Report of the Health Service Executive Service Forum

on

Child & Adolescent Psychiatric In-Patient Capacity

Report 1 of 2

September 2006

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SECTION 1 Context

1.1 Background

The Mental Health Act 2001, Part 2, will commence on 1st November 2006. The Act places significant additional responsibilities on the Health Service Executive. In preparation for the commencement of the Act, the HSE established a number of Consultative Fora earlier this year. This Report is the outcome of the work of the Forum dealing with the issue of Additional In-Patient Capacity for Children and Adolescents with a Mental Illness in anticipation of the commencement of the Act. The membership of the Forum is outlined at Appendix 1.

1.2 Introduction & Terms of Reference

The Forum was convened under the chairmanship of Mr D Drohan, Local Health Manager, and has met on a number of occasions to date.

The Terms of Reference governing the work of the group are as follows:

- To explore options capable of creating immediate additional capacity for the provision on a regional basis of in-patient facilities for children and adolescents who require involuntary admission under Section 25 of the Mental Health Act 2001.

- To identify the most appropriate, integrated and cost efficient models which can provide HSE with readily accessible quality service settings for the client group

- To make proposals to the Mental Health Directorate of the HSE on options to be pursued to ensure interim arrangements at commencement of the remaining sections of the Mental Health Act 2001.

1.3 Approach:

During the early work of the Forum, and on the basis of the Terms of Reference, it became clear that there were 3 distinct but inter-related tasks which needed to be undertaken:

A The identification of interim additional in-patient capacity, on a regional basis, which can be developed in the immediate future for children and adolescents who require involuntary admission under Section 25 of the Mental Health Act 2001.

B The development of detailed Operational Guidelines to ensure the smooth operation of all sections of the Mental Health Act 2001, particularly those around involuntary admission of children to in-patient care.

These Guidelines will be drafted and cross-referenced with the Mental Health Commission Code of Practice relating to the admission of children under the Mental Health Act 2001. This work will be completed in September 2006.

C The requirement for a long term plan to ensure that full provision of in-patient services for children is developed taking into account the established needs and on the basis of the forthcoming legislative provisions. The Forum understands that this task has now been assigned to the newly formed HSE Implementation Group for *A Vision for Change*.

This report from the Forum deals with Task A – The identification of Interim additional In-patient capacity for Children.

1.4 Mental Health Act 2001 – Implications for Children & Adolescents

The Mental Health Act 2001 introduces a number of key changes, specifically defining a child as a person under the age of 18 years (other than a person who is or has been married) Section 2. This definition is in line with the Child Care Act 1991.

The definition of mental disorder in Section 3 of the Mental Health Act 2001 applies to children in relation to involuntary admission (details can be found in Section 3 of the Act or in Part 4.1, pages 1 – 7, of the Reference Guide). See Appendix 4 for Reference Guide extract.

Section 4 of the Mental Health Act 2001 states that when making a decision under the Act regarding the care and treatment of a person, the best interests of the person shall be the principal consideration. The Reference Guide to the Mental Health Act 2001 (Mental Health Commission, 2005) recommends that the principle of best interests as expressed in Section 4 of the Mental Health Act 2001 should "*inform all actions undertaken in relation to children under the Mental Health Act 2001*."

The majority of children requiring in-patient treatment will be admitted voluntarily at the request of their parent(s)/guardian(s). A minority of children will be admitted involuntarily for treatment for a mental illness or a mental disorder (as defined in Section 3 of the Mental Health Act 2001) and in such instances the procedures outlined in Section 25 of the Mental Health Act 2001 (Appendix 5) will apply. For children who require to be admitted involuntarily, an application to the District Court is required. While arrangements for such applications will be dealt with in the Second Report of the Forum (Operational Guidelines), the Forum is of the view that this matter is primarily the responsibility of Child and Adolescent Psychiatry Services but that other services (Adult Mental Health and Child Protection Services) also have a role here. The Forum is strongly of the view that the Operational Guidelines being developed must operate from the principle of what is in the best interests of the child.

1.5 National Mental Health Policy - *A Vision for Change*

A Vision for Change (Department of Health and Children, 2006) is the new national mental health policy, adopted by government earlier this year. In terms

of services for children and adolescents, the following extracts from *A Vision for Change* were regarded by the Forum as pertinent and have influenced this Report and its recommendations.

The policy outlines a framework for a mental health system that is population based, and has an emphasis on partnership to maximise community resources and the involvement of service users and carers, and appropriate provision for mental health in primary, secondary and tertiary care services. The spectrum of services is also emphasised, from mental health promotion and prevention, through primary care and the full provision of a range of secondary mental health services, primarily provided through community mental health teams (CMHTs) and liaison teams.

1.5.1 Framework for Child and Adolescent Mental Health Services

Mental health care for children and adolescents takes a key role in the lifespan approach to mental health which was adopted by *A Vision for Change,* and *the need to prioritise the full range of mental health care, from primary care to specialist mental health services for children and adolescents* is the first recommendation relating to children (Recommendation 10.1). Mental health promotion and prevention programmes have also been shown to have significant benefits for children and adolescents and several recommendations are made in this area (10.4 to 10.6). It is recognised that there is a wide range of community care services for children (in most, but not all, parts of the country) that deliver mental health care at the primary care level in the community and that this needs to be further supported, specifically community care psychology services. Clear links must be developed between primary care / community resources to co-ordinate appropriate service provision for children and adolescents at risk of mental health problems (10.8).

1.5.2 Additional Resources and Facilities Recommended

Chapters Ten, Fourteen and Fifteen of *A Vision for Change* make the following recommendations specifically around resources required to respond to need:

a) *Child and adolescent mental health services should provide mental health services to all aged 0-18 years. Transitional arrangements to facilitate the expansion of current service provision should be planned by the proposed National Mental Health Service Directorate and the local CMHTs.*

Recommendation 10.2

b) ***Two child and adolescent CMHTs*** *should be appointed to each sector (population: 100,000).*

One child and adolescent CMHT *should also be provided in each catchment area (300,000 population) to provide* ***liaison cover***

Recommendation 10.7

c) *Composition of Community Mental Health Team (CMHT) for Child and Adolescent Psychiatry* Section10.9

- *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*

d) *One **day hospital** per 300,000 population*

The provision of *100 **in-patient beds** for child and adolescent psychiatric services nationally. (This provision to be evaluated after five years to assess how it is meeting the needs of the population).*

Section 10.10

e) *A dedicated **forensic residential 10-bed facility** with a fully resourced child and adolescent mental health team should be provided with a national remit.*

*An additional **child and adolescent forensic CMHT** should also be provided*. Recommendation 15.1.6

1.5.3 In-Patient Units for Children & Adolescents

Of particular relevance to this Forum is the recommendation that "*Urgent attention should be given to the completion of the planned four 20-bed units in Cork, Limerick, Galway and Dublin and multidisciplinary teams should be provided for these units*" (Recommendation 10.9). The type of in-patient facilities required are described, and it is emphasised that "*a person-centred approach to service provision requires that these facilities should be user-friendly and sensitive to the needs of children and adolescents*."

The issue of in-patient provision in the longer term will be addressed by the HSE Implementation Group for *A Vision for Change* (third task set out at 1.1*)*. The location of these units and the number of beds to be provided will be addressed through that process.

1.5.4 Mental Health Services for people with co-morbid severe mental illness and substance abuse problems (Read at 15.3, p.146)

Two additional (currently 2 in Dublin) *adolescent multidisciplinary teams should be established outside Dublin to provide expertise to care for adolescents with co-morbid addiction and mental health problems*. *Uncomplicated substance abuse and alcohol addiction is not the responsibility of child and adolescent mental health services* (Ref. p.148 at Section15.3.4). Recommendation 15.3.6

1.5.5 Eating Disorders - Services for Children and Adolescents

Eating disorders in children and adolescents should be managed by the child and adolescent CMHTs on a community basis, using beds in one of the five in-patient child and adolescent units if required. Recommendation 15.4.4

There should also be a full multidisciplinary team in a National Centre for Eating Disorders, to be located in one of the national children's hospitals, for complex cases that cannot be managed by local child and adolescent CMHTs.

Recommendation 15.4.5

1.5.6 Mental Health Services for people with an Intellectual Disability

For information purposes, pertinent issues relating to mental health services for children and adolescents with intellectual disabilities, as addressed by *A Vision for Change* (Chapters Fourteen and Fifteen) are outlined at Appendix 6. A second HSE Service Forum has been established to address implementation of the Mental Health Act 2001 with specific reference to people with an intellectual disability and will report separately.

1.6 Report of the Inspector of Mental Health Services 2005

Mental health services for children and adolescents were reported on in 2005 (*Annual Report of the Mental Health Commission, including the Report of the Inspector of Mental Health Services 2005,* Mental Health Commission 2006). The Inspector places great emphasis on the need for appropriate support at primary care, community care and in schools, to ensure that all children receive the most appropriate intervention without a lengthy waiting period. Child and adolescent mental health team provision is described for the different mental health catchment areas and the shortage of teams and staff is noted.

The Inspector also comments on the lack of psychiatric in-patient facilities for children and adolescents, and emphasises the need for the discussion on beds to take place in the context of broader service issues such as "*the required staffing of community mental health teams and the provision of appropriate community facilities for such teams*". The '*problematic question*' of the 16-18 year old age group is also discussed. The Inspector notes that "*every child should have access to the service most appropriate to their needs, irrespective of age. Boundary disputes between psychiatrists must not result in children being deprived of a necessary service*". This again reinforces what the Forum has stated in 1.4 in relation to operational guidelines: they must operate from the principle of what is in the best interest of the child.

1.7 Other Documents Consulted

The findings and recommendations of a number of other reports were considered in formulating the recommendations of *A Vision for Change,* and were also considered in formulating the interim arrangements for in-patient capacity recommended in this report. A full list of these publications is at Appendix 2. These publications reiterated a number of central principles regarding the provision of child and adolescent mental health services which were key to the working of this Forum and which are stated below. These principles have guided the thinking of this Forum and must guide the implementation of the interim arrangements and longer term provision for children and adolescents with mental health problems.

1.8 Principles applying to the provision of mental health services for children and adolescents

The Forum has adopted the following principles applying to the provision of mental health services for children and adolescents:

1. The best interests of the child should be paramount in all decisions regarding the treatment and care of children with mental health / psychiatric problems. The needs of the child should determine which course of action to take.

