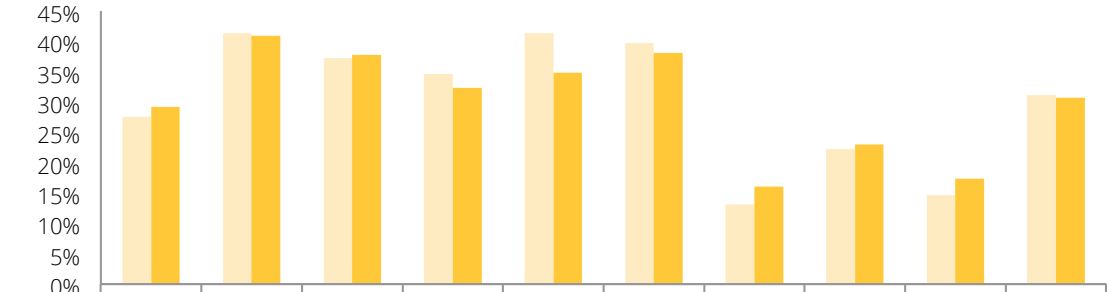
Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen, a proportion will have previously attended the service and been discharged. In 2016 of the 29,235 cases seen, a total of 8,964 had been re-referred to the service. This represents a 30.7% re-referred rate.

In 2015 of the 29,048 cases seen, a total of 9,047 had been re-referred to the service representing a 31.1% re-referred rate.

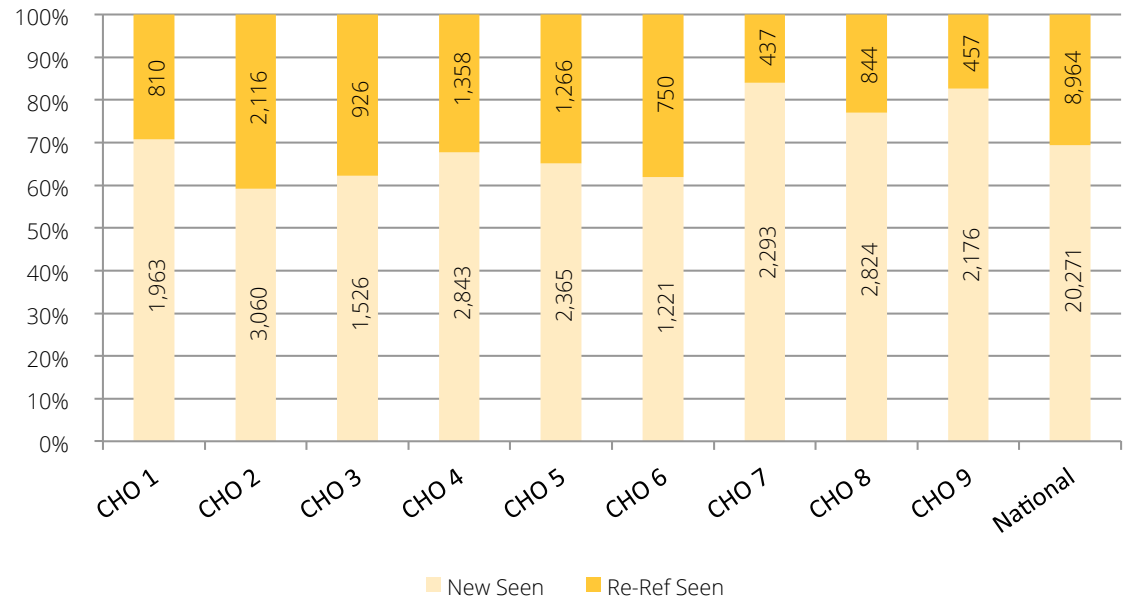
The proportion of re-referred cases in 2016 varied from 16.0% in CHO 7 to 40.9% in CHO 2 (see figures below).

Percentage of Re-referred cases 2016 vs. 2015



	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%
2016	29.2%	40.9%	37.8%	32.3%	34.9%	38.1%	16.0%	23.0%	17.4%	30.7%

Breakdown of New Cases Seen (New vs. Re-referred cases) 2016



New Cases including re-referred seen by age profile

In 2016 a total number of 29,235 new cases were seen by Community General Adult Mental Health Teams. Of these, 0.7% (213) were under 18 years of age and 99.3% (29,022) were over 18 years of age. This compares to 1.1% of cases in 2015.

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

Waiting Times for New Cases Seen

In 2016 a total number of 37,536 were offered an appointment of which 29,235 new cases were seen by Community General Adult Mental Health Teams. The waiting time to be seen was recorded for each case.

Length of wait to 1st appointment by CHO

	Length of wait to 1st appointment offered 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	28.4%	11.6%	10.0%	6.7%	14.8%	5.5%	5.6%	17.4%
CHO 2	38.2%	14.4%	12.7%	10.2%	9.3%	2.8%	0.4%	12.0%
CHO 3	25.1%	12.4%	9.3%	6.1%	12.6%	5.1%	2.1%	27.2%
CHO 4	16.2%	8.4%	6.8%	8.9%	14.8%	7.5%	5.2%	32.2%
CHO 5	24.5%	9.3%	11.2%	10.1%	19.8%	13.1%	4.5%	7.6%
CHO 6	30.6%	15.5%	10.5%	7.7%	13.9%	3.8%	1.2%	16.8%
CHO 7	13.5%	6.5%	8.8%	8.4%	23.1%	13.0%	7.7%	19.0%
CHO 8	15.9%	11.2%	8.4%	9.6%	14.2%	7.3%	3.3%	30.1%
CHO 9	16.2%	8.9%	6.2%	5.5%	14.0%	10.4%	7.6%	31.1%
National	23.0%	10.8%	9.3%	8.4%	14.8%	7.5%	4.1%	22.1%

Cases Closed or Discharged

In 2016 – 24,206 cases were closed and discharged by Community General Adult Mental Health Teams. This compares to 22,837 cases closed in 2015. Of these, 89.1% of the cases closed were discharged to care of the General Practitioner or Primary Care Team (PCT), 3.5% to General Practitioner and other primary / community care services, 4.7% to another Adult Mental Health Service, 1.2% to other services and 1.5% were due to death.

No. of Cases closed and discharged by Community General Adult teams in 2016

	Closed / Discharged to GP/ Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed / Discharged to other Adult Mental Health Service	Closed / Discharged to other Service	Closed due to Death	Total Closed Discharged
CHO 1	2,745	65	297	16	38	3,161
CHO 2	2,066	165	356	26	34	2,647
CHO 3	2,204	26	91	58	51	2,430
CHO 4	3,605	74	151	6	96	3,932
CHO 5	2,157	235	68	161	27	2,648
CHO 6	1,301	210	58	11	32	1,612
CHO 7	2,004	4	25	2	27	2,062
CHO 8	3,191	6	7	0	31	3,235
CHO 9	2,289	58	93	5	34	2,479
National	21,562	843	1,146	285	370	24,206

Chapter 7
Psychiatry of Old Age (POA)
Mental Health Services

Key Facts

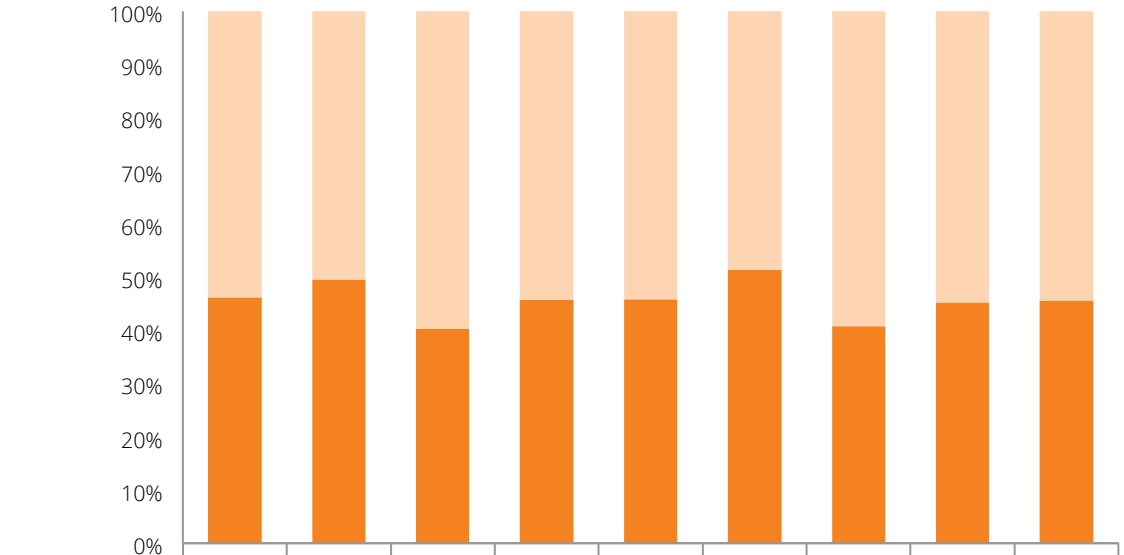
- 2013 – 22 POA teams; 2016 – 29 POA teams
- 2013 – 224.19 Clinical WTE's; 2016 – 286.80 Clinical WTE's
- 54.8% of the Clinical staffing levels recommended in a Vision for Change
- 5.6% increase in referrals received from 2015 to 2016
- 9,012 new appointments offered in 2016
- 39.7% new appointments seen within 1 week
- 85.6% new appointments seen within 4 weeks
- 2.3% new patients did not attend their first appointment

