Fourth Annual Child & Adolescent Mental Health Service Report

2011 - 2012

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

A Vision for Change
ADVANCING MENTAL HEALTH IN IRELAND

Fourth Annual Child & Adolescent Mental Health Service Report

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Contents

Executive Summary

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

The development of comprehensive Child and Adolescent Mental Health Services (CAMHS) for young people up to the age of 18 years is described in the Department of Health and Children *A Vision for Change* (2006) policy document. CAMHS had been organised until then for young people up to the age of 16 years. Key to this is the development of 107 multidisciplinary CAMHS teams, based on the 2011 census population, of which 63 are in place, 58 community teams (an increase of 2 from 2011), 2 day hospital teams and 3 paediatric hospital liaison teams. Further recommendations are contained in the policy concerning inpatient services (a total of 106/8 beds), mental health intellectual disability teams, substance misuse, eating disorder and forensic services for young people.

Community child and adolescent mental health teams are the first line of specialist mental health services. In November 2008 the first month long survey of children and young people seen by all 49 Community based CAMHS teams was carried out. This was the first fully comprehensive exercise to gather information on the age and gender of children and young people attending the service and the mental health problems they present. The results of the survey, together with information on the admission of young people under the age of 18 years admitted for inpatient assessment and treatment for the year 2008 supplied by The Health Research Board, were published in the First Annual CAMHS Report in 2009.

The Fourth Annual CAMHS Report incorporates the fourth month long survey of the clinical activity of 56 Community CAMHS teams carried out in November 2011. The Report includes information collected monthly through HSE HealthStat from each Community CAMHS team for the year long period from October 1st 2011 to September 30th 2012, and information on inpatient admissions provided by The Health Research Board and The Mental Health Commission. This report also includes a section on young people under the age of 18 years presenting to hospital emergency departments as a result of deliberate self harm in 2011 compiled by the National Registry of Deliberate Self Harm.

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

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

The Specialist Child and Adolescent Mental Health Service Advisory Group, established in 2009, has further refined the data collected from teams and services, and the key performance indicators linked to these datasets. It is in the process of finalizing, in collaboration with the Mental Health Commission, operational guidelines for CAMHS based on the Quality Framework Document (Mental Health Commission).

For CAMHS teams to work effectively, a range of disciplines, skills and perspectives are required, so that children and adolescents are offered a care and treatment package geared to their individual needs. The total staffing of the 58

existing community teams is 461.94 whole time equivalents (in 2011 this figure was 464.74), which is 38.1% of the staffing level as recommended in a Vision for Change. There is variation in the distribution and disciplinary composition of the workforce across teams and regions.

All Community CAMHS teams screen referrals received, those deemed to be urgent are seen as a priority, while those deemed to be routine are placed on a waiting list to be seen. In the period October 1st 2011 to September 30th 2012 a total of 9,973 referrals were accepted which is a 17% increase on the previous 12 months. A total of 8,671 new cases were seen by Community CAMHS teams in the same period October 1st 2011 to September 30th 2012, compared with 7,849 for the previous 12 months, an increase of 10%.

Of the 8,671 new cases seen, 967 (11.2%) were 16/17 years of age. Over this period 45% of new cases were seen within 1 month of referral, 66% within 3 months. 10% of new cases had waited between 3 and 6 months, 7% had waited between 6 and 12 months and 5% had waited more than 1 year to be seen, whilst 12% did not attend their first appointment.

In September 2012 the number of active cases attending Community CAMHS was 16,664 which represents 1.45% of the under 18 years of age population.

From 2006 the practice of the Community CAMHS teams keeping on existing cases beyond their 16th birthday and accepting referral of known cases was extended, without the provision of additional resources at that time. The number of teams accepting new referrals of young people up to and including 17 years of age increased from 9 (16%) to 14 (25%) in 2011 with a further 3 (5%) teams accepting new referrals of young people up to and including 16 years of age.

On 4th September 2012, the HSE Management Team approved the new "Access protocols for 16 and 17 year olds to mental health services" to come into effect from 1st January 2013. With effect from that date all new cases of children up to their 17th birthday who require mental health assessment and treatment will be seen by the Child and Adolescent Mental Health Services, in those areas where current limit is 16 years of age. With effect from 1st January, 2014, all children up to their 18th birthday who require mental health assessment and treatment will be seen by the Child and Adolescent Mental Health Services.

A total of 2,056 children and adolescents were waiting to be seen at the end of September 2012. This represented an increase of 159 (8%) from the total number waiting at the end of September 2011 (1,897). The total number waiting greater than 12 months decreased by 9%, from 300 to 272. Forty-four (76%) Community CAMHS teams had a waiting list of less than 50 cases, 10 (17%) had a waiting list of 50 to 99 cases, 2 (5%) had a waiting list of 100 to 149 cases and 1 (2%) had a waiting list of 150 to 200 cases.

In the course of the month of November 2011 a total of 8,479 cases were seen, 7,724 (91.1%) of these cases were returns and 755 (8.9%) were new cases. A total of 14,724 appointments were offered, 12,024 appointments were attended, with a resulting non-attendance rate of 18.3%, decreasing from 19.6% in 2010. Analysis of the data collected indicated that:

- Children aged 15 years were the most likely to be attending community CAMHS, followed by the 16/17 year old age group and children in the 10 to 14 age group.
- Adolescents aged 16/17 years constituted 16.5% of the caseload.
- The ADHD / hyperkinetic category (35.7%) again was the most frequently assigned primary presentation followed by the Anxiety category which accounted for 18.7%.
- The ADHD / hyperkinetic category peaked in the 4 to 9 years age group at 43.8% of cases in this age group, dropping to 23.3% of adolescents in the 15 years and older age group.
- Depressive disorders increased with age, accounting for 21.6% of the 15 years and older age group.

- Deliberate Self Harm, which increased with age, accounted for 7% of the primary presentations of the 15 years and older age group, however deliberate self harm / suicidal ideation was recorded as a reason for referral in 28% of the new cases seen.

- Eating disorders increased with age, accounted for 5.6% of the primary presentations of the 15 years and older age group.

- Males constituted the majority of primary presentations apart from Emotional Disorders (49.5%), Depression (36.5%), Deliberate Self Harm (28.1%), and Eating Disorders (12.6%).

- 24% of cases were in treatment less than 13 weeks, 11.5% from 13 to 26 weeks, 13.8% of cases were in treatment from 26 to 52 weeks and 50.8% greater than 1 year.

In 2011 the new 20 bed inpatient units at Bessboro, Cork and Merlin Park, Galway opened replacing the interim unit at St. Stephen's Hospital and St. Anne's inpatient unit. In 2012 the second phase of development at St. Vincent's Hospital, Fairview was completed with the opening of the new 12 bed adolescent unit. Warrenstown inpatient unit transferred to an interim 8 bed unit at St. Loman's Hospital, Palmerstown in May 2012 where a new 6 bed older adolescent unit is due to open in the first quarter of 2013. Planning application has been submitted for a new 24 bed inpatient unit at Cherry Orchard Hospital that will accommodate this service. It is envisaged that the new unit will open in 2015.

It was announced in November 2012 that the New Children's Hospital will be developed at the campus of St James's Hospital in Dublin. It will accommodate the national specialist eating disorder service with 8 inpatient beds and a 12 bed general inpatient unit. Construction is scheduled to be completed by the end of 2017 or early 2018. The new central mental hospital to be located in North Co. Dublin will include a 10 bed secure adolescent inpatient unit. The project which commenced in 2012 will take five years to complete.

In 2011 there were 432 admissions of children and adolescents up to the age of 18 years to inpatient units. Females accounted for 56% of admissions. Forty-one percent of all admissions were aged 17 years on admission, 27% were aged 16 years, 15% were aged 15 years and 17% were aged 14 years or younger. Of the 432 admissions, 300 (69%) were to child and adolescent units and 132 (31%) to adult inpatient units. Seven admissions of young people aged less than 16 years were to adult units.

The average length of stay was significantly longer in the child and adolescent units, at 48.34 days (median 39 days), than in adult units at 9.9 days (median 5 days). Twenty-five percent of admissions to adult units were discharged within two days of admission and 64% within one week. Sixty percent of admissions to child and adolescent units were for periods longer than 4 weeks.

Depressive disorders accounted for 35% of all admissions in 2011. The next largest diagnostic category was neuroses at 13%, followed by schizophrenia and delusional disorders at 12%, eating disorders at 10%, and behavioural and emotional disorders of childhood and adolescence at 6%. The diagnosis of mania accounted for 5% of admissions.

In the nine months January to September 2012, 228 (75%) of the 303 admissions of children under the age of 18 years were to child and adolescent units and the remaining 75 (25%) to adult units. Of the admissions to adult units; 50 (67%) were 17 years of age, 21 (28%) were 16 years of age and 4 (5%) were 15 years of age. Fifteen (20%) of the adolescents admitted to the adult inpatient units were subsequently transferred to Merlin Park, St. Joseph's and Eist Linn units.

For the period from 1 January to 31 December 2011, the National Registry of Deliberate Self Harm recorded 1,076 deliberate self harm presentations to hospital that were made by 904 children (316 boys and 588 girls) aged from 10 to 17 years which represented 9% of all cases.

Of the recorded presentations for all children aged from 10 to 17 years in 2011, 35% were made by boys and 65% were made by girls.

SECTION 1 Introduction

1.1 Children in the population

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

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

Figure 1.1 (i) 2011 & 2006 Census by Age

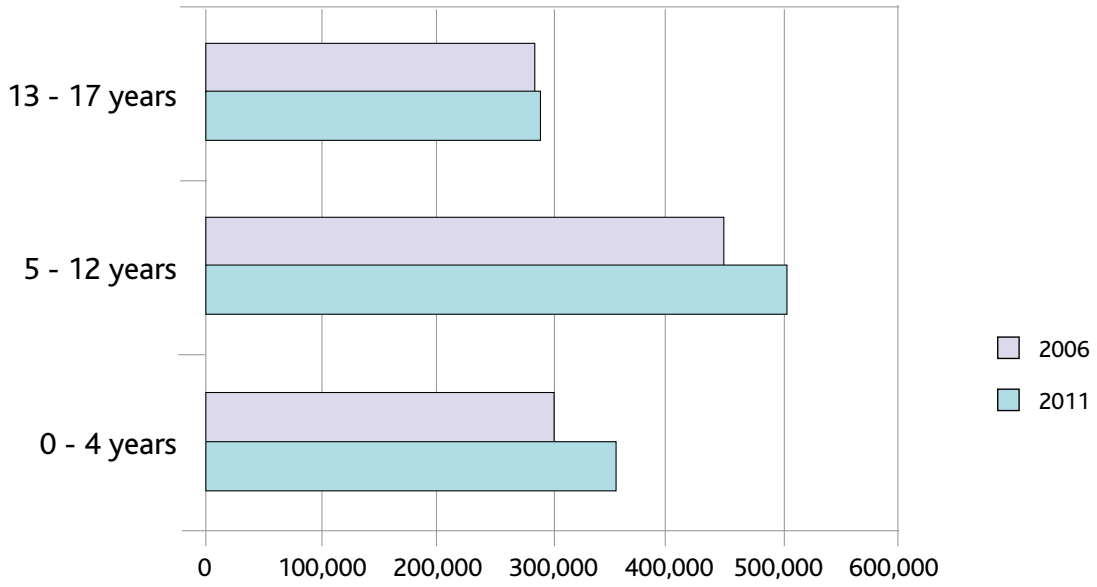

Table 1.1 (a) 2011 & 2006 Census by Age

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

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

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

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

Table 1.1 (b) 2011 Census by Age 0 – 17 Years by HSE Region

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

1.2 Prevalence of childhood psychiatric disorders

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

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

1.3 Child and adolescent mental health services (CAMHS)

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

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

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

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

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

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

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

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

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

Child & Adolescent Mental Health Services	Recommended	
Community Child & Adolescent Mental Health Teams	77	
Adolescent Day Hospital Teams	15	107
Hospital Liaison Mental Health Teams	15	
Eating Disorder Mental Health Team	1	
Forensic Mental Health Teams	2	
Substance Misuse Mental Health Teams	4	
Intellectual Disability Mental Health Teams	15	
Total	**129**	

Specialist Inpatient Child and Adolescent Mental Health Services:

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

Table 1.4 (b) Vision for Change Recommendations – Inpatient Services

Inpatient Services (Beds)	Recommended
General	90
Forensic / Secure	10
Eating Disorder	6/8
Total	**106/8**

1.5 Community child and adolescent mental health teams

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

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

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

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SECTION 2 Workforce

2.1 Staffing of child and adolescent mental health services

A survey of the staffing of Community CAMHS teams, Day service programmes, Hospital Liaison teams and Inpatient services was carried out in September 2012. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 679.83.

Table 2.1 (a) Vision for Change Recommendations – Actual Staffing (2012)

Mental Health Services	Vision For Change (2006)	No. of Recommended Teams	Teams In Place	Rec. Staff	Total Staff In Place	%
Community MHTs	1 : 50,000	92	58	1,196	461.94	67.95%
Adolescent Day Services		(15)	2		17.45	2.57%
Hospital Liaison MHTs	1 : 300,000	15	3	195	31.0	4.56%
Total	**1 : 42,857**	**107**	**63**	**1,391**	**510.39**	
Inpatient Services			4 Units		169.4	24.92%
				Total Staff	**679.83**	**100%**

Table 2.1 (b) Staffing of Day Services and Liaison Teams

Discipline	Day Service		Paediatric Hospital Liaison			Total
	St Joseph's Adolescent & Family Day Service	Dunfillan Young Person's Unit	Children's University Hospital Temple St.	Our Lady's Hospital Crumlin	National Children's Hospital Tallaght	
Consultant Psychiatrist	0.65	1	2.2	2	1.6	7.45
Senior Registrar	1	1	1	0.5		3.5
Registrar / SHO				1		1
Social Worker	0.5	0.5	3.9			4.9
Clinical Psychologist	0.7		3.7			4.4
Occupational Therapist		0.5	2			2.5
Speech & Lang. Therapist	0.5	0.5	1			2
Nurse	4	4.6	2.5	2	1.4	14.5
Administrative Staff	1	1	4.2	1	1	8.2
Total	**8.35**	**9.1**	**20.5**	**6.5**	**4.0**	**48.45**

Each of the three Dublin paediatric hospitals has a liaison team and the total number of staff on these teams is 31. There are two adolescent day services in Dublin with a total staff of 17.45. Dunfillan Young Person's Unit is located at the St. John of God Lucena Clinic in Rathgar, and St. Joseph's Adolescent and Family Service at St. Vincent's Hospital, Fairview.

The total number of staff at the 4 inpatient units was 169.4 (August 2012).

Table 2.1 (c) Child and Adolescent Inpatient Units

Inpatient Unit	Linn Dara	St. Joseph's	Eist Linn	Merlin Park	National
Operational Beds (August 2012)	6	6	12	17	41
Discipline	**In Post**	**In Post**	**In Post**	**In Post**	**In Post**
Consultant Psychiatrist	1.0	0.5	1.0	2.0	4.5
Senior registrar	0.0	1.0	1.0	1.0	3.0
Registrar/SHO	1.0	0.0	1.0	2.0	4.0
Director of Nursing	1.0	0.3	1.0	0.0	2.3
Assistant Director of Nursing/CNM III	0.0	0.5	2.0	1.0	3.5
CNM II	1.0	1.0	2.0	3.0	7.0
CNM I	1.0	3.0	0.0	2.0	6.0
Clinical Nurse Specialist	0.0	0.0	1.0	0.0	1.0
Staff Nurse	11.5	14.0	27.0	29.0	81.5
Clinical Psychologist	1.0	1.0	1.0	2.0	5.0
Occupational Therapist	1.0	0.5	0.4	1.0	2.9
Speech and Language Therapist	1.0	0.3	0.8	1.0	3.1
Social Worker	1.0	0.5	1.0	1.7	4.2
Childcare Worker	2.0	0.0	0.0	3.0	5.0
Dietician	0.0	0.0	1.0	0.5	1.5
Physiotherapy	0.0	0.0	0.0	0.0	0.0
Other Therapist	0.0	0.0	0.0	0.0	0.0
Administrative Support staff	1.0	1.7	2.0	4.0	8.8
Non Nursing Care Assistant/ Multi Task Attendant	0.0	0.0	2.0	5.5	7.5
Non Nursing Chef (Household)	2.0	0.0	0.0	1.0	3.0
Non Nursing Catering Assistant	1.0	1.7	0.0	0.0	2.7
Non Nursing Driver/Porter	1.0	0.0	0.0	2.0	3.0
Teaching Staff	2.0	1.0	1.0	3.0	7.0
Teaching Support Staff	0.0	0.0	0.0	3.0	3.0
Other Staff	0.0	0.0	0.0	0.0	0.0
Total	29.5	27.0	45.2	67.7	169.4
Clinical WTE	22.5	22.6	40.2	49.2	134.5

2.2 Community child and adolescent mental health teams

It is possible to compare the staffing of Community CAMHS teams with previous surveys carried out in March 2007, November 2008, November 2009, and September 2010. The staffing levels in the Community teams marginally decreased in the period from September 2011 to September 2012.

Table 2.2 (a) Community Child & Adolescent Mental Health Teams (2007 to 2012)

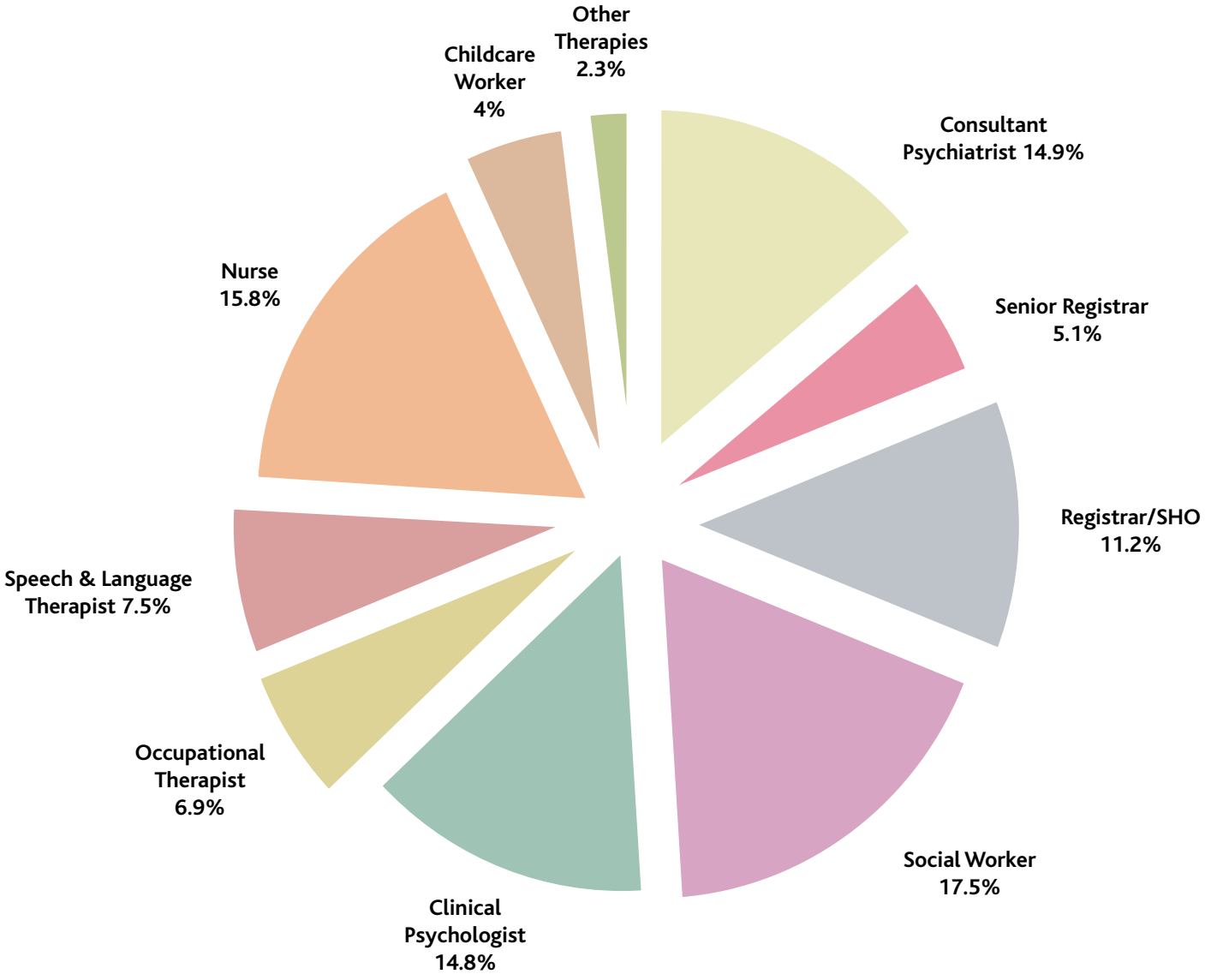
HSE Region	Population 2011 Census	Clinical Staff March 2007	Clinical Staff Nov 2008	Clinical Staff Nov 2009	Clinical Staff Sept 2010	Clinical Staff Sept 2011	Clinical Staff Sept 2012	Change +/-
Dublin Mid-Leinster	1,320,945	127.74	128.51	123.77	125.98	130.68	116.55	-14.13
Dublin North East	1,020,891	77.05	85.22	89.5	89.76	89.69	86.69	-3.00
South	1,162,112	61.1	60.60	55.35	78.04	74.65	79.85	5.20
West	1,084,304	74.3	76.90	80.75	86.79	94.24	102.49	8.25
Total	**4,588,252**	**340.19**	**351.23**	**349.37**	**380.57**	**389.26**	**385.58**	**-3.68**
Administrative/ Support staff		67.8	70.7	71.75	75.54	75.48	76.36	0.88
Total Staff		**407.99**	**421.93**	**421.12**	**456.11**	**464.74**	**461.94**	**-2.60**

In September 2012 there was 461.94 staff (clinical 385.58) working in 58 Community CAMHS teams, with an average of 7.96 staff of which 6.65 were Clinical staff per team. The range of team size varies from the smallest team of 4 (3 clinical) to the largest which comprises of 15 (13 clinical).

- This translates to a ratio of 1 clinical staff member, working in Community based CAMHS teams, to 2,979 children aged 0 to 17 years
- The staff complement for a Community CAMHS teams as recommended in *A Vision for Change (2006)* is 13, comprising of 11 clinical and 2 administrative support staff. The recommended for staffing for 58 Community teams is 754 (638 Clinical).

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

Figure 2.2 (i) Community CAMHS Clinical Workforce by Profession (2012)



- The largest professional group was psychiatry making up 29.92% of the workforce (consultant child & adolescent psychiatrists (15.68%), and doctors in training (14.24%).
- The other main professional groups were social work (14.57%), nursing (12.91%), clinical psychology (12.51%), speech and language therapy (6.43%), occupational therapy (5.57%), childcare (2.76%), and other therapies (1.4%).

Table 2.2 (b) shows the changes in staffing by discipline from 2007 to 2012.

Table 2.2 (b) Community CAMHS Teams Staffing Breakdown 2007 to 2012

Community Teams	Staffing					
Discipline	**March 2007**	**November 2008**	**November 2009**	**September 2010**	**September 2011**	**September 2012**
Consultant Psychiatrist	45.6	49.37	51.05	54.69	58.19	60.44
Senior Registrar	17.8	19.5	18	19	19.80	20.6
Registrar/SHO	45.2	49.85	48.5	47.49	43.49	45.2
Social Worker	61.15	53.4	56.65	65.10	68.01	67.29
Clinical Psychologist	48.04	50.1	47.3	53.67	57.78	57.78
Occupational Therapist	13.65	15.1	16.5	24.65	26.70	25.72
Speech & Language Therapist	27.6	26.97	26.7	27.54	29.22	29.72
Nurse	55.95	56.78	53.07	60.49	61.33	59.64
Childcare Worker	19.9	21.8	21	20.34	15.74	12.74
Other Therapist	5.3	8.76	10.6	7.6	9.00	6.45
Administrative Staff	67.8	70.7	71.75	75.54	75.48	76.36
Total	**407.99**	**422.33**	**421.12**	**455.57**	**464.74**	**461.94**

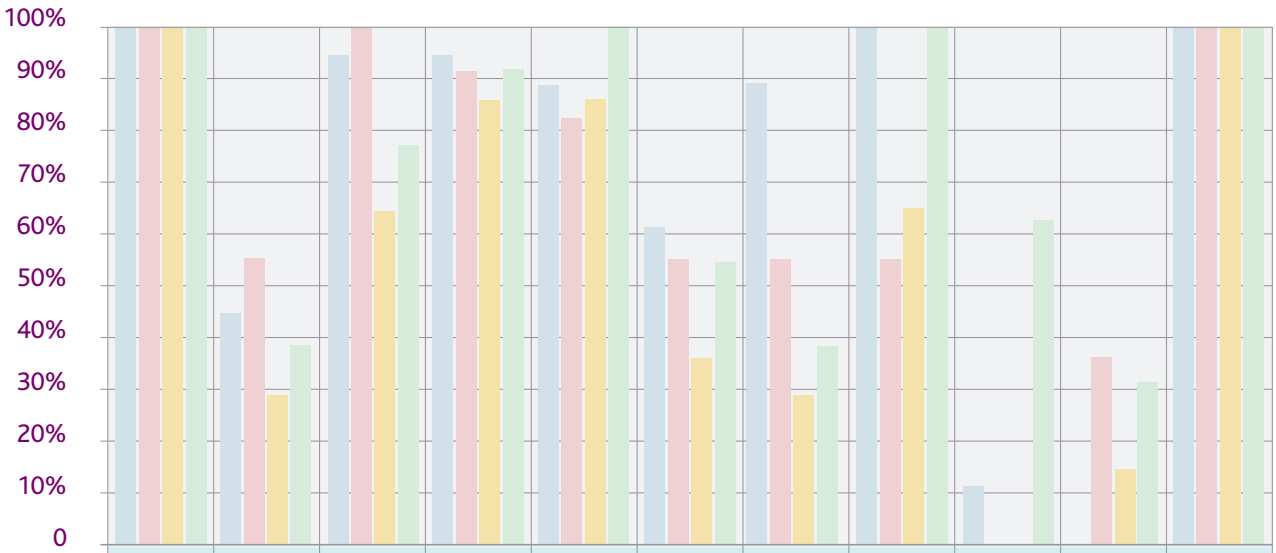
Table 2.2 (c) Community CAMHS Teams Staffing Breakdown by HSE Region 2012

Discipline	Dublin Mid Leinster	Dublin North East	South	West	Total
Consultant Psychiatrist	17.44	13.20	15.00	14.80	60.44
Senior Registrar	5.80	5.80	4.00	5.00	20.60
Registrar/SHO	16.40	10.00	8.80	10.00	45.20
Social Worker	18.87	17.22	15.30	15.90	67.29
Clinical Psychologist	13.44	14.64	14.90	14.80	57.78
Occupational Therapist	5.82	6.00	7.40	6.50	25.72
Speech & Language Therapist	13.70	8.92	3.00	4.10	29.72
Nurse	23.08	7.46	10.55	18.55	59.64
Childcare Worker	2.00	0.00	0.00	10.74	12.74
Other Therapist	0.00	3.45	0.90	2.10	6.45
Administrative Staff	25.81	13.25	18.40	18.90	76.36
Total	**142.36**	**99.94**	**98.25**	**121.39**	**461.94**

Composition of Community CAMHS Teams by Professional Discipline

- The numbers of each professional discipline employed across the regions shows variation as does their representation on teams as demonstrated in Figure 2.2 (ii).

Figure 2.2 (ii) Representation of the professional disciplines on each Community CAMHS team by HSE region (2012)



	Consultant Psychiatrist	Senior Registrar	Registrar/ SHO	Social Worker	Clinical Psychologist	Occupational Therapist	Speech & Language	Nurse	Childcare Worker	Other Therapist	Administrative Support Staff
DML	100%	44%	94%	94%	89%	61%	89%	100%	11%	0%	100%
DNE	100%	55%	100%	91%	82%	55%	55%	55%	0%	36%	100%
South	100%	29%	64%	86%	86%	36%	29%	64%	0%	14%	100%
West	100%	38%	77%	92%	100%	54%	38%	100%	62%	31%	100%

2.3 Community CAMHS staffing compared against Vision for Change recommendations

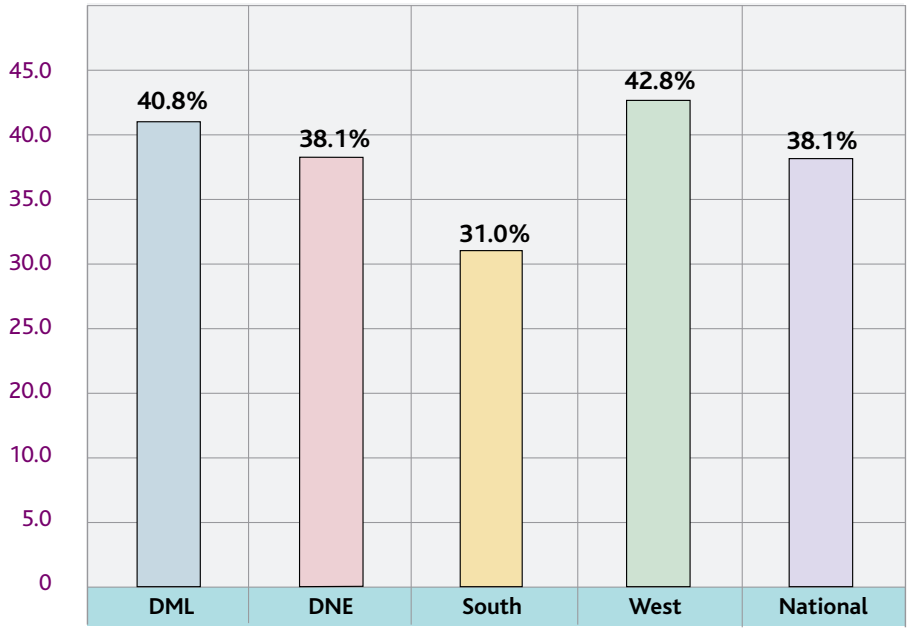
Vision for Change (2006) recommends that there should be two child and adolescent community mental health teams for each sector of 100,000 population with individual child and adolescent community mental health teams comprising of the following:

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

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

In Ireland 25% of the population is under 18 years of age and in September 2012 there was a total of 461.94 staff in situ (385.58 Clinical), this represents 38.1% of the staffing level as recommended in a Vision for Change. Figure 2.3 (i) displays the regional comparisons of these staffing levels.