2. The majority of children with mental health and behaviour disorders should be appropriately treated within the primary and community care model of health care (ref. 10.7, *A Vision for Change*) and those requiring psychiatric intervention should be assessed and treated by an adequately resourced team (CMHT). These services (primary and secondary) should have an agreed way of working with the best interest of the child taking precedence (10.9, *A Vision for Change*).

3. Psychiatric treatment and care should be delivered by adequately resourced child and adolescent CMHTs who will have responsibility for all those aged under 18 years in their catchment areas. Properly resourced mental health services should be available to ensure that this is achievable.

4. In-patient beds are just one part of a full spectrum of care, from primary through secondary care, that needs to be available for children and adolescents with psychiatric problems. For those children who need secondary mental health care, a range of treatment options should be delivered by fully staffed, multidisciplinary teams, in a range of settings, including the child's home, day and hospital settings and in-patient care (tertiary care).

5. Psychiatric treatment and care should be delivered in the least restrictive setting required and in-patient admission, either voluntary or involuntary, should be used judiciously and always within a framework of a supported discharge pathway.

6. Best practice guidelines and an evidence-based approach should guide all service delivery, including the service pathway through in-patient care. Quality standards should be available and adhered to.

7. The *Children First* guidelines should inform all policies and procedures relating to mental health treatment and care for children and adolescents. All staff working with children and adolescents should be trained in child protection procedures and should have Garda clearance.

8. All settings admitting children and adolescents with mental health difficulties should:

- provide an appropriate treatment environment
- provide an appropriate social and educational environment
- take due account of their developmental age
- recognise the significance of home, family, parents / guardians / persons acting in loco parentis and other carers
- consult those who use the service.

The principles at 7 and 8 above are to be worked towards as part of the interim solution and have their limitations in the absence of customised units for this age range.

Familiarisation with the broad principles of the *Children First* guidelines should be commenced and training progressed during the Interim period.

1.9 Funding

Revenue and capital funding has been made available in 2006 in preparation for the commencement of the Mental Health Act 2001.

Capital funding to be determined by local services and a revenue sum of € 3.25M has been made available for the necessary enhancement of services for children on foot of the new requirements of the Act.

The focus of this Report is on additional facilities, both community based and in-patient which can be provided urgently on a Regional basis.

Additional funding will be provided in 2007 and following years to implement the recommendations of the policy document *A Vision for Change* in the area of Child and Adolescent Psychiatry.

Section 2: Current Provision and Estimated Need

2.1 Introduction

The need for the specific range of child and adolescent psychiatric services to meet the general population requirements is internationally recognised.

In Ireland, that level of services has been identified by the policy document *A Vision for Change* 2006 and the summary of teams required to meet that need set out in Table 2.7 (Page 23 of this document).

The current level of service provision by administrative area is set out under Tables 2.2 to 2.5 (Pages16-19) in this Section of the Report.

Setting the level of provision in the different geographical areas throughout the country against the recommended level of service required will identify the gaps in services to be prioritised for development to meet population based need.

The more complex issues, e.g. deprivation levels or age range, requiring additional resources have not been addressed in this interim report and should be a matter for the local management structures to identify. This will be a task for the *Vision for Change* Implementation Group to oversee.

2.2 Current service provision

A comprehensive and up-to-date picture of current (April 2006) service provision in child and adolescent psychiatry was obtained by conducting a 'mapping exercise' of child and adolescent mental health services. A summary of current service provision is shown in Tables 2.1 to 2.5. These tables include a national summary 9Table 2.1) and one for each of the four HSE administrative areas (Tables 2.2, 2.3, 2.4, 2.5).

2.2.1 National picture

Table 2.1 shows that there are currently 45 child and adolescent mental health teams spread throughout the country; 10 in the HSE Dublin North East, 12 in the HSE Dublin Mid-Leinster, 12 in HSE South and 11 in HSE West. Most of these teams do not have their full complement of staff. The total number of teams is considerably below that recommended in *A Vision for Change* of 78 teams, based on the 2002 Census population.

The *Vision for Change* policy document has set out the composition of these teams (1.5.2c). Our mapping process sets out the number of existing community child and adolescent teams (CMHTs) and other services in each of the four geographical areas set against that template. We have set the quantity of service required for each geographical area and nationally against the 2002 Census figures and made an estimation of need based on the provisional 2006 Census figures.

Nationally, of the 45 Community Teams mapped that should comprise 585 team members, 461.03 are funded, with actually 406.08 in situ. To complete these 45 teams, funding will be required for 123.97 staff (585 minus 406.08 funded posts).

There are only two day hospitals available nationally at Lucena Clinic, Rathgar, Dublin, and at St. Vincent's Hospital, Fairview, Dublin, with finance provided for a third Day Hospital in Dublin Mid Leinster.

There are ten child and adolescent psychiatric in-patient beds in the public sector, at St. Anne's Galway (4 beds) and Warrenstown Dublin (6 beds).

There are also twelve dedicated beds in the private sector (St. John of God, Stillorgan, Dublin).

2.2.2 HSE Dublin North East

There are 10 mapped teams in the Dublin North East Area. Of the recommended figure of 130 people, 95.45 are funded, with actually 81.8 staff in situ at April 2006. To complete these 10 teams, funding needs to be provided for 34.55 staff (130 minus 95.45 funded posts).

Based on the 2002 Census population, 828,638, *A Vision for Change* recommends 16 community mental health teams (CMHTs) to serve this population. A completed 10 teams will leave six additional teams to be provided (6 x 13 team members = 78) with additional team adjustments for new population growth. Provisional 2006 population = 927,525 would indicate a requirement for an additional two CMHTs (2 x 13 = 26 members) to serve those under 18 years. This will bring the CMHTs to 18 teams in HSE Dublin North East.

Two teams included in the mapping exercise are Blanchardstown and Castleknock Teams that provide for the population within Dublin North East but their funding base is in Dublin Mid Leinster Area.

Community Care Areas 7 and 8 (Mater Child Guidance Service) have additional staff which provides for a family therapy training service comprising 2 Family Therapists, 4 administrative grades, 0.5 Psychologist, 0.3 Social Worker and 1 Speech and Language Therapist. Some of these staff provide additional services not associated specifically with the community teams.

There is only one Adolescent Day Hospital in Dublin North East, based at St. Vincent's Psychiatric Hospital, Fairview, with a staff complement of 11.15. This is not a complete team.

Additional Day Hospital and Liaison Teams are to be provided per 300,000 population.

These additional resources are to be delivered in a planned way through the established implementation process of *A Vision for Change*.

2.2.3 HSE Dublin Mid-Leinster

There are 12 mapped teams in the Dublin Mid Leinster Area. Of the recommended figure of 156 people, 171.08 are funded, with actually 149.58 staff in situ. Table 2.3 shows the additional staff for 12 teams to be medical and nursing, while some other teams in Dublin Mid Leinster are not complete..

Based on the 2002 Census population, 1,141,943, *A Vision for Change* recommends 23 community mental health teams (CMHTs) to serve this population. A completed 12 teams will leave 11 additional teams to be provided (11 x 13 team members = 143) with additional team adjustments for new population growth. Provisional 2006 population =1,215,711 would indicate a requirement for one additional team to serve those under 18 years. This will bring the CMHTs to 24 teams in HSE Dublin Mid Leinster.

There are two Day Hospitals provided for in Dublin Mid Leinster, one at Lucena Clinic, Rathgar, which has a complete team. The other, in Dublin South West, is funded but staff are not recruited due to the ceiling on staff being exceeded. The total staffing funded is 34.78 for both of these services.

The Warrenstown in-patient unit is also provided for within Dublin Mid Leinster and has a staff number of 30.2.

Additional Day Hospital and Liaison Teams are to be provided per 300,000 population.

These additional resources are to be delivered in a planned way through the established implementation process of *A Vision for Change*.

2.2.4 HSE South

There are 12 mapped teams in the Southern Area. Of the recommended figure of 156 people, 93.3 are funded, with actually 83.2 staff in situ. To complete these 12 teams, funding needs to be provided for 62.7 mapped vacancies on these individual teams (156 minus 93.3 funded posts).

Based on the 2002 Census population, 1,003,972, *A Vision for Change* recommends 20 community mental health teams (CMHTs) to serve this population. A completed 12 teams will leave eight additional teams to be provided (8 x 13 team members = 104) with additional team adjustment for new population growth. Provisional 2006 population = 1,080,990 would indicate a requirement for one additional team (13 members) to serve the under 18s population. This will bring the CMHTs to 21 in HSE South.

The Southern Area has no Day Hospital of Liaison Service. These are to be planned for at one per 300,000 population.

These additional resources are to be delivered in a planned way through the established implementation process of *A Vision for Change*.

2.2.5 HSE West

There are 11 mapped teams in the Western Area. Of the recommended figure of 143 people for these 11 teams, 101.2 staff are funded, with 91.5 staff in situ at April 2006. To complete these 11 teams, funding needs to be provided for 41.8 mapped vacancies on these individual teams (143 minus funded posts of 101.2)

Based on the 2002 Census population, 942,650, *A Vision for Change* recommends 19 community mental health teams (CMHTs) to serve this population. A completed 11 teams will leave eight additional teams to be provided (8 x 13 team members = 104) with additional team adjustments for new population growth. Provisional 2006 population = 1,010,692 would indicate a requirement for one additional team (13 members) to serve the under 18s population. This will bring the CMHTs to 20 in HSE West.

Additional Day Hospital and Liaison Teams are to be provided per 300,000 population.

St. Anne's in-patient unit, which currently provides 4 in-patient beds and operates a Day Hospital, has 31.3 funded staff.

These additional resources are to be delivered in a planned way through the established implementation process of *A Vision for Change*.