Over 65 year of age population

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

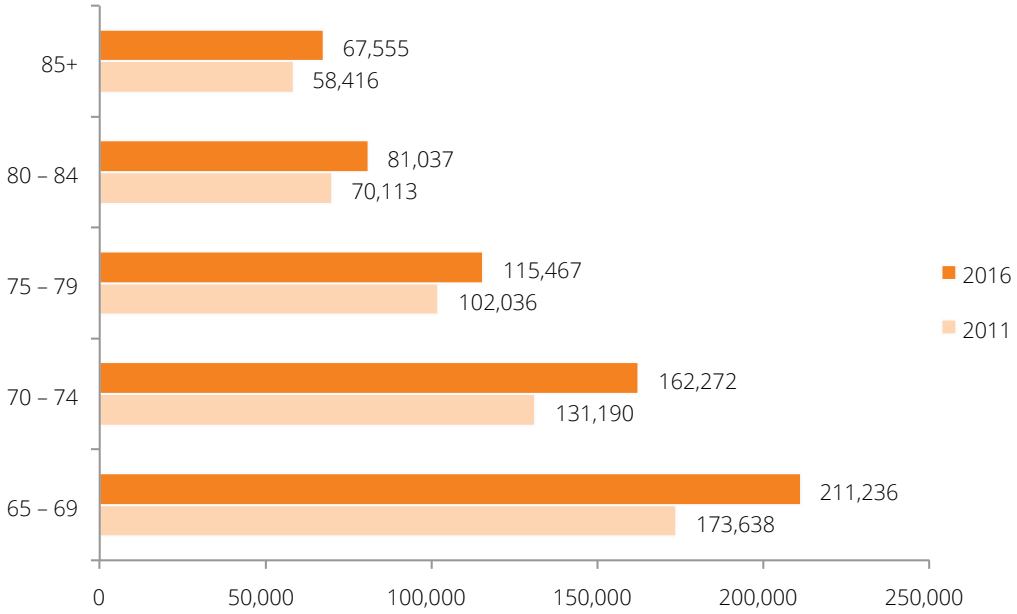
In line with other European countries, the population over 65 years is increasing in Ireland and now forms 13.4% of the total population. From 2011 to 2016 there was a 19% increase in the over 65 year's population. This significant increase in population will result in increased demand for POA services.

2016 & 2011 Census – Number over 65



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
Census 2016	60,063	68,558	55,935	98,877	74,302	50,822	82,991	74,258	71,761
Census 2011	51,546	67,380	37,832	83,368	62,821	53,679	57,109	61,487	60,171

2016 census by Age



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

	> 65 years Population of Ireland		
	Census 2016	Census 2011	+/- Variance
CHO 1	60,063	51,546	17%
CHO 2	68,558	67,380	2%
CHO 3	55,935	37,832	48%
CHO 4	98,877	83,368	19%
CHO 5	74,302	62,821	18%
CHO 6	50,822	53,679	-5%
CHO 7	82,991	57,109	45%
CHO 8	74,258	61,487	21%
CHO 9	71,761	60,171	19%
National	637,567	535,393	19%

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 most common illness with a rate of 10.3% identified in a Dublin community study (Kirby, 1997) with a considerably higher prevalence of 17 - 35% of those in hospital or residential care (Blazer, 2003). The causes are complex and arise from an interaction of biological, psychological and

social factors. Depression is most prevalent in those with functional limitations with causality in both directions. Effective treatment improves both functioning and quality of life (Unutzer, 2002).

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

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

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

Psychiatry of Old Age Services

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

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

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

Psychiatry of Old Age Team - Assessment

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

The rationale for this approach is:

- This service is maximally accessible to older people who may by reason of physical frailty, dementia or hesitation in accepting referral to a mental health service be provided with a service as required.
- Particularly for those with cognitive impairment it enables a baseline assessment of the person i.e. at their best level of cognitive function because they are in familiar surroundings.
- The home assessment also allows the person to be seen in their home environment which is crucial in terms of drawing up an integrated care plan taking into account not just biological but

also social and psychological factors.
- It allows maximal access to any carers involved with the person and again this assists in getting both a complete history and in being made aware of who is available to be active in the care plan.

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

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

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

Access to Psychiatry of Old Age Services

Between 2014 and 2016, there was an increase of 6% nationally in the number of referrals accepted by the Psychiatry of Old Age Service as outlined in the table below.

	2016	2015	+/- Variance 2015/2016	2014	+/- Variance 2014/2016
CHO 1	1,296	1,380	-6.1%	1,494	-13.3%
CHO 2	1,748	1,807	-3.3%	1,375	27.1%
CHO 3	1,021	965	5.8%	989	3.2%
CHO 4	647	339	90.9%	454	42.5%
CHO 5	1,416	1,487	-4.8%	1,439	-1.6%
CHO 6	1,035	1,031	0.4%	957	8.2%
CHO 7	856	839	2.0%	980	-12.7%
CHO 8	1,625	1,523	6.7%	1,514	7.3%
CHO 9	1,181	1,073	10.1%	1,046	12.9%
National	10825	10,444	3.6%	10,248	5.6%

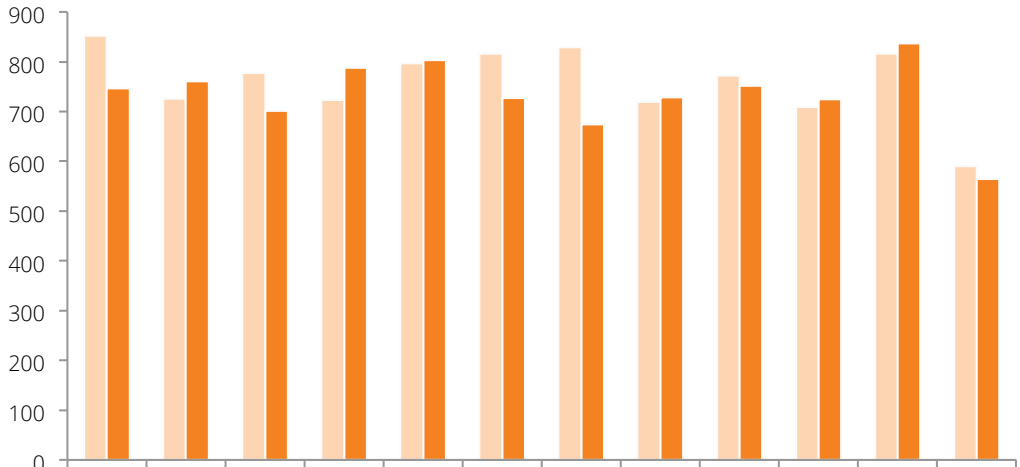
New cases seen by Psychiatry of Old Age Service 2016

In 2016 a total number of 9,012 new cases were offered an appointment by Psychiatry of Old Age Services. This compares to 9,386 cases in 2015.