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



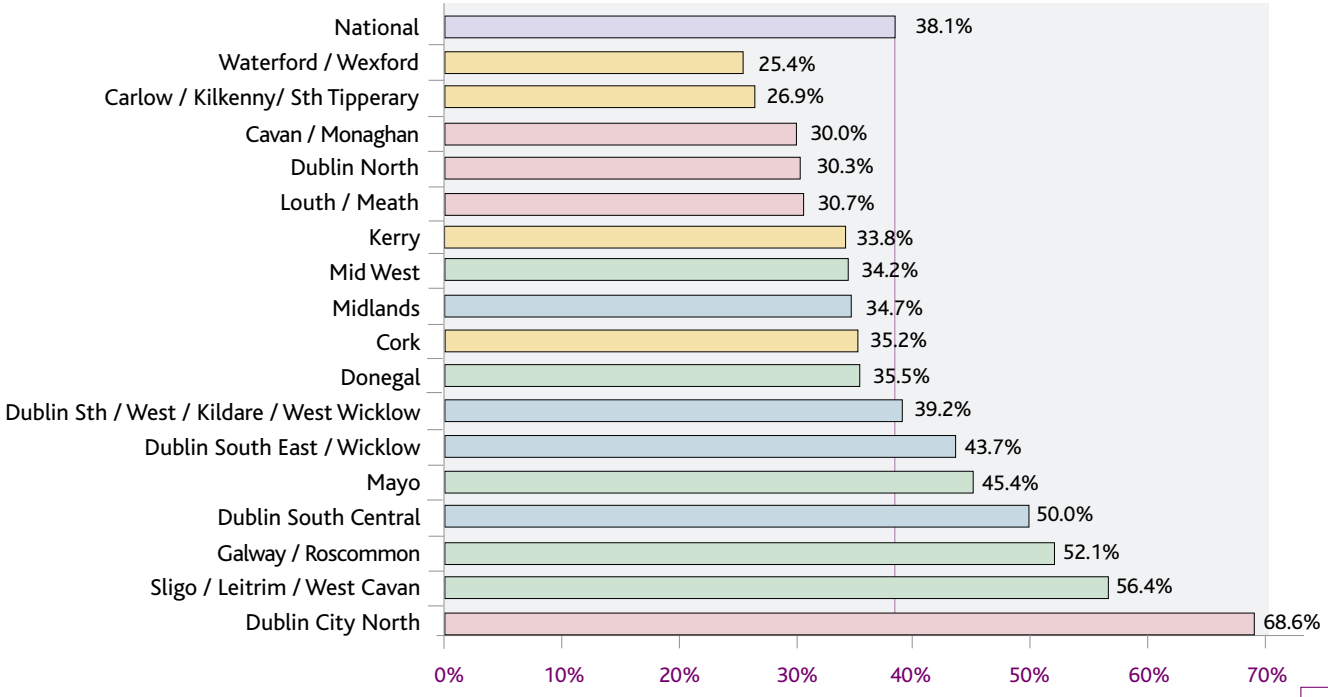
The Health Service Executive (HSE) has mapped the community child and adolescent mental health service by the populations' district electoral division (DED).

Table 2.3 (a) demonstrates the variances across the HSE Management Area Structures in each region per under 18 years of age population and this ranges from 25.4% (Waterford/Wexford) to 68.6% (Dublin City North) of the staffing level as recommended in a Vision for Change.

Table 2.3 (a) Community CAMHS Teams Staffing vs. VFC Recommendation by HSE Area Structures 2012

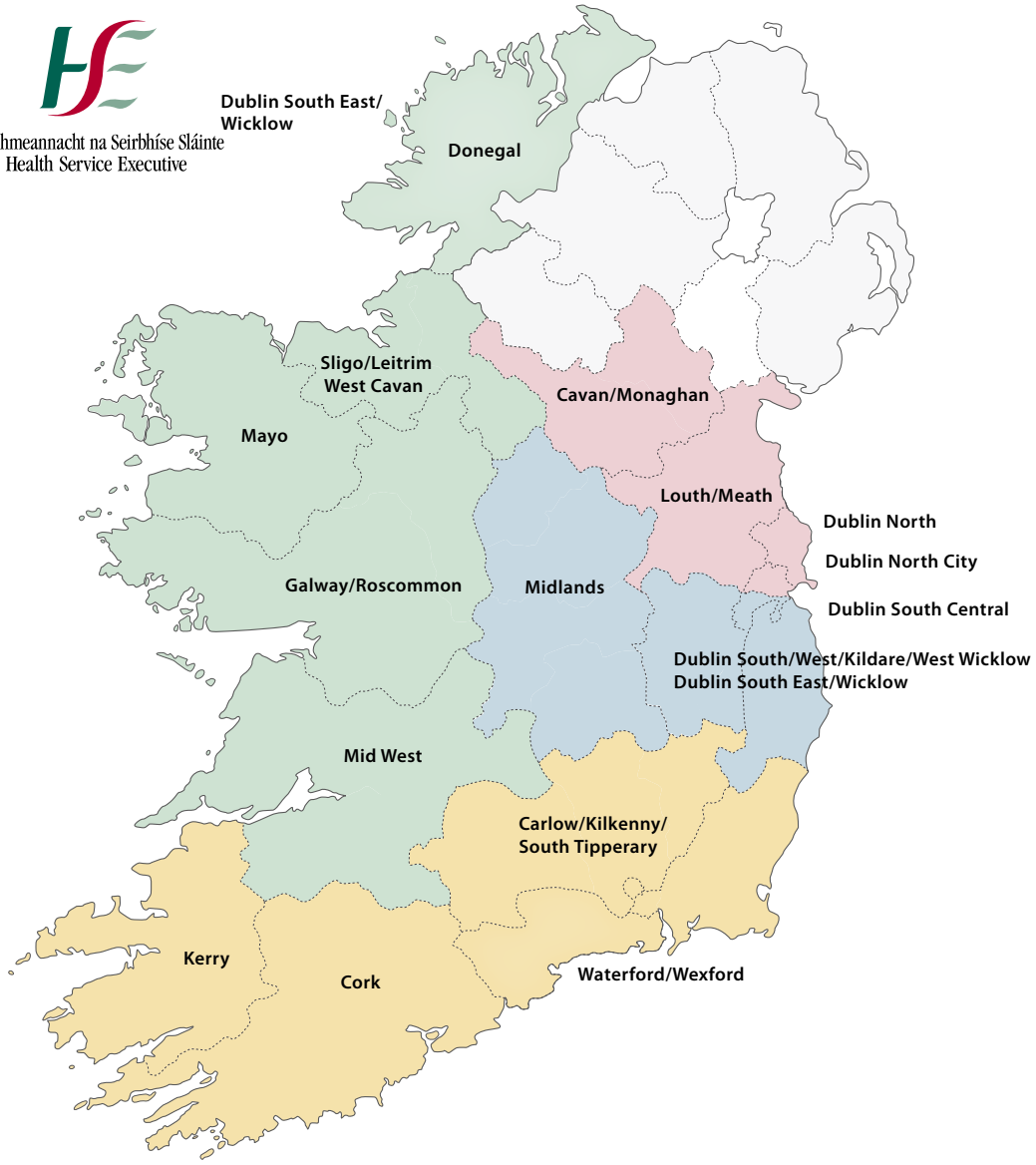
HSE Area Management Structures	Under 18 yrs Population	Actual	Clinical	% of VFC recommendation
Dublin South Central	40,483	21.57	17.80	50.0%
Dublin South/West/Kildare/West Wicklow	113,552	47.20	39.20	39.2%
Dublin South East/Wicklow	93,194	45.15	35.84	43.7%
Midlands	77,726	28.44	23.71	34.7%
Dublin Mid Leinster	**324,955**	**142.4**	**116.6**	**40.8%**
Dublin North	83,891	26.05	22.40	30.3%
Dublin City North	52,031	35.00	31.40	68.6%
Louth/Meath	86,692	27.39	23.39	30.7%
Cavan/Monaghan	35,955	11.50	9.50	30.0%
Dublin North East	**258,569**	**99.9**	**86.7**	**38.1%**
Carlow/Kilkenny South Tipperary	57,800	16.30	13.70	26.9%
Waterford/Wexford	71,608	19.50	16.00	25.4%
Cork	128,448	50.05	39.75	35.2%
Kerry	34,940	12.40	10.40	33.8%
South	**292,796**	**98.3**	**79.9**	**31.0%**
Mayo	32,514	15.00	13.00	45.4%
Galway/Roscommon	77,270	41.30	35.40	52.1%
Donegal	43,732	16.65	13.65	35.5%
Sligo/Leitrim/West Cavan	23,862	13.84	11.84	56.4%
Mid West	94,989	34.60	28.60	34.2%
West	**272,367**	**121.4**	**102.5**	**42.8%**

Figure 2.3 (ii) Community CAMHS Teams Staffing vs. VFC Recommendation by HSE Area Structures 2012



HSE Area Management Structures

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Legend

Dublin North East
Cavan / Monaghan 30.0%
Louth/Meath 30.7%
Dublin City North 68.6%
Dublin North 30.3%

West
Mid West 34.2%
Sligo / Leitrim /
West Cavan 56.4%
Donegal 35.5%
Galway/Roscommon 52.1%
Mayo 45.4%

South
Kerry 33.8%
Cork 35.2%
Waterford/Wexford 25.4%
Carlow/Kilkenny/
South Tipperary 26.9%

Dublin Mid Leinster
Midlands 34.7%
Dublin South East/
Wicklow 43.7%
Dublin South/West/Kildare/
West Wicklow 39.2%
Dublin South Central 50.0%

2.4 New developments 2012

In the Health Budget for 2012 a provision was made for an additional 35m for mental health services in line with the commitment contained in the Programme for Government.

Part of this provision will be the recruitment of 150 new posts into existing community child and adolescent mental health teams, ensuring a more complete multidisciplinary composition within these teams and thus enhancing service delivery.

SECTION 3 Access to Community CAMHS Teams

3.1 Referrals

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

Since the 2010/11 to 2011/12 reporting period there has been an increase of 17% nationally in the number of referrals accepted by the Community Child and Adolescent Mental Health service as outlined in Table 3.1 (a).

Table 3.1 (a) Referrals accepted October 2011 to September 2012 vs. October 2010 to September 2011

	2011/12	2010/11	+/- Variance
DML	3,479	2,895	20%
DNE	1,809	1,651	10%
South	1,905	1,674	14%
West	2,780	2,278	22%
National	9,973	8,498	17%

3.2 Number and length of time waiting to be seen

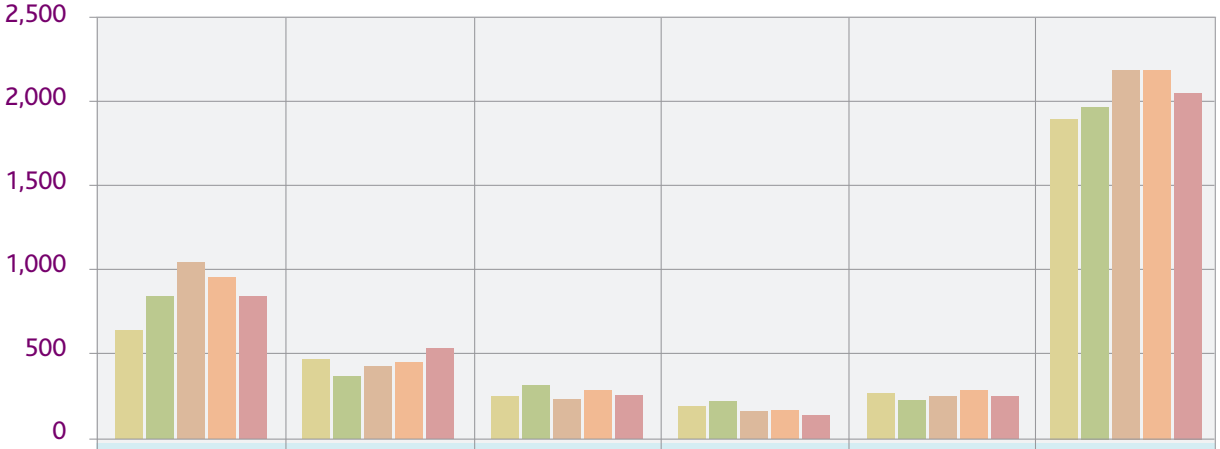
All CAMHS teams screen referrals received, those deemed to be urgent are seen as a priority, while those deemed to be routine are placed on a waiting list to be seen.

Community CAMHS Teams reported a total of 2,056 children and adolescents waiting to be seen at the end of September 2012.

- 819 (40%) were waiting less than 3 months.
- 520 (25%) 3 to 6 months.
- 285 (14%) 6 to 9 months.
- 160 (8%) 9 to 12 months.
- 272 (13%) more than 12 months.

This represented an increase of 159 (8%) from the total number of 1,897 waiting at the end of September 2011.

Figure 3.2 (i) Waiting List for Community CAMHS September 2011 to September 2012



	0-3 mths	3-6 mths	6-9 mths	9-12 mths	12+ mths	Total
Sep-11	655	475	273	206	288	1,897
Dec-11	839	361	309	233	241	1,983
Mar-12	1,067	424	253	195	260	2,199
Jun-12	950	454	296	198	300	2,198
Sep-12	819	520	285	160	272	2,056

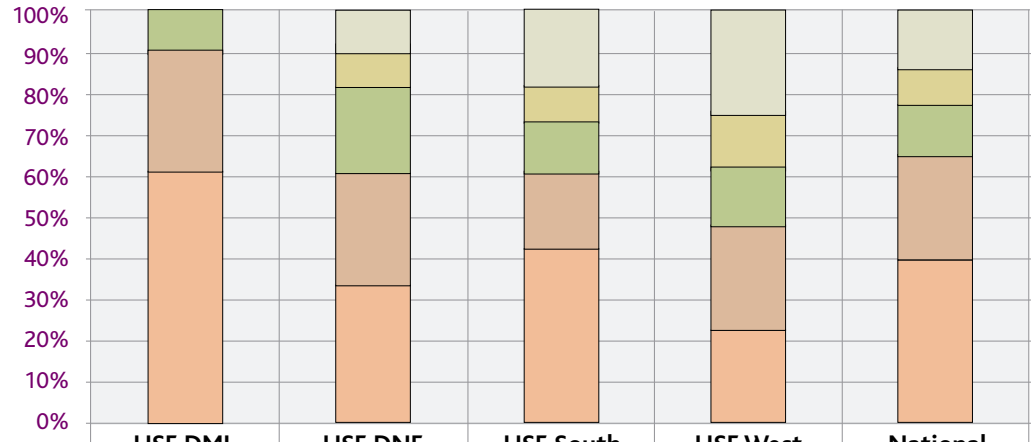
The greatest decrease (-22%) was seen in the group waiting 9 to 12 months from 206 to 160 and there was also a decrease seen in the group waiting more than 12 months from 288 to 272 (-6%).

Table 3.2 (a) Size of Waiting Lists by Team in each HSE Region (September 2012)

Total Number Wait List	No. of Teams		Dublin Mid Leinster	Dublin North East	South	West
	2011	2012				
0 - 49	44	44	17	8	10	9
50 - 99	10	10	2	3	2	3
100 - 149	2	3	0	0	2	1
150 - 200	0	1	0	0	0	1
Total	**56**	**58**	**19**	**11**	**14**	**14**

There was variation in the numbers waiting by Community team, with the majority of teams (44) having a total number of less than 50 on the routine waiting list.

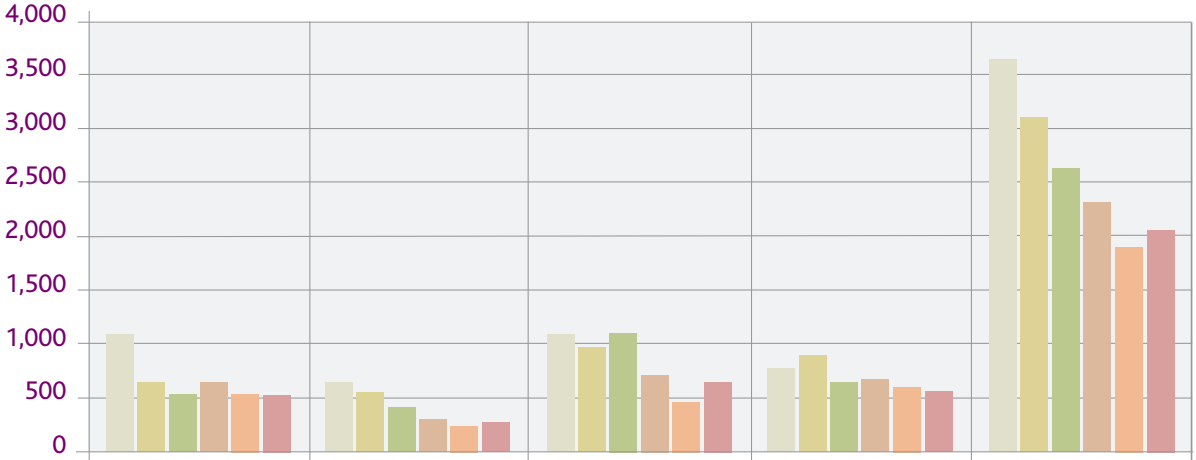
Figure 3.2 (ii) Breakdown of Waiting Lists by HSE Region September 2012



	HSE DML	HSE DNE	HSE South	HSE West	National
12+ mths	0	23	119	130	272
9-12 mths	4	32	49	75	160
6-9 mths	42	68	79	96	285
3-6 mths	161	88	118	153	520
0-3 mths	303	107	280	129	819
Total	**510**	**318**	**645**	**583**	**2,056**

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

Figure 3.2 (iii) Changes in Waiting Lists from March 2007 to September 2012



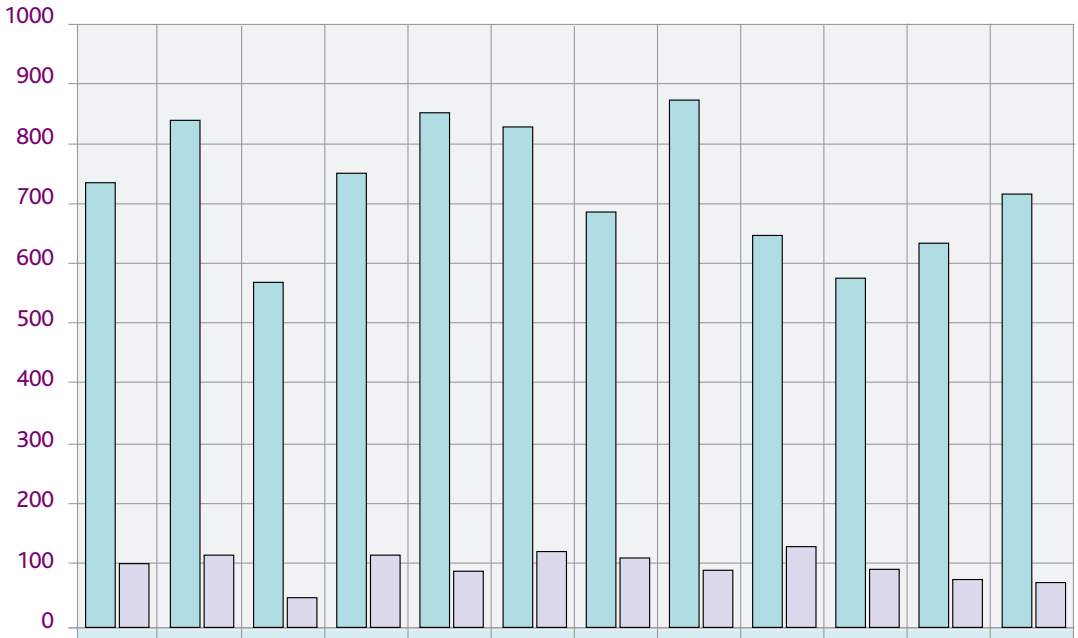
	HSE DML	HSE DNE	HSE South	HSE West	Total
Mar-07	1072	661	1110	776	3619
Nov-08	651	634	997	835	3117
Sep-09	517	414	1045	641	2617
Sep-10	669	337	711	653	2370
Sep-11	536	275	488	598	1897
Sep-12	510	318	645	583	2056

There was a decrease of 1,563 (-43%) in the number on waiting lists for Community CAMHS teams in the period March 2007 to September 2012.

3.3 New cases seen by Community CAMHS teams October 2011 to September 2012

From the October 1st 2011 to September 30th 2012 a total number of 9,843 new cases were offered an appointment by Community CAMHS teams. A total of 8,671 were seen and 1,172 did not attend. This gives a non-attendance rate of 12%, ranging from 8% to 15% across the 12 month period.

Figure 3.3 (i) New Cases seen and DNAs from October 2011 to September 2012



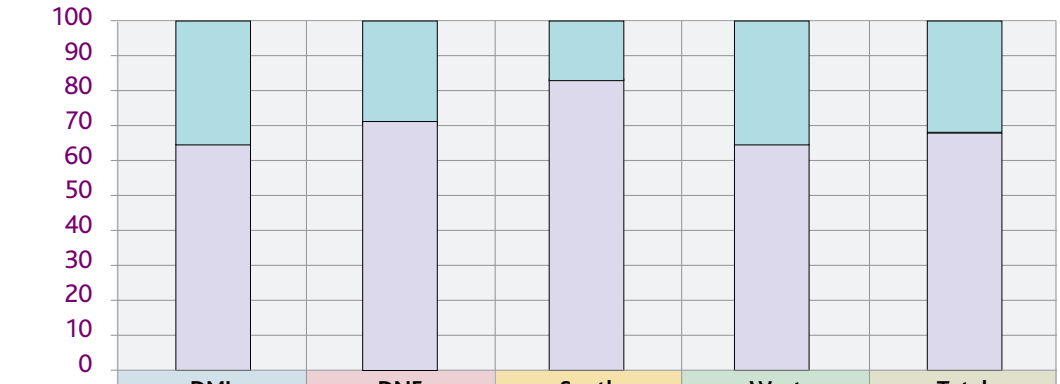
	Oct-11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	June 12	July 12	Aug 12	Sep 12
Seen	736	824	566	739	843	821	695	866	645	588	636	712
DNA	100	108	48	104	92	122	115	94	114	99	89	87

3.4 Breakdown of new cases (New vs. re-referred cases)

Of the new cases seen a proportion will have previously attended the service and been discharged. Between October 2011 and September 2012 of the 8,671 cases seen a total of 2,685 had been re-referred to the service. This represents 31% of the new cases seen and can be compared with the national percentages in 2010/11, 2009 and 2008 of 22%, 21.6% and 20.5% respectively.

- The proportion of re-referred cases varied from 17.3% in the South to 35.9% in the Dublin Mid Leinster region (Figure 3.4 (i)).

Figure 3.4 (i) Breakdown of New Cases (New vs. Re-referred Cases) 2011-2012



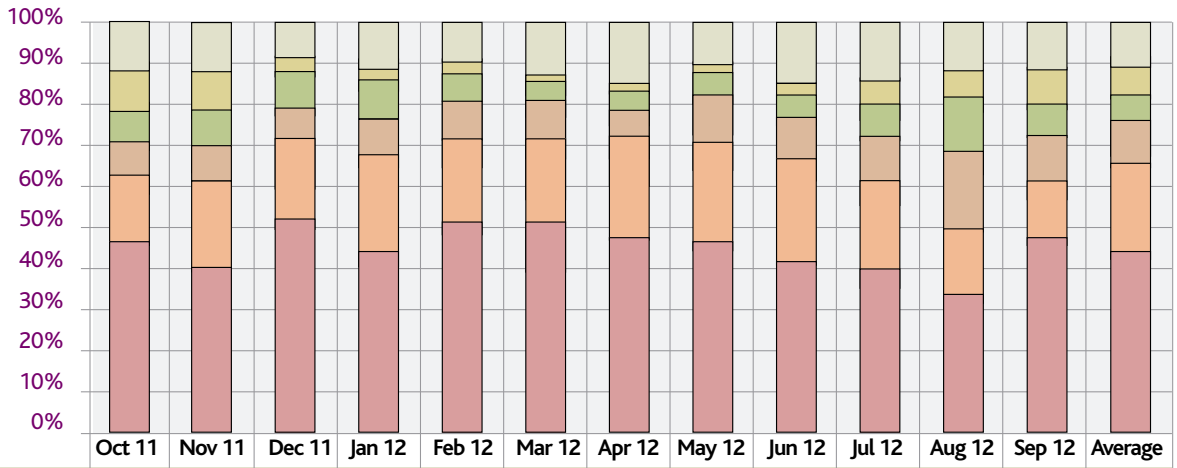
	DML	DNE	South	West	Total
Re-referred	35.9%	29.0%	17.3%	35.3%	31.0%
New	64.1%	71.0%	82.7%	64.7%	69.0%

3.5 Waiting times for new cases seen

For the 12 month period October 2011 to September 2012 a total number of 8,671 new cases were seen by Community CAMHS teams. The waiting time to be seen was recorded for each case. Over the 12 month period:

- 45% of new cases were seen within 1 month of referral
- 66% seen within 3 months
- 10% of new cases had waited between 3 to 6 months
- 7% had waited between 6 and 12 months
- 5% had waited more than 1 year and
- 12% did not attend their appointment.

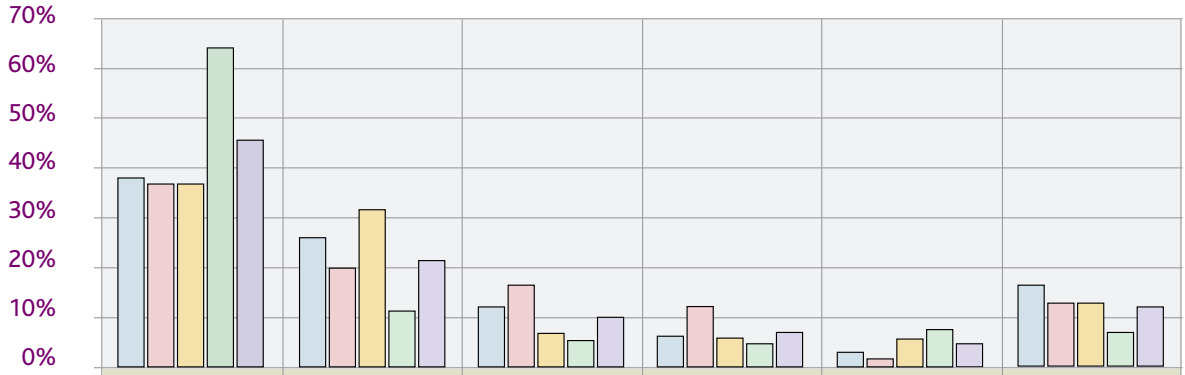
Figure 3.5 (i) Length of Wait to 1st appointment seen October 2011 to September 2012



	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Average
DNA	12%	12%	8%	12%	10%	13%	14%	10%	15%	14%	12%	11%	12%
>12 Months	10%	9%	4%	3%	3%	2%	2%	2%	3%	6%	7%	10%	5%
6-12 Month	7%	9%	9%	9%	6%	4%	5%	5%	4%	7%	12%	8%	7%
3-6 Months	8%	9%	7%	9%	8%	8%	6%	12%	11%	12%	18%	10%	10%
1-3 Months	17%	21%	20%	22%	21%	22%	26%	25%	25%	21%	17%	15%	21%
0 - 1 Month	46%	40%	52%	45%	51%	51%	46%	45%	42%	40%	34%	47%	45%

Figure 3.5 (ii) Length of Wait to 1st Appointment seen October 2011 to September 2012 by HSE Region

In HSE West 64% of new cases were seen within one month of referral with 75% seen within three months of referral.



	<1 mth	1-3 mth	3-6 mth	6-12 mth	>12 mth	DNA
DML	37%	26%	12%	6%	4%	16%
DNE	36%	20%	16%	13%	2%	13%
South	36%	31%	7%	6%	6%	13%
West	64%	11%	6%	5%	8%	7%
Total	**45%**	**21%**	**10%**	**7%**	**5%**	**12%**

3.6 Community CAMHS caseload

- In September 2012 the number of Active open cases was 16,664; with the number in the West (5,571), Dublin Mid-Leinster (5,232), the South (3,167), and Dublin North East (2,694).
- 1.45% of the under 18 population is currently attending the Community Child and Adolescent Mental Health Service.

Figure 3.6 (i) The Number of Active Open in Cases in September 2011 for the Community CAMHS Service by HSE Region

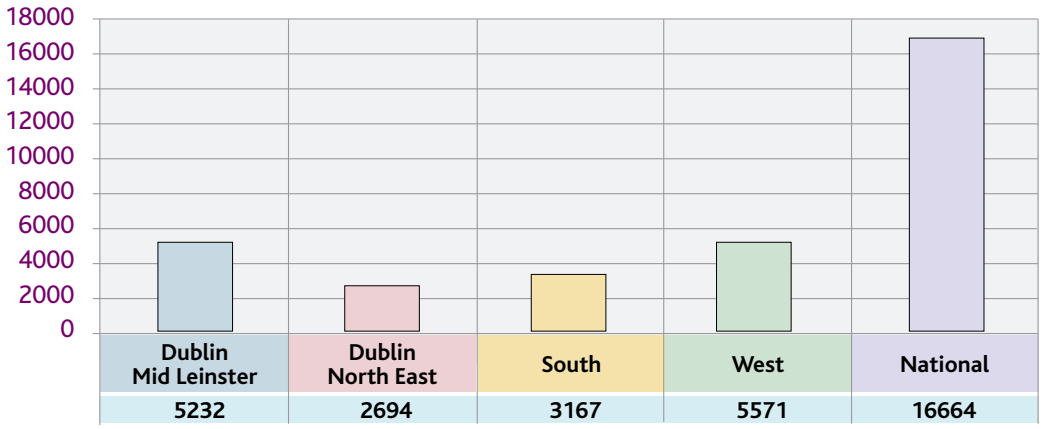


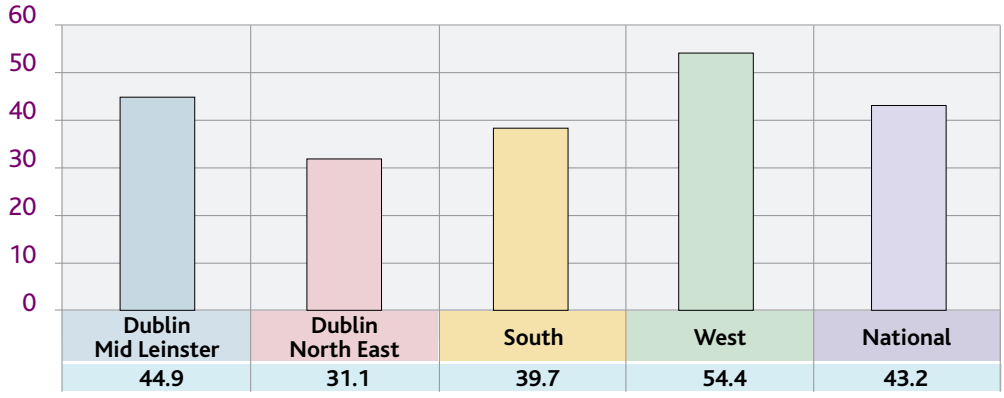
Table 3.6 (a) Percentage of Population under 18 Years Old Attending CAMHS

HSE Region	>18 yrs.	Case-load	Percentage
Dublin Mid Leinster	324,955	5,232	1.61%
Dublin North East	258,569	2,694	1.04%
South	292,796	3,167	1.08%
West	272,367	5,571	2.05%
Total	**1,148,687**	**16,664**	**1.45%**

3.7 Community CAMHS caseload per clinical whole time equivalent (WTE)

- In September 2012 the number of active cases per Clinical Whole Time Equivalent was 43.2.
- The number of active cases per Whole Time Equivalent was in the West (54.4), Dublin Mid Leinster (44.9), South (39.7), and Dublin North East (31.1).