Table 2.1

HSE – National **Source: HSE Areas**

Total population - 2002 Census	3,917,203 (100%)
Population under 18 years - 2002 Census	1,013,031 (25.9%)
No. of Community Teams (CMHTs)Mapped	45
No. of Community Teams (CMHTs) Recommended	78

					Additional Facilities	
Composition of *Recommended CMH Team per 50,000 population	**45 Mapped Teams, if Complete**	**No. Funded**	**No. Actual**	**Deficit/ Surplus**	**Day Hospital Teams (Funded Posts)**	**In-Patient Units (Funded Posts)**
1 x Consultant	45	50.15	45.75	+5.15	2.00	1.0
1 x Doctor in Training	45	63.00	62.00	+18.00	3.80	3.0
2 x Psychiatric Nurses	90	68.12	59.27	-21.88	11.00	32.8
2 x Psychologists	90	59.39	44.59	-30.61	1.00	1.0
2 x Social Workers	90	72.35	63.45	-17.65	2.00	2.5
1 x Occupational Therapist	45	22.10	13.60	-22.90	1.50	1.0
1 x Speech & Language Therapist	45	27.70	24.60	-17.30	1.00	1.0
1 x Childcare Worker	45	16.70	14.80	-28.30	7.48	11.0
2 x Administrative Support	90	73.42	70.32	-16.58	3.00	3.0
Sub-total	**585**	**452.93**	**398.38**	**-132.07**	**32.78**	**56.3**
Other Posts						
Counsellor Therapist		1.0	0.6	+1.0		
Play Therapist		4.0	4.0	+4.0		
Art Therapist		1.1	1.1	+1.1	1.0	
Family Therapist		0.5	0.5	+0.5		
School Principal					1.0 (not included)	
Therapist						1.0
Household					1.0	3.2
Caretaker						1.0
Psychotherapist		1.5	1.5	+1.5		
Overall Total		**461.03**	**406.08**	**-123.97**	**34.78**	**61.5**

***** *A Vision for Change* (Page 88, 10.9)

Table 2.2

HSE – Dublin North East **Source: Dublin North East**

Total population - 2002 Census	828,638 (100%)
Population under 18 years - 2002 Census	212,608 (25.7%)
No. of Community Teams Mapped	10
No. of Community Teams Recommended	16

Composition of *Recommended CMH Team per 50,000 population	**10 Mapped Teams, if Complete**	**No. Funded**	**No. Actual**	**Deficit/ Surplus**	**Additional Facilities Day Hospital Team (Funded Posts)**
1 x Consultant	10	9.0	7.4	-1.0	0.45
1 x Doctor in Training	10	12.7	12.7	+2.7	1.0
2 x Psychiatric Nurses	20	13.0	10.45	-7.0	5.0
2 x Psychologists	20	15.8	11.4	-4.2	1.2
2 x Social Workers	20	17.95	16.85	-2.05	1.0
1 x Occupational Therapist	10	3.0	0	-7.0	1.0
1 x Speech & Language Therapist	10	7.9	7.3	-2.1	0.5
1 x Childcare Worker	10	1.0	1.0	-9.0	
2 x Administrative Support	20	12.5	12.5	-7.5	1.0
Sub-total	**130**	**92.85**	**79.6**	**-37.15**	**11.15**
Other Posts					
Counsellor Therapist		1.0	0.6	+1.0	
Art Therapist		0.1	0.1	+0.1	
Psychotherapist		1.5	1.5	+1.5	
School Principal					1.0 (not included)
Overall Total		**95.45**	**81.80**	**-34.55**	**11.15**

***** *A Vision for Change* (Page 88, 10.9)

Table 2.3

HSE – Dublin Mid Leinster **Source: HSE Dublin Mid Leinster**

Total population - 2002 Census	1,141,943 (100%)
Population under 18 years - 2002 Census	287,990 (%)
No. of Community Teams Mapped	12
No. of Community Teams Recommended	23

Composition of *Recommended CMH Team per 50,000 population	**12 Mapped Teams, if Complete**	**No. Funded**	**No. Actual**	**Deficit/ Surplus**	**Additional Facilities**	
					Day Hospital Teams (Funded Posts)	**In-Patient Unit (Funded Posts)**
1 x Consultant	12	15.35	15.35	+3.35	2.00	1.00
1 x Doctor in Training	12	21.80	21.80	+9.80	3.80	2.00
2 x Psychiatric Nurses	24	28.12	23.02	+4.12	11.00	15.00
2 x Psychologists	24	20.09	16.69	-3.91	1.00	
2 x Social Workers	24	25.40	20.40	+1.40	2.00	1.50
1 x Occupational Therapist	12	11.10	7.10	-0.90	1.50	
1 x Speech & Language Therapist	12	14.80	12.30	+2.80	1.00	0.50
1 x Childcare Worker	12	7.00	6.00	-5.00	7.48	3.00
2 x Administrative Support	24	25.42	24.92	+1.42	3.00	2.00
Sub-total	**156**	**169.08**	**147.58**	**+13.08**	**32.78**	**25.00**
Other Posts						
Play Therapist		2.0	2.0	+2.0		
Therapist						1.00
Household					1.00	3.20
Caretaker						1.00
Art Therapist					1.00	
Overall Total		**171.08**	**149.58**	**+15.08**	**34.78**	**30.20**

***** *A Vision for Change* (Page 88, 10.9)

Table 2.4

HSE – South **Source: HSE South**

Total population - 2002 Census	1,003,972 (100%)
Population under 18 years - 2002 Census	262,970 (26.2%)
No. of Community Teams Mapped	12
No. of Community Teams Recommended	20

Composition of *Recommended CMH Team per 50,000 population	**12 Mapped Teams, if Complete**	**No. Funded**	**No. Actual**	**Deficit/ Surplus**
1 x Consultant	12	13.8	13.0	+1.8
1 x Doctor in Training	12	15.0	14.0	+3.0
2 x Psychiatric Nurses	24	9.0	9.0	-15.0
2 x Psychologists	24	15.0	11.8	-9.0
2 x Social Workers	24	14.5	12.9	-9.5
1 x Occupational Therapist	12	4.0	2.5	-8.0
1 x Speech & Language Therapist	12	1.5	1.5	-10.5
1 x Childcare Worker	12	0	0	-12.0
2 x Administrative Support	24	18	16	-6.0
Sub-total	**156**	**90.8**	**80.7**	**-65.2**
Other Posts				
Play Therapist		1.0	1.0	+1.0
Art Therapist		1.0	1.0	+1.0
Family Therapist		0.5	0.5	+0.5
Overall Total		**93.3**	**83.2**	**-62.7**

***** *A Vision for Change* (Page 88, 10.9)

Table 2.5

HSE – West **Source: HSE West**

Total population - 2002 Census	942,650 (100%)
Population under 18 years - 2002 Census	249,463 (26.5%)
No. of Community Teams Mapped	11
No. of Community Teams Recommended	19

Composition of *Recommended CMH Team per 50,000 population	**11 Mapped Teams, if Complete**	**No. Funded**	**No. Actual**	**Deficit/ Surplus**	**Additional Facilities St. Anne's In-Patient Unit (Funded Posts)**
1 x Consultant	11	12.0	10.0	+1.0	
1 x Doctor in Training	11	13.5	13.5	+2.5	1.0
2 x Psychiatric Nurses	22	18.0	16.8	-4.0	17.8
2 x Psychologists	22	8.5	4.7	-13.5	1.0
2 x Social Workers	22	14.5	13.3	-7.5	1.0
1 x Occupational Therapist	11	4.0	4.0	-7.0	1.0
1 x Speech & Language Therapist	11	3.5	3.5	-7.5	0.5
1 x Childcare Worker	11	8.7	7.8	-2.3	8.0
2 x Administrative Support	22	17.5	16.9	-4.5	1.0
Sub-total	**143**	**100.20**	**90.5**	**-42.80**	**31.3**
Other Posts					
Play Therapist		1.0	1.0	+1.0	
Overall Total		**101.20**	**91.50**	**-41.80**	**31.3**

** A Vision for Change* (Page 88, 10.9)

2.2.6 Child and Adolescent Community Mental Health Teams (CMHTs)

There are 45 Child and Adolescent Community Mental Health Teams (CMHTs) across the country at the present time.

The full implementation of *A Vision for Change* will increase the current complement of child and adolescent community mental health teams (CMHTs) from 45 to 78, based on 2002 Census figures. This number (78) is revised upwards to 98 using the 2006 Census figures and includes the 14 Liaison Teams recommended in the policy document *A Vision for Change*.

It is accepted that the majority of children and young people referred to the child and adolescent psychiatric services are assessed and treated by community-based services (CMHTs). Young people with more severe and acute psychiatric difficulties often require admission for assessment and treatment. Well-resourced, well-functioning community-based services can have a significant effect on the need for admission and the length of stay in the following ways:

- Early identification of those at risk
- Early intervention preventing escalation of crises
- Early treatment with an associated improvement in longer term prognosis
- Provision of support for families/carers to facilitate the child/young person remaining at home even when quite unwell.
- Length of admission can be reduced as early discharge can be considered when community-based services are resourced to provide post-discharge support and follow-up
- Repeat admissions may be reduced

2.2.7 Day Hospital Services

Provision of Day Hospital facilities reduces the need for in-patient admission and facilitates earlier discharge for those who are admitted.

Currently, two Day Hospitals for Child and Adolescent Psychiatry are established in the Dublin Mid Leinster area (Lucena Clinic, Rathgar, Dublin) and in Dublin North East (St. Vincent's Hospital, Fairview, Dublin).

2.2.8 In-Patient Units

Even with the full complement of well staffed multidisciplinary teams in place there will be a need for in-patient beds. In-patient psychiatric treatment is usually indicated for children and adolescents with severe psychiatric disorders, such as schizophrenia, depression and mania. Other presentations include severe complex medical/psychiatric disorders such as anorexia and bulimia, deliberate self harm and suicidality. Admission may also be required for clarification of

diagnosis and appropriate treatment, or for the commencement and monitoring of medication. Occasionally admission is required where a mental health concern contributes to a family crisis.

The aim of a Child and Adolescent In-Patient Unit is:

- to provide accurate assessment of those with the most severe disorders
- to implement specific and audited treatment programmes
- to achieve the earliest possible discharge of the child back to the family and the general community.

The interdependencies between the Community Child and Adolescent Teams (CMHTs) and dedicated in-patient services require that both aspects of service provision be developed simultaneously so as to optimise the quality of care and treatment services available to children, young people and their families.

2.2.8.1 Public Sector Child and Adolescent In-Patient Units

These units currently provide 4 beds at St. Anne's, Galway (1,460 bed days) and 6 beds available Monday to Friday at Warrenstown, Dublin (1,560 bed days) and cater for children aged up to 16 years.

2.2.8.2 Private Sector Child and Adolescent In-Patient Units

Twelve beds are available at St. John of God Hospital, Stillorgan, Co. Dublin in a specially commissioned unit which is fully operational since early 2006 for children aged 14-18 years, with flexibility to admit younger adolescents (12 and 13 year olds). Admissions to this independent facility are voluntary, elective in nature and funded on a case-by-case basis.