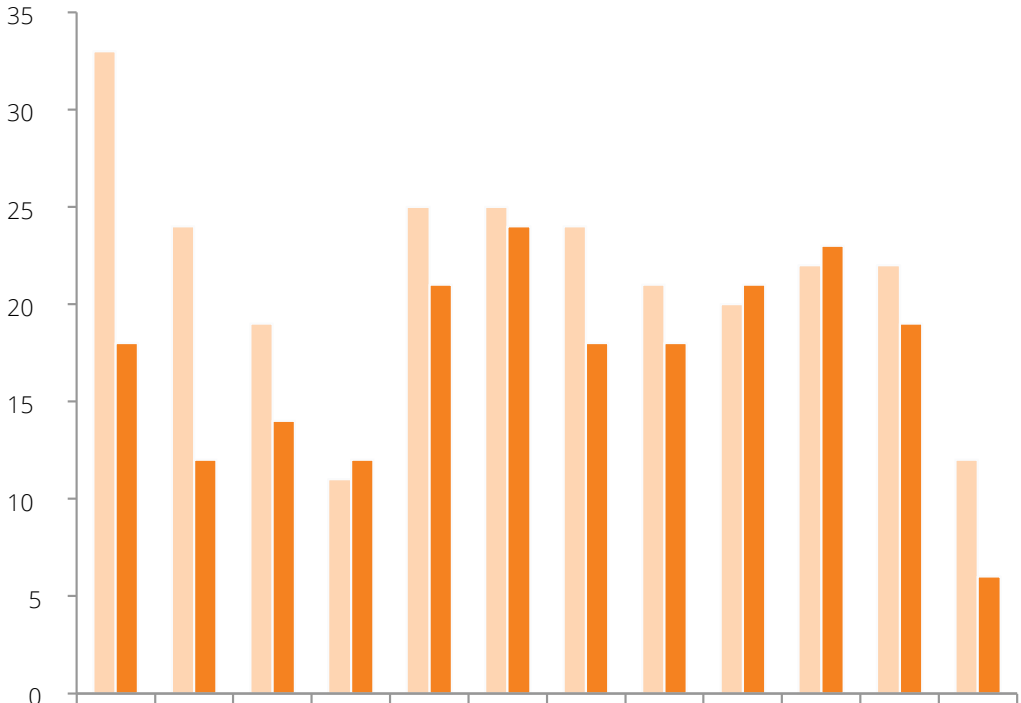
A total of 8,806 (9,128 in 2015) were seen and 206 (258 in 2015) did not attend (DNA).

This gives a non-attendance rate of 2.3%, ranging from 1.1% to 3.2% across the 12 month period. The national DNA rate is impacted by particular challenges experienced by one area over this period, which have been addressed with planned improvement in 2017.

New (including re-referred) Cases Seen 2016 vs. 2015

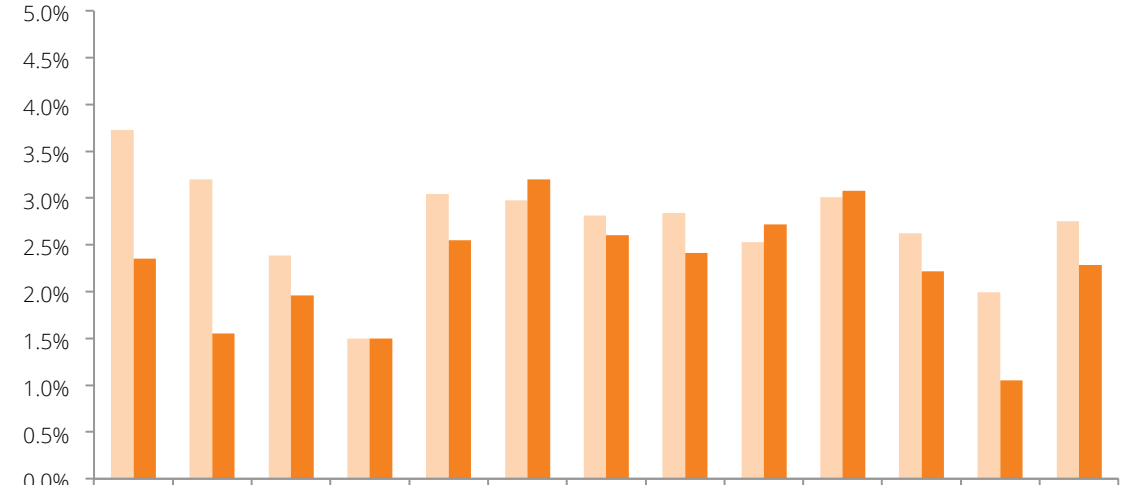


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen – 2015	853	726	778	723	797	816	829	719	772	709	816	590
Seen – 2016	747	761	701	788	803	727	674	728	752	724	837	564



	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 – 2016	18	12	14	12	21	24	18	18	21	23	19	6

New (including re-referred) DNA cases 2016 vs. 2015



	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%
2016	2.4%	1.6%	2.0%	1.5%	2.5%	3.2%	2.6%	2.4%	2.7%	3.1%	2.2%	1.1%	2.3%

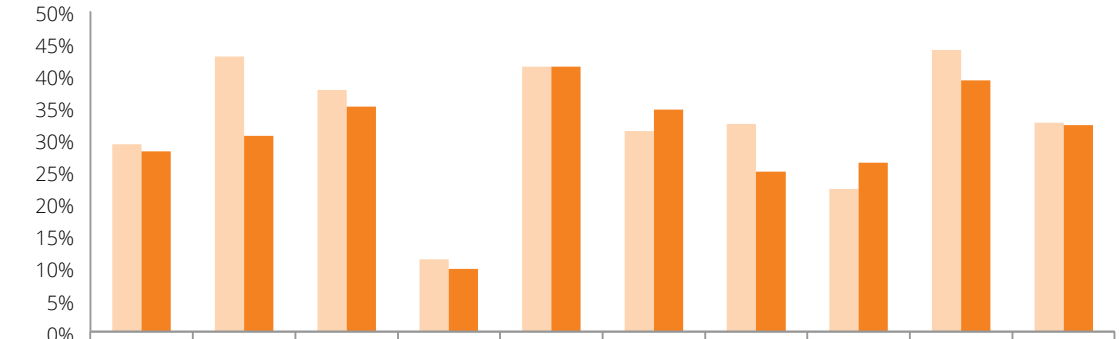
Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen, a proportion will have previously attended the service and been discharged. In 2016 of the 8,806 cases seen a total of 2,835 had been re-referred to the service. This represents a 32.2% re-referred rate.

In 2015 of the 9,128 cases seen, a total of 3,834 had been re-referred to the service representing a 32.6% re-referred rate.

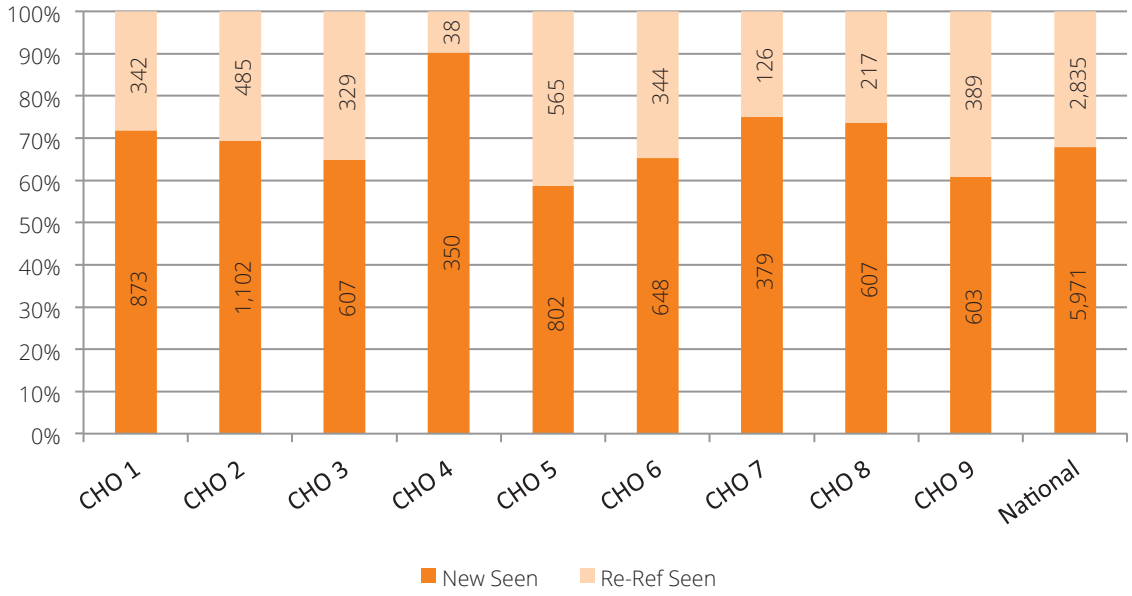
The proportion of re-referred cases varied in 2016 from 9.8% in CHO 4 to 41.3% in CHO 5 (in figure below).