Figure 3.7 (i) The Number of Active Cases for the Community CAMHS Service by Actual Clinical Whole Time Equivalent in September 2011



3.8 Cases closed or discharged

From October 2011 to September 2012 – 9,159 cases were closed and discharged by Community CAMHS teams.

- 85.2% of the cases closed were discharged to care of the General Practitioner or Primary Care Team
- 9.4% to a Community Based Service
- 3.6% to another CAMHS service
- 1.8% to an Adult Mental Health Service.

Table 3.8 (a) Cases Closed and Discharged by Community CAMHS Teams

HSE Region	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service
Dublin Mid Leinster	83.7%	11.0%	4.2%	1.0%
Dublin North East	83.6%	11.8%	3.3%	1.3%
South	86.3%	7.2%	3.9%	2.6%
West	90.0%	4.5%	2.1%	3.4%
Total	**85.2%**	**9.4%**	**3.6%**	**1.8%**

SECTION 4 Audit of Clinical Activity November 2011

Clinical Audit November 2011

In the month of November 2011 the fourth annual clinical audit was carried out by the 58 Community CAMHS Teams which recorded information on a total of 8,479 cases seen in the course of the month. Results from 2011 were compared with those from 2010.

4.1 Source of referral

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

Table 4.1 (a) Source of Referral to Community CAMHS Teams (2011)

Source of Referral	Mid Leinster	North East	South	West	% 2011	% 2010
General Practitioner	63.4%	49.7%	71.0%	71.9%	64.6%	65.8%
Child Health Services	2.9%	7.0%	7.0%	6.3%	5.5%	8.5%
A & E Department	3.2%	7.0%	6.5%	5.2%	5.1%	3.0%
Education	15.3%	13.4%	3.2%	2.8%	9.0%	7.2%
Primary Care Services	2.2%	3.7%	5.9%	3.9%	3.7%	4.5%
Social Services	2.2%	4.3%	2.7%	2.1%	2.7%	2.2%
Youth Justice	0.3%	0.5%	0.0%	0.0%	0.2%	0.0%
Learning Disability Services	0.3%	1.1%	1.1%	0.7%	0.7%	0.6%
Adult Mental Health	0.3%	0.0%	0.5%	0.3%	0.3%	0.3%
Voluntary Agencies	1.0%	2.7%	0.0%	0.3%	0.9%	0.6%
Self referral	1.9%	2.1%	0.0%	0.7%	1.2%	1.4%
Medico legal	0.0%	0.0%	0.0%	1.7%	0.5%	0.9%
Other	4.5%	3.2%	0.5%	2.4%	2.9%	2.4%
Other CAMHS	2.5%	5.3%	1.6%	1.7%	2.7%	2.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100%**

A total of 64.6% of referrals were received from general practitioners, child health services, and A & E departments. Educational services were the next largest source of referral with 9%, primary care services 3.7% (community psychology, speech and language therapy, occupational therapy), and social services (community social work) accounting for 2.2% of referrals. Self referral accounted for 1.2%. Adult mental health services, other child and adolescent mental health services, learning disability services, voluntary services, medico legal, and other accounted for the remaining 7.4%. As in 2010 referrals from educational services were much higher in the Dublin Mid Leinster and Dublin North East regions. The majority of Community CAMHS Teams have referral protocols in place.

4.2 Case profile

During the period of measurement a total of 8,479 cases were seen by the 58 teams. 7,724 (91.1%) of these cases were returns and 755 (8.9%) were new cases.

4.3 Number of appointments offered

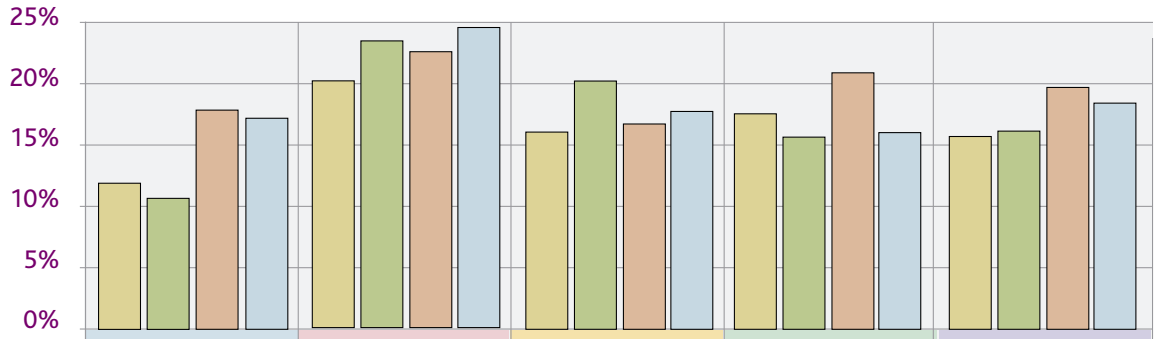
During the period of measurement a total of 14,724 appointments were offered. A total of 12,024 appointments were attended, with a resulting non-attendance rate of 18.3%. In November 2010 the overall non-attendance rate was 19.6%.

Table 4.3 (a) Attendance at Appointments

	Dublin Mid Leinster		Dublin North East		South		West		Total	
Appointments	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**
Attended	4787	4401	2495	2183	1966	2312	2705	3128	11953	12024
Not Attended	1034	903	739	707	395	498	738	592	2906	2700
Total Number	5821	5304	3234	2890	2361	2810	3443	3720	14859	14724
Non Attendance Rate %	**17.8%**	**17.0%**	**22.9%**	**24.5%**	**16.7%**	**17.7%**	**21.4%**	**15.9%**	**19.6%**	**18.3%**

The non-attendance rate was highest in Dublin North East at 24.5%, increasing from 22.9% in 2010. Next highest was the South at 17.7%, increasing from 16.7% in 2010. The non-attendance rate in Dublin Mid Leinster was 17%, decreasing from 17.8% recorded in 2010. The lowest rate was in the West at 15.9% which was lower than the 21.4% recorded in 2010.

Figure 4.3 (i) Appointments offered % DNA Rate by HSE Region



	Dublin Mid Leinster	Dublin North East	South	West	National
Nov-08	12.1%	20.1%	16.2%	17.5%	15.9%
Nov-09	10.5%	23.7%	20.3%	15.7%	16.1%
Nov-10	17.8%	22.9%	16.7%	21.4%	19.6%
Nov-11	17.0%	24.5%	17.7%	15.9%	18.3%

4.4 Location of appointments

The majority of appointments took place in the clinic (93.9%) with a small percentage taking place in the home (1.3%). A significant number of school visits were recorded (3.2%). The difference in hospital appointments across the regions reflects the presence of dedicated hospital liaison teams in each of the three Dublin paediatric hospitals.

Table 4.4 (a) Location of Appointments

Location of Appointments	Dublin Mid Leinster	Dublin North East	South	West	% 2011	% 2010
1. Clinic	95.8%	96.0%	90.9%	91.9%	**93.9%**	**94.2%**
2. Home	1.1%	0.5%	1.9%	1.6%	**1.3%**	**1.5%**
3. Hospital	0.2%	1.2%	1.2%	0.8%	**0.7%**	**0.7%**
4. School	2.6%	1.9%	4.2%	4.3%	**3.2%**	**2.9%**
5. Other	0.3%	0.4%	1.8%	1.4%	**0.9%**	**0.7%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

4.5 Clinical inputs

The number of recorded clinical inputs is greater than the number of appointments as members of the multidisciplinary team will frequently work jointly with a child and family as clinically indicated with an average of 1.12 clinical inputs per appointment.

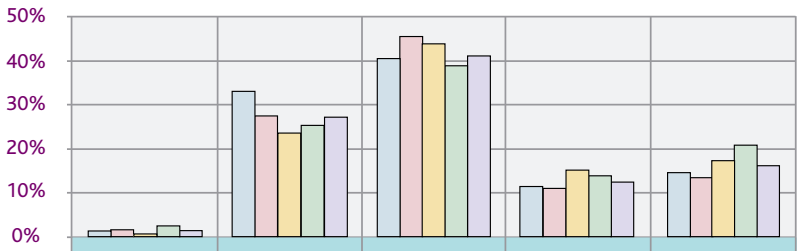
Table 4.5 (a) Clinical Inputs

Clinical Inputs	2011	%	2010	%
Dublin Mid Leinster	5841	35.6%	7050	41.4%
Dublin North East	3114	19.0%	3435	20.2%
South	3275	19.9%	2691	15.8%
West	4190	25.5%	3842	22.6%
Total	16,420	100%	17,018	100%

4.6 Age profile of cases seen

Adolescents from the 15 year old age group are most likely to be attending the Community CAMHS teams, followed by children aged 10-14 year olds. Adolescents aged 16/17 years of age constituted 16.5% (an increase since the 2010 figure of 13.7%) of the caseload aged less than 17 years. One-hundred and three cases 1.5% of the total caseload, were over 18 years of age.

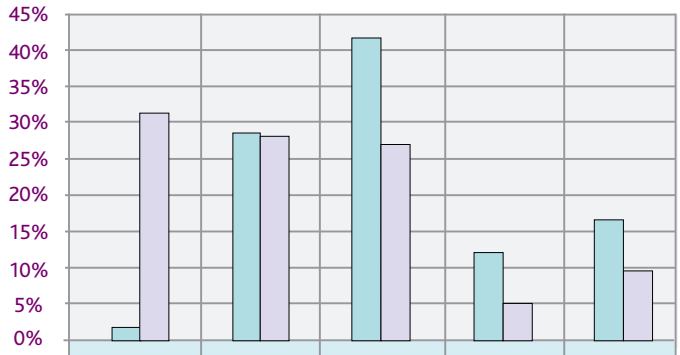
Figure 4.6 (i) Caseload Age Profile by Region



	0-4 yrs	5-9 yrs	10-14 yrs	15 yrs	16/17yrs
Dublin Mid Leinster	1.3%	33.2%	40.4%	10.7%	14.3%
Dublin North East	1.6%	28.4%	45.7%	10.6%	13.7%
South	0.4%	24.1%	43.9%	14.5%	17.0%
West	2.2%	25.5%	38.8%	13.0%	20.4%
National	1.4%	28.4%	41.6%	12.1%	16.5%

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

Figure 4.6 (ii) Age of Caseload Compared to Age Groups in the Population (0 to 17 years)



	0-4 yrs	5-9 yrs	10-14 yrs	15 yrs	16/17yrs
CAMHS Caseload (2011)	1.4%	28.4%	41.6%	12.1%	16.5%
Population Census (2011)	31.0%	27.9%	26.3%	5.0%	9.7%

4.7 Ethnicity

The ethnic profile of children and adolescents attending the service changed little from 2010 (Table 4.7 (a)).

- 90.1% of children and adolescents attending were from a white Irish ethnic background. The proportion in the population 0-19 years is 84.4%.
- 3.5% were from a white any other white ethnic background, highest in the South at 4.2%. The proportion in the population 0-19 years is 6.8%.
- The white Irish Traveller community accounted for 3% of cases, highest in the West Region at 5.7%. The proportion in the population 0-19 years is 1.2%.
- Children from a Black ethnic background accounted for a total of 1.7% of all children attending. The proportion in the population 0-19 years is 2.5%.
- Children from an Asian ethnic background accounted for a total of 0.7% of all children attending. The proportion in the population 0-19 years is 2.1%.

Table 4.7 (a) Ethnic Background

Ethnic Background	Dublin Mid Leinster	Dublin North East	South	West	Total 2011	Total 2010	Census <19 yrs 2011
White: Irish	89.6%	92.6%	91.1%	88.3%	**90.1%**	**90.0%**	**84.4%**
White: Irish Traveller	1.8%	1.2%	2.8%	5.7%	**3.0%**	**2.9%**	**1.2%**
White: Roma	0.2%	0.2%	0.1%	0.3%	**0.2%**	**0.3%**	*
White: Any other White background	3.8%	2.3%	4.2%	3.4%	**3.5%**	**3.4%**	**6.8%**
Black / Black Irish: African	2.1%	2.1%	1.0%	1.0%	**1.6%**	**1.7%**	**2.3%**
Black / Black Irish: Any other Black background	0.2%	0.1%	0.1%	0.1%	**0.1%**	**0.3%**	**0.2%**
Asian / Asian Irish: Chinese	0.5%	0.0%	0.2%	0.1%	**0.2%**	**0.3%**	**0.3%**
Asian / Asian Irish: Any other Asian background	0.8%	0.4%	0.3%	0.3%	**0.5%**	**0.5%**	**1.8%**
Other	1.0%	1.1%	0.2%	0.8%	**0.8%**	**0.6%**	**1.3%**
Not Stated							**1.7%**
	100%	100%	100%	100%	**100%**	**100%**	**100%**

** Not recorded*

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

Twenty per cent of children (1684) who attended Community CAMHS teams in November 2011 were in contact with social services, a further 8.76% (743) had a history of contact with social services. Of this number 72.7% (1,223) were reported to be in contact only with social services, 6.7% (113) were in relative foster care, 13.2% (223) were in non-relative foster care, and 4.8% (80) were in residential care (Table 4.8 (a)).

The figures were largely consistent across the four regions and showed an increase from the findings of the 2010 survey where 10% of cases seen were in the care of the HSE or in contact with social services.

Table 4.8 (a) Children in the Care of the HSE or in Contact with Social Services

Social Services	DML	%	DNE	%	South	%	West	%	Total	%
Contact with Service	521	81.4%	168	69.8%	249	61.5%	285	71.8%	1223	72.7%
Foster Care – Relative	40	6.2%	16	6.6%	35	8.6%	22	5.5%	113	6.7%
Foster Care – Non Relative	49	7.6%	35	14.5%	77	19.0%	62	15.6%	223	13.2%
Residential Unit	23	3.6%	21	8.7%	27	6.7%	9	2.3%	80	4.8%
High Support Unit	2	0.3%	1	0.4%	10	2.5%	1	0.3%	14	0.8%
Special Care Unit	6	0.9%	0	0.0%	7	1.7%	18	4.5%	31	1.8%
Total	641	100.0%	241	100.0%	405	100.0%	397	100.0%	1684	100.0%
All Cases Seen	2941	**22%**	1415	**17%**	1837	**22%**	2286	**17%**	8479	**20%**
History of Contact	248	8.43%	40	2.83%	86	4.68%	369	16.14%	743	8.76%

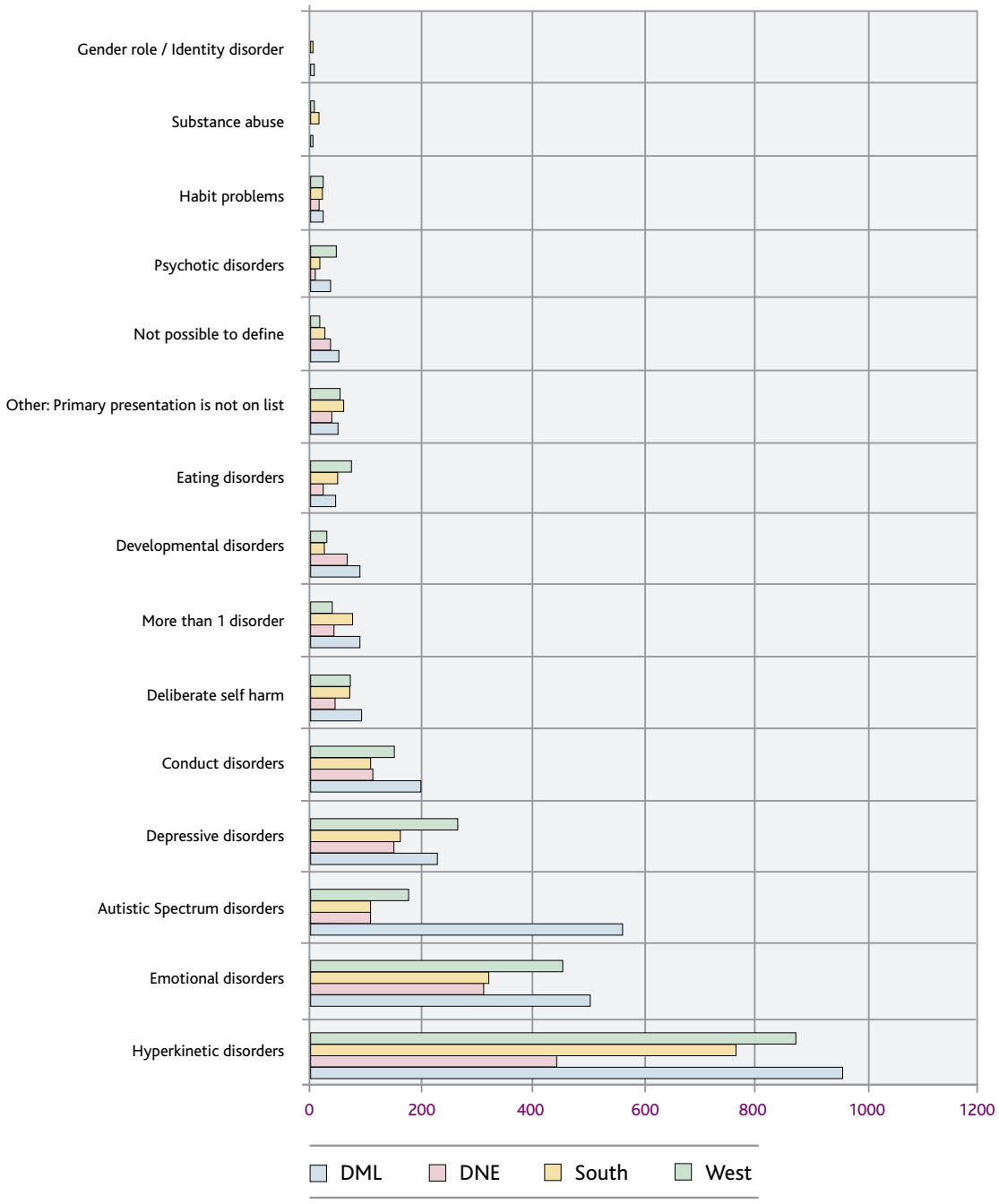
4.9 Primary presentation

The primary presentations of 8,479 cases were recorded by gender and age. For the purpose of the audit only one disorder / problem was entered for each case (Figures 4.9 (i – vi)).

- **Hyperkinetic disorders/problems** included ADHD and other attentional disorders, 3,025 (35.7%) cases.
- **Depressive disorders/problems** included depression, 798 (9.4%) cases.
- **Anxiety disorders/problems** included anxiety, phobias, somatic complaints, obsessional compulsive disorder, post traumatic stress disorder, 1,588 (18.7%) cases.
- **Conduct disorders/problems** included oppositional defiant behaviour, aggression, anti social behaviour, stealing, and fire-setting, 580 (6.8%) cases.
- **Eating disorders/problems** included pre-school eating problems, anorexia nervosa, and bulimic nervosa, 207 (2.4%) cases.
- **Psychotic disorders/problems** included schizophrenia, manic depressive disorder, or drug-induced psychosis, 108 (1.4%) cases.
- **Deliberate self harm** included lacerations, drug/medication and alcohol overdose, 285 (3.4%) cases.
- **Substance abuse** referred to drug and alcohol misuse, 30 (0.4%) cases.
- **Habit disorders/problems** included tics, sleeping problems, and soiling, 84 (1%) cases.
- **Autistic Spectrum Disorders/problems** referred to presentations consistent with autistic spectrum disorder, 947 (11.2%) cases.
- **Developmental disorders/problems** referred to delay in acquiring certain skills such as speech, and social abilities, 217 (2.6%) cases.

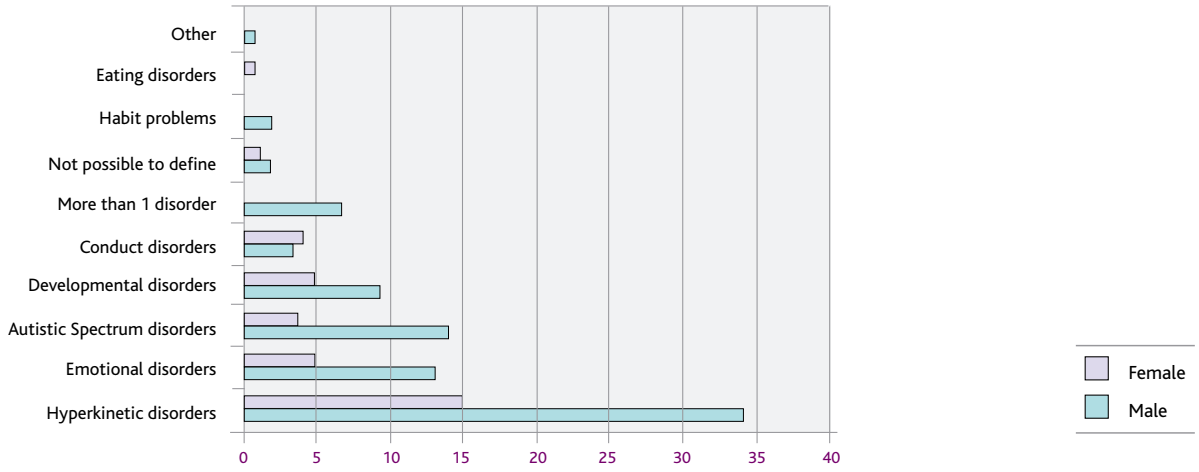
- **Gender Role / Identity disorder/problems** referred to gender role or identity problems or disorder, 16 (0.2%) cases.
- **Not possible to define** was only to be used if it was impossible to define the prominent disorder, 136 (1.6%) cases.
- **Other** was to be used when Primary presentation was not included in the list, 196 (2.3%) cases.
- **More than one disorder/problem** was only to be used if there was more than one prominent disorder, to the extent that it is not possible to identify one **primary** presenting disorder / problem, 252 (3%) cases.

Figure 4.9 (i) Primary Presentation by Region (2011)



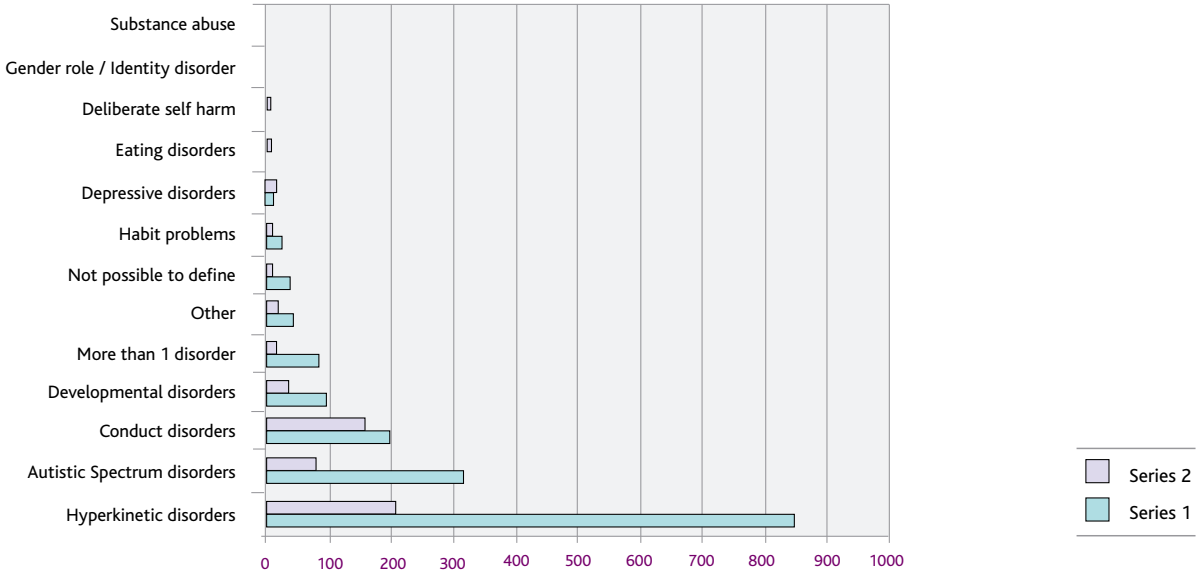
- The ADHD and other attentional disorders (35.7%) was the most frequently assigned primary presentation overall and in each of the regions.
- The Anxiety category the next largest accounting for 18.7% of primary presentations.
- The Autistic spectrum disorder category was more frequently assigned in Mid Leinster, accounting for 19% of primary presentations.

Figure 4.9 (ii) Primary Presentation by Gender and Age Group (0 – 4 years)



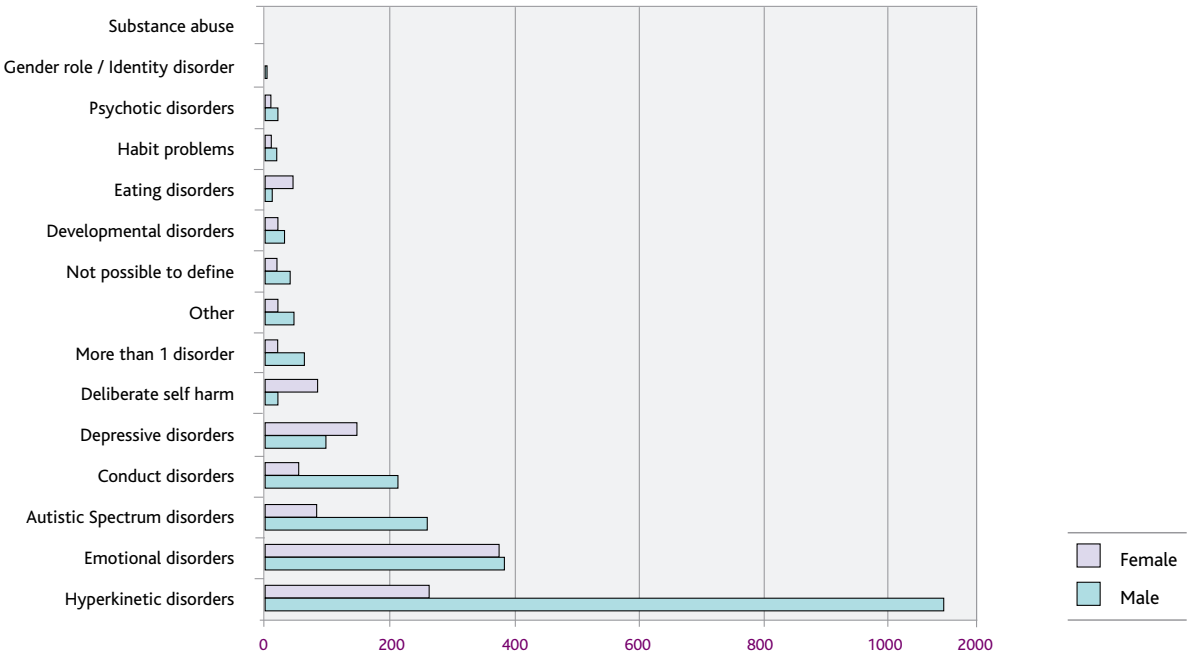
- In the 0 to 4 year old age group males comprised 28.6% (34) and females 12.6% (15) of the 119 children seen presenting with ADHD or other attentional disorders, a presentation consistent with autistic spectrum disorder or behavioural problems predominantly.

Figure 4.9 (iii) Primary Presentation by Gender and Age Group (5 - 9 years)



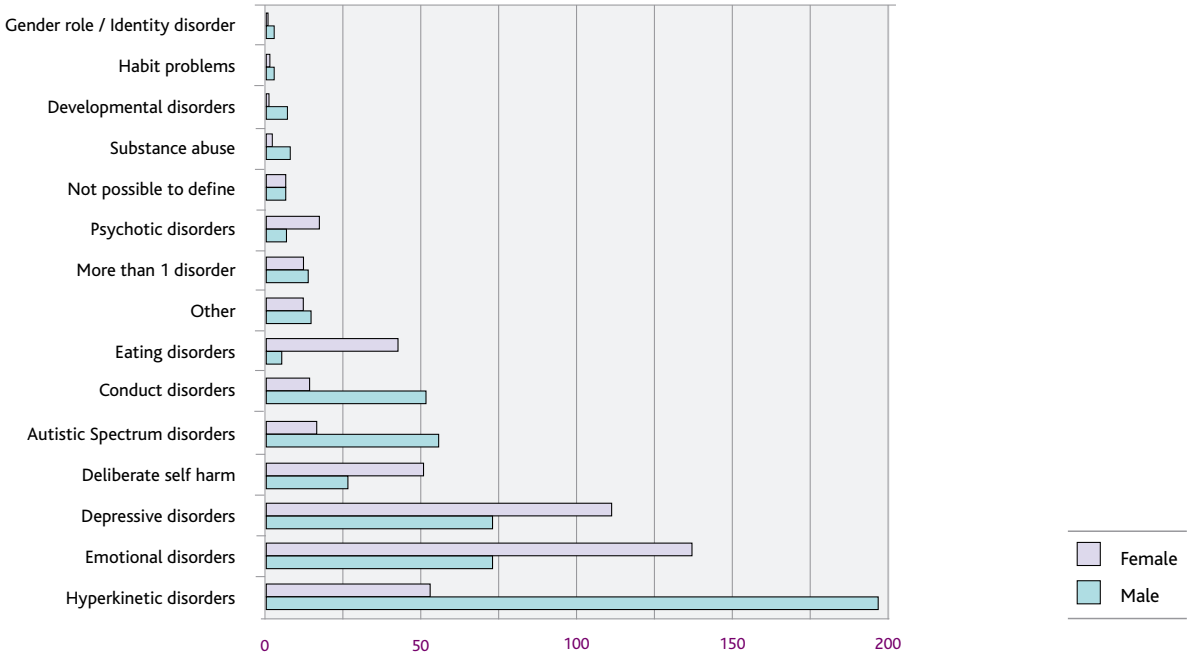
- Boys account for 75.3% (1,812) of children seen in the 5 to 9 year old age group. ADHD and other attentional disorders account for 47% of primary presentations in boys of this age group.
- 17.7% (321) of boys seen in the 5 to 9 year old age group had a primary presentation consistent with autistic spectrum disorder.
- Girls account for 24.7% (594) of children seen in the 5 to 9 year old age group. ADHD and other attentional disorders account for 34% of primary presentations in girls of this age group.
- The male to female ratio for ADHD or other attentional disorders is 4:1.