Beds are available to HSE through funding of individual admissions, Referral is clinician to clinician, with those referred coming through the CMHTs system. GP referral is to local CMHTs and only those appropriate and prioritised by local child psychiatrist are referred.

St. Patrick's Hospital, Dublin, operates a Young Adult Programme and is a significant provider of in-patient services for the under 18 age group. In 2004, it had 62 admissions (17.6%) of the total number of admissions for that age group.

2.2.8.3 Acute Adult In-Patient Units

The figures in Section 2 of this report and at Appendix 3 show how almost all adult psychiatric hospitals and units in the country have admitted those under 18 years. In some instances, children under 16 have also been admitted to adult units where the need arose.

2.2.8.4 Paediatric Beds

Arrangements for admission to paediatric wards have evolved on an ad hoc basis and generally reflect the non-availability of child and adolescent in-patient beds. Child and adolescent liaison teams exist only in the three Dublin Paediatric Hospitals (Table 2.6).

Table 2.6 Referrals to Child and Adolescent Psychiatry Departments, Paediatric Hospitals, 2004

	Our Lady's Hospital for Sick Children, Crumlin	The National Children's Hospital, AMiNCH	Children's University Hospital, Temple Street
New In-Patients	83	79	148
New Out-Patients	21	34	377
Total	**104**	**113**	**525**

Source: Council for Children's Hospital Care Child and Adolescent Psychiatry Services, Discussion Paper, August 2005

Generally, with the exception of the National Children's Hospital, Tallaght, Dublin, paediatric in-patient services do not accept over-14 year olds. Consequently, 14-18 year olds are admitted to adult general wards.

2.2.8.5 General Beds in Acute Hospitals

Although to date admissions to paediatric, medical and surgical beds for the initial management of a range of psychiatric conditions have not been quantified, reports would indicate that this may account for a significant number of children. The National Parasuicide Registry records that over 11,000 cases of deliberate self harm are seen in the accident and emergency departments of our hospitals annually. (This number refers to all age groups). They report that there is considerable diversity with regard to assessment procedures and treatment patterns and onward referrals.

2.3 Estimated Need

This report is concerned directly with outlining an interim solution for in-patient capacity for those aged under 18 years. A detailed consideration of the prevalence of mental health problems is set out in the policy document *A Vision for Change*.

Based on *A Vision for Change*, Table 2.7 (below) is the Forum's estimate of the national resource required for Child and Adolescent Psychiatry.

The need for child and adolescent community-based response (CMHTs) is, therefore, an integral part of the care continuum that includes in-patient services and must be developed in tandem with other tertiary care facilities, even in the interim.

Table 2.7: Summary of Resources and Facilities recommended:

	Based on 2002 Census	Based on 2006 Census
Community - CMHT x 2 per 100,000	78 teams	84 teams
Liaison Psychiatry – 1 team per 300,000	13 teams	14 teams
Day Hospital – 1 per 300,000	13 facilities	14 facilities
Forensic Beds x 10	1 team	1 team
Forensic CMHT x 1	1 team	1 team
Substance co-morbidity	4 teams	4 teams
Eating Disorders	1 team	1 team

* *A Vision for Change* recommends the provision of 100 beds nationally for Child and Adolescent Psychiatry.
****** This Forum, as an interim group, will not be addressing the last four items on Table 2.7.

The *Vision for Change* Implementation Team will address both of the above issues and identify the staffing required for these beds

In-Patient Capacity:
The delivery of the 100 beds recommended in *A Vision for Change* is to be addressed substantially by the HSE Implementation Group. However, there is an interim need to be met by November 2006. This was the particular focus of this consultative Forum.

In order to estimate need for in-patient services, the pattern of admissions for this age group (0-18 years) for the last three years for which figures are available, is examined here. The legal status of these admissions is also shown. A detailed breakdown of admissions for those aged under 18 years for every psychiatric hospital and unit for the last three years is provided at Appendix 3. This shows that almost every psychiatric hospital and unit had at least one admission for this age group in the years 2002 to 2004.

Table 2.8 shows the number of admissions for children under 18 years for 2002-2004. A decrease in admissions for this age group is evident in these three years, from 452 in 2002 to 352 in 2004. There are various reasons postulated for this decreasing figure year on year. For this report, however, we have not advanced them, but for the Implementation Group to look at longer term planning, they should be identified and addressed.

Table 2.8: Admissions of children aged under 18 years - 2002 to 2004.

	2002	2003	2004
HSE Dublin North East	77	69	59
HSE Dublin Mid-Leinster	44	40	32
HSE South	101	97	66
HSE West	80	61	69
Private hospitals	91	64	67
Child and adolescent units	59	62	59
Total	**452**	**393**	**352**

Source: Health Research Board

Table 2.9: Admissions of children aged less than 18 years by legal category. 2002 to 2004. Numbers and percentages

Legal category	2002	%	2003	%	2004	%
Voluntary	401	88.7	356	90.6	318	90.3
Non-voluntary	51	11.3	37	9.4	34	9.7
Total	**452**	**100.0**	**393**	**100.0**	**352**	**100.0**

Source: Health Research Board

The figures in the above tables demonstrate the immediate requirement for the provision of beds for children with a mental illness. The Forum supports the findings in *A Vision for Change* in terms of bed numbers required, subject to a further increase based on 2006 Census figures.

Of the total of 352 admissions of young people under the age of 18 years to mental health facilities in 2004, 293 (83%) were admitted to adult mental health facilities and 59 (17%) were to child and adolescent in-patient units.

Of the total of 293 admissions of young people to adult psychiatric facilities in 2004, 267 (91%) were 16/17 years of age and 26 (9%) were under the age of 16 years.

Of the total of 59 admissions to the 2 Child and Adolescent Units at St. Anne's, Galway, and Warrenstown, Dublin, 54 (92%) were under the age of 16 years and 5 (8%) over the age of 16 years. The 12-bed Unit at St. John of God Hospital, Stillorgan, Co. Dublin was not operational in the period 2002-2004.

The proportion of these admissions that were non-voluntary has also decreased from 11.3% in 2002 to 9.7% in 2004, when there were 34 such admissions. There is no reason to presume that the numbers in the non-voluntary category of patient will increase under new legislation.

Not included in Tables 2.8 and 2.9 are admissions to paediatric wards and general wards in acute hospitals. Arrangements for such admissions have evolved on an ad hoc basis and generally reflect the non-availability of child and adolescent mental health beds.

Interim Solution:
This Section of the Report has outlined current service provision and the basis for estimating need going forward. Specific proposals to provide an interim solution are outlined in the next Section of this Report (Section 3).

Section 3: Provision of Interim Solution

3 Introduction

In Section 2 of this Report, the Forum outlined in detail current service provision and identified the requirement going forward taking account of the recommendations in A Vision for Change and a review of current service provision undertaken by the Forum. The focus of the Forum in this Section of the Report is on the provision of an interim solution taking into account the imminent commencement of the Mental Health Act 2001.

It is recognised that the interim arrangements proposed in this report are not the ideal which all service providers are striving for. In order to be in a position to implement the Mental Health Act 2001 on 1st November 2006, however, in-patient capacity needs to be identified and guidelines agreed. This is recognised as an interim solution, until the in-patient units recommended in *A Vision for Change* are in place (see Section 1.5 of this document).

The proposed interim solution for the care of children and adolescents with a mental illness, which needs to be in place for 1st November 2006, has three facets.

3.1 Additional Specialist Beds

It will not be possible to put in place the 100 specialist beds recommended in *A Vision for Change* within a few months. However, it may be possible to produce about one third of that capacity within the next six months. The Forum strongly recommends that the full number of beds (100) be delivered prior to the review period of 5 years set out in *A Vision for Change*.

3.2 Child and Adolescent Community Mental Health Teams (CMHTs)

It is recognised that child and adolescent community mental health teams (CMHTs) assess and treat children who are referred to them, a small number of which will require assessment and treatment in an in-patient unit. The absence of fully developed CMHTs increases the likelihood of an individual child's mental health deteriorating to such an extent that s/he needs in-patient admission. Also, the difficulty experienced by a CMHT in accessing an in-patient place for a child who requires admission can put an intolerable strain on the resources of the community team.

3.3 Continuation of Current Arrangements on an Interim Basis and Increased Supports

The current arrangements for in-patient care, as described in Section 2 of this Report, are provided in a variety of ways throughout the country. These arrangements are not satisfactory and should cease as quickly as possible in tandem with the development of specific in-patient facilities for children.

These three facets to the interim solution are described in more detail below.

3.1.1 Additional Specialist Beds

The Forum has noted the proposals in *A Vision for Change* which recommends 100 beds for children and adolescents with a mental illness. The Forum has determined that **an interim 36 - 44 beds should be identified immediately.** The recommended arrangements for the provision of these beds are as follows:

a) New Interim Beds on a Regional Basis

It is recommended that **an additional 24-32 dedicated adolescent psychiatric beds, primarily for the 16 and 17 year age group,** should be made available nationally in the interim. **Eight locations should be identified** across the four Health Service Executive administrative areas, taking account of geographical accessibility. Two locations should be selected for each administrative area and **3-4 beds provided in each**.

- HSE West
- HSE South
- HSE Dublin Mid-Leinster
- HSE Dublin North East

The provision of 3-4 beds in each of these geographical locations will provide a minimum of 24 and a maximum of 32 beds nationally. **The proposed locations must provide an appropriate treatment and social environment for children and adolescents. They must also be registered approved units and be in a position to comply with the regulations under the Mental Health Act 2001. The standards laid down by the Mental Health Commission (when available) should be met by these interim locations.**

b) Expansion of Existing Facilities

We also recommend **an increase of 12 beds at the existing child psychiatric units, primarily for the under 16 years age group** (6, St. Anne's Galway; 6, Warrenstown, Dublin). (Section 3.3.2.).

3.2.1 Child and Adolescent Community Mental Health Teams (CMHTs)

The national policy *A Vision for Change* sets out the model of child and adolescent mental health service that needs to be provided and resourced into the future. This service should be provided through fully staffed multidisciplinary teams working in the community, in well equipped and designed community mental health centres. To support this increased capacity, this Forum is recommending the **immediate recruitment of eight additional child and adolescent teams (CMHTs).** In the following four years, an additional eight teams per year are recommended, so that 40 additional teams will be in place by 2010. .