Percentage of re-referred cases 2016 vs. 2015



	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%
2016	28.1%	30.6%	35.1%	9.8%	41.3%	34.7%	25.0%	26.3%	39.2%	32.2%

Breakdown of New Cases Seen (new vs. re-referred cases) 2016



Waiting Times for New Cases Seen

In 2016, a total number of 9,012 patients were offered an appointment, of which 8,806 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:

Length of wait to 1st appointment seen 2016 by CHO

	Length of wait to 1st appointment offered 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	63.5%	15.1%	5.3%	3.4%	6.1%	2.2%	1.4%	3.1%
CHO 2	37.2%	24.9%	17.4%	13.9%	5.4%	0.0%	0.0%	1.2%
CHO 3	52.7%	24.5%	13.5%	8.7%	0.0%	0.0%	0.0%	0.6%
CHO 4	36.4%	15.3%	7.5%	7.3%	10.2%	5.5%	3.8%	14.0%
CHO 5	40.4%	24.6%	16.4%	10.5%	7.1%	0.4%	0.0%	0.6%
CHO 6	27.8%	20.8%	19.2%	11.4%	19.6%	1.3%	0.0%	0.0%
CHO 7	33.0%	25.9%	10.6%	6.1%	18.1%	4.3%	1.2%	0.8%
CHO 8	31.7%	32.6%	11.0%	7.4%	7.3%	2.3%	1.6%	6.2%
CHO 9	24.9%	20.9%	15.7%	10.9%	19.3%	6.2%	0.9%	1.2%
National	39.7%	22.9%	13.6%	9.4%	9.4%	2.0%	0.7%	2.3%

Cases Closed or Discharged

In 2016, 7,012 cases were closed and discharged by Psychiatry of Old Age Service. This compares to 6,883 cases closed in 2015.

88.7% of the cases closed were discharged to the care of the General Practitioner or Primary Care Team (PCT) / Community Care Service and 11.3% due to death.

	Closed / Discharged to GP/Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed due to Death	Total Closed Discharged
CHO 1	848	174	89	1,111
CHO 2	778	179	109	1,066
CHO 3	250	125	73	448
CHO 4	221	10	39	270
CHO 5	997	0	220	1,217
CHO 6	702	0	52	754
CHO 7	218	83	19	320
CHO 8	852	0	142	994
CHO 9	716	58	58	832
National	5,582	629	801	7,012

Percentage of Cases closed and discharged by CHO

	Closed / Discharged to GP/Primary Care Team / community care service	Closed due to Death
CHO 1	92.0%	8.0%
CHO 2	91.2%	8.8%
CHO 3	76.5%	23.5%
CHO 4	100.0%	0.0%
CHO 5	81.8%	18.2%
CHO 6	94.0%	6.0%
CHO 7	96.5%	3.5%
CHO 8	83.7%	16.3%
CHO 9	94.2%	5.8%
National	88.7%	11.3%

Chapter 8
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 - 82% admission to CAMHS inpatient beds
- 10.5% increase in bed days used in 2016
- 97% bed days used in Child Adolescent Acute Inpatient Units as a total of bed days.

In 2007 there were a total of 12 beds available for the admission of children under the age of 18 years. Over the last number of years significant investment in the construction of new age appropriate inpatient facilities has resulted in significant progress being made in achieving the targets set out in A Vision for Change (2006). With regard to the provision of child and adolescent inpatient facilities, 66 CAMHS Acute Inpatient beds were provided at the end December 2016.

HSE inpatient services and bed capacity (2008 to 2016)

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

Transfer from Warrenstown to Interim Linn Dara Unit May 2012
† Partial opening of new unit
‡ 22 plus 2 additional high observation beds

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

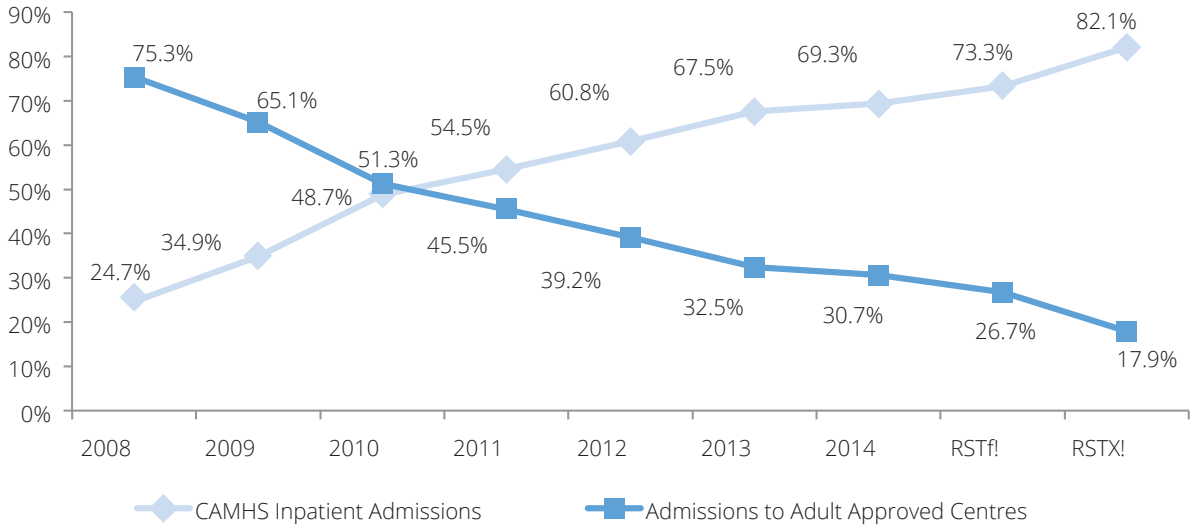
The increase in the availability of age appropriate CAMHS acute inpatient facilities has enabled the CAMHS service to ensure, in so far as possible, that when a child is admitted, that admission is to age appropriate inpatient facilities.

In 2016, there were 380 children and adolescents admitted and of these, 312 (82.1%) were admitted to child and adolescent inpatient units and 68 (17.9%) to adult units. Of these 380 admissions, 97% (368) of these were voluntary admissions with parental consent with a very small number under Section 25 of the Mental Health Act 2001. Of the 68 admitted to Adult Approved Centres, 60 or 88.2% were 16/17 years old with 63.2% (43) of these discharged either the same day or within 3 days and 83.8% (57) within a week.

In 2015, 261 (73.3%) admissions were to child and adolescent inpatient units and 95 (26.7%) to adult units.

Admissions of children to Acute Inpatient Units 2008-2016

Figure below shows the increase in the percentage of admissions of children to age appropriate units in the period from 2008 to 2016.



Number of admissions by Unit/Unit Type

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

† 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 2016, the total number of bed days used by the admission of children was 20,924, an increase of 10.5% (1,988) on the 2015 position of 18,936.

In 2016, 97.4% (20,373) of bed days used were in the age appropriate Child and Adolescent Acute Inpatient Units with 2.6% (551) used in adult approved centres. These figures are comparable with 2015 position of 94.3% (17,858) in CAMHS inpatient and 5.7% (1,078) in adult approved centres.

The following table provides a detailed breakdown of bed usage in CAMHS and adult units by each CHO. In interpreting the data it should be noted that a small number of individuals having an unusually long length of stay can impact the statistics.