Figure 4.9 (iv) Primary Presentation by Gender Age Group (10 - 14 years)



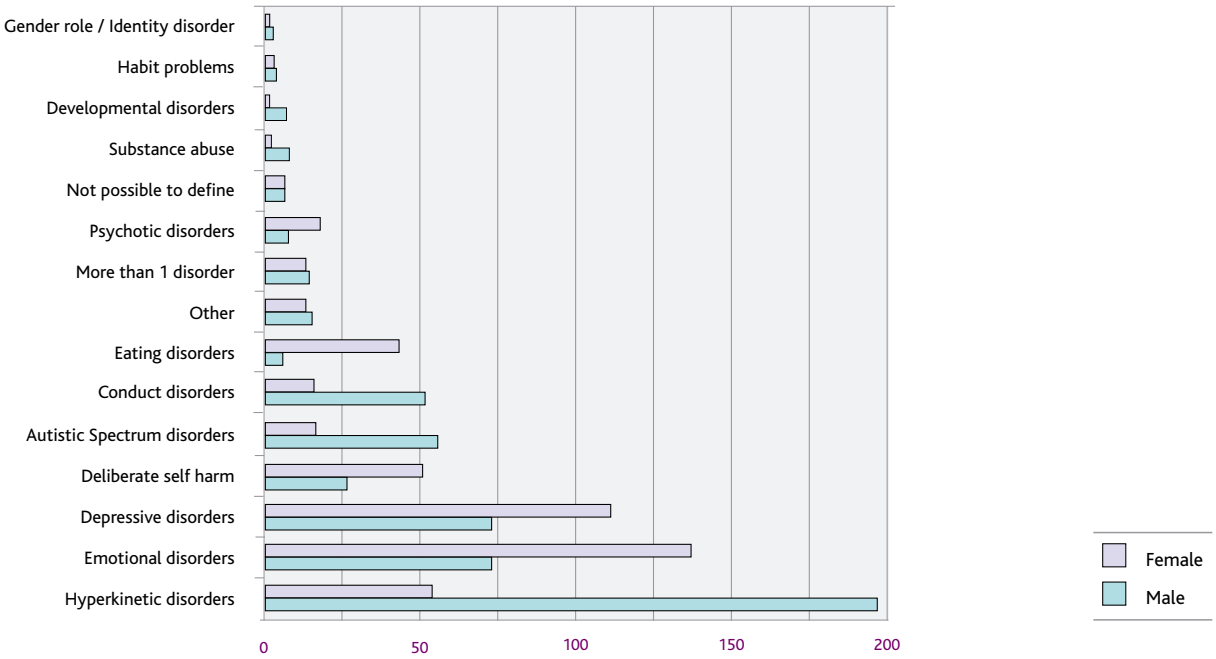
- Boys account for 66.1% (2,334) of children seen in 10 to 14 year old age group. ADHD and other attentional disorders is by far the most frequent presentation, depression and anxiety disorders were increasing in frequency.
- Girls account for 33.9% (1,195) of children seen in this age group. Anxiety and depressive disorders (44.2%) occur with the greatest frequency, the frequency of ADHD and other attentional disorders increased to 22.3% from 21% in 2010.

Figure 4.9 (v) Primary Presentation by Gender and Age Group (15 years)



- Boys account for 53.3% (548) of children seen in the 15 year old age group. ADHD and other attentional disorders continue to predominate but the rates of emotional disorders including depressive and anxiety disorders was increased.
- Girls account for 46.7% (481) of children in this age group. Emotional disorders were the most frequent primary presentation, followed by depressive disorders, eating disorders, and self harm.

Figure 4.9 (vi) Primary Presentation by Gender Age Group (16+ years)

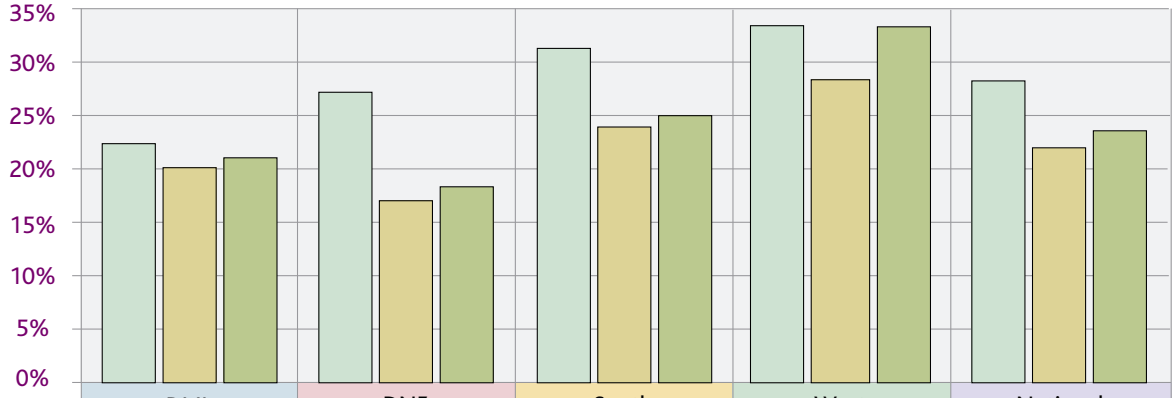


- Boys account for 51.6% (721) of children seen in the 16+ year old age group. ADHD and other attentional disorders continue to predominate but the rates of emotional disorders including depressive and anxiety disorders was increased.
- Girls account for 48.4% (675) of children in this age group. Depression was the most frequent primary presentation, followed by anxiety disorders, eating disorders and self harm.

4.10 Suicidal ideation / deliberate self harm

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

Figure 4.10 (i) Suicidal Ideation / Deliberate Self Harm as Part of Reason for Referral



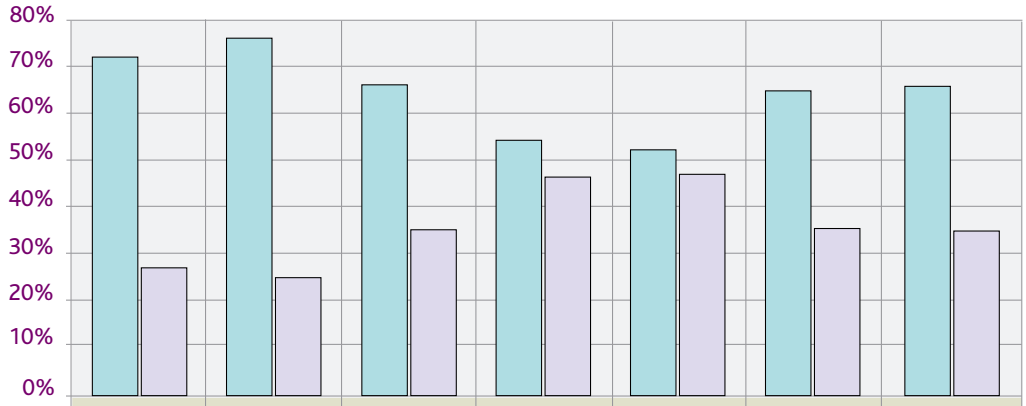
	DML	DNE	South	West	National
2011	22%	27%	31%	33%	28%
2010	20%	17%	24%	28%	22%
2009	21%	18%	25%	33%	24%

In 28% of the new cases the reason for referral to CAMHS included suicidal ideation or deliberate self harm.

4.11 Gender profile of cases and primary presentations

Males accounted for 64.9% of all children seen and were in the majority in each of the age groups (Figure 4.11 (i)).

Figure 4.11 (i) Gender by Age Group 2011



	0 to 4 yrs	5 to 9 yrs	10 to 14 yrs	15 yrs	16+ yrs	2011	2010
Male	71.4%	75.3%	66.1%	53.3%	51.6%	64.9%	66.2%
Female	28.6%	24.7%	33.9%	46.7%	48.4%	35.1%	33.8%

Males constituted the majority of primary presentations apart from Emotional Disorders (49.5%), Depression (36.5%), Deliberate Self Harm (28.1%), and Eating Disorders (12.6%), (see Figure 4.11 (ii) and Table 4.11 (a)).

Figure 4.11 (ii) Primary Presentation by Gender

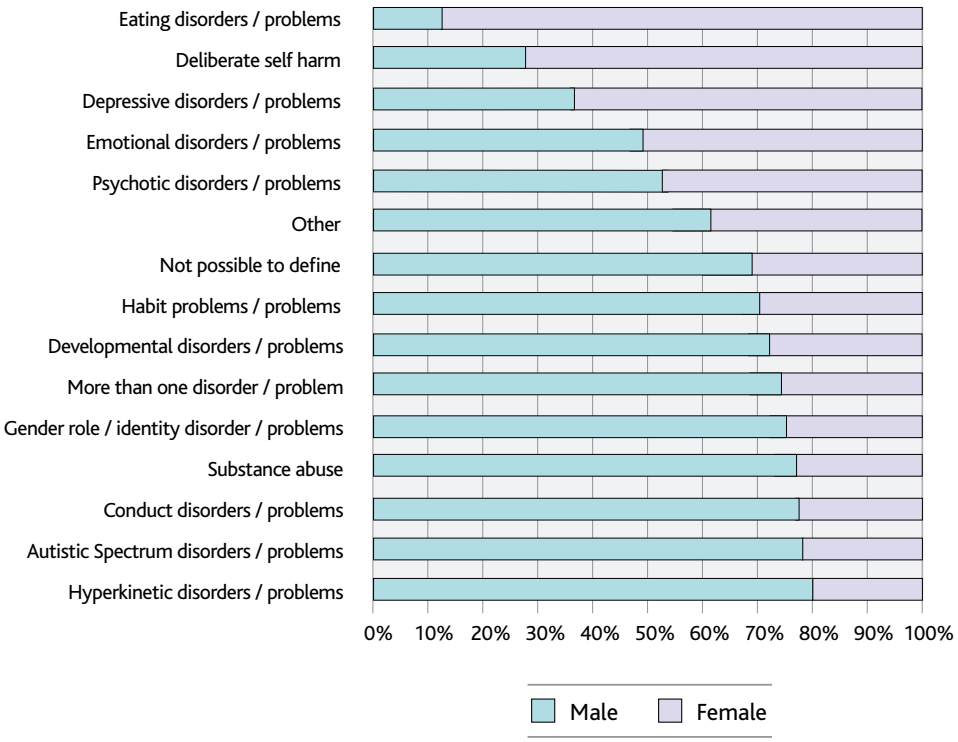


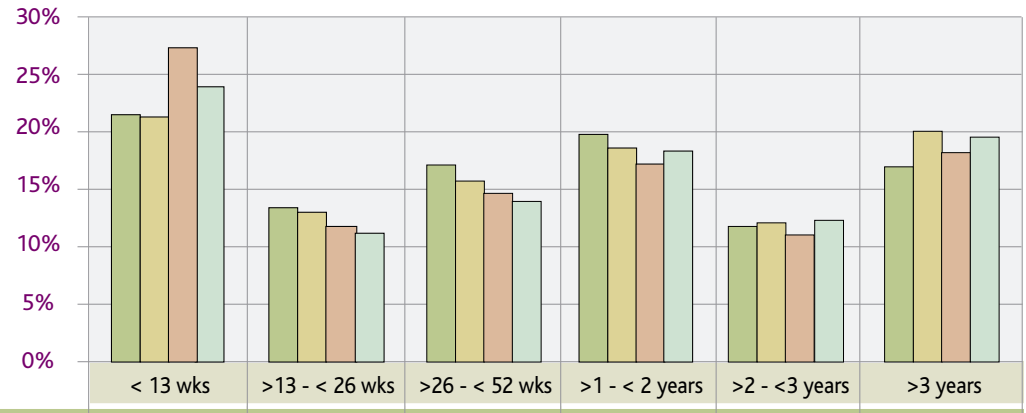
Table 4.11 (a) Primary Presentation by Gender 2011

Primary Presentation	Male %	Female %
Hyperkinetic disorders / problems: Includes ADHD and other attentional disorders.	79.9%	20.1%
Autistic Spectrum Disorders / problems: Refers to presentation consistent with autistic spectrum disorder.	78.0%	22.0%
Conduct disorders / problems: Includes oppositional defiant behaviour, aggression, antisocial behaviour, stealing, and fire-setting.	77.4%	22.6%
Substance abuse: Refers to drug and alcohol misuse.	76.7%	23.3%
Gender role / Identity disorder / problems: Refers to gender role or identity problems or disorder.	75.0%	25.0%
More than 1 disorder / problem: Only use if is not possible to identify one 'primary presenting disorder'.	74.2%	25.8%
Developmental disorders / problems: Refers to delay in acquiring certain skills such as speech, and social abilities.	71.9%	28.1%
Habit problems / problems: Includes tics, sleeping problems, and soiling.	70.2%	29.8%
Not possible to define: Only use if it is impossible to define the primary disorder / problem.	69.1%	30.9%
Other: Primary presentation is not included in the list.	61.2%	38.8%
Psychotic disorders / problems: Includes schizophrenia, manic depressive disorder, or drug-induced psychosis.	52.5%	47.5%
Emotional disorders / problems: Includes anxiety, phobias, somatic complaints, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder.	49.5%	50.5%
Depressive disorders / problems: Includes depression.	36.5%	63.5%
Deliberate self harm: Includes lacerations, drug/medication, and/or alcohol overdose.	28.1%	71.9%
Eating disorders / problems: Includes pre-school eating problems, anorexia nervosa, and bulimia nervosa.	12.6%	87.4%

4.12 Length of treatment

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

Figure 4.12 (i) Duration of Treatment (2011)



	< 13 wks	>13 - < 26 wks	>26 - < 52 wks	>1 - < 2 years	>2 - <3 years	>3 years
Nov 08	21.5%	13.4%	16.8%	19.7%	11.9%	16.7%
Nov 09	21.3%	13.0%	15.5%	18.1%	12.1%	20.0%
Nov 10	27.0%	12.3%	14.9%	17.0%	11.0%	17.8%
Nov 11	24.0%	11.5%	13.8%	18.8%	12.2%	19.8%

- 24% of cases were in treatment less than 13 weeks.
- 11.5% of cases were in treatment from 13 to 26 weeks.
- 13.8% of cases were in treatment from 26 to 52 weeks.
- 18.8% of cases were in treatment greater than 1 year but less than 2 years.
- 12.2% of cases were in treatment greater than 2 years but less than 3 years.
- 19.8% of cases were in treatment greater than 3 years.

Over all there were 49.2% of cases were in treatment greater than 1 year.

4.13 Day services

A total of 38 children and adolescents attended St. Joseph's Adolescent & Family Day Service at St. Vincent's Hospital, Fairview and Dunfillan Young Person's Unit at St. John of God Lucena Clinic Rathgar, Dublin, in the month of November 2011.

Nine new cases commenced attendance during the month. Seven were referred from Community CAMHS teams and in 2 of the cases a reason for referral included suicidal ideation or a history of deliberate self harm. Seven of the young people had commenced attendance in less than 2 weeks of referral and two had commenced within 2 to 4 weeks of referral.

Table 4.13 (a) Age and Gender Profile

Age	Male	Female	Total
< 12 years	0	0	0
12/13 years	3	3	6
14/15 years	4	9	13
16/17 years	7	10	17
18 years	0	2	2
Total	**14**	**24**	**38**

Thirty-two (84%) of children attending the day programmes were aged 14 years or older. There were a greater number (63%) of females than males attending. One child (3%) had previously been admitted for inpatient treatment and 1 (3%) was in foster care with a non-relative, they remaining 36 (94%) had no previous contact with HSE social services.

Table 4.13 (b) Primary Presentation

Primary Presentation	%
ADHD and other attentional disorders	24%
Anxiety, phobias, OCD, PTSD, etc.	21%
Depression	18%
Eating problems including anorexia nervosa	8%
Presentation consistent with autistic spectrum disorder	8%
Primary presentation is not included in the list	8%
Schizophrenia, manic depressive disorder, or drug-induced psychosis	5%
Lacerations, drug/medication, and/or alcohol overdose	3%
Behavioural Problems	3%
Oppositional defiant behaviour	3%

ADHD (24%) was the most frequent primary presentation followed by Anxiety (21%) and Depression (18%).

Table 4.13 (c) Duration of Treatment

Duration of treatment	No.
< / = 4 weeks	5
> 4 weeks but < / = 6 weeks	6
> 6 weeks but < / = 8 weeks	5
> 8 weeks but < / = 10 weeks	1
> 10 weeks but < / = 12 weeks	5
> 12 weeks but < / = 26 weeks	12
> 26 weeks	4
Total No.	**38**

Thirty-four (58%) of the young people had attended for less than 3 months.

4.14 Paediatric hospital liaison services

A total of 85 new cases were seen by the liaison teams at the three Dublin paediatric hospitals.

Table 4.14 (a) New Cases seen by Paediatric Liaison Teams

Paediatric Hospital	New Cases	Suicidal ideation / Deliberate Self harm	%
Temple St. Children's University Hospital (CUH)	68	13	19%
Our Lady's Hospital for Sick Children, Crumlin (OLHSC)	8	4	50%
National Children's Hospital, Tallaght (NCH)	9	4	44%
Total	**85**	**21**	**24.7%**

In 21 (24.7%) cases suicidal ideation or deliberate self harm was a reason for referral to the liaison services.

A total of 307 children and adolescents were seen by liaison services in November 2011. The much larger size of the liaison team at Temple St. Children's University Hospital was reflected in the greater number seen by that service. Seven children were in contact with or in the care of HSE social services.

Fifty-five percent of the children were male, 36% were between the age of 10 and 14 years and 25% were over the age of 14 years.

Table 4.14 (b) Age and Gender Profile

Age	0 – 4 yrs		5 – 9 yrs		10 – 14 yrs		15 yrs		16 / 16+ yrs	
Gender	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
CUH	27	16	39	22	42	46	13	16	15	9
OLHSC	0	0	3	2	8	4	4	4	2	5
NCH	2	1	6	2	4	6	1	0	2	6
Total	**29**	**17**	**48**	**26**	**54**	**56**	**18**	**20**	**19**	**20**
2011	**15%**		**24%**		**36%**		**12%**		**13%**	
2010	**16%**		**19%**		**35%**		**15%**		**15%**	
2009	**9%**		**29%**		**40%**		**11%**		**11%**	

A total of 114 out patient appointments, consultations on the ward or in the A & E department took place in November 2011. Sixty-eight percent took place in the out patient department, 23% on the ward and 9% in the A & E department. The non-attendance rate at out patient appointments was 19%.

Table 4.14 (c) Appointments / Consultations

Appointments / Consultations	Children's University Hospital	Our Lady's Hospital for Sick Children	National Children's Hospital	Total	%
Attended appointments OPD	68	2	8	78	68%
Consultations on the ward	16	3	7	26	23%
Consultations in A & E Dept.	4	6	0	10	9%
Total	**88**	**11**	**15**	**114**	**100%**
No. of OPD Apts. not attended	14	1	0	15	19%

The most frequent primary presentation was presentation not listed (21.82%) followed by anxiety problems/disorders (17.92%), ADHD and other attentional disorders (13.03%), autistic spectrum disorder (9.45%), developmental disorders (6.84%), and deliberate self harm (6.84%).

Table 4.14 (d) Primary Presentation Hospital Liaison Services

Primary Presentation	Children's University Hospital	Our Lady's Hospital	National Children's Hospital	Total No.	%
ADHD and other attentional disorders	36	2	2	40	**13.03%**
Depression	7	8	3	18	**5.86%**
Anxiety, phobias, somatic complaints, OCD, PTSD	49	5	1	55	**17.92%**
Oppositional defiant and other behavioural problems	7	2	1	10	**3.26%**
Eating problems, anorexia nervosa, bulimia	11	4	2	17	**5.54%**
Psychotic problems/disorders	1	1	0	2	**0.65%**
Lacerations, drug/medication, and/or alcohol O/D	13	4	4	21	**6.84%**
Drug and alcohol misuse	0	0	0	0	**0.00%**
Tics, sleeping problems, and soiling	12	1	1	14	**4.56%**
Presentation consistent with autistic spectrum disorder	17	1	11	29	**9.45%**
Delay in acquiring certain skills such as speech, etc.	21	0	0	21	**6.84%**
Gender role or identity problems or disorder	0	0	0	0	**0.00%**
It is impossible to define primary disorder/problem	7	0	0	7	**2.28%**
Primary presentation is not included in the list	58	4	5	67	**21.82%**
More than one disorder, impossible to assign single primary presentation	6	0	0	6	**1.95%**
Totals	**245**	**32**	**30**	**307**	**100%**

SECTION 5 Inpatient Child and Adolescent Mental Health Services

5.1 Inpatient services child and adolescent mental health services

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

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

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

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

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

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

Table 5.1 (a) HSE Inpatient Services and Bed Capacity (2008 to 2012)

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

* Transfer from Warrenstown to Interim Linn Dara Unit May 2012

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

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

5.2 Admission of children and adolescents to inpatient units

There were 432 admissions of children and adolescents in 2011. Of this total 300 (69%) admissions were to child and adolescent inpatient units and 132 (31%) to adult units. The 432 admissions compared with a total of 435 in 2010, 367 in 2009, and 406 in 2008.

Table 5.2 (a) Place of Admissions by Age

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

In the period January to September 2012 there was a total of 303 admissions of children and adolescents under the age of 18 years. 228 (75%) were admitted to child and adolescent units and 75 (25%) to adult units. A total of 15 (20%) adolescents admitted to adult inpatient units were subsequently transferred to St. Joseph's, Merlin Park, and Eist Linn units.

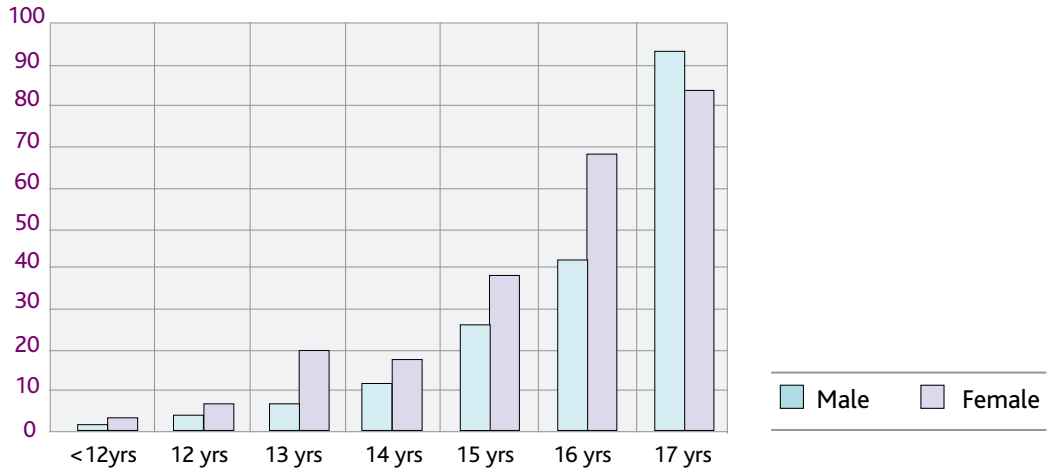
Table 5.2 (b) Place of Admissions

Child and Adolescent Units	2007	2008	2009	2010	2011	2012*
St. Anne's, Galway	32	31	29	33		
Merlin Park Inpatient Unit, Galway					38	48
St. Joseph's, Fairview, Dublin			29	34	42	29
Warrenstown Unit, Blanchardstown, Dublin	46	42	37	37	39	6
Interim Linn Dara Unit, Palmerstown, Dublin						16
Eist Linn, St. Stephen's Hospital, Cork			4	44	5	
Eist Linn, Bessboro, Cork					32	24
Private Units	68	70	56	124	144	105
Total Child	**146**	**143**	**155**	**272**	**300**	**228**
Adult Units						
HSE Adult Units	190	223	185	155	129	75
Central Mental Hospital				1	1	
Private Adult Units	28	40	27	7	2	
Total Adult	**218**	**263**	**212**	**163**	**132**	**75**
Total	364	406	367	435	432	303

5.3 Age and gender of admissions (2011)

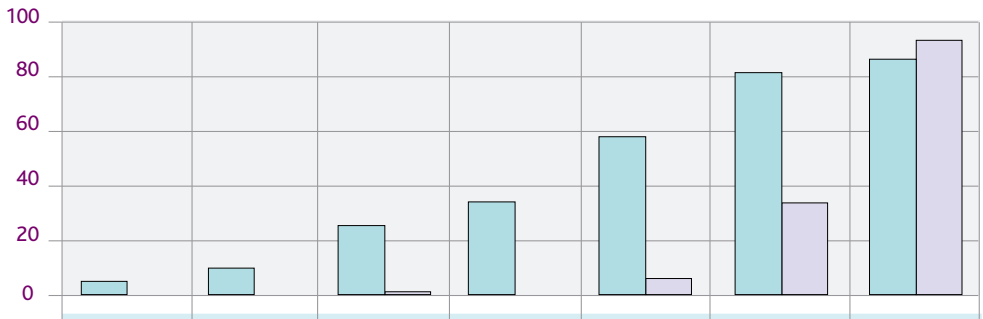
Of the 432 admissions of children and adolescents in 2011 females accounted for 56% of admissions. Forty one per cent of all admissions were aged 17 years on admission, 27% were aged 16 years, 15% were aged 15 years, 8% were aged 14 years, 6% were aged 13 years, 2% aged 12 years, and 1% aged less than 12 years (Figure 5.3 (i)).

Figure 5.3 (i) Age and Gender of Admissions (2011)



Of the 300 (69%) admissions to the child and adolescent inpatient units 29% were aged 17 years on admission, 27% were aged 16 years, 19% were aged 15 years, 12% were aged 14 years, 8% were aged 13 years, 3% were aged 12 years and 2% were aged less than 12 years. Of the 132 (31%) admissions to adult approved centres 69% were aged 17 years on admission, 26% were aged 16 years, 6% (7) were less than 16 years of age on admission. Of this number 6 were aged 15 years on admission and 1 was aged 13 years (Figure 5.3 (ii)).

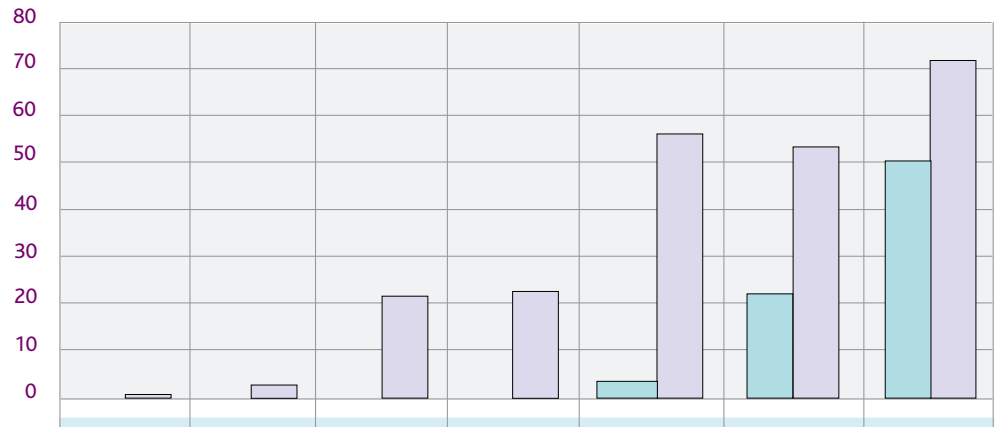
Figure 5.3 (ii) Place of Admission by Age (2011)



	<12 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Child and adolescent inpatient units	5	10	25	35	58	81	86
Adult approved centres	0	0	1	0	6	34	91

In the period January to September 2012 there was a total of 303 admissions of children and adolescents under the age of 18 years. 228 (75%) were admitted to child and adolescent units and 75 (25%) to adult units. The breakdown of the admissions by age is shown in Figure 5.3 (iii).

Figure 5.3 (iii) Place of Admission by Age (January to September 2012)



	<12 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Adult unit					4	21	50
Child and adolescent unit	1	3	21	22	56	54	71

Seventy-five percent (228) of admissions were to child and adolescent units. Of these admissions, 31% (70) were 17 years of age, 24% (54) were 16 years of age, 25% (56) were 15 years of age, 10% (22) were 14 years of age, 9% (21) were 13 years of age, 1% (3) were 12 years of age and the remaining 1% (1) were under the age of 12 years.

Twenty-five percent (75) of admissions were to adult units; 67% (50) of these admissions were 17 years of age, 28% (21) were 16 years of age and 5% (4) were 15 years of age.