The Forum recommends that the eight teams to be initially appointed be collocated with the new interim beds which will number 3-4 beds in eight locations across the country. Based on current admission data available for 16 -18 year olds to Adult Psychiatric units, these additional beds should provide for all admissions of 16-18 year olds who were previously admitted to adult units.

The Forum noted the recommendations of the Comhairle na nOspidéal report *Consultant Staffing in the Mental Health Service (2004), the Second Report of the Working Group on Child and Adolescent Psychiatric Services, (Department of Health and Children, 2003) and A Vision for Change, 2006,* on **the need for flexible arrangements, particularly in the transition to a fully developed 0 – 18 years service.**

The advice set out in *Consultant Staffing in the Mental Health Service (2004),* Comhairle na nOspidéal, recommends:

"In considering the issue of service provision to 16 and 17 year olds, the recommendations contained in the Second Report of the Working Group on Child and Adolescent Psychiatric Services (June 2003) established by the Department of Health and Children in June 2000 were noted. Comhairle na nOspidéal does not feel it would be appropriate to recommend the creation of posts with a special interest in later adolescence as it does not desire to introduce another divide in psychiatric services based on age. Rather it feels that psychiatric services for 16 and 17 years should become the responsibility of the child and adolescent psychiatric service as a whole rather than an identified section within it with a special interest. It may be useful for employing authorities, in consultation with existing postholders, to identify specific existing or future postholders who will be charged with the responsibility of co-ordinating, leading and advising on the transfer of services for 16/17 year olds from the adult service to the child and adolescent service in each region.

The transfer of responsibility for the treatment of 16 and 17 year olds from the adult service to the child and adolescent service will require a great deal of flexibility from both services both now and in the future. ***Comhairle would advise against the strict divide of services solely based on dates of birth of patients but rather recommends that on going flexibility would be built into service provision.*** *This would facilitate for example a 17 year old diagnosed after assessment with a chronic psychiatric illness being treated by the adult service, rather than having to transfer from the child and adolescent service to the adult service after a small number of months. Conversely, a 17 year old diagnosed with an acute psychiatric illness could be treated by the child and adolescent service, even if the necessary treatment extended beyond the patient's 18th birthday. Ultimately smooth transfer and continuity of treatment across services should be a priority and it is recommended that all services are involved in putting in place agreed protocols in each region to ensure that the care of this patient group is not compromised and that the transition between services is planned and seamless."*

An essential brief for the eight new teams recommended is to complete a needs analysis, in their designated area, of adolescent services and to assist Child and Adult Psychiatrists, Paediatricians, Primary Care Stakeholders and

Management in their area in the planning and transition to comprehensive adolescent services.

As the new CMHTs will need a physical infrastructure in which to locate themselves, **attention should be given at this stage to any opportunity to locate these new teams where it is expected that new in-patient units will be sited. Provision for accommodation requirements of new teams needs to be prioritised in drawing down capital funding requirements**.

The policy document *A Vision for Change* recommends 13 **Day Hospital facilities** (rising to 14, using the 2006 Census figures). These facilities **will require a capital allocation to develop the appropriate infrastructure and the opportunity to plan for such a capital outlay arises at this time**. This requirement needs to be prioritized in the short term.

The Forum recommends that immediate planning should commence at national and local level to give effect to the interim solutions outlined in this Section of the Report.

3.3.1 Continuation of Current Arrangements on an Interim Basis and Increased Supports

The Forum considers that the **continuation of present arrangements needs to be maintained for a certain period of time**. Arrangements currently in place for the acute psychiatric care of the under 18 age group vary throughout the country and include admission to both public and private child and adult psychiatric units, paediatric units and general medical wards. A clear timeframe is required for the transition from the current interim arrangements to the ideal arrangements to be set out by the *Vision for Change* Implementation Team.

3.3.2 Public Sector Child and Adolescent In-Patient Units – Proposed Interim Increase in Bed Numbers

The Forum recommends that capacity at St. Anne's, Galway, be increased to ten beds from four – an additional six beds. It is further recommended that **bed numbers at Warrenstown, Dublin, be increased from six to twelve – an additional six beds**. In addition, **the existing five-day service at Warrenstown should be increased to a seven-day service**.

The capital and staff associated costs need to be identified by the local services and submitted for national funding.

The existing capacity of ten beds (**four beds at St. Anne's and six at Warrenstown**) and the additional twelve-bed capacity (**six beds at St. Anne's, six beds at Warrenstown**) should provide **primarily for the under 16 years cohort**.

3.3.3 Private Sector In-Patient Units

The existing arrangements (12 beds at St. John of God Hospital, Stillorgan and the Young Adult Programme at St. Patrick's Hospital, Dublin) should continue.

The Forum recommends that the issue of Private Psychiatric provision for children and adolescents be dealt with in the longer term by the *Vision for Change* Implementation Team.

3.3.4 Acute Adult Psychiatric In-Patient Units

It is proposed that **children aged under 16 years should not be admitted to adult psychiatric hospitals or units, except in exceptional circumstances,** and **where the needs of the child can only be met by admission to an adult unit**.

During the interim period, prior to the development of purpose built child and adolescent psychiatric units, admissions of those aged 16 and 17 years will continue to arise. As an interim arrangement, the management of referrals of 16 and 17 year olds at community and in-patient level should continue to be provided by the Adult Psychiatric service. The eight new Child and Adolescent teams will commence the smooth transfer of responsibility for 16 and 17 year olds: *It may be useful for employing authorities, in consultation with existing postholders, to identify specific existing or future postholders who will be charged with the responsibility of co-ordinating, leading and advising on the transfer of services for 16/17 year olds from the adult service to the child and adolescent service in each region,* (Comhairle na nOspidéal, 3.2.1 (Page 24). **Collegiality and cooperation between adult and child and adolescent services has led to the development of management strategies offering the optimum level of care for individual patients in some service areas**. Where such arrangements exist, they **should continue to be supported and adequately resourced**. **Where such systems do not exist, local adult and child and adolescent mental health teams should be facilitated in developing strategies to meet local demands in the interim period**. This is a short term arrangement only and **local management teams should consider providing current service providers with a deadline by which this arrangement will end. It Is accepted that a considerable increase in both in-patient and community child and adolescent mental health team capacity needs to be in place prior to terminating this arrangement.**

It is recommended that, **in the event of a bed not being available in the local designated units, current arrangements for admission to adult units should continue until such time as a bed becomes available.**

3.3.5. Paediatric services / General Wards in Acute Hospitals

The Forum recommends that the existing 2 Units (St. Anne's, Galway, and Warrenstown, Dublin) will continue, and proposals for an increase in bed numbers have been dealt with in Section 3.3.2.

Child and adolescent psychiatric Liaison Teams exist only in the three Dublin Children's Hospitals. **Developing Liaison Psychiatric Teams should be prioritized.**

The *Vision for Change* policy document recommends a norm of one Liaison Team per 300,000 population. 13 teams will be required nationally, based on 2002 Census figures, revised up to 14 with the 2006 Census figures.

In the interim, pending the introduction of Liaison Teams throughout the country, **existing arrangements should be supported by recruitment of Clinical Nurse Specialists** whose role is to facilitate co-ordination between the CMHT and the paediatric service. This nurse would also support staff by way of expertise in psychiatric care and treatment.

The Department of Health & Children policy document, *Reach Out, National Strategy for Action on Suicide Prevention 2005-2014* recommends a targeted approach (Action 12: Deliberate Self Harm) with the recommended action to be taken, as follows: extend *assessment, treatment and aftercare for people; introduce guidelines for responding to people presenting to hospitals following deliberate self harm; implement an effective service response appropriate to the need in each area;* and *plan and deliver basic awareness training for all levels of hospital staff on suicidal behaviour.*

The Forum suggests that more specific data collection would be helpful in relation to the future planning, targeting and resourcing of specific issues. It would also assist the planning of preventative strategies for the communities / services from which these people originate.

Section 4: Ancillary Issues

4.1 Introduction

The Forum, in reviewing the Ancillary Issues, has determined that there are a number of factors to be dealt with if the recommendations in this Report are to be applied efficiently and effectively. These issues are as follows:

4.2 Human Resource Issues

4.2.1 Staffing:

At present, young adolescents aged 16 and 17 years who are admitted to adult psychiatric facilities are treated as "young adults". Under the Mental Health Act 2001 these young adults will henceforth be legally defined as children.

Both the **continuation of the existing arrangements**, as described above, **and the provision of interim in-patient capacity, may require staff to be deployed into this area**. Increased staff ratios may be required for children who are admitted to settings other than a child psychiatric unit (for example, an adult psychiatric unit) and this needs to be taken into account.

The number and mix of staff required will be a matter for each local service or each of the four administrative areas to decide, depending on the interim arrangements to be put in place.

4.2.2.Recruitment and Retention Issues:

4.2.2.1 There is a recognised deficit in the number of available trained and experienced staff in Child and Adolescent mental health services. **Recruitment drives will need to be national and international**, **and** this will need to be **supported by expanding existing training programmes and increasing the number of entry level posts across all disciplines**. These principles would apply to all disciplines in the multidisciplinary team (MDT).

4.2.2.2 Both in the immediate and longer term, **the provision of clear career progression pathways and appropriate clinical management structures will be essential in recruitment, retention and continuing practice development.**

4.2.2.3. Seven **Senior Registrars** will have completed higher specialist training in the year 2006. **Consideration should be given to increasing the number of training places in order to fill projected consultant posts.**

4.2.2.4 **Processing of approval of permanent Consultant posts should be fast-tracked, locum positions should be advertised immediately in advance of the implementation of the Mental Health Act.**

4.2.3. Training:

All staff involved in caring for children in in-patient settings should be provided with appropriate training. Core areas to be covered by such training programmes would be:

- **Assessment and treatment of children**
- **Child protection - *Children First***
- **Children's rights**

Expansion of the brief of Child and Adolescent psychiatric services to incorporate the 16-18 year old age group will result in changing work practices, specifically existing consultant child and adolescent psychiatrists may need retraining/upskilling in order to deal with the expanded age group and different profile of illnesses and should be facilitated to do so. **Provision will need to be made for funding of relevant training required by staff in the transition period.**

Replacement staff will need to be funded to facilitate the rapid provision of training.