Bed Days used by CHO

Bed Days Used	2015					2016				
	Total days Used	CAMHS IP		Adult IP		Total days Used	CAMHS IP		Adult IP	
CHO 1	2,043	1,958	95.8%	85	4.2%	2,427	2,381	98.1%	46	1.9%
CHO 2	2,583	2,582	100.0%	1	0.0%	2,455	2,453	99.9%	2	0.1%
CHO 3	1,920	1,913	99.6%	7	0.4%	2,160	2,139	99.0%	21	1.0%
CHO 4	2,909	2,840	97.6%	69	2.4%	3,351	3,281	97.9%	70	2.1%
CHO 5	2,224	2,040	91.7%	184	8.3%	928	895	96.4%	33	3.6%
CHO 6	1,000	972	97.2%	28	2.8%	2,137	2,135	99.9%	2	0.1%
CHO 7	1,897	1,835	96.7%	62	3.3%	2,514	2,497	99.3%	17	0.7%
CHO 8	1,736	1,256	72.4%	480	27.6%	2,615	2,348	89.8%	267	10.2%
CHO 9	2,624	2,462	93.8%	162	6.2%	2,337	2,244	96.0%	93	4.0%
National	18,936	17,858	94.3%	1,078	5.7%	20,924	20,373	97.4%	551	2.6%

The following table compares the percentage of admissions of children by length of stay in the Adult Approved Centres between 2014, 2015 and 2016.

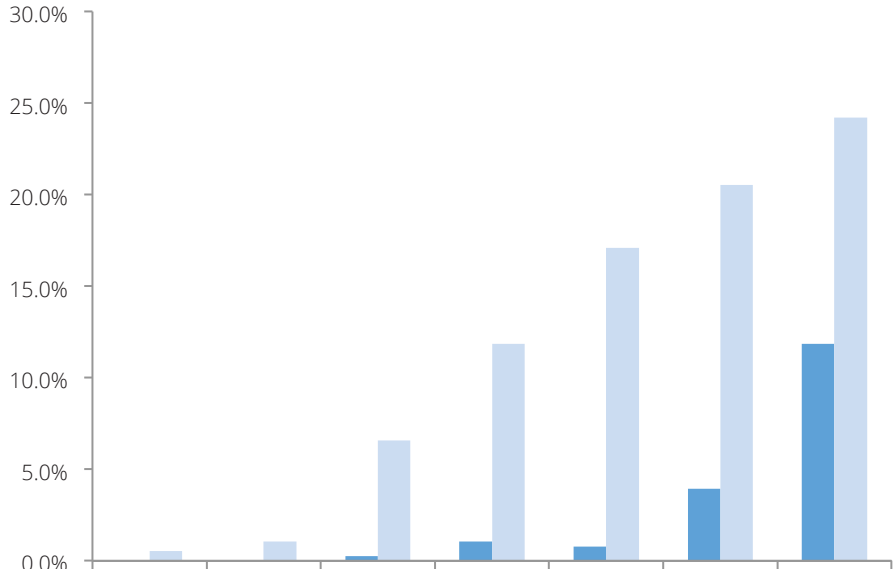
Percentage of admissions by Length of Stay in Adult Approved Centres

	2014	2015	2016
Same day discharged	1.1%	6.3%	14.7%
1-3 days	33.7%	34.7%	48.5%
3-5 days	14.6%	14.7%	13.2%
5-7 days	12.4%	10.5%	7.4%
>7 <=14	21.4%	13.7%	10.3%
2-3 week	6.7%	8.4%	2.9%
3-4 weeks	2.3%	3.2%	0.0%
4-8 weeks	6.7%	6.3%	1.5%
8-12 weeks	0.0%	1.1%	1.5%
12-16 weeks	1.1%	0.0%	0.0%
>16 weeks	0.0%	1.1%	0.0%
Admissions	89	95	68

Age of admissions (2016)

Of the 380 admissions of children and adolescents in 2016, 36.1% were aged 17 years or over on admission, 24.5% were aged 16 years, 17.9% were aged 15 years, 12.9% were aged 14 years, 6.9% were aged 13 years, 1.1% aged 12 years and 0.5% less than 12 years of age .

Age of admissions (2016)



	<12	12	13	14	15	16	17
Adult Units	0.0%	0.0%	0.3%	1.1%	0.8%	3.9%	11.8%
Child & Adolescent Units	0.5%	1.1%	6.6%	11.8%	17.1%	20.5%	24.2%

Planned Development for Child and Adolescent Mental Health Services

New Children's Hospital of Ireland

Construction started at the end of 2016 on the New Children's Hospital which will be developed at the campus of St. James's Hospital in Dublin. The St. James's site ensures that the planned co-location with an adult hospital and, ultimately, tri-location with a maternity hospital, will be delivered. It will accommodate the national specialist eating disorder service with 8 inpatient beds and a 12 bed general inpatient unit. Completion of the new children's hospital is planned for 2021.

New National Forensic Hospital

The new National Forensic Hospital will be built in Portrane, North Co. Dublin. The development will include a 10 bed secure adolescent inpatient unit. Design of the Hospital is well advanced, contractors have been engaged and construction has commenced.

Chapter 9
Adult Acute Inpatient Services

Key Facts

- 29 Acute Inpatients units
- 2007 – 16,293 admissions;- 2016 – 12,590 admissions
- 2007 – 72% re- admission rate;- 2016 – 64% re- admission rate

Mental Health Adult Acute Inpatient Services

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

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

Inpatient psychiatric treatment 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. In 2016 84% of admissions were voluntary admissions.

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

Table 40: 2016 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 - Unit
CHO 4	Cluain Lir Care Centre, Mullingar
Cork University Hospital - Unit	Drogheda Department of Psychiatry, Crosslanes, Drogheda, Co Louth
St Stephen's Hospital, Glanmire	
Kerry General Hospital - Unit	**CHO 9**
Mercy University Hospital - Unit	Mater Hospital - St Aloysius Unit
Bantry General - Unit	Ashlin Centre - Joyce Unit & Sheehan Unit
CHO 5	
St Luke's Hospital Kilkenny - Unit	St Vincent's Hospital Fairview
Waterford General Hospital - Unit	Connolly Hospital - Unit

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

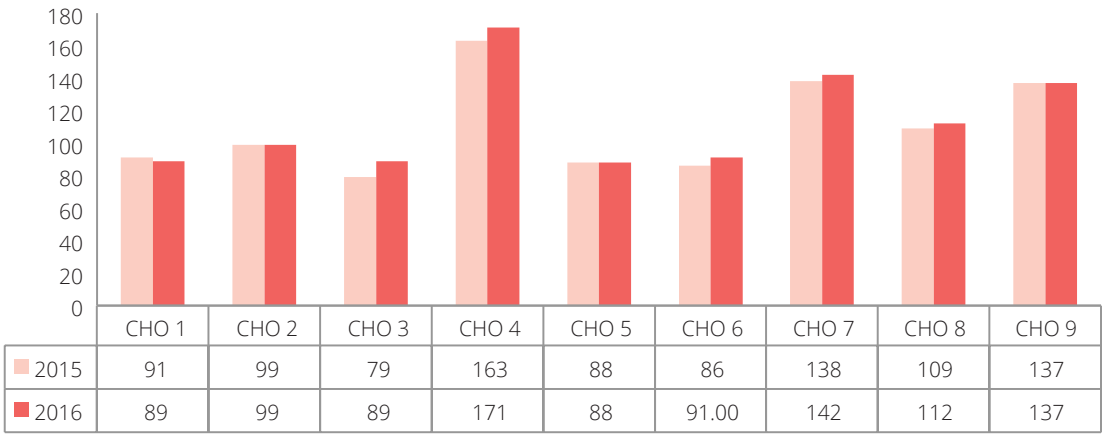
Adult Mental Health Acute inpatient Beds

There are 29 adult acute inpatient units nationally. At the end of 2016, the number of adult acute inpatient places was 972 (990 at the end of 2015) or 21.4 beds per 100,000 population. The information provided below includes General Adult Psychiatry acute admissions and Psychiatry of Old Age acute admissions.

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

	Total Population	Units	Beds	Bed Rate per 100,000		Units	Beds	Bed Rate per 100,000
CHO 1	394,333	3	89	22.6	CHO 1	3	91	23.2
CHO 2	453,109	3	99	21.8	CHO 2	3	99	22.2
CHO 3	384,998	2	89	23.1	CHO 3	2	79	20.8
CHO 4	690,575	5	171	24.8	CHO 4	5	163	24.5
CHO 5	510,333	2	88	17.2	CHO 5	2	88	18.8
CHO 6	549,531	3	91	16.6	CHO 6	3	86	20.1
CHO 7	541,352	3	142	26.2	CHO 7	3	138	21.5
CHO 8	616,229	4	112	18.2	CHO 8	5	109	18.5
CHO 9	621,405	4	137	22.0	CHO 9	4	137	23.6
National	4,761,865	29	1,018	21.4	National	30	990	21.6

Adult Acute Inpatient Beds 2015/2016 by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	91	99	79	163	88	86	138	109	137
2016	89	99	89	171	88	91.00	142	112	137

Vision for Change recommends a separate 8 bed acute Psychiatry of Old Age unit per 300,000 population. Current provision of POA units nationally is shown in the table 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.