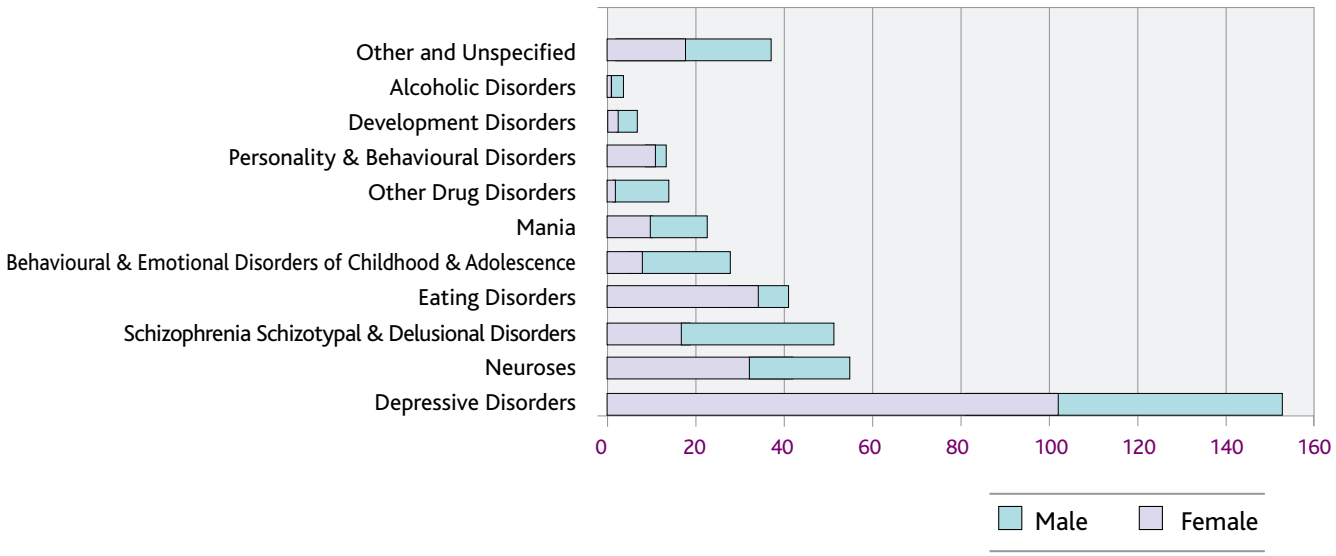
Table 5.3 (a) Admissions to Adult Units by Service Provider (January to September 2012)

Service Provider	No. of units	No. of admissions Jan to Sept 2012	%	No. of admissions Jan to Sept 2011
HSE Dublin Mid Leinster	5 Adult units	11	15%	20
HSE Dublin North East	4 Adult units	12	16%	23
HSE South	5 Adult units	16	21%	25
HSE West	8 Adult units	36	48%	32
Total	**22**	**75**	**100%**	**100**

5.4 Diagnostic categories

Depressive disorders accounted for 35% of all admissions in 2011 (see Figure 5.4 (i)). The next largest diagnostic category was neuroses and schizophrenia and delusional disorders at 13%, eating disorders at 10%, and behavioural and emotional disorders of childhood and adolescence at 6%. The diagnosis of mania accounted for 5% of admissions. A total of 9% of admissions were returned in the other and unspecified category.

Figure 5.4 (i) Diagnostic Categories by Gender (2011)



In 2011 females accounted for 85% of all admissions with personality and behavioural disorders, 83% of all admissions with eating disorder, 67% of all admissions with depressive disorders and 59% of all admissions with neuroses.

Males accounted for 87% of all admissions with other drug disorders, 75% of all admissions with alcoholic disorders, 71% of all admissions with developmental disorders, 68% of all admissions with behavioural and emotional disorders of childhood & adolescence, 67% of all admissions with schizophrenia and delusional disorders, and 52% of all admissions with mania.

In 2010 females accounted for 85% of all admissions with eating disorder, 69% of all admissions with depressive disorders, and 50% of all admissions with mania. Males accounted for 73% of all admissions with schizophrenia and delusional disorders, 67% of all admissions with behavioural and emotional disorders of childhood & adolescence, and 63% of all admissions with neuroses.

5.5 Duration of admission

The average length of stay (for those admitted and discharged in 2011) was 36.2 days (median length of stay 21 days), increasing from 33.2 days in 2010. The average length of stay was significantly longer in the child and adolescent units, at 48.3 days (median 39 days), than in adult units, at 9.9 days (median 5 days). Twenty-nine per cent of children and adolescents admitted in 2011 were discharged within one week of admission.

Table 5.5 (a) Length of Admission (2011)

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

Sixty-four percent of young people admitted to adult units were discharged within one week of admission, 25% were discharged within two days of admission. Eighteen per cent were discharged within one to two weeks of admission, and a further 10% within two to four weeks of admission. Seven per cent were discharged within four to twelve weeks of admission and a further 1% was discharged after admissions of less than eleven weeks.

Thirteen percent of young people admitted to child and adolescent units were discharged within one week, 12% were discharged within one to two weeks of admission, 16% were discharged within two to four weeks, 23% were discharged within four to eight weeks, 19% were discharged within eight to twelve weeks, and a further 17% was discharged after admissions of greater than twelve weeks duration.

Figure 5.5 (i) Duration of Admissions (2011)

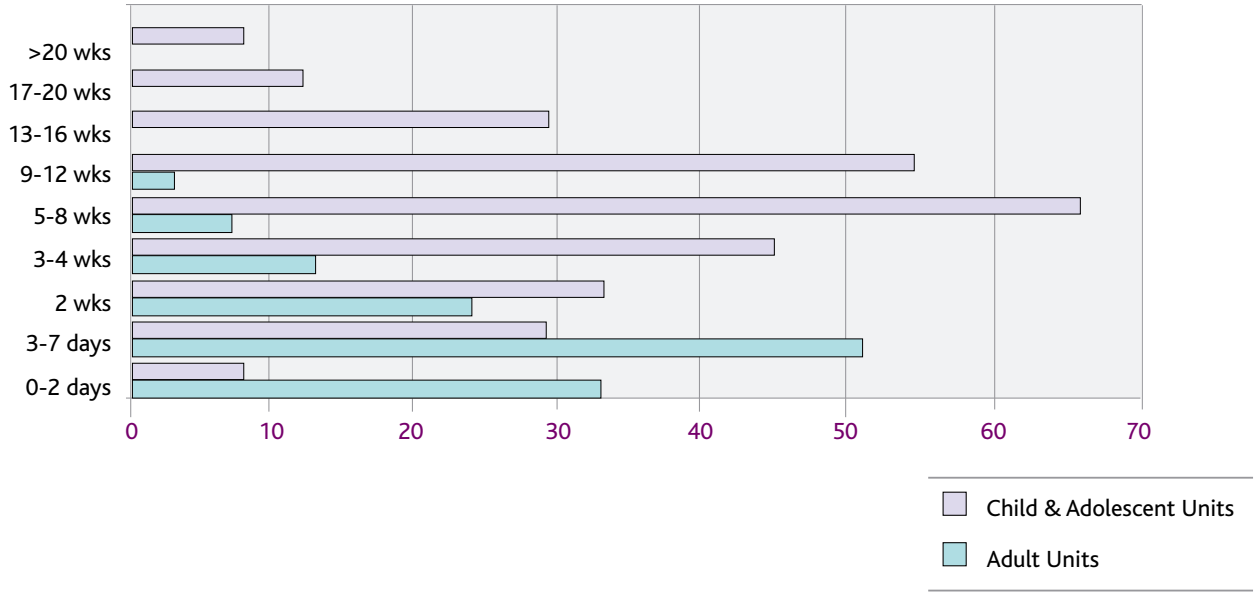


Table 5.5 (b) Duration of Admission by Diagnosis (2011)

	Length of stay in days			
	Number of discharges	Inpatient days	Average number of days	Median number of days
Alcoholic Disorders	4	19	4.75	4.0
Other Drug Disorders	15	80	5.33	2.0
Schizophrenia, Schizotypal and Delusional Disorders	50	1980	39.60	23.5
Depressive Disorders	152	6332	41.66	31.5
Mania	22	763	34.68	20.5
Neuroses	53	1514	28.57	21.0
Eating Disorders	40	2753	68.83	66.0
Personality and Behavioural Disorders	13	242	18.62	9.0
Development Disorders	7	477	68.14	29.0
Behavioural and Emotional Disorders of Childhood & Adolescence	28	436	15.57	11.5
Other and Unspecified	32	478	14.94	7.0
Total	**416**	**15,074**	**36.2**	**21.0**

5.6 Involuntary admissions

There were 12 involuntary admissions of children to approved centres, under Section 25 of the Mental Health Act 2001, in the first 9 months of 2011. Eleven of these involuntary admissions were to child units and one was to an adult unit.

There were 21 involuntary admissions of children to approved centres in 2011. One admission was to the Central Mental Hospital under The Criminal Law Insanity Act and two were admitted under the 1991 Child Care Act; the remainder was under Section 25 of the Mental Health Act 2001. The majority (12) of involuntary admissions was to child units and nine were to adult units. This represented an increase from a total of 14 and 10 involuntary admissions in 2010 and 2009 respectively.

5.7 Development of inpatient services

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

Table 5.7 (a) Developments of Inpatient Services

HSE Region	Capital Project	Cost	Status
West	New 20 Bed Unit at Merlin Park Hospital, Galway	€8.8m	Open 2011
South	New 20 Bed Unit at Bessboro, Cork	€8.2m	Open 2011
Dublin North East	New 12 Bed Adolescent Unit, Dublin	€2.2m	Open 2012
Dublin Mid Leinster	New Interim 8 Child and Adolescent Unit, Dublin	€0.3m	Open 2012
	New Interim 6 Bed Older Adolescent Unit, Dublin	€0.3m	Open 2013
	New 24 Bed Unit at Cherry Orchard Hospital, Dublin	€10.5m	Planning application
National	New 20 Bed Unit in The New Children's Hospital	TBC	Design stage
National	New 10 Bed Adolescent Secure Unit	TBC	Design stage

HSE West

The Merlin Park Inpatient Unit opened on January 14th 2011 with a capacity of 10 Beds. The inpatient service transferred from St. Anne's Inpatient Unit (10 beds), Taylor's Hill, Galway. Approval for additional staff was granted and the recruitment process commenced to facilitate the completion of the team and the commissioning of additional inpatient beds. In May 2011 the Mental Health Commission granted permission to increase the Inpatient Bed capacity to 12, and in September 2011 this was increased to 15 beds. The Unit currently has 20 operational beds.

Merlin Park Child and Adolescent Unit, Galway

HSE South

The Eist Linn service transferred to Bessboro on the March 12th 2011 from the interim 8 Bed Unit at St. Stephen's Hospital. The unit comprises of a 20 bed residential facility, and a separate educational facility commissioned by the Department of Education. It currently accommodates 12 children and young people. It is planned to further increase its capacity in 2013.

Eist Linn Inpatient Unit, Bessboro, Cork

HSE Dublin North East

The second phase of development of adolescent inpatient services at St. Vincent's Hospital, Fairview was completed in September 2012 with the opening of the new 12 bed unit. It is not yet fully operational. The existing unit has been taken over for use by the Adolescent Day Service.

HSE Dublin Mid Leinster

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

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

New Children's Hospital of Ireland

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

National Forensic Hospital

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

SECTION 6 Community Child & Adolescent Mental Health Service Infrastructure

6.1 Accommodation of CAMHS teams

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

Table 6.1 (a) Location of Community CAMHS Teams (2011)

Location of Team	Very good	Good	Adequate	Inadequate	Unsuitable	Total
Rented Premises – Located in the Community	7	2	5	3		17
Premises owned by Voluntary Service Provider located in the community	6	2	2	1		11
Hospital Site (+/- Community Building)	1	1	3	3	1	9
HSE Building located in the community – Sole Occupant		2	1		4	7
HSE Building located in the community – Shared	1	2	1	2	3	9
HSE Building & Rented Premises (in the Community)			2		1	3
Total	**15**	**9**	**14**	**9**	**9**	**56**
2011 %	**27%**	**16%**	**25%**	**16%**	**16%**	**100%**
2010 %	**29%**	**9%**	**33%**	**22%**	**7%**	**100%**

6.2 Suitability of premises

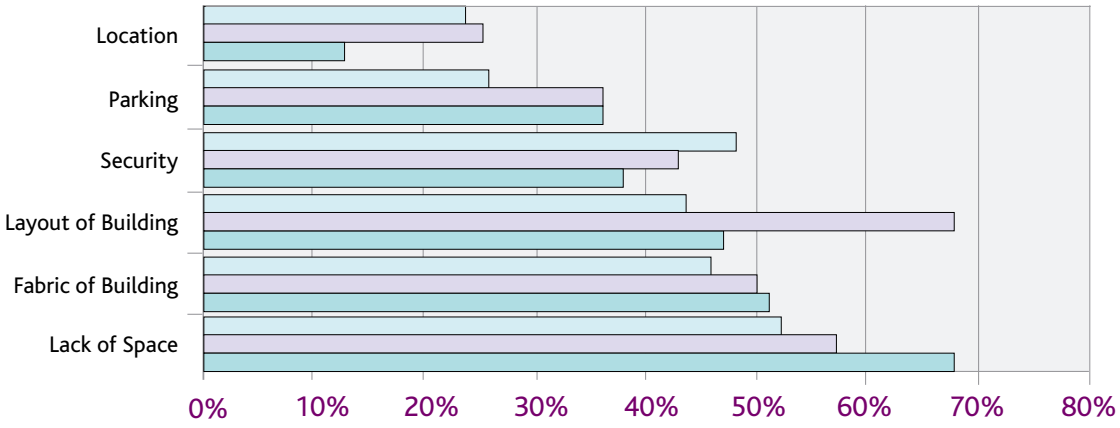
Each team rated the suitability of their premises in order to provide a service:

- 38 (68%) teams rated their premises as adequate, good or very good.
- 18 (32%) teams rated their premises as inadequate or totally unsuitable.
- The number of teams that reported their accommodation as being inadequate or unsuitable increased when compared with the results from the 2010 survey.

6.3 Difficulties encountered with premises

Lack of space was the most frequently encountered problem reported by 68% of teams. This was followed by concerns with regard to fabric of the building (51%), layout of the building (47%), security (38%), and parking problems (36%).

Fig 6.3 (i): Difficulties Encountered with Premises



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

6.4 Infrastructure developments

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

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

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SECTION 7 Demands on Community CAMHS

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

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

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

During the month of November (2010) 16.5% of the cases seen by Community CAMHS teams were aged 16/17 years and 1.5% were over 18 years of age. Teams were asked as to their current arrangements with regard to the 16/17 year age group of young people who previously were the responsibility of Adult Mental Health Services in most areas of the country. From 2006 the practice of teams keeping on existing cases beyond their 16th birthday was extended, without the provision of additional resources at that time.

Table 7.1 (a) Arrangements for 16 and 17 Year Old Age Group

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

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

- The number of teams accepting referrals of young people up to and including 17 years increased from 9 (16%) to 14 (25%). A further 3 (5%) teams accept referrals of young people up to and including 16 years of age. Two teams accept new referrals of young people aged 16/17 years on a case by case basis.
- Child and Adolescent Mental Health Services currently provide a significant level of service to this age group.
- Some young people are transferred to Adult Mental Health Services after their 16th birthday due the nature of their illness and care / treatment needs (1.4% of the cases discharged by CAMHS teams from October 2011 to September 2012).
- As the older age group present with more acute mental health difficulties access to services by younger children to child and adolescent mental health services with less acute presentations may be affected if additional resources are not in place.
- In the period October 2011 to September 2012, 967 (11.2%) of new cases seen were aged 16/17 years of age.

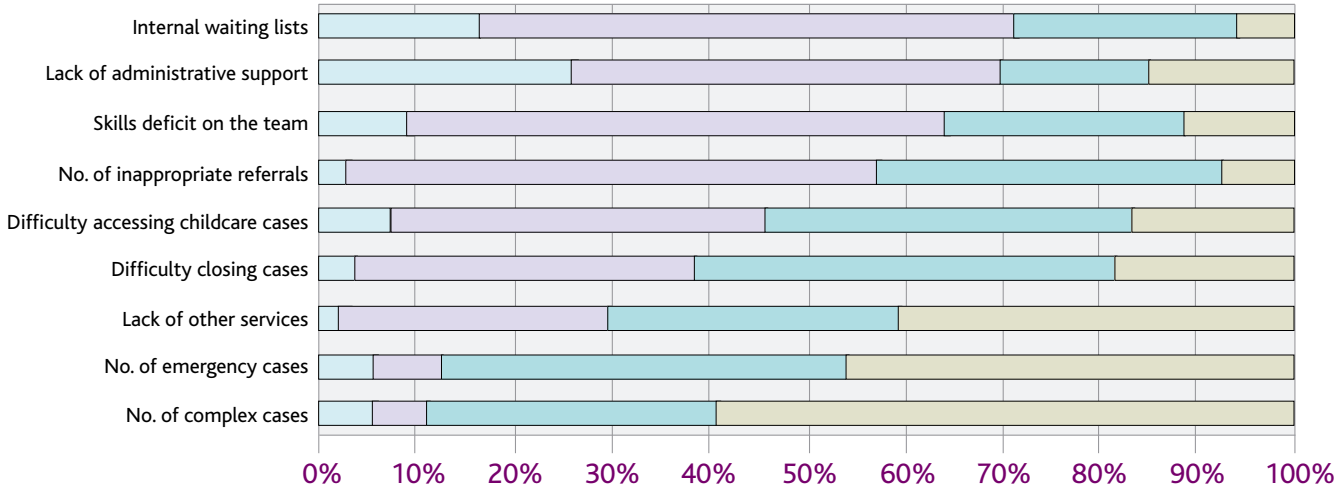
On 4th September 2012, the HSE Management Team approved the new "Access protocols for 16 and 17 year olds to mental health services" to come into effect from 1st January 2013. With effect from that date all new cases of children up to their 17th birthday who require mental health assessment and treatment will be seen by the Child and Adolescent Mental Health Services, in those areas where current limit is 16 years of age.

With effect from 1st January 2014, all children up to their 18th birthday who require mental health assessment and treatment will be seen by the Child and Adolescent Mental Health Services.

7.2 Capacity of CAMHS teams to respond to demand

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

Figure 7.2 (i) Factors which Impact on a Team's Capacity to Respond to Demand (2011)



	No of complex cases	No of emergency cases	Lack of other services	Difficulty closing cases	Difficulty accessing childcare cases	No of inappropriate referrals	Skills deficit on the team	Lack of Administrative Support	Internal Waiting Lists
Very often	59.3%	46.3%	40.7%	18.5	16.7%	7.4%	11.3%	14.8%	5.7%
Often	29.5%	40.7%	29.6%	42.6%	37.0%	35.2%	24.5%	14.8%	22.6%
Occasionally	5.6%	7.4%	27.8%	35.2%	38.9%	53.7%	54.7%	44.5%	54.7%
Never	5.6%	5.6%	1.9%	3.7%	7.4%	3.7%	9.5%	25.9%	17.0%

As in 2010 Community CAMHS teams rate the number of complex cases, the number of emergency cases and the lack of other services in the area as the factors having the greatest impact on their capacity to respond to demand which can in turn lead to increased numbers on waiting lists and longer waiting times for routine assessments.

7.3 Provision of dedicated ADHD clinics by community CAMHS teams

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

Table 7.3 (a) ADHD Clinics

ADHD Clinic	Dublin Mid Leinster	Dublin North East	South	West	Total
Number	16	5	11	13	45
All Teams	17	11	14	14	56
2011 %	94%	45%	79%	93%	80%
2010 %	94%	45%	57%	93%	75%

Eighty percent of teams are employing such dedicated ADHD clinics. Over 90% of teams in the West and in Dublin Mid Leinster run ADHD clinics, 79% of teams in the South while only 45% of teams in Dublin North East do so.

The majority (66%) of clinics take place on a weekly or fortnightly basis. The majority of the clinics are run by nurses and psychiatrists (including consultants and doctors in training).

Table 7.3 (b) Frequency of ADHD Clinics

Frequency	Number	%
Every week	19	42%
Every 2 weeks	11	24%
Every 3 weeks	0	0%
Every 4 weeks / month	6	14%
Other	9	20%
Total	**45**	**100%**

7.4 Referral protocols and referral forms

A total of 41 (73%) Community CAMHS teams had a referral protocol in place and 33 (59%) teams utilised a referral form.

Table 7.4 (a) Referral Protocols

	Dublin Mid Leinster	Dublin North East	South	West	Total 2011	Total 2010
Referral Protocol	12	9	12	8	41	40
Referral Form	9	11	8	5	33	29
No. of Teams	**17**	**11**	**14**	**14**	**56**	**55**

SECTION 8 Deliberate self harm in children aged from 10 to 17 years in the Republic of Ireland

8.1 The National Registry of Deliberate Self Harm

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

The Registry collects data on persons presenting to hospital emergency departments as a result of deliberate self harm in the Republic of Ireland. In 2011 the Registry recorded 12,216 presentations to hospital due to deliberate self harm nationally, involving 9,834 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital following deliberate self harm in 2011 was 215 per 100,000.

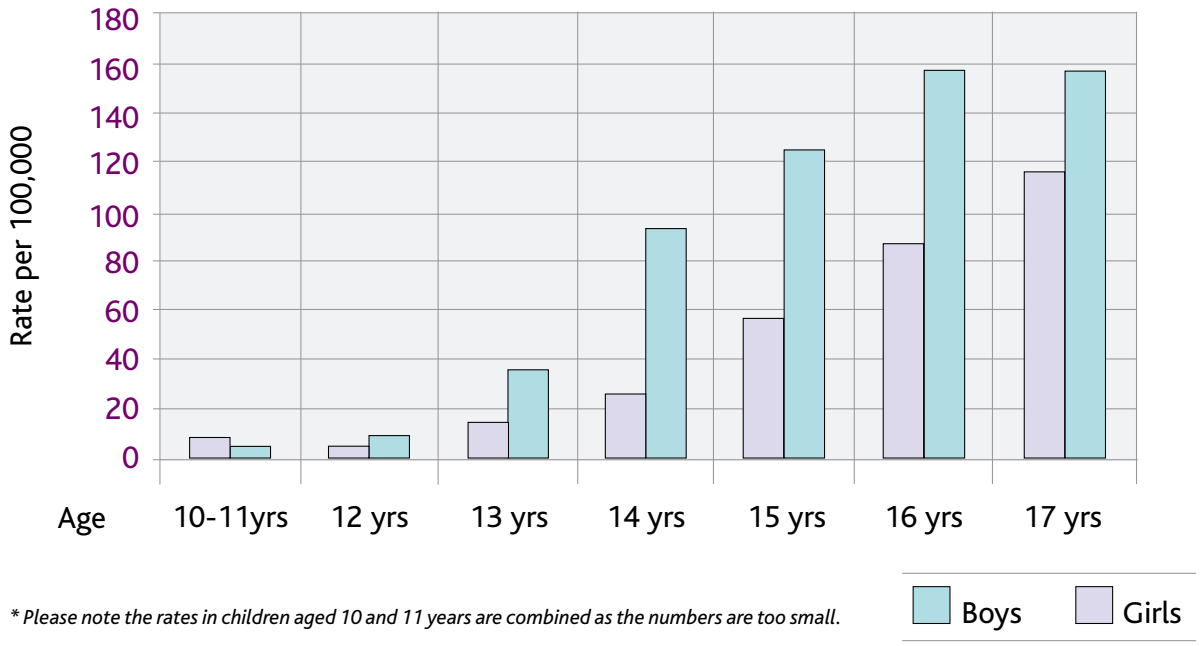
8.2 Hospital presentations

For the period from 1st of January to 31st of December 2011, the Registry recorded 1,076 deliberate self harm presentations to hospital that were made by 904 children (316 boys and 588 girls) aged from 10 to 17 years.

The national rate for all children (aged from 10 – 17 years) presenting to hospital in the Republic of Ireland following deliberate self harm in 2011 was 192 per 100,000. Looking at the rates in terms of gender, the male rate was 131 per 100,000 and the female rate was 256 per 100,000. Rates were based on population figures available from the National Census 2011.

Of the recorded presentations for all children aged from 10 to 17 years in 2011, 34% were made by boys and 66% were made by girls.

Figure 8.2 (i) Person Based Rate of Deliberate Self Harm in the Republic of Ireland by Age and Gender, 2011

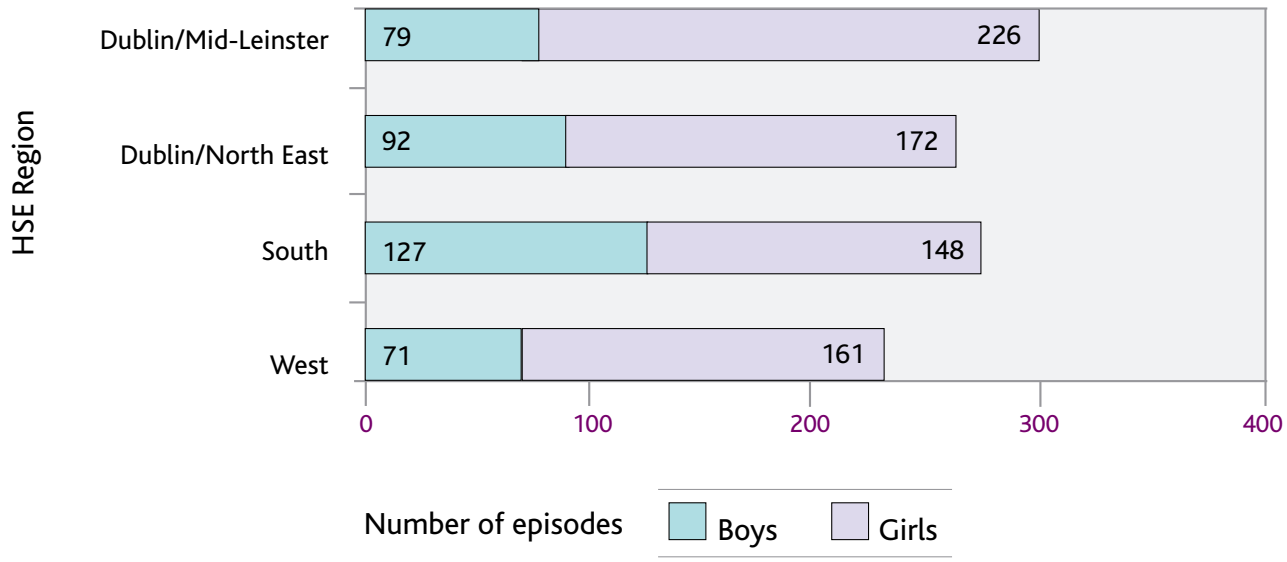


** Please note the rates in children aged 10 and 11 years are combined as the numbers are too small.*

8.3 Deliberate self harm by HSE Regions

The number of deliberate self harm presentations by girls outnumbered those by boys in all of the four HSE Regions, although the female to male ratio varies significantly from 2.8:1 in Dublin Mid-Leinster to 1.16:1 in HSE South.

Figure 8.3 (i) Gender Balance of Deliberate Self Harm Presentations in Children aged 10 to 17 Years by HSE Region, 2011

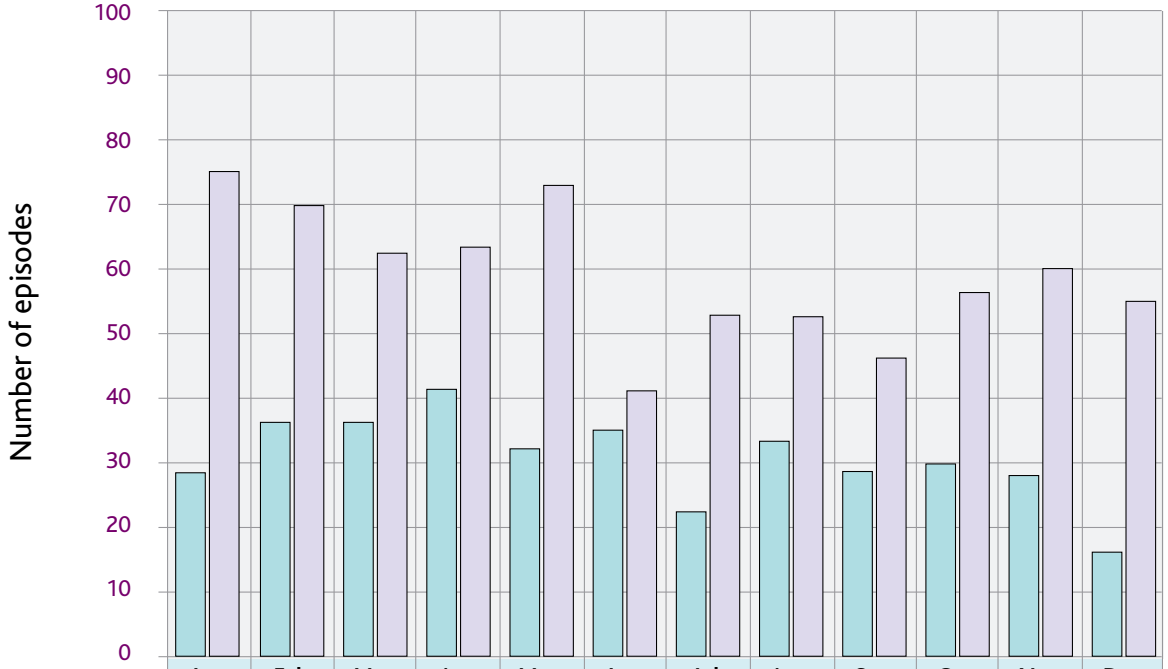


8.4 Episodes by time of occurrence

Variation by Month

There is a clear pattern of deliberate self harm presentations over the course of the year with a late Spring/Summer peak and a pre end of year fall in self harm presentations. In boys the lowest number of deliberate self harm presentations to hospitals in 2011 occurred in December and in girls the lowest number deliberate self harm presentations to hospitals occurred in June. The highest number of deliberate self harm presentations to hospitals for boys occurred in the month of April and for girls it was the month of May.

Figure 8.4 (i) Number of Deliberate Self Harm Presentations by Month for Boys and Girls, 2011

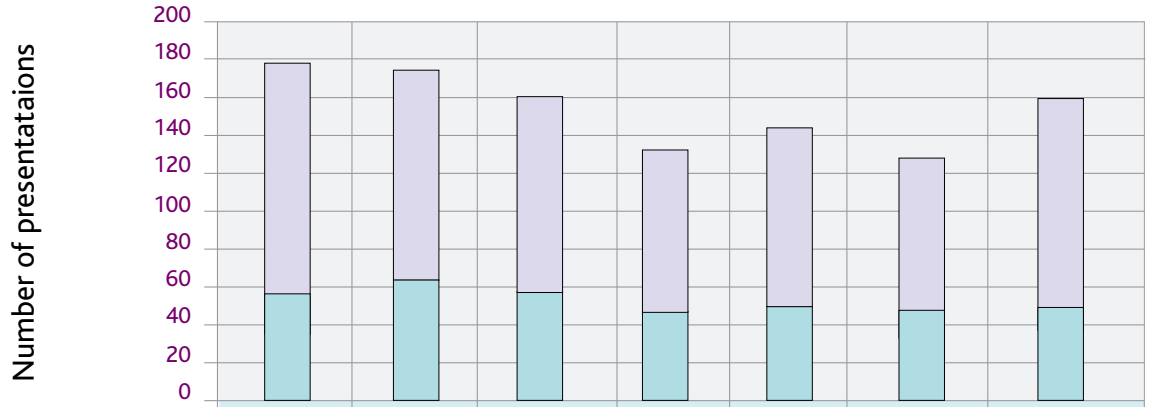


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Boys	29	36	36	41	32	35	23	34	29	30	28	16
Girls	75	70	62	63	73	41	53	53	46	56	60	55

8.5 Variation by day

The number of deliberate self harm presentations was highest on Mondays, Tuesday and Sundays. These days accounted for 48% of all presentations. The number of deliberate self harm presentations was lowest on Saturdays. Saturday accounted for 12% of all presentations.