4.2.4. On Call Arrangements:

The issue of Consultant on call arrangements for Consultants to facilitate the recommended interim arrangements needs to be addressed by the Health Service Executive, Human Resources Directorate and at Regional level.

4.2.5 Out of Hours Availability:

The issue of out of hours availability of the designated person(s) under the Mental Health Act 2001 needs to be addressed as a matter of urgency by the Health Service Executive, Human Resources Directorate and at Regional level.

4.3 Child Protection Issues

At a minimum, all staff caring for admitted children should be trained in *Children First*. These national guidelines for child protection and welfare set out the roles, responsibilities and procedures to be followed in relation to concerns around child abuse. It is applicable to all who work with or have contact with children. There is a four-day training programme associated with the guidelines as well as half-day briefing sessions. **All staff who will be caring for admitted children should have received, as a minimum, the half day briefing before the 1st November 2006, with the four day programme rolled out as soon as possible. Replacement staff will need to be funded to facilitate the rapid provision of training**. **The treatment of children must comply with the rules currently being developed by the Mental Health Commission and as new members are appointed to multidisciplinary teams they must be made aware of their responsibilities under the Mental Health Act 2001.**

Every person working with children in child and adolescent psychiatric services must have Garda clearance and references from three previous employers. Child Protection Services/ Children's Residential Units have a system in place to obtain Garda clearance for staff and this may be a useful model. **A system will need to be put in place for the interim in-patient units and adult psychiatric units. Immediate corporate action involving the HSE Human Resources Directorate is required to advance this issue.**

Section 5: Summary of Key Recommendations and Funding Arrangements

5.1 Introduction

This Section of the Report concentrates on the recommendations that are key to creating the interim capacity required for the commencement of the Mental Health Act, 2001. There are other recommendations in this Report that do not appear in Section 5 that have medium to long term importance.

5.2 Key Recommendations

5.2.1 The Forum recommends that immediate planning should commence at national and local level to give effect to the interim solutions outlined.

5.2.2 The capital and staff associated costs of the additional capacity (beds and CMHTs) should be identified by the regional services and submitted for national funding. See **5.3 Funding Arrangements**

5.2.3 An additional 24-32 dedicated adolescent psychiatric beds, primarily for the 16 and 17 year age group, should be made available nationally in the interim. Eight locations should be identified across the four Health Service Executive administrative areas, taking account of geographical accessibility. Two locations should be selected for each of the four administrative areas and 3-4 beds provided in each.

5.2.4 The proposed locations must provide an appropriate treatment and social environment for children and adolescents.

5.2.5 They must also be registered approved units and be in a position to comply with the regulations under the Mental Health Act 2001.

5.2.6 The standards laid down by the Mental Health Commission (when available) should be met by these interim locations.

5.2.7 We recommend an increase of 12 beds at the existing child psychiatric units, primarily for the under 16 years age group (6, St. Anne's Galway; 6, Warrenstown, Dublin).

5.2.8 To support increased capacity, this Forum is recommending the immediate resourcing of eight additional child and adolescent teams (CMHTs) and a further eight consultant posts and teams per year over the following four years.

5.2.9 The Forum recommends that the eight teams to be initially appointed be collocated with the new interim beds which will number 3-4 beds in eight locations across the country.

5.2.10 An essential brief for the eight new teams recommended is to complete a needs analysis, in their designated area, for adolescent mental health services. This will assist Management and Stakeholders in the planning and transition to comprehensive adolescent services. .

5.2.11 Provision for accommodation requirements of new teams needs to be prioritised in drawing up capital funding requirements. See **5.3 Funding Arrangements**.

5.2.12 Capital should be allocated in the short term for new Day Hospital facilities. See **5.3 Funding Arrangements**

5.2.13 The Forum recommends that the continuation of current arrangements as outlined at Section 3.3.1 of this Report must be maintained. These include Public Sector in-patient access (3.3.2), Private Sector in-patient access (3.3.3), Acute Adult Psychiatric in-patient access (3.3.4) and Paediatric and General Ward in-patient access (3.3.5)

5.2.14 During the interim period, admissions of those aged 16 and 17 years will continue to arise. As an interim arrangement, the management of referrals of 16 and 17 year olds at community and in-patient level should continue to be provided by the Adult Psychiatric service. The eight new Child and Adolescent teams will commence the smooth transfer of responsibility for 16 and 17 year olds.

5.2.15 The arrangements described in the previous recommendation (5.2.14) are short term only and consideration should be given to providing adult mental health services with a deadline by which this arrangement will end. It Is accepted that a considerable increase in both in-patient and community mental health team capacity needs to be in place prior to terminating this arrangement**.**

5.2.16 It is recommended that, in the event of a bed not being available in the local designated units, current arrangements for admission to adult units should continue until such time as a bed becomes available.

5.2.17 The number and mix of staff to be recruited will be a matter for each local service or each of the four administrative areas to decide, depending on the interim arrangements to be put in place.

5.2.18 Immediate recruitment of staff required for the interim arrangements should take place.

5.2.19 Processing of approval of Consultant posts should be fast-tracked, locum positions should be advertised immediately on approval in advance of the implementation of the Mental Health Act, 2001.

5.2.20 The provision of interim increased in-patient capacity may require the re-deployment of staff from their current areas of work.

5.2.21 All staff involved in caring for children in in-patient settings should be provided with appropriate training. Core areas to be covered by such training programmes would be:

- Assessment and treatment of children
- Child protection – *Children First*
- Children's Rights

All staff who will be caring for admitted children should have received, as a minimum, the half day briefing on *Children First* before the 1st November 2006, with the four day programme rolled out as soon as possible.

5.2.22 Provision will need to be made for funding of staff to access any upskilling needed to cater for the 16 and 17 year old age group in in-patient settings.

5.2.23 Replacement staff will need to be funded to facilitate the rapid provision of training.

5.2.24 The issue of Consultant on call arrangements for to facilitate the recommended interim arrangements needs to be addressed by the Health Service Executive, Human Resources Directorate and at Regional level.

5.2.25 The issue of out of hours availability of the designated person(s) under the Mental Health Act 2001 needs to be addressed as a matter of urgency by the Health Service Executive, Human Resources Directorate and at Regional level.

5.2.26 Every person working in child and adolescent psychiatric services must have a Garda clearance and references from three previous employers. A system will need to be put in place immediately by the HSE to cater for this.

5.3 Funding Arrangements

5.3.1 Each of the four administrative areas must produce a capital and revenue costed action plan to meet the requirements of the interim recommendations of the Forum.

5.3.2 The 2006 revenue cost should only be for the remainder of this year, with full year costs for 2007 to be identified. A sum of €3.25m revenue is available for the 2006 costs and priorities should be agreed for the use of this funding.

5.3.3 Capital funding costs should also be set out by each Local Service / Administrative Area in respect of the interim arrangements. Ongoing capital costs should be identified through the implementation of *A Vision for Change*.

Section 6 - Appendices

Appendix 1	Members of the Forum
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Appendix 1: Members of Forum

Name	Position	Location	Nominating Organisation
Dr Mandy Burke	Consultant Child & Adolescent Psychiatrist	University College Hospital, Galway	ICP
Ms Phil Canny	Asst Dir of Nursing	Child & Adolescent MH Services, Limerick	HSE
Dr Ian Daly	Clinical Director, Consultant Adult Psychiatrist	Dublin West/South West Mental Health Services	HSE
Dr Brendan Doody	A/Clinical Director, Child & Adolescent Psychiatrist	Warrenstown House, Blanchardstown, Dublin 15	HSE
Mr Dave Drohan	LHO Manager	North Lee, Cork	HSE - **Chair**
Dr Bob Fitzsimons	Consultant Paediatrician	Kerry General Hospital, Tralee, Co. Kerry	HSE
Dr Kate Ganter	Consultant Child & Adolescent Psychiatrist	Lucena Clinic, Rathgar, Dublin 6	IMO
Dr Colette Halpin	Consultant Child Psychiatrist	Midlands Regional Hospital, Portlaoise, Co. Laoise	IHCA
Dr Keith Holmes	Consultant Child Psychiatrist	Lucena Clinic, Rathgar, Dublin 6	ICP (Substitute for Mandy Burke)
Ms Breda Lawless	Service Planner	HSE, Mill Lane, Palmerstown, Dublin 20	HSE
Dr Joan Michael	Consultant Child & Adolescent Psychiatrist	Lucena Clinic, Rathgar, Dublin 6	IMO (Substitute for Kate Ganter)
Mr Barry Murray	Childcare Manager	Floor 2, Abbeycourt House, Georges Quay, Cork	HSE
Mr Martin Rogan	National Care Group Manager for Mental Health	Millennium Park, Naas, Co. Kildare	HSE
Dr Noel Sheppard	Consultant Adult Psychiatrist	Waterford Regional Hospital	ICP

Appendix 2: Publications considered by the Forum

1. A Vision for Change **Expert Group on Mental Health, DoHC 2006**

2. Annual Report of the Mental Health Commission, including the Report of the Inspector of Mental Health Services 2005
Mental Health Commission 2006

3. Mental Health Act 2001
Reference Guide to Mental Health Act
Mental Health Commission 2005

4. Reach Out – National Strategy for Action on Suicide Prevention 2005-2014
Health Service Executive, National Suicide Review Group and Department of Health and Children 2005

5. Discussion Paper on Child and Adolescent Psychiatry in the Three Children's Hospitals, Dublin **Council for Children's Hospitals' Care 2005**

6. Consultant Staffing in the Mental Health Service
Comhairle na nOspidéal 2004

7. A Better Future Now **Irish College of Psychiatrists 2005**

8. Mental Illness – The Neglected Quarter
Amnesty International (Irish Section) 2003

9. Working Group on Child and Adolescent Psychiatric Services, First Report
Department of Health and Children 2001

10. Working Group on Child and Adolescent Psychiatric Services, Second Report
Department of Health and Children 2003

11. QNIC Quality Network for In-patient CAMHS – Service Standards 2005/2006
Royal College of Psychiatrists Research Unit

12. National In-patient Child and Adolescent Psychiatry Study (NICAPS)
Royal College of Psychiatrists Research Unit

13. Psychiatric Inpatient Services for Children and Young People in Scotland: A Way Forward **Child Health Support Group 2004**

14. Variations in the costs of child and adolescent psychiatric in-patient units
British Journal of Psychiatry 2003

15. Safeguarding Children and Adolescents detained under the Mental Health Act 1983 on Adult Psychiatric Wards – Executive Summary

Appendix 3: Admissions to Each Psychiatric Hospital of Young People <18 yrs.