Adult Acute Inpatient Units with separate POA Provision

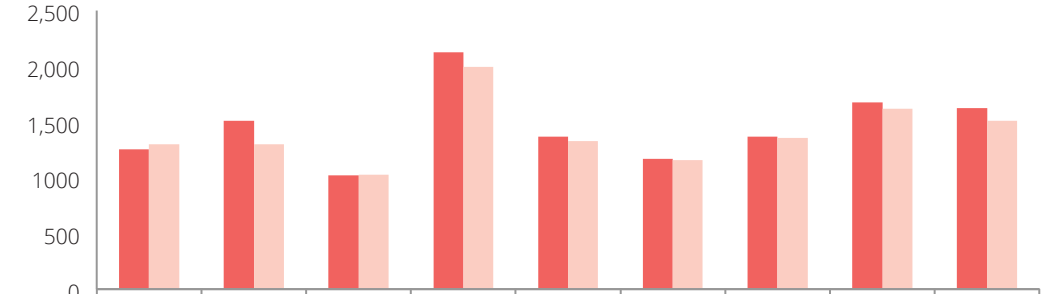
CHO	Approved Centre	POA Unit	Comment
CHO3	Acute Psychiatric Unit 5B, University Hospital Limerick	•	New and being commissioned
CHO3	Acute Psychiatric Unit, Ennis, Co Clare	•	
CHO4	Acute Mental Health Unit, Kerry General Hospital, Tralee	•	When unit fully commissioned
CHO4	South Lee Mental Health Unit,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

Admissions to Adult Acute Inpatient Units

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

At the end of 2016 the number of admissions was 12,590 compared to 13,123 at the end of 2015.

Adult Acute Admissions 2015/2016 by CHO



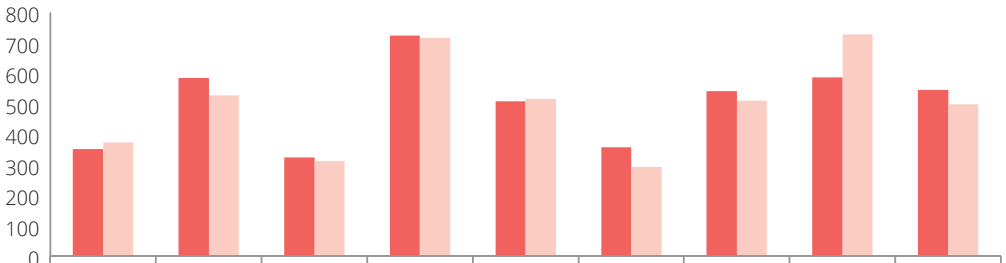
	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	1,254	1,510	1,024	2,127	1,366	1,172	1,369	1,675	1,626
2016	1,299	1,300	1,026	1,997	1,327	1,156	1,356	1,621	1,508

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 2016 the number of First admissions was 4,471 this is compared to 4,523 at the end of 2015. First admissions accounted for 35.6% of admissions in 2016.

Adult Acute First admissions by CHO



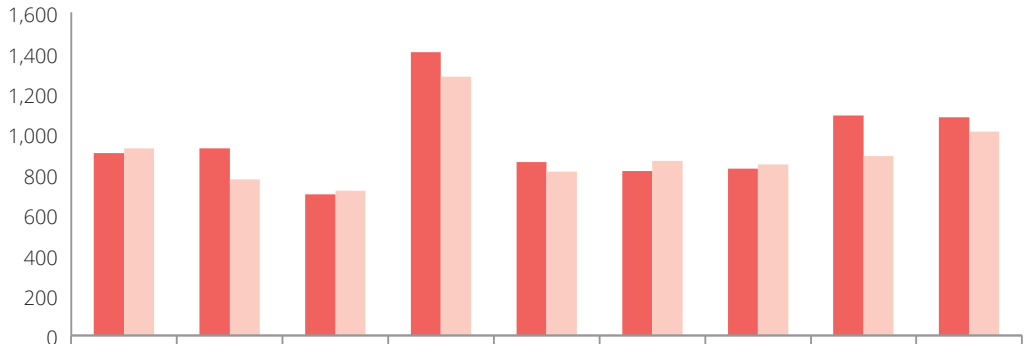
	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	352	584	324	724	509	357	542	586	545
2016	373	527	311	715	516	293	510	727	499

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.

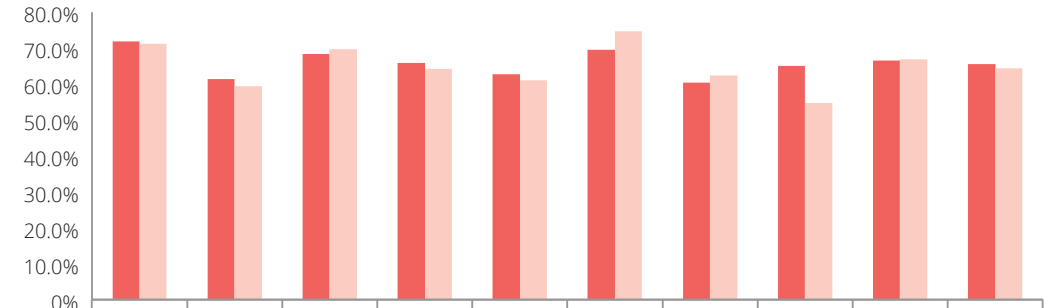
At the end of 2016 the number of re-admissions was 8,111. This is compared to 8,600 at the end of 2015. Re-admissions accounted for 64.4% of admissions in 2016.

Adult Acute Re-Admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	902	926	700	1,403	857	815	827	1,089	1,081
2016	926	773	715	1,282	811	863	846	887	1,008

Percentage of Adult Acute Re-Admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	71.9%	61.3%	68.4%	66.0%	62.7%	69.5%	60.4%	65.0%	66.5%	65.5%
2016	71.3%	59.5%	69.7%	64.2%	61.1%	74.7%	62.4%	54.7%	66.8%	64.4%

Length of Stay

Length of stay is the amount of time, counted in days, spent in adult acute inpatient units by an individual from the date of admission to the date of discharge. The date of admission and the date of discharge figures are calculated for those who were discharged during the reporting year. The length of stay calculation excludes those with a length of 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 2016 the median length of stay was 11 days.

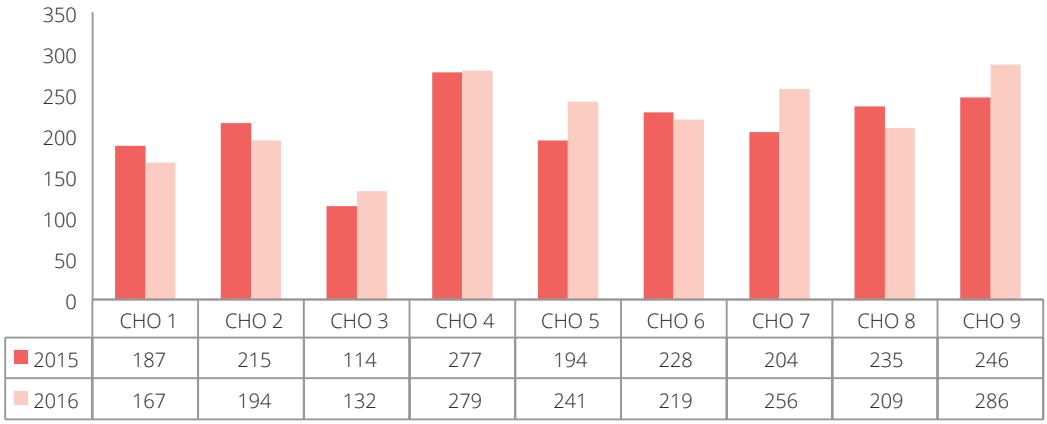
Median length of stay by CHO

	Median Length of stay			
	2013	2014	2015	2016
CHO 1	12	10.4	9.8	8.3
CHO 2	13.2	12.7	11.1	11.1
CHO 3	12.3	13.3	12.9	14.8
CHO 4	13.2	13.5	13.4	14.5
CHO 5	10.1	9.8	9.3	9.5
CHO 6	16.5	14.0	14.3	11.5
CHO 7	8.1	9.3	11.2	10.3
CHO 8	14.7	11.7	11.4	9.3
CHO 9	17.3	23.9	16.1	10.3
National	13.0	13.2	12.2	11.0

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 2016 the number of involuntary admissions was 1,958 (1,900 at the end of 2015). Involuntary admissions accounted for 15.6% of both first and re-admissions to adult acute inpatient units in 2016.