Figure 8.5 (i) Number of Presentations in Children Aged 10 to 17 Years by Weekday, 2011

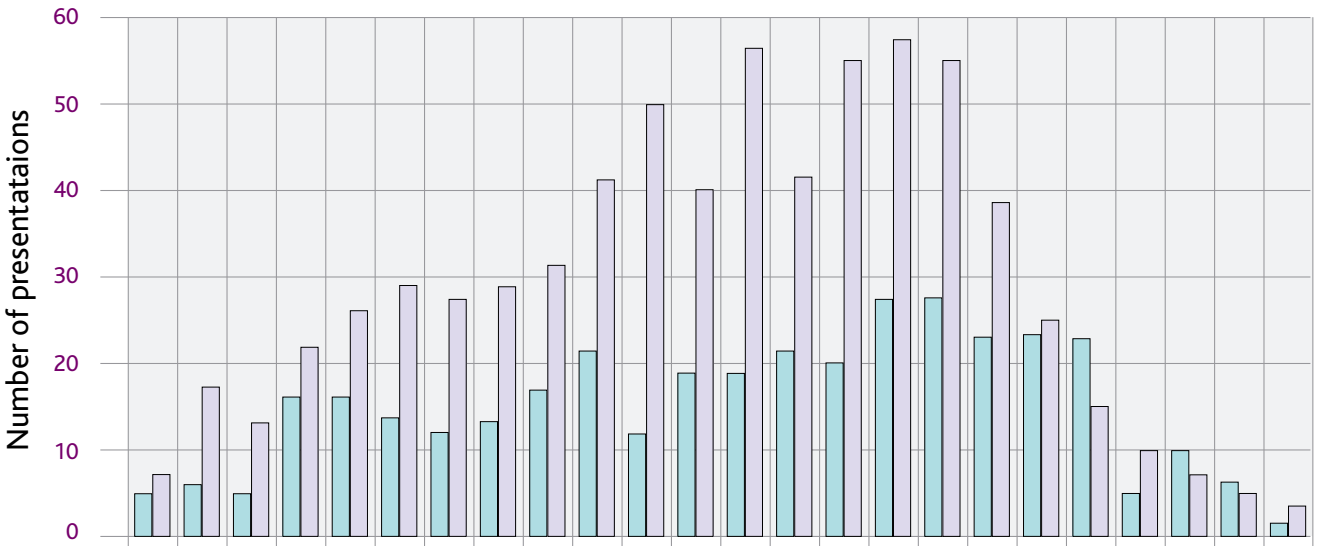


	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Boys	57	63	57	46	49	48	49
Girls	121	111	104	86	94	80	111

8.6 Variation by hour

There was a striking pattern in the number of deliberate self harm presentations seen over the course of the day. The number of presentations for both boys and girls gradually increased during the day. The peak for boys was 11pm and 12 midnight and for girls it was 8pm and 11pm. Over half (51%) of the total number of presentations were made during the eight-hour period 7pm-3am. This contrasts with the quietest eight-hour period of the day, from 5am-1pm, which accounted for just 16% of all presentations.

Figure 8.6 (i) Number of Presentations by Time of Attendance in Children Aged 10 to 17 Years, 2011



Hour	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	0	1	2	3	4	5	6	7
Boys	5	6	5	16	16	14	13	14	17	21	12	19	19	21	20	27	27	23	24	23	5	10	6	2
Girls	7	17	13	22	26	29	27	29	31	41	50	40	56	41	55	57	55	39	25	15	10	7	5	4

Times above are based on the 24 hour clock

8.7 Method of self harm

Over half (64%) of all deliberate self harm presentations involved an overdose of medication. Drug overdose was more commonly used as a method of self harm by girls than by boys. It was involved in 56% of male presentations and 68% of female episodes. In children aged 10 to 17 years the number of deliberate self harm presentations to hospital involving overdoses in 2011 (688) showed a slight decrease compared to the numbers recorded in 2010 (759).

While rare as a main method of self harm, alcohol was involved in 15% of all cases. The involvement of alcohol was more common in deliberate self harm episodes for boys (18%) than in episodes for girls (13%).

Cutting was the only other common method of self harm, involved in 32% of all episodes. The use of cutting was similar across episodes in boys (33%) and girls (31%). In 85% of all cases that involved self-cutting, the treatment received was recorded. Under half (42%) received steristrips or steribonds, 25% did not require any treatment, 15% required sutures while 2% were referred for plastic surgery. The treatment received was similar for boys and girls who cut themselves with 17% of girls receiving sutures compared to 12% of boys and 2% of both boys and girls were referred for plastic surgery due to self cutting injuries.

Attempted hanging was involved in 7% of all deliberate self harm presentations (13% for boys and 4% for girls).

Table 8.7 (a) Methods of Self Harm involved in Presentations to Hospital by Children Aged 10 to 17 years, 2011

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	Total
Boys	205	67	13	47	6	123	16	369
	56%	18%	4%	13%	2%	33%	4%	100%
Girls	483	90	12	30	7	222	32	707
	68%	13%	2%	4%	1%	31%	5%	100%
Total	688	157	25	77	13	345	48	1076
	64%	15%	2%	7%	1%	32%	4%	100%

Table 8.7 (b) Method of self harm used by Boys aged 10 – 17 years, 2011

% Males	10-13yrs	14yrs	15yrs	16yrs	17yrs
Drug overdose only	24	41	45	54	50
Self-cutting only	31	26	27	27	21
Overdose & self-cutting	0	0	6	5	8
Attempted hanging only	24	19	8	6	8
Attempted drowning only	3	4	3	0	1
Other	17	11	11	8	12

Table 8.7 (c) Method of self harm used by Girls aged 10 – 17 years, 2011

% Females	10-13yrs	14yrs	15yrs	16yrs	17yrs
Drug overdose only	51	54	63	57	63
Self-cutting only	28	26	20	21	22
Overdose & self-cutting	6	9	8	7	6
Attempted hanging only	3	2	3	4	1
Attempted drowning only	0	0	2	0	1
Other	12	8	4	9	7

8.8 Drugs used in overdose

The total number of tablets taken was known in 51% of all cases of drug overdose. Twenty two was the average number of tablets taken in the episodes of deliberate self harm that involved drug overdose. On average, boys and girls took the same number of tablets in an overdose act (mean: 23 vs. 22). Figure 8.8 (i) illustrates the pattern of the number of tablets taken in drug overdose episodes for both genders.

Figure 8.8 (i) The Pattern of the Number of Tablets taken in Male and Female Acts of Drug Overdose in Children Aged 10 to 17 Years, 2011

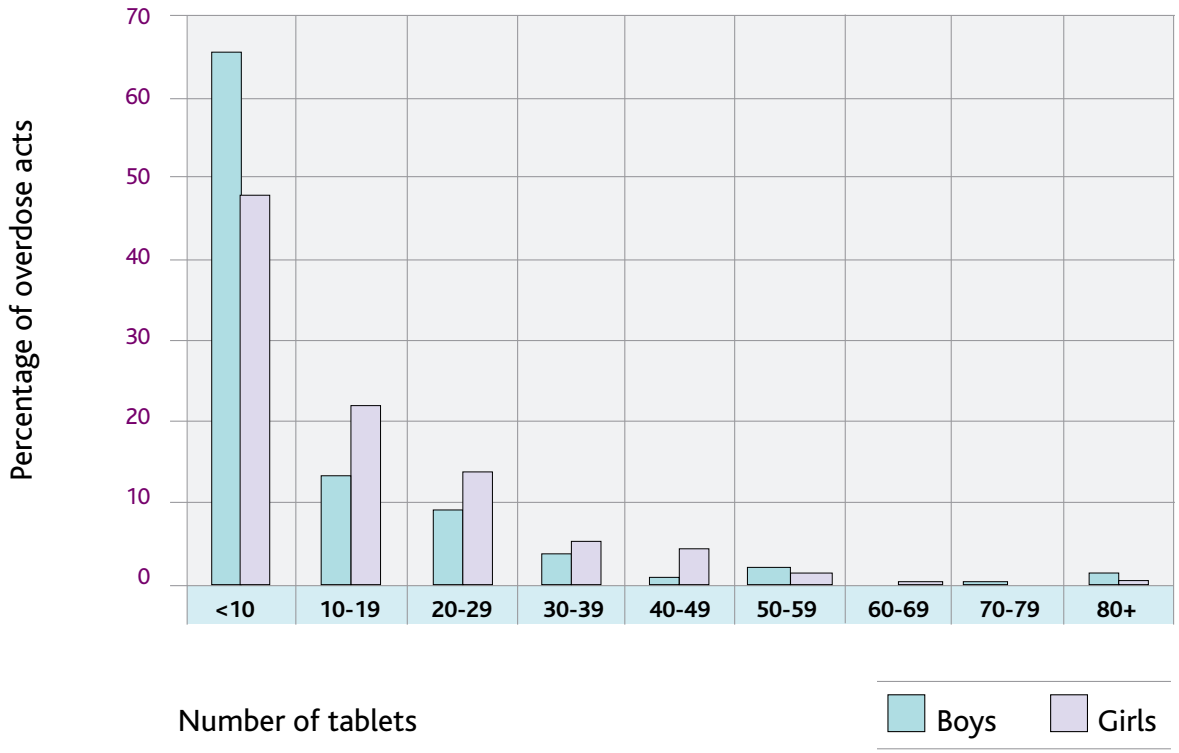
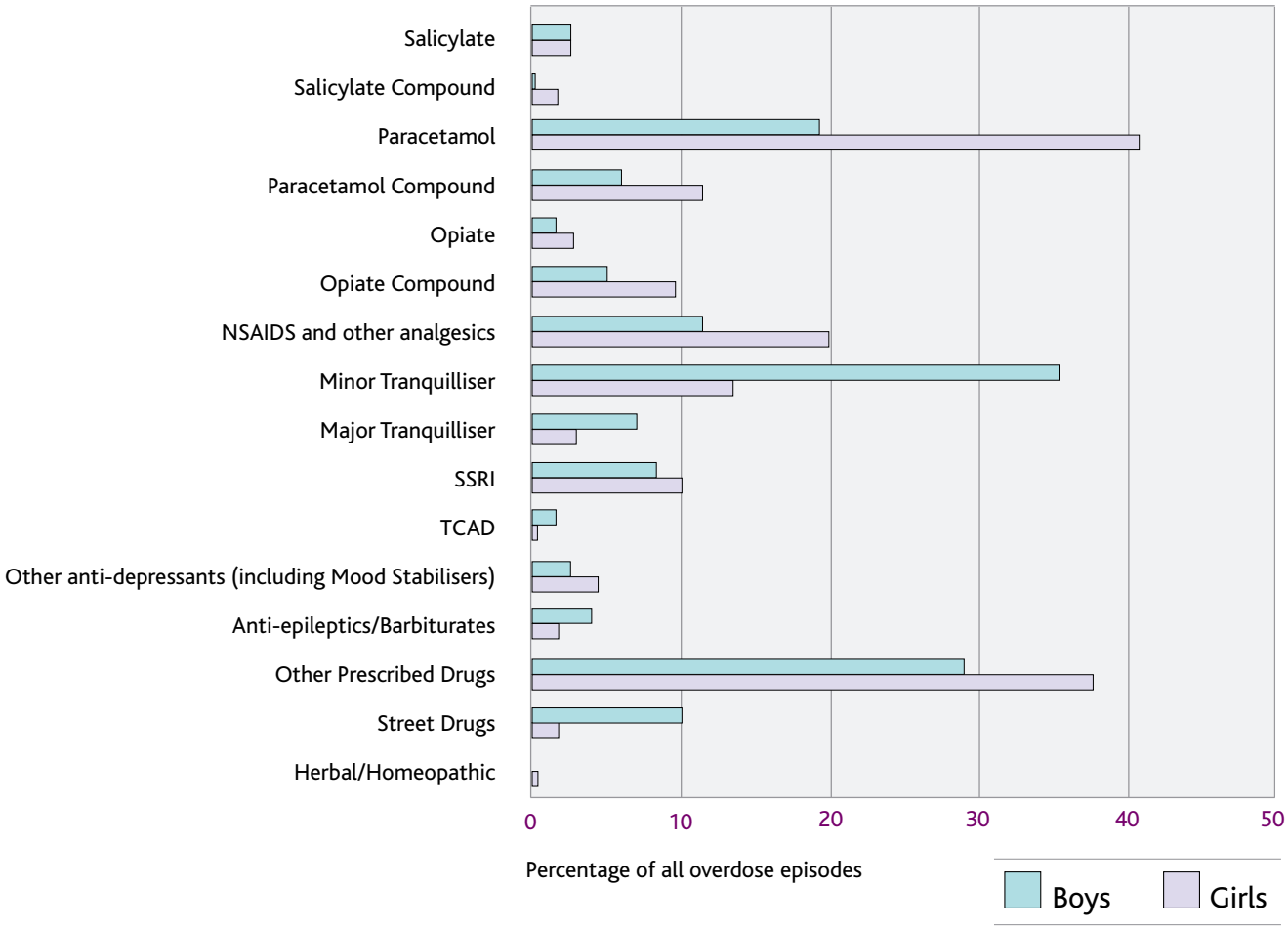


Figure 8.8 (ii) illustrates the frequency with which the most common types of drugs were used in overdose. Paracetamol was the most common analgesic drug taken, being involved in some form in 40% of overdoses. Paracetamol was used more often by girls (47%) than boys (25%). Minor tranquillisers were involved in 20% of overdoses and such a drug was used more often by boys (36%) than by girls (14%). This high rate of usage of anxiolytic/sedative drugs is reflective of the high levels of these drugs in the general population. A major tranquilliser was involved in 5% of overdose cases. An anti-depressant/mood stabiliser was involved in 15% of deliberate overdose acts. The group of anti-depressant drugs known as Selective Serotonin Reuptake Inhibitors (SSRIs) were present in 10% of overdose cases. Street drugs were involved in 10% of male and 2% of female intentional drug overdose acts. "Other drugs" were taken in 35% of all overdoses which reflects the wide range of drugs taken deliberately in acts of drug overdose.

Figure 8.8 (ii) The Variation in the Type of Drugs used in Children Aged 10 to 17 Years, 2011.



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

8.9 Recommended Next Care

In 6% of cases involving children aged 10 to 17 years, the child left the emergency department before a next care recommendation could be made. Following their treatment in the emergency department, inpatient admission was the next stage of care recommended for 41%, irrespective of whether general or psychiatric admission was intended and whether admission was refused or not. Of all deliberate self harm cases, 35% resulted in admission to a ward of the treating. In just 0.5% of cases, admission for either general or psychiatric care was refused. Most commonly, 53% of cases were discharged following treatment in the emergency department.

Next care recommendations in 2011 were broadly similar for boys and girls. However, boys more often were discharged following treatment in the emergency department (56% vs. 51%) and girls were more often admitted to a ward of the treating hospital than boys (37% vs. 30%).

Recommended next care varied according to the main method of self harm. General inpatient care was most common following cases of drug overdose and self-poisoning, and less common after attempted drowning, attempted hanging and alcohol and least common after cutting and "other methods" of self harm. Of those cases where the patient used cutting as the main method of self harm, 60% were discharged after receiving treatment in the emergency department.

8.10 Repetition of deliberate self harm

There were 904 children aged 10 to 17 years treated for 1,076 deliberate self harm episodes in 2011. This implies that 16% (172) of the presentations in 2011 were due to repeat acts. Of the 904 deliberate self harm patients treated in 2011, 112 (12.4%) made at least one repeat presentation to hospital during the calendar year.

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

Table 8.10 (a) Repeat Presentation after Index Deliberate Self Harm Presentation by Method of Self Harm in Children Aged 10 to 17 Years, 2011

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	Total
Children treated	606	140	20	63	11	266	37	904
No. who repeated	75	19	0	7	0	42	4	112
% who repeated	12.4%	13.6%	0.0%	11.1%	0.0%	15.8%	10.8%	12.4%

The lowest repetition rate of deliberate self harm (7%) was found in patients that were treated in the HSE South Region and the highest repetition rate (16%), was found in patients treated in the HSE West Region.

Table 8.10 (b) Repetition by Gender and HSE Region in Children Aged 10 to 17 Years, 2011

		HSE Dublin / Mid Leinster	HSE Dublin / North East	HSE South	HSE West	National
Children treated	Boys	64	74	114	64	**316**
	Girls	179	145	137	127	**588**
	Total	**243**	**219**	**251**	**191**	**904**
No. who repeated	Boys	9	10	10	8	**37**
	Girls	23	22	8	22	**75**
	Total	**32**	**32**	**18**	**30**	**112**
% who repeated	Boys	14.1%	13.5%	8.8%	12.5%	**11.7%**
	Girls	12.8%	15.2%	5.8%	17.3%	**12.8%**
	Total	**13.2%**	**14.6%**	**7.2%**	**15.7%**	**12.4%**

SECTION 9 Supporting the Development of Child & Adolescent Mental Health Services

9.1 Monitoring progress and evaluating outcomes

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

The Specialist CAMHS Advisory Group reports to Mr. Martin Rogan, Assistant National Director, Mental Health Services and advises HSE Corporate Planning and Corporate Performance on issues relating to child and adolescent mental health services.

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

- Continued to develop and refine the minimum dataset for CAMHS that is completed and returned by each team on a monthly basis and reported through HealthStat and Performance Reports.
- Developed a suite of key performance indicators linked to the dataset that take into account resource allocation, case mix, demographic and other factors.
- Researched the use of routine outcome measurement across services.
- Fostered service user involvement in the planning and evaluation of services through engagement with youth service user panels.
- Is developing a strategy to foster sharing of best practice and service innovation.
- Is addressing manpower planning and training needs through detailed surveys.
- Has extended the collection of information from child and adolescent inpatient mental health services.
- Is working with the Mental Health Commission to finalise operational guidelines for child and adolescent mental health services based on the Quality Framework Document.

The Fifth Annual Report on Child and Adolescent Mental Health Services will be published in the fourth quarter of 2013.

Membership of the Specialist CAMHS Advisory Group

1. **Dr. Brendan Doody,** Chair, Consultant Child and Adolescent Psychiatrist, Clinical Senior Lecturer, Clinical Director HSE Linn Dara CAMHS.

2. **Ms. Pamela Carroll,** Child Care Leader, HSE Child & Family Mental Health Service, Sligo.

3. **Ms. Lisa Corrigan,** Occupational Therapy Manager, Mater Child & Adolescent Mental Health Service.

4. **Dr. Antoinette D'Alton,** Consultant Child and Adolescent Psychiatrist, HSE Longford / Westmeath CAMHS.

5. **Dr. Maura Delaney,** Consultant Child and Adolescent Psychiatrist, Eist Linn Child and Adolescent Inpatient Unit, Cork.

6. **Dr. Michael Drumm,** Principal Clinical Psychology Manager, Mater Child & Adolescent Mental Health Service.

7. **Mr. Philip Flanagan,** Business Analyst, HSE Corporate Planning and Corporate Performance (CPCP), Dr. Steevens' Hospital, Dublin.

8. **Ms. Sarah Houston,** Social Worker, St. John of God Lucena Clinic Child & Adolescent Mental Health Service.

9. **Ms. Sinead Kennedy,** Speech and Language Therapist Manager, Mater Child and Adolescent Mental Health Service.

10. **Dr. Susan O'Hanrahan,** Consultant Child and Adolescent Psychiatrist, HSE Mid Western CAMHS.

11. **Ms. Aoife Price,** Youth Advisor, Headstrong.

12. **Mr. Michael Walshe,** Clinical Nurse Specialist, Wexford Child and Adolescent Mental Health Service.

Appendix

CAMHS Teams were invited to provide information on service initiatives and developments under a number of headings.

Dublin Mid Leinster

1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Feedback Forms from Service Users (Longford / Westmeath).

We have had good informal feedback on information meetings we provided last year for School Principals. This year we have met with the Educational Psychology Service to share information about each of our services (Linn Dara CAMHS, Ballyfermot).

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

Link with Jigsaw in Clondalkin has been further developed since 2010. Links developed with The Base Youth Centre, Ballyfermot, which is located near the new CAMHS building in Ballyfermot (Linn Dara CAMHS, St. James's & Clondalkin).

Ascend Programme: Psychoeducation for parents of kids with Autism Spectrum Disorder. Evaluation of same (Lucena Dun Laoghaire, < 12 years, Team 1).

ADHD Parent Satisfaction Survey planned for 2012 (Linn Dara CAMHS, Mid Kildare).

Development of client satisfaction feedback continues (Lucena Clinic Tallaght, Team 1).

Evaluation of group interventions, including user feedback (Lucena Dun Laoghaire, < 12 years, Team 2).

Involvement in the National Mental Health Collaborative in Service User Planning Initiative. Lucan CAMHS have developed a form to document individual service plans involving service users and carers (Linn Dara CAMHS, Lucan).

Feedback sought at regular basis throughout therapeutic sessions. Plan is being developed to incorporate formal feedback (Lucena Team C).

Clients of ADHD Clinic engaged in service user questionnaire & feedback (Linn Dara CAMHS, North Kildare).

1B. MEASUREMENT OF OUTCOME:

Pre and post intervention measures i.e. Becks Depression Inventory, Culture Free Self-Esteem Inventory (Psychology Department). Triple P – use outcome measurements. Conners' pre and post interventions. Family Welfare – Scale used by Family Therapist (Longford / Westmeath).

Improved compliance with new appointments since introduction of a text box in each appointment letter explaining the impact of non-attendance. We have introduced practice of using SDQ before and after intervention (Linn Dara CAMHS, Ballyfermot).

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

Feedback from families & other professionals. Measures of outcome in ADHD, using Connors Rating Scales (Linn Dara CAMHS, St. James's & Clondalkin).

Standardised rating scales (Lucena Clinic Tallaght, Team 1).

Feedback post groups (Lucena Dun Laoghaire, < 12 years, Team 2).

Standardised outcome tools as per intervention (Lucena Team C).

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

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

Standard outcome measures, used following Psychological Interventions (Linn Dara CAMHS, North Kildare).

1C. RESEARCH / AUDIT PROJECTS:

Audit on pre-medication work-up. ADHD Research by Psychology PhD Student (Longford / Westmeath).

Audit by Senior Registrar in relation to impact of new appointment letter showed improved attendance at first appointments (Linn Dara CAMHS, Ballyfermot).

Audit of CAPA (Choice and Partnership Approach) system (Lucena Wicklow - Bray).

Audit of GP referrals. Staff survey of current service provision and needs of clients with emerging Borderline Personality Disorder. Audit of Psychology Statistics (Linn Dara CAMHS, St. James's & Clondalkin).

Audit of introduction of effective patient record. Research study of caregiver stress in parents with children with Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder (Lucena Dun Laoghaire, < 12 years, Team 1).

Effectiveness of Incredible Years Training Project. Parents Experience of an Attachment Based Intervention. Comparison of service provision for children in care compared to children remaining in the home (Lucena Clinic Tallaght, Team 1).

Audit of Computerised Records introduction. Research on prevalence of ADHD in parents (Lucena Dun Laoghaire, < 12 years, Team 2).

Audit Use of service plans (x2) (Linn Dara CAMHS, Lucan).

Critical incidents reviews. DNA rates. ADHD management (Lucena Team C).

Senior Registrar completed a quantitative and qualitative clinical review / analysis of all referrals, accepted referrals, open cases and discharges from 2010 to 2011. Team participation in the multi-centre I TRACK study of 16 – 18 year olds. The team is facilitating a research project on the neurocognitive profile of children with ADHD attending our service. A trainee Clinical Psychologist completed a qualitative review of the assessment process within our Department (Laois / Offaly).

ADHD Clinic audited (Linn Dara CAMHS, North Kildare).

Over 18s with ADHD. Use of DARE option and outcomes (Lucena Dun Laoghaire, 12 – 15 years).

1D. WAITING LIST OR OTHER INITIATIVES:

As capacity allows, we allocate appointments to patients on Waiting List. Offer new patient appointments in satellite clinics to enhance attendance and increase access (Longford / Westmeath).

All team members trialled the use of care plans following new assessments. This will be audited by member of the Senior Management Team. We are now practising policy of not offering more than two appointments to new cases who do not attend. We have compiled our own Risk Register. Two members of team on Working Party for development of services in South Dublin (Linn Dara CAMHS, Ballyfermot).

Waiting room notice board and information leaflets. Discharge policy on inactive cases. Assertiveness Group (Lucena Wicklow - Bray).

Weekly triage of referrals with direct phone contact with families and referrers, as necessary, within a few days of receiving the referral. Currently in the process of rolling out CAPA (Linn Dara CAMHS, St. James's & Clondalkin).

Psychoeducation programmes through the Lucena Foundation (Lucena Dun Laoghaire, < 12 years, Team 1).

Waiting List criteria widened to include the full range of referrals. CAPA commenced Nov 2011 (Linn Dara CAMHS, Mid Kildare).

Wait list initiative commenced over Summer 2011 resulting in significant reduction in wait list. Initiative continues. Quarterly audit of open cases to facilitate timely discharge (Lucena Clinic Tallaght, Team 1).

Lucena Foundation lectures. Liaison with Early Intervention Service. Streamlining referrals (Lucena Dun Laoghaire, < 12 years, Team 2).

Two waiting list initiatives in 2011 (Linn Dara CAMHS, Lucan).

Ongoing active wait list management (Lucena Team C).

Consultant Child Psychiatrist and Senior Nurse Manager involved in a waiting list initiative. Quarterly team days looking at referrals pathways, team processes and service planning. All service protocols reviewed and revised by the team. Group assessments of children referred with ADHD / developmental issues. This involves initial assessment of the child with their parents, followed by an assessment in a group setting which is observed. Groups are facilitated by the occupational therapist and another clinician. A proposal to meet with Community Psychology on a regular basis to discuss referrals, complex cases and cases co-worked. Use of the social and communication questionnaire as a screening tool for ASD when this diagnosis is considered clinically. The purpose is for early diversion of children and families to the specific ASD / Disability Service for further assessment. Sub-team development committee set up and at the initial stages of looking at the transfer of the team to an alternative site which will require our input in planning and development (Laois / Offaly).

Waiting List – Oct / Nov 2011. CAPA Preparation / Training. Phone calls used as screening tools to explore need for CAMHS (Linn Dara CAMHS, South Kildare).

Waitlist initiative – opt-in, and waitlist blitz. Referral management team set up to process referrals, and ensure referrals are appropriate for the service. Emergency referral assessment allocated to process emergency, and urgent referrals (Lucena Team A).

CAPA principles incorporated into waiting list management (Linn Dara CAMHS, North Kildare).

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

1E. FOR CHILDREN WITH ADHD:

Streamlined ADHD Clinics. Ensure multimodal interventions are offered to all children and parents (Longford / Westmeath).

We continue our practice as before (Linn Dara CAMHS, Ballyfermot).

ADHD Educational Group (Lucena Wicklow - Bray).

ADHD Clinic set up in 2011, over 2 sites, St James and Clondalkin Clinics. Link with Archways in Clondalkin to provide parenting and child groups for children with ADHD. Social Skills group (Linn Dara CAMHS, St. James's & Clondalkin).

Audit of children attending Attention Deficit Hyperactivity Disorder clinic (Lucena Dun Laoghaire, < 12 years, Team 1).

Increased frequency of ADHD Clinic (Linn Dara CAMHS, Mid Kildare).

Extension of ADHD clinic due to numbers (Lucena Clinic Tallaght, Team 1).

Continuation of clinical audit of services offered (Lucena Dun Laoghaire, < 12 years, Team 2).

Audit of ADHD Attendance (Linn Dara CAMHS, Lucan).

Further development of ADHD Clinic (Lucena Team C).

ADHD / development review clinics increased to four per month. The team is facilitating a research project on the neurocognitive profile of children with ADHD attending our service. Group assessment including observation of children referred with possible ADHD. This includes screening for developmental disorders (Laois / Offaly).

Information session for parents on ADHD and medication – group format (Linn Dara CAMHS, South Kildare).

ADHD Clinic run weekly (Lucena Team A).

ADHD clinic audited, service user feedback incorporated into review of service (Linn Dara CAMHS, North Kildare).

None new – ADHD clinic mainly Nurse led due to no NCHD on team (Lucena Wicklow – Arklow).

1F. GROUPS PROVIDED:

Triple P (Parent Management Training) – Children and teens. Listening and attention 6-8 year olds (mixed diagnostic group). Social Communication Skills Groups teens, 8-10 year olds (mixed diagnostic group) (Longford / Westmeath).

Parenting Group Incredible Years. ASCEND – Parenting Group for Parents with ASD child. ADHD Educational Group. Social and Motor Group. Mindfulness Group. Transition to Secondary School Group. Assertiveness Group (Lucena Wicklow - Bray).

Group for parents of children with ASD, linked with Aspire. Anxiety management group. Social Skills & Communication group. Group for adolescents with diagnosis of ASD. CBT group (Linn Dara CAMHS, St. James's & Clondalkin).

Parents of children with anxiety. Social use of Language groups. Handwriting and organisation. School transition groups (Lucena Dun Laoghaire, < 12 years, Team 1).

Drama Therapy Group. Social Skills / Observation Group (Linn Dara CAMHS, Mid Kildare).

Four Incredible Years Parenting Groups. ASCEND programme for parents of children on the autistic spectrum. School Transition Group (Lucena Clinic Tallaght, Team 1).

ASCEND groups for parents of young people with recent diagnosis of ASD. IY groups. Diagnostic groups (Lucena Clinic Tallaght, Team 2).

School Transition Group. ALERT Group. Healthy Lifestyle Group. Study Skills Group. Social Skills. Early Childhood Programme (Lucena Team C).