Northern Area	2002	2003	2004	North East	2002	2003	2004
St Ita's Hospital, Portrane	15	10	14	St Brigid's Hospital, Ardee	5	15	5
St Vincent's Hospital, Fairview	9	5	1	Cavan General Hospital	1	1	0
St Brendan's Hospital, Dublin	8	3	2	St. Davnet's Hospital, Monaghan	1	0	0
Mater Misericordiae Hospital	3	1	4	Our Lady"s Hospital, Navan	2	2	3
James Connolly Memorial Hospital	0	3	3				
Total	**35**	**22**	**24**	**Total**	**9**	**18**	**8**

South Western / East Coast Area	2002	2003	2004	Midlands	2002	2003	2004
St James's Hospital, Dublin	2	6	1	St Loman's Hospital, Mullingar	12	15	7
Tallaght Hospital, Dublin	15	2	12	St Fintan's Hospital, Portlaoise	7	8	8
Naas General Hospital	23	9	13	Midland Regional Hospital, Portlaoise	0	0	4
Vergemount Clinic, Clonskeagh	3	0	1				
Cluain Mhuire Family Centre, Dublin	10	13	8				
St Vincent's Hospital, Elm Park	4	4	5				
Central Mental Hospital, Dublin	1	0	2				
Newcastle Hospital, Greystones	3	4	8				
Total	**61**	**38**	**50**	**Total**	**19**	**23**	**19**

Southern	2002	2003	2004	South East	2002	2003	2004
Our Lady's Hospital, Cork	2	1	0	Waterford Regional Hospital	9	15	11
St Stephen's Hospital, Cork	5	3	7	St Senan's Hospital, Enniscorthy	9	15	2
Cork University Hospital	8	8	4	St Luke's Hospital, Clonmel	1	3	2
Mercy Hospital, Cork	11	16	16	St Joseph's Hospital, Clonmel	22	17	10
Carraig Mór, Cork	0	0	2	St Luke"s Hosptial, Kilkenny	0	4	4
Bantry General Hospital	1	2	0	St Canice's Hospital, Kilkenny	1	0	0
Tralee General Hospital	25	12	7	St Dympna's Hospital, Carlow	7	0	0
St Finan's Hospital, Killarney	0	1	1				
Total	**52**	**43**	**37**	**Total**	**49**	**54**	**29**

Western	2002	2003	2004	Mid West	2002	2003	2004
Mayo General Hospital	0	0	2	Regional Hospital, Limerick	29	27	11
St Mary's Hospital, Castlebar	7	1	0	Ennis General Hospital	9	13	4
University College Hospital, Galway	12	9	15	**Total**	**38**	**40**	**15**
St Brigid's Hospital, Ballinasloe	3	8	12	**North West**			
Roscommon County Hospital	4	5	5	Mental Health Service, Sligo	3	4	4
				Letterkenny General Hospital	10	2	6
Total	**26**	**23**	**34**	**Total**	**13**	**6**	**10**

Private Adult Hospitals	2002	2003	2004	Child & Adolescent Units	2002	2003	2004
St Patrick's Hospital, Dublin	67	55	62	Warrenstown House, Dublin	20	25	35
St John of God Hospital, Dublin	24	9	4	Courthall, Dublin	10	0	0
Palmerstown View, Dublin	0	0	1	St Anne's Children's Centre, Galway	29	37	24
Total	**91**	**64**	**67**	**Total**	**59**	**62**	**59**

Appendix 4

Part 4.1, Mental Health Commission Reference Guide to Mental Health Act 2001.

4.1 DEFINITION OF MENTAL DISORDER1

This definition of mental disorder applies to children in relation to involuntary admissions.
The term "mental disorder", as defined in the Mental Health Act 2001, means mental illness, severe dementia or significant intellectual disability where either:
• because of the illness, dementia or intellectual disability there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,
or
• because of the severity of the illness, dementia or disability, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such an admission
and that
the reception, detention and treatment of the person in an Approved Centre would be likely to benefit or alleviate the condition of the person to a material extent.

For the first time in Irish mental health law a definition is provided of mental disorder for which a person may be involuntarily admitted and treated. In some respects, the definition is clinical in nature in that it is defined as being mental illness, severe dementia or significant intellectual disability. *Mental illness, severe dementia, or significant intellectual disability are crucial to but not sufficient in themselves for a person to have a mental disorder and thereby admitted involuntarily.*

The clinical condition may be such that there is a serious likelihood of the person causing serious and immediate harm to self or others. In such cases a person may be involuntarily admitted for his or her own safety or for the safety of others. This is not a new concept. However, where such potential harm to self or others is not an issue a person may nonetheless be involuntarily admitted on the other grounds of mental disorder.

Such an admission may occur where the severity of the illness, dementia or intellectual disability is such that the judgment of the person is so impaired that failure to admit the person would be likely to cause a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such an admission. In such circumstances involuntary admission may be warranted, but only where such admission would be likely to benefit or alleviate the condition of that person to a material extent.

HOW IS MENTAL ILLNESS DEFINED?

The 2001 Act defines mental illness as:
"... a state of mind of a person which affects the person's thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons."[2]

1 Mental Health Act 2001, S3.
2 Mental Health Act 2001, S3.

WHAT IS A MENTAL DISORDER IN THE CONTEXT OF MENTAL ILLNESS?

In addition to the clinical presentation of mental illness as described above, to fulfil the criteria for involuntary admission one of the following two criteria must also be met:

• because of the mental illness there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,

or

• because of the severity of mental illness, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition, **or**

would prevent the administration of appropriate treatment that could only be given by such admission, **and that**

the reception, admission and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

HOW IS SEVERE DEMENTIA DEFINED?

The 2001 Act defines severe dementia as:

"...a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression."[3]

The definition in the 2001 Act therefore, places the emphasis on the presence of severe psychiatric or behavioural symptoms in addition to the severity of the cognitive impairment as clinically defined in accordance with ICD-10 and DSM-IV-TR.[4]

Thus a person may present with varying levels of cognitive impairment within a diagnosis of dementia but, to fulfil the criteria for involuntary admission, the person must also present with severe psychiatric or behavioural symptoms such as aggressive behaviour. The symptoms could also include delusions or hallucinations – the 2001 Act does not limit the symptoms to aggressive behaviour.

WHAT IS A MENTAL DISORDER IN THE CONTEXT OF SEVERE DEMENTIA?

In addition to the clinical presentation of severe dementia as described above, to fulfil the criteria for involuntary admission one of the following two criteria must also be met:

• because of the dementia there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,

or

• because of the severity of dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition, **or**

would prevent the administration of appropriate treatment that could only be given by such admission, **and that**

the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

3 Mental Health Act 2001, S3.

4 World Health Organisation (1992), The ICD-10 "Classi.cation of Mental and Behavioural Disorders"; American Psychiatric Association (1996), "Diagnostic and Statistical Manual of Mental Disorder" – Text Revision (1994).

HOW IS SIGNIFICANT INTELLECTUAL DISABILITY DEFINED?

The Mental Health Act, 2001 defines significant intellectual disability as:
"...a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person."[5]

In order to establish a mental disorder through a finding of significant intellectual disability, in accordance with the 2001 Act, a state of arrested or incomplete development of the mind includes:
• significant impairment of intelligence
and
• significant impairment of social functioning
and
• abnormally aggressive **or** seriously irresponsible conduct
all of the above criteria must be established separately.

WHAT DO THE TERMS OF THE DEFINITION MEAN AND HOW CAN THEY BE ESTABLISHED?

The Mental Health Commission provides the following guidance in relation to Significant Intellectual Disability, and shall, from time to time, furnish additional guidance.

SIGNIFICANT IMPAIRMENT OF INTELLIGENCE

The principal method for determining levels of intellectual functioning is psychometric assessment. Assessment of intellectual functioning should be obtained by using an individually administered standardised test, which is recognised as reliable and valid. The assessor should have training and experience in the administration of standardised psychological instruments. An Intelligence Quotient (IQ) level of under 69 is an indication of significant intellectual disability rather than conclusive evidence and the test employed in any given case must be appropriate for the person's age; cultural; linguistic; and social background (The British Psychological Society, 2001). It is acknowledged that formalised assessment may not always be possible due to the individual's level of functioning. Best practice also advises that allowance should be made for the possibility of measurement error and IQ figures should only be quoted with explicit confidence limits based on the standard error of measurement.

Assessment findings should be interpreted in the light of knowledge of the uses and limitations of such assessment findings. It is advised that the psychometric assessment would have been completed within the past five years (or as best practice dictates).

SIGNIFICANT IMPAIRMENT OF SOCIAL FUNCTIONING

An assessment of impairment of social functioning is related to a person's performance in coping on a day-to-day basis with the demands of his or her environment. It is related to a person's age and the socio-cultural expectancies associated with his/her environment at any given time. It is concerned with what a person does (i.e. actual behaviour/performance).

Impairment of adaptive/social functioning may range from occasional to pervasive, i.e. needing support intermittently to continuously in such areas as self-care; communication; home living; self-direction; occupational; social; and interpersonal skills.

The British Psychological Society (2001) notes that impairment of social functioning is usually measured by direct observation and/or in conjunction with at least one informant who knows the person well (e.g. a parent, carer or friend). While standardised assessments of adaptive and social functioning may be helpful, the British Psychological Society (2001) is of the opinion that there is not, as yet, sufficient consensus within the area for one single assessment to be recommended.[6]

5 Mental Health Act 2001, S3

6 British Psychological Society (2001) "Learning Disability: De.nitions and Contents".

ABNORMALLY AGGRESSIVE OR SERIOUSLY IRRESPONSIBLE CONDUCT

The criterion of abnormally aggressive or seriously irresponsible conduct is behaviour which must be associated with 'a state of arrested or incomplete development of mind'. Any assessment of *abnormally aggressive conduct* should be based on observations of behaviour which lead to a conclusion that the actions are outside the usual range of aggressive behaviour – unpredictability or unreasonableness under the circumstances will be factors which may establish the criterion.

Irresponsible conduct is that which shows a lack of responsibility and/or a disregard of the consequences of the action – it does not necessarily require the person to be capable of judging these consequences. In certain circumstances failure to act can also be evidence of irresponsibility.