Involuntary admission by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	187	215	114	277	194	228	204	235	246
2016	167	194	132	279	241	219	256	209	286

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.

Chapter 10
National Forensic Mental Health Service

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

Referred by whom

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

Where assessed

The NFMHS provides in-reach clinics at Cloverhill, Mountjoy, Dochas Centre, Wheatfield, the Midlands, Portlaoise and Arbour Hill Prisons and also at Oberstown Children's Detention Centre. These prison in-reach clinics are equivalent to community out-patient clinics. The prison in-reach clinics are provided in close cooperation with the Irish Prison Service primary care teams so that a system of two stage reception screening is used to ensure early intervention. Weekly multi-disciplinary multi-agency meetings are held to ensure continuity of care and monitoring across prisons and through-care pathways back to community services. This includes a psychiatric in-reach and court liaison service in Cloverhill, the largest remand prison, for diversion from the criminal justice system where possible.

The Central Mental Hospital (CMH) provides secure hospital services at high, medium and pre-discharge levels. It is an Approved Centre under the Mental Health Act 2001 and the only designated centre under the Criminal Law (Insanity) Act 2006. The National Forensic Mental Health Service also provides forensic rehabilitation and recovery teams that meet the requirements of Section 13A of the Criminal Law (Insanity) Act 2010 concerning the supervision of patients who are conditionally

discharged when 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.

Recovery

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

Special Needs Groups

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

Service Activity Levels of Prison In-Reach Teams

Trends in committals to Irish prisons by gender and total, 2007-2016 as per Irish Prison Service Annual Report 2016

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

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

Prison In-reach Service 2016

Prison	New Referrals	Patient Reviews	Transfer to other inreach teams	Transfer from other inreach teams	Total discharges	Avg. % Met Clinics
Midlands	198	619	46	60	150	96%
Mountjoy	141	1,190	21	17	168	100%
Castlerea Jan-June (No consultant cover)	9	102	8	7	15	96%
CloverHill	334	1,562	60	0	241	89%
Wheatfield	79	597	22	18	58	98%
Dochas	98	407	3	0	72	94%
Shelton Abbey	3	16	0	0	2	100%
Arbour Hill	20	293	1	1	20	90%
Oberstown (Feb-Dec)	20	8	0	0	26	100%
Portlaoise (Apr-Oct)	18	103	No data	No data	0	100%
Total	920	4,897	161	103	752	96% Avg

Service Activity Levels of Central Mental Hospital

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

Admissions and Discharges 2007 to 2016

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

Waiting List

The numbers admitted and discharged each year are therefore falling while demand from the prison population and local approved centres is increasing. The waiting list for admission to the Central Mental Hospital is therefore an increasingly prolonged one, leading to admissions driven almost exclusively by crisis and worsening psychosis while on the waiting list. For 'legacy' reasons the NFMHS has 2 secure forensic beds per 100,000 population while most modern European states have in excess of 7/100,000. It is intended to open ten additional beds at the CMH as part of the transition to the new Central Mental Hospital in Portrane in 2020.

Length of Stay

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

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

Cross-sectional length of stay in bands

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

Service Activity Levels of Forensic Rehabilitation and Recovery Teams

Patient Numbers 2016

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

Community Consultation and Liaison Work

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

Community Consultation and Liaison Clinics 2016

	Referrals	Referrals Seen
Referrals received from HSE Community Mental Health Teams conducted in our outpatient clinic in Usher's Island and Approved Centres nationally	104	*99
Referrals seen for the purpose of reports at request of Judges of District and Circuit Courts, DPP, Solicitors, and Prison Referrals from prison with no inreach,	136	136
Prison in-reach team Cloverhill Prison Voluntary & Requested reports to District & Circuit Courts	163	163
Total	**403**	**398**

5 referrals received were deemed inappropriate by the referrals meeting.

Chapter 11
Other Speciality and Subspecialty Mental Health Services

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 mild or moderate co-existing/ comorbid mental illness is 25%, and if people with behavioural problems are included, which includes people with a severe learning disability, this means that up to 50% may experience 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, specialist mental health intellectual disability (MHID) 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 mental illnesses, and, in some cases, chronic and persistent behavioural problems. Behavioural issues in those with an intellectual disability can be particularly challenging where individuals may have reduced verbal capacity.
- Complicated psychotropic drug therapies are associated with an increased frequency of side effects in the intellectual disability population and equal difficulty in recognising response to treatment which is more by way of behaviour than subjective report.
- Co-existing epilepsy and medical conditions.
- Particular ethical issues related to capacity and consent in this population.

Service provision can be more complicated for people with intellectual disability as many ID services are provided contractually through voluntary agencies. The management of issues and clinical governance can be more complex when services are delivered on an in reach basis to third party providers.

There are a number of Consultant Psychiatrists specialising in the area of MHID, working in these voluntary providers and work is on-going to ensure that they have access to full multi-disciplinary teams. The agencies are funded by the HSE through annually negotiated Service Level Agreements.

In other parts of the country, ID services are provided directly by the HSE. Again, some of these services have Consultant Psychiatrists working within them but the teams are not always fully staffed. In general, whilst there are some MHID services for adults, there are relatively few available for children.

Investment in the provision of MHID services began in 2013, with the allocation of Programme for Government development posts. Since then the Mental Health Division has allocated further posts specifically for the development of multi-disciplinary teams, initially for adults and latterly for children. Approximately 102 posts in total have been allocated.

The following table shows the multi-disciplinary resource allocations made available specifically for MHID services per CHO. These resources are a combination of resources assigned to both Adult and Children MHID services. For comprehensiveness purposes, the table also shows additional MHID

resources in both HSE and Voluntary agencies' services, which pre-exist the 2013 development posts or have been included in addition to allocation.

Mental Health Intellectual Disability: multi disciplinary team resources October 16

	Pop.	Consultant	NCHD	Clinical Nursing	Psychology	Social Work	Occupational Therapy	Other inc. Admin	Total for 2016 of allocated and additional posts in place
CHO 1	394,333	4 +(2)	1+(2)	9	6	3	2	1+(2)	32
CHO 2	453,109	1+(1.5)	(4)	3	4	2	1	(1)	17.5
CHO 3	384,998	2	0	5	2	1	0	2	12
CHO 4	690,575	2.9	0	4	2	1	2	3	14.9
CHO 5	510,333	1+(2)	0	1	3	2	1	2	12
CHO 6	445,590	2.5 +(1.5)	(1)	2+(1)	0	0	0	1	9
CHO 7	645,293	1.6 + (4.4)	(4)	6	4	2	0	2 +(1.2)	25..2
CHO 8*	616,229	2+(1)	(2)	(1)	0	0	(1)	(1)	8
CHO 9	621,405	(9.1)	(0.8)	2+(2)	3	2	1	0	20
Forensic Service	National	1							1

**** Figures for Midlands only. Louth and Meath resources shared with CHO1***
( ) Additional posts in place, including pre 2013 positions, due be verified in 2017 by the National MHID programme

In July 2016, in order to further progress the development of MHID services, a Developmental Clinical Lead was appointed to work with Mental Health's National Clinical Advisor and Clinical Programmes Group Lead and Head of Operations to oversee the development of services within each CHO area. Additionally, the development of MHID services was identified as one of the core strategic priorities for the Mental Health Division in 2017. To support this move a Service Improvement Lead was assigned to project manage the co-ordinated development of MHID services nationally and to support the work of the Clinical Lead.

A national programme of work has been identified which aims to operationalise Vision for Change and provide specialist, multi-disciplinary, community MHID services for adults and children, with equitable and clear access across Ireland, through partnership with HSE Social Care Division and Voluntary agencies.