Adolescent CBT group. The Alert Programme. Social skills groups. Parenting programmes provided (Laois / Offaly).

Transition to Secondary School. Crisis Intervention. Anxiety Management (Linn Dara CAMHS, South Kildare).

Friends group for anxiety management for 9-12 year olds. Run on three occasions (Lucena Team A).

Occupational Therapy group for organisational skills. Social Skills Group for Autism Spectrum Disorder. Occupational Therapy group for Attention Deficit Hyperactivity Disorder – managing arousal (Lucena Dun Laoghaire, 12 – 15 years).

Teenage Asperger group. Social use of Language. ASCENT – for parents of children on the Autistic Spectrum. Incredible Years. School Transition Group – for those moving into secondary school (Lucena Wicklow – Arklow).

1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Triple P training. One team member has commenced Masters in Systemic Psychotherapy. Psychologists workshop in Anxiety Management. Training in Locke Programme for Eating Disorders. Sensory Integration training completed by OT (Longford / Westmeath).

Further CAPA training and STORM training for all team members. Individual team members have undertaken EMDR training and an Eating Disorder module (Linn Dara CAMHS, Ballyfermot).

SIPS training. Sensory Integration training. Certificate Course Working with Self Harm (TCD) (Lucena Wicklow - Bray).

Attendance at CAPA training. SIPS training attended by 3 team members. Forensic training day (Prof Sue Bailey) attended by 3 team members. Eating Disorders workshop. STORM facilitator training. Psychosis in Adolescence course. CBT workshop. Children First training. Narrative therapy course. Production of Psychology Handbook (Linn Dara CAMHS, St. James's & Clondalkin).

Family therapy (commenced Masters in Systemic Therapy) (Lucena Dun Laoghaire, < 12 years, Team 1).

SIPS / SOPS Training. Storm Training. CBT Training. CAPA Training (Linn Dara CAMHS, Mid Kildare).

ADOS training. SIPS Training (Lucena Clinic Tallaght, Team 1).

SIPS training by Dr Barbara Walsh provided through the Lucena Foundation (Lucena Clinic Tallaght, Team 2).

ADOS Training. Children First (Lucena Dun Laoghaire, < 12 years, Team 2).

Storm Training (Linn Dara CAMHS, Lucan).

ADOS. CBT. Social skills. ASD study days. SIPS training (Lucena Team C).

This has been seriously impacted on due to limited resources. Review of the new Children First guidelines completed by all team members. Psychology participation in Mindfulness Training (Laois / Offaly).

STORM training. CAPA Training. Eating Disorders Training. Updates on ADHD Presentation. CBT Computer Programme – Training (Linn Dara CAMHS, South Kildare).

ADOS training undertaken by one team member. Management training (Lucena Team A).

Up-skilling of Team Members in core CAMHS Skills of CBT, PTSD, Parent Training delivered by internal CPD. Formal CAPA Training within Linn Dara Service. Storm Training provided by Linn Dara Service. MSc (1st Class Hons) obtained by Art Therapy Trainee. Marte Meo supervision course completed by Team Member. MSc in Medical Leadership undertaken by Team Member (Linn Dara CAMHS, North Kildare).

None new funding issues (Lucena Dun Laoghaire, 12 – 15 years).

None new funding issues (Lucena Wicklow – Arklow).

1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Students – OT, Psychology, SLT – rotate through department. Formalised interagency links with Community Care Social Work, Child Development Team (Longford / Westmeath).

1½ days facilitated by Consultant Psychiatrist to explore how we might adapt the CAPA principles of 'letting go' and discharging more effectively. We provide good consultation to local schools (Linn Dara CAMHS, Ballyfermot).

Sit Still and Complete Your Homework. Handwriting Workshop. Get Organised. Social Stories Workshop. Social Skills Training for Parents and Teacher. Parenting in Recession. Consultation with Enable Ireland. Nursing student placement. SLT students placement. OT student placement. Incredible Years monthly supervision. IY Parent Leader Group Training Workshop. Workshop for TCD Psychology trainee on Interviewing Skill with Parents. Asperger's Syndrome and Social Skills Training Workshop by Tony Attwood (Lucena Wicklow - Bray).

STORM training to Linn Dara staff. Teaching and provision of placements for Dublin University medical students. Training for Senior Registrars on their Day Release Programme. ASD training for schools in Clondalkin & D8. ADHD training for schools in Clondalkin & D8. Speech & Language therapy provided to D10 CAMHS for part of 2011. Liaison with Early Years initiative in Rialto. Membership of Londubh Project Monitoring Group. Participation in Area Child Protection Committee. Training day for Adult Psychiatrists – "Management of Children & Adolescents who present to Adult Psychiatric Services". Mentoring Psychology students from TCD. Registrar Induction Training Development of Standardised Clinical Interview Assessment (Linn Dara CAMHS, St. James's & Clondalkin).

Occupational Therapy, Speech and Language Therapy, Psychology students on placements (Lucena Dun Laoghaire, < 12 years, Team 1).

Supervision of Drama Therapist in training. Supervision of Art Therapist in training. Supervision of Post Grad Clinical Psychology Trainee (Linn Dara CAMHS, Mid Kildare).

Nursing, social work, psychotherapy and OT student placements. Teaching on Masters in Social work Students in UCD (Lucena Clinic Tallaght, Team 1).

Yes, as part of intra disciplinary peer review sessions (Lucena Clinic Tallaght, Team 2).

Psychiatry, Psychology, SLT, OT, and SW trainees provided training (Lucena Dun Laoghaire, < 12 years, Team 2).

CBT. Family therapy. Teachers. Social work student training. Nursing student training. Medical Student Training. OT students (Lucena Team C).

Psychology, occupational therapy and art psychotherapy students rotate regularly through our Department. This is hoped to be extended to include post graduate medical students from Limerick University in 2012. Consultation provided to Community Social Work and Community Psychology. Joint assessment promoted with our colleagues in Community Psychology on cases shared and consulted on. Fortnightly participation in a Paediatric psycho-social meeting. Team participation in a catchment area group involving all stakeholders providing services to children with disabilities (Laois / Offaly).

Crisis Intervention Group work. Intro to CBT Workshop. Revised ASD Pathway. Locke Model for Eating Disorders. Use of Conners-3 forms. Consultation to fostering social workers (Linn Dara CAMHS, South Kildare).

Team Member provides Marte Meo supervision within the HSE. In-service training provided to Phoenix Park Special School. Marte Meo training initiative to staff of Phoenix Park Special School (Linn Dara CAMHS, North Kildare).

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

Dublin North East

1A. SERVICE USER INVOLVEMENT / FEEDBACK:

The Clinical Nurse Specialist who ran the ADHD parenting group is currently evaluating feedback forms from parents with the aim of improving the group for next year (Monaghan).

Questionnaires. Parent Satisfaction Survey (North Meath).

Piloting of Individual Service Plans (collaborative goal-setting with service users) (Linn Dara CAMHS, Castleknock).

Feedback from ADHD Review Clinic indicates that patients and parents would appreciate if there was continuity of medical staff at the review clinics. Poster presented at ACAMH Research Day in September 2011 – Parents with Mental Illness, Service Users Perspective: How Mental Health Services can Help? (South Meath).

Team A Mater CAMHS participates in an ongoing service wide user feedback system involved in soliciting direct feedback from clients through questionnaire and through reflection and response on feedback and ongoing awareness within the service of the importance of client views. Child and Parent views on service provision are routinely sought formally and informally in the development of care plans for individual clients. Mater CAMHS – Feedback forms have been introduced in the waiting area in all clinics (Mater Team A).

We embarked on a joint service user involvement initiative with Jigsaw Young Ballymun, including a site visit and detailed feedback from current service users and prospective service users in the 16-18 year old age range as part of service planning for the expansion of service to this age band. Mater CAMHS – Feedback forms have been introduced in the waiting area in all clinics (Mater Team B).

Mater CAMHS – Feedback forms have been introduced in the waiting area in all clinics. Outreach – Team C/D met with schools / voluntary services in the locality to discuss service issues and obtain their feedback. A team member and an adolescent service user met with staff from the Department of Health regarding the Mental Health Act (Mater Team C & D).

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

Young Person's Group (Day Programme feedback). Also, MHC Quality Assurance Framework – we are moving towards compliance with these on empowerment of service user (Louth).

1B. MEASUREMENT OF OUTCOME:

Ongoing clinical monitoring for each case – supervision and team meetings (North Meath).

Several measures of outcome have been employed this year including: systematic feedback was sought from parent groups held throughout the year, and in individual cases, pre and post clinical monitoring is routinely evaluated (Mater Team A).

Introduction of IIP (Individual Intervention Plan) and use throughout the service. Service user outcomes / satisfaction continues to be monitored (Mater Team B).

Discussed at team C/D in November 2011 re: introducing outcome measures listed in the CORC website in 2012. Measured outcomes for groups e.g. Parents Plus, OT Teenage Girls Group (Mater Team C & D).

Qualitative measures are used pre / post group – Parents Plus Programme. SLT assessment – pre / post to evaluate progress. The CGAS and SDQ are being used by team members and is being looked at subcommittee level for implementation across the service (Mater Team E).

Yes – CGAS (all children) (Louth).

1C. RESEARCH / AUDIT PROJECTS:

Registrar is undertaking an audit of Monaghan CAMHS use of inpatient beds nationally (Monaghan).

Parent Satisfaction Survey. ADHD – Transition to Adult Mental Health Services. ADHD – Identification if unmet therapeutic need (North Meath).

Audit of emergency referrals over a 1 year period (Linn Dara CAMHS, Castleknock).

Audits. An audit of reasons for parental telephone contact to CAMHS. Parental reported outcome of 17 year old adolescent with ADHD – Poster presented at Irish College Meeting. Medication Safety. Research. Research proposal submitted to Ethics Committee "The prevalence of Mental health Disorders in Secondary School Adolescents". Chapter published Teachers & Teen Bullying in Psychology of Teen Violence and Victimisation Vol. 1 2011. Paper published A Friend in Deed? Can Adolescent Girls be Taught to Understand Relational Bullying in Child Abuse Review November 2011. Two chapters in Pressure Points in Irish Families published on internet (South Meath).

Several research projects are underway at present within team A, including 1) an audit of on call activity by registrars in child psychiatry, 2) an evaluation of an adolescent communication group is ongoing at present 3) a qualitative evaluation of an ADHD Parent Group is ongoing at present 4) comparison of group treatment (Working Things Out) with treatment as usual is ongoing 5) Clinical activity within the service is monitored through the Fios system within Mater CAMHS and the wider CAMHS audit systems (Mater Team A).

The team is carrying out an audit of long-term cases with a view to improving throughput. The team is also currently conducting an audit of the involvement, both quantitatively and qualitatively, of the service with children in care / contact with HSE child protection services. Clinical activity within the service is monitored through the Fios system within Mater CAMHS and the wider CAMHS audit systems (Mater Team B).

Audit of caseload and number of new cases seen by individual team members in 2011 and plan developed re meeting KPIs in 2012 within targets set for individual team members and review dates. Clinical activity within the service is monitored through the Fios system within Mater CAMHS and the wider CAMHS audit systems (Mater Team C & D).

Audit of ASD Cases. Selective Mutism – Research Project. We have completed an audit of clients attending our clinic whose needs could be met by offering Groups, following this Parents Plus Group and Working Things Out Groups were initiated (Mater Team E).

Thesis completed on August 12th. Title: "What are the benefits of group parent Training for parents of children with Attention Deficit Hyperactivity disorder and / or behavioral disorders: A critical review of the literature". This was completed by the Community Mental Health Nurse on the team as part of Graduate Diploma in Child Mental Health at UCD School of medicine and Medical Science (Cavan).

Audit of 16-18 year olds attending service currently attending and services they require (Linn Dara CAMHS, Blanchardstown).

Research Masters in Mental Health. Regular Audit Group & Projects – all Registrars do an audit project / monthly audit meetings / full Mental Health Commission quality assurance framework in place (Louth).

1D. WAITING LIST OR OTHER INITIATIVES:

The Continued development of a regional specialist Eating Disorder Interest Group. This includes all interested parties from PCCC, Dublin North East including CAMHS teams, St. Joseph's Adolescent in-patient unit and paediatric hospitals such as Temple Street. This group secured funding from Nursing and Midwifery Continuing Educational Council to organize its first conference on Eating Disorders in children and adolescents. This will take place on 1st & 2nd December 2011 and the training will be given by Professor Rachel Bryant Waugh. The Paediatric Liaison Service further developed its role in Our Lady of Lourdes Hospital – we now have a monthly meeting with the Cystic Fibrosis team in addition to the Diabetic team. The purpose of this is to discuss new referrals and complex cases. We have prepared and presented a business case proposal to provide additional psychological support to those children who suffer chronic illness i.e. Cystic Fibrosis and Diabetes. This proposal was passed by the Hospital in March 2011 presently we are waiting for approval from the Area Employment Monitoring Group. The Paediatric Liaison Service has finally succeeded in obtaining permanent accommodation in the Lourdes Hospital commencing November 2011. It is expected that this will increase the efficiency in providing a high quality service. Paediatric Liaison as part of the multidisciplinary team have drafted an information leaflet with the diabetes team. The vision is for this leaflet to be given to parents of

children & adolescents of newly diagnosed diabetes. It will help them identify each person on the team and their role in supporting them and their child. We hope that this will assist them through the difficult time of diagnosis. The Child Psychiatry team in Monaghan offered a six month placement to an Art Psychotherapy student undertaking a Masters which was mutually beneficial to all concerned. Monaghan CAMHS provided preceptorship and mentorship of 4th year BSc Nursing students from Dundalk Institute of Technology as approved by An Bord Altranais. The Consultant on the team was elected to the chair of the Child & Adolescent Faculty of the Irish College of Psychiatry in March 2011. Her role is to chair the faculty meetings, attend meetings of council and represent Child Psychiatry on advisory clinical group meetings and meetings with the Mental Health Commission. As the chair, the Consultant received an invitation from the President, Mary McAleese to participate in a forum in the Aras on Youth Mental Health in June 2011. She also undertook to write an article about Child Psychiatry – in particular on the provision of inpatient beds for the GP Forum magazine. This article was approved by the College (Monaghan).

Lack of Registrar has led to significant waiting list increase. Other team members fully occupied to ensure timely response to urgent / emergency referrals (North Meath).

Opt-in system introduced to reduce DNA rates. Clarification on consent for assessment and direct liaison with referral agents. Quicker decision-making process re referrals. Review of referral criteria (Linn Dara CAMHS, Castleknock).

Primary School Programme. Mother and Baby Clinic (South Meath).

The team have a multidisciplinary rota for priority and urgent cases which remains an ongoing waitlist initiative within the team structure. Two team members act as Team Co-ordinators and regularly review progress in waitlist management (Mater Team A).

There is an ongoing initiative to reduce numbers on the routine waiting list. The team introduced a policy and rota for the team-based management of risk / urgent cases (Mater Team B).

OT initiatives – Parent evenings screening internal OT waiting list. Audit of new cases seen – plan agreed to be implemented in 2012 re meeting KPIs. Introduced a priority new assessment rota in addition to the urgent new assessment rota (Mater Team C & D).

Wait list co-ordinator role established to review and manage referrals. Team E Team-Working document produced. Information is now provided on community resources available to clients while on waiting list. Headstrong initiative – Team Member on Family Resource Panel; Team Members on Headstrong Committee; Team Member on Fingal Mental Health Initiative and is involved with Central Referrals Committee. Successful in securing 2 years funding for Headstrong in the area (Mater Team E).

Due to the loss of 0.3 WTE Consultant (clinical), the loss of Senior SW, 1 WTE, who has not been replaced on sick and maternity leave and the non replacement of the Senior Clinical Psychologist, 1 WTE, who was transferred out of the service, we have had to develop internal waiting lists of many of their ongoing clients in order to continue to be able to also take people off the waiting list and address the urgent referrals (Cavan).

First Joint meeting with Community Care Social Worker. Participation and support of Jigsaw Project. Participation and support of iTrack study (Linn Dara CAMHS, Blanchardstown).

Yes – 2011 new formats for assessment clinic (Louth).

1E. FOR CHILDREN WITH ADHD:

There is a standardised protocol for the assessment and diagnosis of children and adolescents presenting with ADHD and all team members have been trained in this. A group for parents with children with ADHD was run over 4 weeks (Monaghan).

Assessment and treatment – medication, parent training, social skills group. Family Therapy where indicated (North Meath).

ADHD clinic (Linn Dara CAMHS, Castleknock).

Completion of information booklet for parents of children with ADHD (South Meath).

Specialist ADHD team. Follow-up of Parent Support Group (Mater Team A).

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

Alert groups for children with ADHD. Psychoeducational group for children with ADHD. Parenting group for parents of children with ADHD (Mater Team C & D).

Specific parenting group re: ADHD, Alert Group for children. ADHD database set up (Mater Team E).

Group for parents of children with ADHD (Cavan).

O.T. Group (x1) (Louth).

1F. GROUPS PROVIDED:

ADHD group which was run over 4 weeks (Monaghan).

ADHD – Parent Training for parents / carers of children under 12 years with ADHD. Adolescent Parent Training Group for parents / carers of children 12 years and older with ADHD. Social Skills Group. Planned Parent Group for the East Meath – Outreach (North Meath).

Two Social Skill Groups. Transition to Secondary School Group for Children with Social Communication Group (Linn Dara CAMHS, Castleknock).

Parenting children with ADHD. Parenting teens with ADHD. Additional session introduced into ADHD Parenting Programme about language and communication by the Speech & Language Therapist (South Meath).

CAMHS Team A offered the following in 2011. Working Things Out CBT group for adolescents; Alert group run by Occupational Therapy Dept., Diagnostic Communication Group offered, Parents' Plus Group for Adolescents, Communication Group run for Adolescents, Transition to secondary school group offered (Mater Team A).

ADHD parents group. Group for children with selective Mutism. School transition programme (Mater Team B).

The following groups were run: Parents Plus, Alert programme, Secondary School Transition, Teenage boys / girls, Working Things Out, Social Skills Group, Parents of Children with ADHD, Psychoeducational Group for Children with ADHD, Speech and Language Groups (Mater Team C & D).

School transition, Alert, Working Things Out Group, Parents Plus Programme – Early Years, Middle Years and Adolescent Years Groups, ADHD parenting (Mater Team E).

Group for parents of children with ADHD (Cavan).

Parents group for parents of children with Anxiety Disorders (separation anxiety) (Linn Dara CAMHS, Blanchardstown).

Psychotherapy. Drama. Transition. Parenting (Louth).

1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Weekly Journal Club. Monthly complex case presentation. Attendance at Regional CAMHS Conferences run by Meath / Louth / Cavan / Monaghan. All team members undertook mandatory training on the findings of The Roscommon Report. Team members undertook training in the following: Early intervention in Psychosis, Cognitive Behaviour Therapy for Obsessive Compulsive Disorder, Bi-Polar Disorder, Cognitive Remediation Therapy training for Eating Disorders. Attendance at the Winter Conference of Irish College of Psychiatry – 10th & 11th November in Killarney, Co. Kerry. Attendance at the Institute of Psychiatry's ADHD meeting in Belfast – 6th & 7th October 2011. Attendance at the ADHD Institute Conference in Barcelona on 24th & 25th March 2011 in Barcelona, Spain. One of the Clinical Nurse Specialists on the team avails of CBT (cognitive behavioural therapy) supervision weekly (Monaghan).

All team members participate actively in CPD including training in a variety of skills e.g. working with eating disorders (North Meath).

STORM training completed by most team members (skills-based training in risk assessment and management). Team attendance on training day on CAPA (Choice & Partnership Approach) model. Attendance at Group Facilitators course (2 team members) (Linn Dara CAMHS, Castleknock).

Mater Team A staff participated in the following: Non-violent Crisis Intervention training, Assist Training, Asperger's Training, Psychoanalytic Seminars, Mental Health and Adolescence Training, Ongoing participation in Mater Academic Programmes and Study Days (Mater Team A).

Floortime. Risk Management. Two Family Therapy Workshops. Early Onset Psychosis Conference (Mater Team B).

Diploma in Creative Therapy, Training in Jungian Bodywork, Psychopharmacology update course for psychiatrists, Certificate in Health Care Management, Masters in Research, Masters in Medical Education, Masters in Sensory Integration (Advanced Sensory Practitioner) (Mater Team C & D).

Safe-talk Training; Monthly Academic Programme attendance and participation; Infant Mental Health Training; Short Term Memory Training; Supervision Training; Non-violent Crisis Intervention; Speech and Language Mental Health Special Interest Group; Social Work CAMHS Special Interest Group (Mater Team E).

All team members attended two days of training in management of eating disorders given by Dr. Rachel Bryant Waugh. All team members attended 1 day of training on psychological management of psychosis given by APT. All team members who were available attended three Northeast Regional Psychiatric conferences during the year, each of which was arranged by a different CAMHS team in the Northeast Area. All team members attended a workshop on "The Roscommon Report". Complex case discussion and Journal Club held jointly by Cavan and Monaghan CAMHS on a monthly basis except for summer months. Included were session by art therapy student and session on CBT for OCD. All team members are involved in these meetings. Consultant attended the American Academy of Child & Adolescent Psychiatry on 18th – 21st October 2011. Consultant attended a one day course on CBT for young people by Prof. Paul Stallard. Consultant attendance at and participation in regional specialist Eating Disorder interest group. The CMH nurse attended 2 day training Title: Training Program for Public Health Nurses and Doctors in Child Health Screening, Surveillance and Health Promotion. Unit 9 Child Emotional and Mental Health. June 14th and June 21st. The CMH nurse also successfully completed the Graduate Diploma in Child Mental Health at UCD School of medicine and Medical Science. The Senior OT attended the Annual Conference of the Sensory Integration Network September 24th and the Paediatric Advisory Group Conference – the Art of Sensory Integration on September 16th. The Senior OT attended Sensory Integration Module 1: Theory and Intervention (Paediatrics) on May 9th to May 13th 2011, Sensory Integration Network UK and Ireland. The Senior OT attended 1 Day – CAMHS Advisory Group Conference on Innovative service provision across ages including assessment groups, sensory strategies, efficacy of the Alert Programme and working with Adolescents on 31st October 2011. The Senior OT attended ½ day competency based fieldwork endeavour workshop – Practice education handbook for MSc O.T. student uptake in 2012 – Competencies, curriculum, roles, learning outcomes / objective / assessment of students. This was on November 8th 2011 (Cavan).

CAPA training (Linn Dara CAMHS, Blanchardstown).

Family Therapy. Supervision (Louth).

1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

The Paediatric Liaison Nurse presented her thesis on "Caring for a Child with Type 1 Diabetes; the Parents experiences. All staff undertook lecture presentations to final year medical students. A number of staff undertook lectures for Nursing students in Dundalk I.T. undertaking the BSc in Nursing. One Clinical Nurse Specialist has undertaken to write up a course on Eating Disorders for the training prospectus us for Primary Care workers. One Clinical Nurse Specialist provided training to staff in Ballydowd High Support Unit on motivational work for Eating Disorders. Presentation on the role of social work in CAMHS to Social Workers in Primary Care and Child Protection. Presentation to Inver College – post primary students on topics re: mental health (Monaghan).

Regular consultation to Children's Disability Service. Ad Hoc consultation to variety of professionals in health and education including schools. Teaching for trainee doctors. Children First Training / Child Protection - provided by Social Worker. (North Meath).

Participation in teacher training on mental health issues for SESS (Special Education Support Service). Lecturing on Masters of Educational Psychology course, UCD. Consultation service provided to referral agents / external agencies (Linn Dara CAMHS, Castleknock).

Ongoing consultation provided to Child Abuse Programme. Consultation to Child Protection Committee (South Meath).

Supervision and Training is ongoing with students from TCD, UCD and UL across the following disciplines: Social Work, Clinical Psychology, Visual Arts Psychotherapy and Occupational Therapy, Speech and Language Therapy, medical students. Training provided to UCD and to local Drug Centres on Working with Children and Families. Training to Junior Doctors regarding Child and Adolescent Mental Health as part of the Mater Psychiatry Training Scheme. Lecturing to

junior doctors at intern level on Child and Adolescent Mental Health. Outreach by team to World Mental Health Day in local community representing CAMHS team A. Training of Senior Registrars in Child Psychiatry via clinical supervision and via lecturing on the Senior Registrar Academic Programme (Mater Team A).

Training to Masters Mental Health in Trinity College. Doctorate in Clinical Psychology training provided on Critical Psychology (Mater Team B).

Workshops on Play Therapy and Narrative Therapy to the D. Clin. Psych. Course in TCD. Workshop on Creative Therapy to the Social Work discipline. Workshop on Attachment theory to psychiatry discipline. National conference for OT's working in CAMHS (Mater Team C & D).

Fingal Child Care Committee – Consultation provided. Consultation to Home Start. Parents Plus programme training provided to Community Services. Infant Mental Health Programme – Consultation Provided. Grove Lodge – Consultation provided. Academic Programme – Presentations by Team Members. Training for Registrars in preparation for clinical examinations (Mater Team E).

Consultant attendance at and participation in regional specialist Eating Disorder interest group. This includes all interested parties from PCCC, Dublin North East including CAMHS teams, St. Joseph's adolescent in-patient unit and paediatric Hospitals such as Temple Street. This has been used to develop skills in this area and facilitate sharing of knowledge and consultation regarding management of eating disorder cases. Recently two days of training on the management of eating disorders was arranged through this group and this training was made available to a large number of therapists who are involved in treating these disorders. Also a Regional Northeast Area Psychiatric conference was arranged by this team and all of the CAMHS teams, adult psychiatrists and paediatricians in the Northeast area, were invited to the day. Topics included ADHD, compliance, CBT for eating disorders and syndromes with congenital brain involvement (Cavan).

Consultation (case be case) to Aistear Beo (Linn Dara CAMHS, Blanchardstown).

CAMHS Principal Social Worker with Community Care Social Workers. Student Nurses in DKIT. O.T. Training of Students (Louth).

South

1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Feedback from groups– parents and children (Waterford / South Kilkenny).

This service is participating in a multi-site research project, the purpose of which is to seek the views of service users in relation to their attendance at a CAMHS Service. The title of the project is 'An Evaluation of Client Satisfaction with the Child & Adolescent Mental Health Services' – Ongoing (North Lee East).

Pre and Post Parenting Groups (North Lee West).

Insufficient staff to facilitate a specific structured review, however regular meetings occur Senior management team, children's service committee to ensure service users are advocated for and feedback (South Tipperary).

Multifamily Group for service users with Anorexia Nervosa. Trialogue – Youth Mental Health Day with local schools and services. 4 internal audits in 2011. Monthly HSE statistics. Feedback from group interventions (Brothers of Charity, West Cork).

Garden and graffiti project (YP who volunteered designed a friendly and positive courtyard and 'Phoenix' garden off the waiting area) using fundraising donations. Feedback / Comment form developed. Suggestion box in waiting area. Leaflets on the service, sleep incorporating images designed by young people (Brothers of Charity South Lee 3).

Experience of service questionnaire (CHI) with children 9 – 17 years and parents is being used within the service (Brothers of Charity South Lee 2).

CHI Questionnaire Nov 2011 (Parents and Young People). Experience of service questionnaire (Brothers of Charity Kerry).

Routinely sought at end of Parents Plus Groups. Evaluation of Working Things Out Group which was run Oct - Dec 2010 was completed by Psychologist in Clinical Training in Spring 2011 (North Cork).

We set up user feedback boxes in waiting areas and implemented some of the changes in waiting room décor we could afford to do so (Carlow / Kilkenny 1).

Audit re: patient satisfaction with waiting area (Wexford North).

1B. MEASUREMENT OF OUTCOME:

Groups – SDQ / Eyeberg / parenting scales / Dass / Parenting Tasks Checklists (Waterford / South Kilkenny).

Pre and Post measures used for all Parenting Plus Groups, as well as user feedback after three months or more (North Lee East).

Service User Questionnaires (North Lee West).

Team Members attended conference with a view to develop tools to do same an date panned for same in Jan 2012 to begin project on outcome measurement (South Tipperary).

All groups evaluated (standardised and individualised goals). Individualised Goal setting introduced for YP / parents at time of care plan being agreed. Standardised measures before and afterwards introduced in many cases (SDQ, Connors, CDI, Spence, MOVES, EDI, etc. in regular use. See below re staff training in Outcomes measurement (Brothers of Charity South Lee 3).

CORC Training for team members. Strengths and Difficulties Questionnaires. Measurement of goals. Session feedback question (Brothers of Charity South Lee 2).

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

Evaluation of Working Things Out Group which was run Oct – Dec 2010 was completed by Psychologist in Clinical Training in Spring 2011 (North Cork).

None but funding of any psychometric tools is haphazard task in terms of ordering, delivery and consequently implementation (Carlow / Kilkenny 1).

1C. RESEARCH / AUDIT PROJECTS:

Audit Recent study on GPs understanding of role of this Department & satisfaction with service (Waterford / South Kilkenny).

Audit of Treatment Plan Record (North Lee East).

Audit on record keeping to commence in 2012. Referral protocol / policy in development. Triage of common referral form for complex cases for all children's services. Pilot referral form in development for all routine psychiatric referrals with a view to assessing increased efficiency of triaging from same (South Tipperary).

Four internal file audits in 2011 (Brothers of Charity, West Cork).

ADHD service – next cycle. Team poster presented ESCAP. Experience of multifamily therapy for anorexia (Psychology doctorate student thesis) (Brothers of Charity South Lee 3).

Audit of Record Keeping completed (Carlow / Kilkenny 2).

Clinical audit of ADHD open cases – NICE guidelines (Brothers of Charity Kerry).

Paper on ADHD by Consultant Child & Adolescent Psychiatrist and Clinical Nurse Specialist. Development of an LC-MS / MS method for the analysis of serotonin and related compounds in urine and the identification of a potential biomarker for attention deficit hyperactivity / hyperkinetic disorder Analytical and Bioanalytical Chemistry, Volume 401, Number 8, 2011 p2481-2493, Merisa Moriarty, Aoife Lee, Brendan O'Connell, Ann Kelleher, Helen Keeley and Ambrose Furey (North Cork).

Audit of consultation liaison demands made by local general hospital is being undertaken (Carlow / Kilkenny 1).

Audit of clinical monitoring of atypical antipsychotic medications (Wexford South).

Audit re: patient satisfaction with waiting area (Wexford North).

1D. WAITING LIST OR OTHER INITIATIVES:

Met the team's specified targets for New Assessments which were in line with the National Guidelines (North Lee East).