The assessment of 'abnormally aggressive or seriously irresponsible conduct' can be seen to have both observational (i.e. the actual behaviour) and judgement (i.e. the abnormality and/or seriousness component). To meet the criteria for each, abnormally aggressive and seriously irresponsible conduct should result in actual damage and/or real distress (in some cases to the self), and should occur either recently or persistently or with excessive severity.

HOW DOES ONE DECIDE WHEN ABNORMALLY AGGRESSIVE OR SERIOUSLY IRRESPONSIBLE CONDUCT HAS CEASED?

In order to act in the best interest of the person, it would not be appropriate to continue to regard a person as having 'significant intellectual disability' under the terms of the Mental Health Act, 2001, if remission or treatment has eliminated their abnormally aggressive or seriously irresponsible conduct. In arriving at such a decision, account should be taken of the extent to which the current environment and social context may reduce the possibility of such conduct occurring. Observation is the recommended tool of assessment and judgement is likely to be most readily optimised by drawing upon **clinical experience** of similar profiles.

WHAT IS A MENTAL DISORDER IN THE CONTEXT OF SIGNIFICANT INTELLECTUAL DISABILITY?

In addition to the clinical presentation of significant intellectual disability, as described above, to fulfil the criteria for mental disorder (involuntary admission) one of the following two criteria must also be met:

• because of the significant intellectual disability there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,

or

• because of the significant intellectual disability, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition, or would prevent the administration of appropriate treatment that could only be given by such an admission,

and that

the reception, admission and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

ARE THERE ANY EXCLUSION CRITERIA FOR MENTAL DISORDER?[7]

Yes.

The Mental Health Act 2001 outlines three exclusions from the definition of mental disorder. These exclusions are behaviour, conditions or circumstances that **cannot on their own** be considered mental disorder.

Section 8(2) of the 2001 Act states that it is not lawful to admit a person involuntarily in an Approved Centre solely because that person is:

(a) suffering from a personality disorder,

(b) is socially deviant, or

(c) is addicted to drugs or intoxicants.

7 Mental Health Act 2001, S8.

The 2001 Act does not define personality disorder, socially deviant or addiction to drugs or intoxicants. The Mental Health Commission provides the following guidance for general practitioners, the Garda Síochána and staff in Approved Centres, to assist them in relation to the provisions of this section.

WHAT IS A PERSONALITY DISORDER?

Personality disorders are described in the *International Classification of Mental and Behavioural Disorders* (ICD-10)[8] as 'deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations'; they represent either extreme or significant deviations from the way an average individual in a given culture perceives, thinks, feels and particularly relates to others and are 'developmental conditions, which appear in childhood or adolescence and continue into adulthood'.[9]

WHAT IS SOCIALLY DEVIANT?

Socially deviant is a term that refers to any behaviour that does not conform to social norms.[10] What is perceived as deviant behaviour is subject to change as it is culturally determined and depends on the values and beliefs of society. Different cultures have different perceptions of social order, therefore making what may be perceived as deviant behaviour in one culture wholly acceptable in another.

Difficulty in adapting to
- moral;
- social;
- political; or
- other values,

in itself, should not be considered a mental disorder.[11]

Non conformity with
- moral;
- social;
- cultural; or
- political values, or
- religious beliefs prevailing in a person's community,

shall never be a determining factor in diagnosing mental illness.[12]

The explicit exclusion of a person who is socially deviant from the definition of mental disorder brings Irish mental health law into conformity with international standards.

WHAT IS ADDICTION TO DRUGS OR INTOXICANTS?

Addiction to drugs or intoxicants is clinically defined as '*dependence syndrome*' in the ICD-10 Classification of Mental and Behavioural Disorders or '*substance dependence*' in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).

The Mental Health Act 2001 prohibits the involuntary admission of a person whose primary diagnosis is addiction to drugs or intoxicants.[13]

It should be noted that a person who is suffering from a personality disorder, who is socially deviant or is addicted to drugs or intoxicants may nonetheless require involuntary admission from time to time if he/she develops a mental disorder as defined in the 2001 Act.

8 World Health Organisation (1992), "International Classi.cation of Mental and Behavioural Disorders" (ICD-10).
9 World Health Organisation (1992)
10 Giddens A., (2001), "Sociology", 4th Edition.
11 Council of Europe Recommendation No. R(83)2 of the Committee of Ministers to Member States concerning the legal protection of persons suffering from mental disorders placed as involuntary patients (1983).
12 "The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care", Principle 4.3(1991).
13 Mental Health Act 2001 S8(2)(c).

WHY ARE THERE EXCLUSION CRITERIA?

These exclusions bring Irish mental health law into conformity with the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991)[14] and are essential protection to ensure that a person's moral; social; cultural; religious; or political values shall never be the sole determining factor in diagnosing mental disorder. They bring Irish legislation in line with most other countries in respect of substance abuse and addictions. The rationale generally behind having exclusion criteria is to protect against political abuse and to encourage the idea of individual responsibility.

These exclusions ensure that the application of the legislation is confined to persons with a mental disorder as defined in the 2001 Act. In the absence of mental disorder as defined in the 2001 Act, a person cannot be involuntarily admitted solely in order to prevent criminal behaviour. Even if admission to an Approved Centre is likely to be of benefit, in the absence of mental disorder as defined in the 2001 Act, a person cannot be involuntarily admitted. Similarly, in the absence of mental disorder as defined in the 2001 Act, a person cannot be involuntarily admitted if a failure to admit would be likely to lead to a serious deterioration in his or her condition.

14 "The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care", Principle 4.3(1991).

Appendix 5

Section 25, Mental Health Act, 2001

(1) Where it appears to a health board with respect to a child who resides or is found in its functional area that—

(*a*) the child is suffering from a mental disorder, and

(*b*) the child requires treatment which he or she is unlikely to receive unless an order is made under this section,

then, the health board may make an application to the District Court (''the court'') for an order authorising the detention of the child in an approved centre.

(2) Subject to *subsection (3)*, a health board shall not make an application under *subsection (1)* unless the child has been examined by a consultant psychiatrist who is not a relative of the child and a report of the results of the examination is furnished to the court by the health board.

(3) Where—

(*a*) the parents of the child, or either of them, or a person acting in *loco parentis* refuses to consent to the examination of the child, or

(*b*) following the making of reasonable enquiries by the health board, the parents of the child or either of them or a person acting in *loco parentis* cannot be found by the health board,

then, a health board may make an application under *subsection (1)*without any prior examination of the child by a consultant psychiatrist.

(4) Where a health board makes an application under *subsection (1)* without any prior examination of the child the subject of the application by a consultant psychiatrist, the court may, if it is satisfied that there is reasonable cause to believe that the child the subject of the application is suffering from a mental disorder, direct that the health board arrange for the examination of the child by a consultant psychiatrist who is not a relative of the child and that a report of the results of the examination be furnished to the court within such time as may be specified by the court.

(5) Where the court gives a direction under *subsection (4)*, the consultant psychiatrist who carries out an examination of the child the subject of the application shall report to the court on the results of the examination and shall indicate to the court whether he or she is satisfied that the child is suffering from a mental disorder.

(6) Where the court is satisfied having considered the report of the consultant psychiatrist referred to in *subsection (1)* or the report of the consultant psychiatrist referred to in *subsection (5)*, as the case may be, and any other evidence that may be adduced before it that the child is suffering from a mental disorder, the court shall make an order that the child be admitted and detained for treatment in a specified approved centre for a period not exceeding 21 days.

(7) An application under this section may, if the court is satisfied that the urgency of the matter so requires, be made *ex parte*.

(8) Between the making of an application for an order under this section and its determination, the court, of its own motion or on the application of any person, may give such directions as it sees fit as to the care and custody of the child who is the subject of the application pending such determination, and any such direction shall cease to have effect on the determination of the application.

(9) Where, while an order under *subsection (6)* is in force, an application is made to the court by the health board concerned for an extension of the period of detention of the child the subject of the application, the court may order that the child be detained for a further period not exceeding 3 months.

(10) On or before the expiration of the period of detention referred to in *subsection (9)*, a further order of detention for a period not exceeding 6 months may be made by the court on the application of the health board and thereafter for periods not exceeding 6 months.

(11) A court shall not make an order extending the period of detention of a child under this section unless—

(*a*) the child has been examined by a consultant psychiatrist who is not a relative of the child and a report of the results of the examination is furnished to the court by the health board concerned on the application of the board to the court under *subsection (9)* or *(10)*, as the case may be, and

(*b*) following consideration by the court of the report, it is satisfied that the child is still suffering from a mental disorder.

(12) Psycho-surgery shall not be performed on a child detained under this section without the approval of the court.

(13) A programme of electro-convulsive therapy shall not be administered to a child detained under this section without the approval of the court.

(14) The provisions of sections 21, 22, 24 to 35, 37 and 47 of the Child Care Act, 1991, shall apply to proceedings under this section as they apply to proceedings under those sections with the modification that references to proceedings or an order under Part III, IV or VI of that Act shall be construed as references to proceedings or an order under this section and with any other necessary modifications.

(15) References in sections 13(7), 18(3) and 19(4) of the Child Care Act, 1991, to psychiatric examination, treatment or assessment do not include references to treatment under this Act.

Appendix 6

Mental Health Services for Children and Adolescents with Intellectual Disability **– selected extract, *A Vision for Change***

Chapter Fourteen: Mental Health Services for People with Intellectual Disability
Chapter Fifteen: Special Categories

14.6:
Mental health services for people with intellectual disability should be provided by a specialist mental health of intellectual disability (MHId) team that is catchment area-based. These services should be distinct and separate from, but closely linked to, the multidisciplinary teams in intellectual disability services who provide a health and social care service for people with intellectual disability.

14.8:
One MHId team per 300,000 population should be provided for children and adolescents with intellectual disability.

14.9: *(Read at 14.8.1 Children and Adolescents)*
A spectrum of facilities should be in place to provide a flexible continuum of care based on need. This should include day hospital places, respite places, and acute, assessment and rehabilitation beds/places. A range of interventions and therapies should be available within these settings.

14.10: *(Read at 14.9 Links with other services. Chapter Fifteen also provides for additional services)*
In order to ensure close integration, referral policies should reflect the needs of individuals with intellectual disability living at home with their family, GPs, the generic intellectual disability service providers, the MHId team and other mental health teams such as adult and child and adolescent mental health teams.