The MHID national programme will also specifically look at:

- Mapping all existing resources, including pre 2013 posts and resources in both the HSE and Voluntary Agencies. A specific focus will be on and looking at allocated posts, to determine which are in place and which remain to be filled.
- Establishing baseline services and teams for each CHO and augmenting existing teams, where strategically needed

- Developing a National Model of Service to support staff and ensure consistency and high standards in practice.
- Establishing a national Clinical Activity Data Collection Process for MHID
- Governance structures for both Adult and CAMHS services and Service Level Agreements between the HSE and Voluntary Agencies

Working in partnership with the Social Care Division and relevant Voluntary Agencies will be a vital part of this programme, to ensure there is 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 and clinically led by a consultant liaison psychiatrist who will have higher specialty training in General Adult Psychiatry with subspecialty endorsement in Liaison Psychiatry. Many liaison psychiatrists will also have 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 high quality administrative support.

The rationale for developing the subspecialty is as follows:

- It is estimated that 5% of all Emergency Department attendances are due to mental disorders. Within the ED group, self-harm is a prominent presenting symptom. Chronic and repeat attenders to ED may also benefit from liaison psychiatry input and typically count for 8% of all ED attendances. The most common reason for frequent attendance is an untreated mental health problem.
- 25% - 33% of people with long-term physical health problems also have a concurrent mental illness. This increases the risk of physical health complications together with the costs of treating the physical illness and is associated with an increased length of stay and worse outcome.
- 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.

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.

Specialist Perinatal Mental Health

Perinatal mental health disorders are those which complicate pregnancy (antenatal) and the first postnatal year. They include both new onset and a relapse or reoccurrence of pre-existing disorders. Their unique aspect is their potential to affect the relationship between mother, child and family unit with consequent later development of significant emotional and behavioural difficulties in the child.

Currently 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, in recognition of the importance of Perinatal Mental Health, included in its 2016 Service Plan the development of a model of care for the specialist component of perinatal mental health services.

The Model of Care will cover the specialist component of what should be an overall HSE cross divisional approach to perinatal mental health services. The focus of the perinatal specialist component includes:

- Maternity liaison teams
- Specialist perinatal mental health teams
- Mother and baby units

The interface with secondary care mental health services (general adult psychiatry community mental health teams). The Working Group will also take the opportunity to propose a design for an overall perinatal mental health clinical pathway.

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:

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			
7	DSC		
	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, there will be full national coverage.

Chapter 12
Conclusion

As can be seen from the foregoing, Mental Health Services have continued the journey of transformation from hospital to community based services, and in many areas have gone further in developing multi-disciplinary, community-based alternatives to hospital than any other part of the health system. This transformation of services has been guided by the Mental Treatment Act 2001 and the associated regulations and the Government Policy document "A Vision for Change" Report of the Expert group on Mental health Policy (Government of Ireland 2006).

The Mental Health Division and mental health staff nation-wide are fully committed to the provision of high quality evidence based mental health services. One of the key supports to the delivery of quality services is the provision of information about the mental health services to stakeholders.

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

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

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

Appendix 1

Community Health Organisations (CHOs)

Community mental health service populations by CHO

	CAMHS		GAMHT		POA	
CHO Areas	0 - < 18 years	Total pop	>=18 years to <65 years	Total pop	> = 65 years	Total pop
CHO 1	103,778	394,333	230,492	394,333	60,063	394,333
CHO 2	111,880	453,109	272,671	453,109	68,558	453,109
CHO 3	96,266	384,998	232,797	384,998	55,935	384,998
CHO 4	168,542	690,575	423,156	690,575	98,877	690,575
CHO 5	131,522	510,333	304,509	510,333	74,302	510,333
CHO 6	116,264	549,531*	286,670	445,590	50,822	341,409*
CHO 7	144,296	541,352*	409,840	645,293	82,991	749,474*
CHO 8	172,373	616,229	369,600	616,229	74,258	616,229
CHO 9	145,581	621,405	404,063	621,405	71,761	621,405
Total	1,190,502	4,761,865	2,933,798	4,761,865	637,567	4,761,865
Percentage	**25.00%**		**61.60%**		**13.40%**	

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

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

List of Geography by each CHO and Heads of Service

CHO	Area	Current Head of Service
CHO 1	Donegal, Sligo/Leitrim/West Cavan and Cavan/Monaghan	Mr Leo Kinsella
CHO 2	Galway, Roscommon and Mayo	Mr Charlie Meehan
CHO 3	Clare, Limerick, and North Tipperary/East Limerick	Mr Mark Sparling
CHO 4	Kerry, North Cork, North Lee, South Lee, and West Cork	Ms Sinead Glennon
CHO 5	South Tipperary, Carlow/ Kilkenny, Waterford and Wexford	Ms Liz Kinsella
CHO 6	Wicklow, Dun Laoghaire and Dublin South East	Ms Antoinette Barry
CHO 7	Kildare/West Wicklow, Dublin West, Dublin South City, and Dublin South West	Mr Kevin Brady
CHO8	Laois/Offaly, Longford/ Westmeath, Louth and Meath	Ms Siobhan McArdle
CHO 9	Dublin North, Dublin North Central and Dublin North West	Ms Angela Walsh

Appendix 2 Service Improvement Projects 2016

Project ID.	Project Name	Executive Sponsor	Project Manager	Strategic Programme
AOE001	Option Appraisal Project -Approved Acute Centre admission data reporting	Yvonne O'Neill	Philip Flanagan (SIL)	Automation Organisation Effectiveness
AOE002	National Mental Health e-Rostering Project	Yvonne O'Neill	Lily Connolly	Automation Organisation Effectiveness
AOE003	MHD ICT Infrastructure Improvement Project (Phase 1)	Yvonne O'Neill	Fearghal Duffy	Automation Organisation Effectiveness
AOE004	Standardised Management of first/ re-referred appointment DNA's in the Community Mental Health setting	Yvonne O'Neill	Philip Flanagan (SIL)	Automation Organisation Effectiveness
SIQ001	Development of HSE Best Practice Guidance for Mental Health Services	JP Nolan	Linda Moore	Service Improvement and Quality
SIQ002	Training Plan to enable the implementation of the HSE Best Practice Guidance for Mental Health Services	JP Nolan	Laura Molloy (SIL)	Service Improvement and Quality
SIQ003	Development of a National Recovery Framework for Mental Health Services	Yvonne O'Neill	Michael Ryan (SIL)	Service Improvement and Quality
SIQ004	Improving the Accessibility of Out-of-Hours Mental Health Services in Ireland	Jim Ryan Dr Wrigley	Conor Kennedy (SIL)	Service Improvement and Quality
SIQ005	Establishment of Peer Support Workers within CMHTs	Jim Ryan	Patricia O'Neill (SIL)	Service Improvement and Quality
SIQ006	Implementation of Team Coordinators for Community Mental Health Teams	Jim Ryan	Patricia O'Neill (SIL)	Service Improvement and Quality
SIQ007	Develop a Stepped Model of Mental Health Care for the Homeless Population in Dublin (CHO 6,7,9)	Jim Ryan	Una Twomey (SIL)	Service Improvement and Quality
SIQ008	Building Capacity in CAMHS	Jim Ryan	Sarah Hennessy (SIL)	Service Improvement and Quality
IAD001	Develop a model of care for people with Severe and Enduring Mental Health Illnesses and Challenging Behaviours	Dr Wrigley Jim Ryan	Anne Callinan Cahill (SIL)	Innovation and Design
IAD002	MHID	Dr Wrigley Jim Ryan	Ciara Latimer (SIL)	Innovation and Design
SUE001	Mental Health Engagement - Research & Evaluation	Liam Hennessy	Gerry Maley	Service User Engagement
SUE002	Implementation of the roles and structures to support mental health engagement through local and area fora development and Area Leads posts	Liam Hennessy	Catherine O'Grady	Service User Engagement
SUE003	Training and capacity building required to support roles and engagement structures - MHE	Liam Hennessy	Catherine O'Grady	Service User Engagement
PWB001	Alignment of CHO CFL Action Plans	Jim Ryan	Poul Walsh Olesen (SIL)	Prevention and Wellbeing

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

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

Mental Health Performance Reports can be found at

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