National Waiting List Initiative (North Lee West).

Locum Consultant (60 days) to allow additional new cases to be seen. Social Worker redeployed. Nurse on maternity leave. Referral protocol / policy in development. Triage of common referral form for complex cases for all children's

services. Pilot referral form in development for all routine psychiatric referrals with a view to assessing increased efficiency of triaging from same. Staff training in computerised CBT. Social Worker redeployed to adult psychiatry without backfilling to child psychiatry waiting list in excess of 70 families awaiting Social Work intervention. Wait list screening for continued need for all referrals over 6 months old (South Tipperary).

Basic Grade Social Worker was employed for 2 months in June and July 2011 and helped with some group interventions listed below, saw service users on an individual basis to do e.g. anger management etc. Locum Consultant-led reduced wait list to below three months (Brothers of Charity, West Cork).

Temporary social worker (basic grade) taken on for 6 months as part of waiting list initiative. She took on the coordination role also – positive impact on waiting list and attitude of families waiting (kept informed etc). Volunteer assistant psychology 6 month placement. Self help information packs developed for those waiting for assessment on Waiting list (Brothers of Charity South Lee 3).

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

Waiting list initiative 2011 (Brothers of Charity Kerry).

Two Agency Staff employed from Sept 2010 to March 2011 as a waiting list initiative – discontinued. Unable to engage with further initiative offered in September 2011 due to lack of admin support (North Cork).

Institution of Nurse lead ADHD assessments, under the supervision of Consultant child and Adolescent Psychiatrist, for new and return appointments (Wexford South).

Group tutorials, regular staff supervision (Wexford North).

1E. FOR CHILDREN WITH ADHD:

Psychoeducation programme for parents (Waterford / South Kilkenny).

In response to feedback from parents about frequent staff changes, children who attend the ADHD clinic are now allocated a lead clinician. This ensures continuity of care for clients and progression of the treatment plan (North Lee East).

Group psycho-education for parents and carers in collaboration with Barnardos and community agencies (South Tipperary).

Separate clinic held approximately once a month by Community Psychiatric Nurse and where required and available Locum Consultant Psychiatrist (Brothers of Charity, West Cork).

As previously described in 2010 audit, plus: Life skills and social skills groups (see below). ADHD Clinic broadened to include other disciplines as required (Brothers of Charity South Lee 3).

Boys Teen group. Life Skills group. Stop, Think and Do group. How does your engine run group (Brothers of Charity Kerry).

We have a specialist ADHD assessment clinic but will close that down in August 2012 if likely staff reduction is not halted (Carlow / Kilkenny 1).

Institution of Nurse lead ADHD assessments, under the supervision of Consultant child and Adolescent Psychiatrist, for new and return appointments (Wexford South).

ADHD clinics (Wexford North).

1F. GROUPS PROVIDED:

Triple P Parenting (x4). Socialization / Coping skills (x2) (Waterford / South Kilkenny).

Friends Programme – Anxiety Management. 'Working Things Out' – Skills based programme for Adolescents with internalising Disorders. Adolescent Parenting Plus Group. Mid-Years Parenting Plus Group – May / June 2011. Sensory Motor Group – Summer 2011 (North Lee East).

Parents Plus adolescent 12 -16 year old group for eight weeks. Transition to Secondary School Group – 5 weeks (two groups). Motor skills Group – 6 weeks – 8-11 years (two groups). Sensory Motor Group 8 - 12 year olds 6 week course. Dialectical behavioural therapy group – 7 week course (North Lee West).

Group over the summer for young people on "Anxiety Management" (South Tipperary).

2 Social Skills Group. 3 Parenting Courses. 1 Art Project. Multifamily Group for service users with Anorexia Nervosa

in conjunction with other Brothers of Charity CAMHS Teams (Brothers of Charity, West Cork).

Friends group (x1). Parents plus groups (x2) (mid years and adolescent). Life skills (x2) (mid years and adolescent). Social skills (x2). Multifamily group for anorexia (x1) plus follow up group. Graffiti group (art / service user week long project for adolescents) (Brothers of Charity South Lee 3).

Incredible Years Basic Parenting Programme. Advanced Incredible Years Parenting Programme (Brothers of Charity South Lee 2).

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

CBT anxiety management groups (x2). Psychoeducation groups for parents. Social Skills groups. Working Things Out group. ADHD Parent groups (Brothers of Charity Kerry).

Parents Plus Group Feb / Apr 2011 and Oct / Nov 2011 (Middle Years). Parents Plus Groups (x3) – Jan / Mar; Apr / Jun (a.m.) and Sep / Nov (p.m.) (Adolescent Years) (North Cork).

None due to service capacity (Carlow / Kilkenny 1).

1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Clinical Outcomes and Evaluation (Oct 2011). Brief Encounters (Oct 2011). Sexualised Behaviour In Children. Two days of Narrative Training (March 2011). One day of Narrative Systemic Training (Feb 2011). Eating Disorder Forum – Bi-monthly. Space Programme facilitated by CAMHS Mater Hospital in the Inpatient Child & Adolescent Unit. Assessment Framework by Mr. Hanz Maas, Principal Social Worker. Infant Mental Health Training. Incredible Years Training. Training in Child Abuse – one afternoon for Psychology only. Attention Deficit Hyperactivity Disorder Training (Dublin). All the above were paid by clinicians personally due to a lack of funding from the HSE (North Lee East).

Self harm training group – 2 day course. 8 week Mindfulness stress based reduction course. Sensory based self-regulation course – UCC – 2 day course (North Lee West).

Infant Mental Health training. Parenting groups. Children's First guidelines. Masters in Nursing. Training in Early onset Psychosis. CPD in ADHD, psychopharmacology, CBT and legal training (South Tipperary).

CPN attended 2nd year of a 4-year Family Therapist course. Principal Social Worker attended 8 sessions of Acquired Brain Injury course. Clinicians attended a two day Space Programme on self harm. Clinicians attended bi-monthly Eating Disorder Forum. Principal Social Worker attended a two day Assist Training Course. Clinicians attended updated Child First Guidelines one day course. CPN attended Strengthening Families Programme training. Consultant attended Peer Review Groups during the course of the year. Psychologist and CPN attended one day Friends First Programme training course. Consultant attended two day course on early signs of Psychosis. Consultant attended one day course re: CBT on Psychosis. CPN and Principal Social Worker attended course on evaluating technology addiction. All clinicians attended a 2 day course on Clinical Outcomes. Principal Social Worker attended bi-monthly Family Therapy Forum (Brothers of Charity, West Cork).

Continuing masters in CBT, Family therapy and Med Education masters across team as previous. Outcome evaluation Masterclass (UK) and conference (Cork) (see below). Sensory integration training. Narrative therapy course. Coaching skills for psychiatrists. SPACE training (Brothers of Charity South Lee 3).

Cognitive Remediation Therapy Training for Eating Disorders (Carlow / Kilkenny 2).

CORC Training. Master class on ADHD. Friends Training Programme. Conference on Mental Health of Children in Care. Training for Detecting Early Psychosis (Brothers of Charity South Lee 2).

CORC Training (Brothers of Charity South Lee 1).

Social Phobia. Cognitive Behaviour Therapy. CAMHS Occupational Therapy conference (Brothers of Charity Kerry).

Children's First Guidance Training (attended by PSW). Marte Meo Training (x1) day - Dublin (attended by PSW). Infant mental Health Conference (x1) day – Cork (attended by PSW). Autism National Conference (x1) day - Cork (attended by PSW). "SPACE Training" (self-harm) (x2) days – Cork (attended by PSW). Tony Attwood / ASD Conference (x1) day in May 2011 in Dublin (attended by Senior Clinical Psychologist). CBT Workshop (x1) day in September 2011 in University of Limerick given by Dr Gary O'Reilly, UCD (attended by Senior Clinical Psychologist). Family Therapy Training attended

by Senior Registrar at Institute of Family Therapy in London (9 days – Jan to Jun 2011). Foundation Course in Attachment Theory – Tavistock London attended by Senior Registrar (5 days – Oct / Nov 2011). Teaching / Academic mandatory training by Senior Registrar alternate Fridays (North Cork).

As part of revalidation training requirements of individual team members (Carlow / Kilkenny 1).

Medical Update for child and Adolescent Psychiatrists, ADHD seminar, Psychoanalytic training-consultant. Eating disorder seminar attended by CNS (Wexford North).

1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Occupational Therapists / Speech Therapists consultation with schools. Advice on programme implementation (Waterford / South Kilkenny).

Occupational Therapy Students (x2). Medical Students – alternate weeks during academic year (North Lee East).

Teaching provided fortnightly to Undergraduate Medical Students. Placement provided to psychologist in clinical training and assistant psychologist. Placement provided to student occupational therapists (North Lee West).

Consultation provided on certain individual cases to Adult Psychiatry service (> 16 cases). Infant mental health offered to all HSE staff interested. Public Health Nurse training in mental health for young people. Schools consultation on case by case basis. NEPS twice yearly consultation forum on 30 or so cases of mutual interest. Psychology / Social Work as needed on a case by case basis with specific liaison times with community psychology (South Tipperary).

Principal Social Worker held information meeting with Family Resource Centre in Dunmanway. CPN met West Cork Travellers Association to provide information / education on service. Principal Social Worker held a joint presentation with Adult Mental Health Services to a local school following a critical incident (Brothers of Charity, West Cork).

Ran a 2 day Conference on Evaluating Clinical outcomes in CAMHS in association with EBPU (Anna Freud centre) – attended by CAMHS, Community psychology from 10 services. Student placements / teaching: Social work, medical. Tutorial / Training to: GP scheme (Cork). Educational psychology (Limerick). Induction to CAMHS programme (registrars) (Brothers of Charity South Lee 3).

Consultation to Local General Hospital. Public Health Nurse Training on Mental Health Provided (Carlow / Kilkenny 2).

Consult with ASD team, ID teams and Child Protection teams (Brothers of Charity South Lee 2).

Training to Jigsaw Project mentors. CAMHS Presentation to School with NEPS (Brothers of Charity Kerry).

Hosted Social Work Students (x2) (Spring & Autumn placements). Senior Clinical Psychologist facilitates training placement from Oct-April each year. Senior Clinical Psychologist & Clinical Nurse Specialist involved in Infant Mental Health Network Group –meets monthly. Senior Clinical Psychologist presented at same in 2011 and provided teaching to clinical trainees in UL and UCD on Infant Mental Health Module in Jan / Mar 2011. Senior Clinical Psychologist presented at Infant Mental Health Conference in Cork on 25th November 2011. Senior Clinical Psychologist / Clinical Nurse Specialist / Senior Registrar delivered training to Area Medical Officers and Public Health Nurses on child emotional health in Sept 2011 (2 sessions) (North Cork).

Consultation provided frequently to social work and community services such as NEPS, schools (Carlow / Kilkenny 1).

Via tutorials and to Social Services, GPs, school, EWOs (Wexford North).

West

1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Suggestions box in waiting room (West Limerick).

Consumer Feedback forms available in waiting room. Different forms for children and adolescents / adults (Donegal South).

Consumer feedback forms given out and satisfaction ratings with various aspects of service analysed and forms for parents, children and adolescents now in waiting room on ongoing basis. Written feedback / ratings sought from social phobia group attendees (Donegal North).

Development of three 0-18 years CAMHS teams in Limerick City and County (Limerick Central).

Your Service Your Say (South Galway).

Prescreening interview with parents of ADHD clients' pre to group to identify their needs / expectations from group (East Limerick).

Attitude of parents – see below. Multi-centre study – client satisfactory – see below (West Galway).

'What's in a name' user involvement in selecting a name for the service (Mayo South & North).

Feedback from Adolescents admitted to Inpatient Unit (North Galway).

1B. MEASUREMENT OF OUTCOME:

Student psychologist project using CGAS as outcome measure (West Limerick).

Early stages – consideration of HONOSCA and other outcome measures (Donegal South).

Outcome measures used ad hoc more than routinely but service planning to introduce routinely in 2012 (Donegal North).

Measurement on various questionnaires (clinical). Patient and therapist view of outcome (Limerick Central).

Goal based outcomes measured on Likert scale SDQ at beginning a six month or end of therapy (East Limerick).

Multi-centre study of client satisfaction questionnaire. Group Therapy outcome measures: Speech and Language and Occupational Therapy Departments (West Galway).

Introduction of care planning (Mayo South & North).

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

1C. RESEARCH / AUDIT PROJECTS:

Regular caseload review. Piloted use of CGAS, GBOM and ESQ (see CORC website) for a cohort of cases (West Limerick).

Medical monitoring of children on medication. Study of completion of care plans. Audit of consumer feedback (above) (Donegal South).

Care plan utilisation & suitability audit to be repeated after amendments made to care plan. Consumer feedback forms audit (Donegal North).

File audit of ASD cases (Roscommon / East Galway).

Insufficient staff and team to do and no research projects. Have to prioritise clinical work (Limerick Central).

Audit of ASD and ADHD Clinical Charts (South Galway).

Annual audit of open cases audit of diagnosis, medication (East Limerick).

Double Blind Study with Gary O'Reilly (UCD) – computer game for children (10-16 yrs) with internalising disorder. Research published looking at attitudes of parents ADHD Medication (West Galway).

A Quantitative and Qualitative analysis took place in 2011 looking at GPs reasons for making referrals to CAMHS or the community psychology department and their expectations with respect to these referrals (North Tipperary).

Patient satisfaction audit. File completion audit (Clare).

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

Audit of socioeconomic and demographic details of clients attending the service with ADHD (Sligo / Leitrim / West Cavan).

1D. WAITING LIST OR OTHER INITIATIVES:

Ongoing attempt to reduce (West Limerick).

Summer blitz of 50 cases from waiting list. Ongoing audit of blitz effectiveness (Donegal South).

Waiting list initiative not conducted by consultant because of commitments in other HSE non-clinic based duties this year. Team have committed to increasing numbers of new patient assessments per month as clinical capacity permits (Donegal North).

Established a waiting list for routine ASD assessments as these children receive no further intervention, so that energy can be devoted to mental health cases (Roscommon / East Galway).

No waiting lists currently (Limerick Central).

Rationalisation of intake process, development of protocol regarding processing new referrals. Elimination of waiting list (in August there was a waiting list of 60) (South Galway).

Introducing CAPA model (East Limerick).

No Waiting list. Pathways of referral documented for CAMHS in West & North Galway (West Galway).

As part of ongoing research (see Section C) information was gathered regarding dual referrals to CAMHS and Community Care Psychology and a process is being undertaken with Community Psychology to decrease the numbers of these dual referrals (North Tipperary).

Membership of Mayo Youth Mental Heath Initiative (Mayo South & North).

No Waiting List (North Galway).

One week designated for new assessments only (Sligo / Leitrim / West Cavan).

1E. FOR CHILDREN WITH ADHD:

Fast track assessment and routine clinics (West Limerick).

Monthly ADHD clinic. Improved medical monitoring with GP involvement (Donegal South).

No change (Donegal North).

Running new patient and review ADHD clinics as usual (Limerick Central).

50% increase in ADHD clinic time to meet identified needs. Audit of availability of medical equipment to clinic and purchase of required items. Development of protocol regarding ADHD assessments to improve efficiency and rationalisation of review appointment intervals (South Galway).

Group for parents – psychoeducation and behaviour management strategies (East Limerick).

Service Day for Galway and Roscommon addressing aspects of ADHD provision by Community Teams (West Galway).

Specific parenting group run for parents of Children with ADHD who were experiencing severe difficulties (North Tipperary).

ADHD clinics (Clare).

Group offered (Mayo South & North).

No Waiting List (North Galway).

Increased number of ADHD clinics. Alert programme (Sligo / Leitrim / West Cavan).

1F. GROUPS PROVIDED:

Interactive group for young adolescent boys with social challenges (West Limerick).

Liaising with voluntary and community providers (Donegal South).

Social phobia treatment group for adolescents conducted over Summer 2012 – excellent feedback (Donegal North).

Parenting and communication groups (Roscommon / East Galway).

None. Team too small to be able to accommodate running of groups (Limerick Central).

Parents Plus. Social Skills Groups. Diagnostic Assessment Groups (South Galway).

Psychoeducation / behaviour management for parents of children with ADHD (East Limerick).

Social Skills Groups: 5 – 8 year olds, 9 – 12 year olds. Transition (primary – secondary school) Group. Alert Programme (S&LT / OT and Social Care) (West Galway).

SPACE program run this year. Using the Mater CAMHS. Program locally to support parents whose children have engaged in deliberate self harm (6 week programme). Mindfulness based program was run for adolescents with recurrent Mental Health problems to decrease relapse rates (North Tipperary).

SPACE Programme to be run in Mid-west in 2012 (Clare).

Transition group developed for anxious children moving from primary school to secondary school. Common sense parenting. Multidisciplinary team for group planning (Mayo South & North).

Transition group for vulnerable children transitioning from Primary to Secondary School. Friends for life, Cognitive Behavioural Approach to Social Skills Training (North Galway).

Alert Programme. Teenage Gardening Group. Group for Teenage Girls. Teenage Language Group (Sligo / Leitrim / West Cavan).

1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Regular fortnightly in-service training. Peer review of psychotherapy cases (West Limerick).

Psychotherapy training and supervision: individual, family, CBT and sandplay. One Marte-Meo course (x1) (Donegal South).

None was permitted due to funding issues (Roscommon / East Galway).

Only local training available and have been advised that there is no funding for staff in team apart from CME funds to medical staff. Team attended local Child Protection and Child Development Training and Space Training (Limerick Central).

ASSIST (Suicide Awareness). Drug Awareness Training. STORM (Suicide Risk Assessment & Self Harm Modules). Children First. TCI (Therapeutic Crisis Intervention) (South Galway).

Port-grad – Practice Teaching / Supervision / Management – NUIG – Social Worker. Post-grad family therapy – Psychology. 3Di (Assessment for Autism) – Senior Registrar (West Galway).

Space programme. Group therapy facilitation training. CBT training for treatment of adolescents with substance abuse problems. Affect phobia training. Mindfulness training (North Tipperary).

Children first training. Sensory integration. Attachment training. Management of eating disorders (Mayo South & North).

MSc undertaken in Systemic Family Therapy. ADOS / 3DI Training. Psychopharmacology Workshop. Drugs Awareness Training. Attendance at two Day Autism Conference (North Galway).

Narrative Training. Play Therapy. Enhanced CBT for eating disorders (Sligo / Leitrim / West Cavan).

1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Regular monthly case conferences are held. The Consultant teaches medical students in formal lectures in NUG. Team memberUndergraduate and postgraduate medics. Other training given to other agencies locally on request (West Limerick).

Senior Registrar and consultant provided consultation and staff training to Children's Home (Donegal South).

Regular consultant liaison / consultation to residential child care services. Medical student training (on placement) (Donegal North).

As a team we provide regular teaching on CAMHS academic sessions to the CAMHS staff. Consultant provides teaching to medical students from the UK. Medical students attend two day clinical placement in CAMHS (Limerick Central).

Consultation provided to Early Intervention Services. Intellectual Disability Service, Enable Ireland and PCCC (South Galway).

Teaching of medical students from the UK. Teaching nursing students. Psychology and social work student placements in team (East Limerick).

Peer Training – Assessments for Autism. Full Service Academic Training day – Galway, Mayo CAMHS (West Galway).

Regular consultation with local services including Community Care psychology, residential services, AMO's and primary care services and schools. Development of a team provided supervision program for team members (North Tipperary).

Undergrad med students, student nurses (Clare).

Presentation at PSI. Frequent skills lab run internally. Workshop on Conners 3 (Mayo South & North).

Supervision of Social Work Students on Placement. Consultation to YAP Workers. Consultation to Social Workers. Medical Students Placements / Seminars (North Galway).

Medical Student Placements. National Fostering Conference – facilitated workshop. 3 members provided input to local radio on exam stress and mental health. Presentation on school refusal and social phobia. Presentation to speech therapists on mental health. Presentation to Paediatric Occupational Therapists on mental health. Presentation to mental health nurses on CAMHS (Sligo / Leitrim / West Cavan).

Day Service

1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Satisfaction Surveys (Young Person Unit, Lucena Clinic).

Psychology – "Assessing Adolescents: Mixed Methods and Teenagers' Preferences". Clinical Specialist in Speech and language Therapy & Clinical Nurse Specialist – Recording testimony upon discharge from service from young people / carers. Social Work / Nursing & Psychology – currently evaluating Parents Support Programme offered to Parents earlier this year with view to offering service in early 2012. Initiatives ongoing include weekly Community Meeting (St. Joseph's Adolescent & Family Service).

1B. MEASUREMENT OF OUTCOME:

Continuing to record CGAS with each young person attending for assessment, recorded on database (St. Joseph's Adolescent & Family Service).

1C. RESEARCH / AUDIT PROJECTS:

ADHD medication use – Senior Registrar (Young Person Unit, Lucena Clinic).

Education – School study as part of SEN course (inclusion of students). Speech and Language Therapy – Review of literature in relation to role of SLT in Mental Health (St. Joseph's Adolescent & Family Service).

1D. WAITING LIST OR OTHER INITIATIVES:

Education – Development of Vocational Programme to run concurrently with current school curriculum. During 2010 MDT discussion re: evaluation of current therapeutic programme being offered in St. Josephs with view to expansion of Day Hospital Service. MDT Team Development Day focusing on Service expansion (St. Joseph's Adolescent & Family Service).

1E. FOR CHILDREN WITH ADHD:

ADHD medication use – Senior Registrar (Young Person Unit, Lucena Clinic).

1F. GROUPS PROVIDED:

Psycho-education. Anxiety Management. Healthy Living. Communication / Social Skills. Assertiveness / Self Esteem (Young Person Unit, Lucena Clinic).

Education–SPHE. Sacred space. Music. Gardening. Psychology – Emotion Regulation, Resourcing, and Sensory Integration as part of Summer programme 2011. Speech and Language Therapy – Meta Cognitive Skills group to young people as part of Summer Programme 2011. Working Things Out Adolescent Group (Teaching and Nursing Staff). Social Work – Narrative Group (St. Joseph's Adolescent & Family Service).

1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

SIPS / SOPS Training. ADOS. CBT Master – 2 nurses Esteem (Young Person Unit, Lucena Clinic).

All MTD Team – Children First Training. Service Development Day. In Service Manual Handling Course. PSYCHIATRY – Work with Complex Cases / Early Psychosis / Children First. EDUCATION – Postgraduate Diploma in Learning Support & Special Education. Board of Management training. Food & Hygiene Training. PSYCHOLOGY – MSc in Child Art Psychotherapy training. SLT – MDT Reflective Practice Group in St. Joseph's AIPU. QNIC Focus Group re mental health literacy of young people in AIPU setting. Attended information day on SASSY in young Ballymun. Attended training day in Counselling Skills Course – SVHF. Nursing: Solution focused therapy recovery model and assessment. Safe management of complaints. CNM audit review & CNM training – managing absences. Training re: emergency equipment. Presentation re: overview of diabetes. De-escalation strategies. Health & Hygiene in St. Vincent's Hospital, Fairview & Food Preparation. Attendance at Launch of Parent Plus Programme. Substance Abuse – SASSY. Into to Youth Mental Health – SASSY. Systemic Family Therapy Training. Introduction to SPACE Program. Clinical Supervision. Intro to Risk Assessment. MEDICAL – MSC in Leadership & Management Development. Introduction to Family Therapy (St. Joseph's Adolescent & Family Service).

1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

MDT – Presentations at Academic Programme CAMHS and Adult Mental Health. Psycho Education slot within MDT. Presentation to Nursing Students in DCU. PSYCHIATRY - Membership of Child Protection Committee Area 7. Supervision of Senior Registrars, Registrars in Psychiatry; Supervision of Child Art Psychotherapy trainee. EDUCATION - PTSD In house training provided by MDT – IPU. New adolescent unit planning consultation. PSYCHOLOGY – Supervising a 3rd year Psychologist in Clinical Training, supervising two assistant psychologists. SLT – Clinical Supervision of Postgraduate student in UL Masters Programme. Consultation and collation of views of MDT in relation to service development planning for AIPU extension. Presentation to student nursing staff: of SLT role in acute mental health setting. Compilation of materials for lecture presentation to Postgraduate student in UL Masters Programme in SLT. SLT National Network meeting / peer supervision, Warrenstown Residential. NURSING – Case Presentations. Preceptorship to Nursing Students. Presentation to CAMHS re: Service provision and managing discharges to Adult Mental Health. Clinical Supervision. Attendance at FINCAMH – on 3/12 basis. Attendance at bi-monthly Special Interest Eating Disorder Group (St. Joseph's Adolescent & Family Service).

Liaison Hospital

1A. SERVICE USER INVOLVEMENT / FEEDBACK:

Development of Quality Improvement Plan in the area of Service User Involvement (December 2010 – January 2011). Developed and delivered to two service user panels – adult / parent & young people over 2011. Joint planning meeting of service user panels & senior management (Children's University Hospital).

1B. MEASUREMENT OF OUTCOME:

Plan of engagement for 2012 in relation to key names i.e. Developing feedback from service users. Consultation and engagement with service users in refurbishment of space. Develop culturally sensitive service (Children's University Hospital).

Please see neurodevelopmental audit (NCH Tallaght).

1C. RESEARCH / AUDIT PROJECTS:

An audit of St. Frances ADHD Clinic, Temple Street Children's University Hospital in light of NICE (National Institute for Health and Clinical Excellence, UK) guidelines, Dublin, 2011 (in progress). Frodl T., Skokauskas N., Mulligan A., Gill M. Clinical and biological outcomes of adults with childhood diagnosed Attention Deficit / Hyperactivity Disorder (ADHD), Health Research Board, Dublin, Ireland. DSH database feeding into NRSF Research with neurology patients carried out by Senior Clinical Psychologist on Living with a sibling with refractory epilepsy – children's experience of having a sibling with epilepsy (Doctoral Dissertation). Student researcher under Psychologist's supervision on Living with the Ketogenic diet as a treatment for their child's epilepsy. Audit of referrals to paediatric liaison service ongoing due to be completed February 2012. Development of Occupational Therapy Peer support group for clinicians working with feeding restrictions across the HSE. Member of Occupational therapy working in acute mental health setting peer group – currently working on assessment tool (Children's University Hospital).

An Audit of the Neurodevelopmental referral pathway is being reviewed by our neurodevelopmental team. An Audit of Self Harm Presentations to the National Children's Hospital and their bed days is being reviewed by our team along with the Paediatricians (NCH Tallaght).

Currently completing an audit of emergency admissions for Psychiatric treatment in 2011. We are conducting an international multi site pharmaceutical research study for children with ADHD between the ages of 6-17 (Our Lady's Children's Hospital, Crumlin).

1D. WAITING LIST OR OTHER INITIATIVES:

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

The National Children's Hospital 'Deliberate Self harm guidelines' have been reviewed and updated by our team and reviewed and accepted by the Paediatric Medical Advisory Committee and the hospitals guidelines committee. The 'Management of the agitated Child Guidelines' have also been reviewed and updated and is currently being reviewed by the Paediatric Medical Advisory Committee along with the hospitals guidelines committee. An information booklet for parents and guardians on Anorexia Nervosa is being produced within the National Children's Hospital by our team (NCH Tallaght).

Development of a policy on the therapeutic management of agitated, aggressive and potentially violent behaviour in children and adolescents in the paediatric emergency setting (Our Lady's Children's Hospital, Crumlin).

1E. FOR CHILDREN WITH ADHD:

An audit of St. Frances ADHD Clinic, Temple Street Children's University Hospital in light of NICE (National Institute for Health and Clinical Excellence, UK) guidelines, Dublin, 2011 (in progress). No social work service to ADHD clinic due to maternity leave (Children's University Hospital).

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

1F. GROUPS PROVIDED:

Space programme (support programme for parents and carers of young people where there is concern regarding self harm). W8Go Programme. Early Bird Programme (Autism). Hungry Hippos Programme (x2). Piloted Teenage Life Skills Group. Parent Support Group (for parents struggling with children's condition). Parenting Plus. Parallel group for parents (to OT teenage life skills group) (Children's University Hospital).

1G. SKILLS TRAINING UNDERTAKEN BY TEAMS:

Anorexia Nervosa Conference Two days (2011). Motivational Interviewing: Introduction Course. Mindfulness Meditation Training for Mental Health Professionals. MORE Course: Integrating Mouth and Postural Function. MSc in CBT (Anna Fraud Centre). MSc in leadership and management development (RCSI). MSc in Health Services Management (TCD). Parent Educator in Circle of Security (Children's University Hospital).

Two members of our team attended a '1st Conference of the Eating Disorder Special Interest Group' on 'Working with young people with eating disorders and their families: A Clinical Toolkit. Members of our team attended the Choice and Partnership Approach training day. Two members of our team attended a Forensic Training Day on the Adolescent. A member of our team attended a training day on ADHD. Two members attended STORM Skills Training in risk assessment and management in suicide and self injury. A member of our team attended a National 2 day ACAMH Liaison Conference on Meaning of Illness: manifestations, interpretations, diagnosis and management (NCH Tallaght).

'Eating Disorder in Children and Adolescents: A Practitioner Training Course' – Institute of Child Health, London (3 day course) (Nurse). SIPS training (Reg). ACAMH Motivational Interviewing for Children & Adolescents (Nurse). Introduction to CBT with Children & Adolescents (Reg & Nurse). Introductory seminar on Cognitive Remediation Therapy for eating disorders (Reg). Irish National ADHD meeting (Cons / Reg / SR). SIG Youth Mental Health Research day (Cons / SR). Working with Young People with Disorders: A Clinical toolkit (2 day training course) (Our Lady's Children's Hospital, Crumlin).

1H. CONSULTATION / TRAINING PROVIDED BY TEAM MEMBERS:

Two study days for Paediatric Nurses nationally (March and November 2011). Lecturing undergrad and post grad student nurses in DCU (2011). Space Training in Limerick / Cork 2011. Informal training to staff nurses / doctors via lectures in CUH. Academic Programme monthly jointly with Mater CAMHS. CUH Weekly Grand Rounds. Input on Social Work Course (Trinity College). Input on Group Analysis Course (St. Vincent's Hospital). Student Placements (x2). Supporting Occupational Therapist's in development of new services outside CUH. Occupational Therapy representative on QCCD for neonates and paediatrics (Children's University Hospital).

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

Regular training / teaching on Child mental health to clinical and lay personnel including parent and teacher information talks. Education and promotion of mental health practice to ward staff & student nurses. University Graduate Diploma and Masters courses (Our Lady's Children's Hospital, Crumlin).

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive