HSE Mental Health Division

Delivering Specialist Mental Health Services **2017**

HSE Mental Health Services

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

Contents

Acknowledgements

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

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

Thanks are also due to the members of the Data Design and Optimisation Group for their input, guidance and advice in the preparation of the Report.

The work of the Planning and Business Information (PBI) Unit of the Deputy Director General's Office for supporting the Division in the production of the Report is also noted with thanks.

Finally, there were a number of individuals who gave their time to authoring sections of the Report and these include Sharon Craig PBI, Maurice Farnan Mental Health Division, Philip Flanagan Mental Health Division, Dr Philip Dodd, National Clinical Advisor and Group Lead for Mental Health; Professor Harry Kennedy, National Forensic Mental Health Services.

Yvonne O Neill
Assistant National Director

Community Operations
November 2018

Foreword

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

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

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

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

Service Framework

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

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

The Mental Health Division is fully committed to and plays an active part in internal service improvement processes within the Division but also in the wider health system reform agenda.

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

Mental Health Services continues to deliver its services in an environment where the population is growing, the number of people seeking to access services is higher than ever before and where public expectations for quality services continue to increase. To address these challenges Mental Health Service are fully committed to the implementation of the Sláintecare Report which has the potential to transform the health and wellbeing of the whole population. As a first step in the implementation of Slaintecare in 2018 the Mental Health Division will become part of a Community Healthcare structure in the HSE which will ensure a more integrated model of service is delivered to service users. This integrated model will include Health and Wellbeing, Primary Care, Mental Health, Older Persons, and Disability services.

Executive Summary

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

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

Building on the success of the annual reports which were published by the Child and Adolescent Mental Health Services up to 2013 and on the Delivering Specialist Mental Health Services Report 2014 to 2016, this 2017 report will provide an overview of the work of the specialist mental health services, describing the services delivered, detailing the resources available to the services and showing the activity of those services in 2017.

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

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

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

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

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

Workforce

- In December 2017 there was a total of 677 staff in the Child and Adolescent Community Mental Health Teams nationally (589 Clinical). This represents 56.2% of the clinical staffing levels recommended in A Vision for Change which is an increase of 3.1% nationally on the 2016 position
- In December 2017 there was a total of 1,714 staff in the General Adult Community Mental Health Service (1,522 Clinical), which represents 76.1% of the clinical staffing levels recommended in a Vision for Change

- In December 2017, there were 344 staff (clinical 305) working in 30 Psychiatry of Old Age Service teams, which represents 58.2% of the clinical staffing level as recommended in a Vision for Change
- There were an additional 239 development posts approved in 2017 which will be recruited across 2017 and 2018.

Child and Adolescent Mental Health Services

- In 2008 there were 49 CAMHS Community Mental Health Teams. There are 69 teams in place in 2017
- There has been a 21% increase in referrals accepted between 2012 and 2017
- 11,498 new appointments were offered in 2017
- 49% of new appointments were seen within 4 weeks
- A quarter of new cases seen are aged over 16 years
- 10% of new patients did not attend their first appointment
- In 2007, 3,609 individuals were waiting to be seen; in 2017, 2,419 individuals were waiting to be seen.

General Adult Mental Health Services

- There are 114 Community General Adult Mental Health Teams
- 2% decrease in referrals accepted from 2016 to 2017
- 36,277 new appointments offered in 2017
- 22% new appointments seen within 1 week
- Over one third are seen within 2 weeks & 50.6% seen within 4 weeks
- Over 1 in 5 new patients did not attend their first appointment.

Psychiatry of Old Age Mental Health Services

- In 2013 there were 22 POA teams; there were 30 POA teams in place in 2017
- 1.8% decrease in referrals from 2016 to 2017
- 8,829 new appointments offered in 2017
- 40% new appointments seen within 1 week
- 83% new appointments seen within 4 weeks
- 2% new patients did not attend their first appointment.

Child and Adolescent Acute Inpatient Services

- In 2008, there were 16 CAMHS Acute Inpatient beds. By the end of 2017, there were 74 CAMHS Acute Inpatient beds
- In 2008, 25% of admissions of children were to CAMHS acute inpatient beds. By the end of 2017, 74% of admissions of children were to CAMHS acute inpatient beds
- 97% of the total bed days used by children who were admitted were in Child and Adolescent Acute Inpatient Units
- Of the 26% (82) admitted to Adult Approved Centres, 94% (77) were 16/17 years old with 45% (37) of these discharged either the same day or within 3 days and 74% (61) within a week.

Adult Acute Inpatient Mental Health Services

- There are 29 Adult Acute Inpatient units
- In line with national policy to enhance community services and reduce hospital admission in 2007, there were 16,293 admissions to acute units, in 2017, there were 12,155 admissions
- In 2007, there was a 72% re-admission rate; and in 2017 this rate reduced to 64%
- Median length of stay was 12 days.

CHAPTER ONE

Supporting the Delivery of Quality Mental Health Services

Mental Health Services consistently strive to develop and progress programmes of work to deliver on its priorities. This has included the development of the Project Management Office in Mental Health Services to drive service improvement nationally. A key feature of this work included vesting the Mental Health Division with full financial, operational and strategic responsibility for mental health services nationally; supported by a performance framework to inform decision making.

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

Mental Health Services remain challenged in providing detailed information about its service provision as the information systems in place are reliant on manual data collection processes and are very labour intensive. This limits the type of data provided, and creates challenges in respect of validation, verification and analysis. The Division is committed to providing ICT enabled solutions to meet its information and decision support requirements, and in the interim, it has established the Data Design and Optimisation Project to leverage the optimum information from the current information system.

Building on the success of the earlier reports which were published by the Child and Adolescent Mental Health Services up to 2013, the Division developed the reports, Delivering Specialist Mental Health Services 2014, 2015, 2016 and now 2017, with the objective of providing on overview of the work of the specialist mental health services, describing what the services do, detailing the resources available to the services and showing the activity of those services.

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

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

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

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

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

Overview

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

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

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

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

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

Strategic Direction of Mental Health Services

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

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

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

Accessing Specialist Mental Health Services

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

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

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

Community Mental Health Teams

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

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

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

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

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

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

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

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

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

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

CHAPTER TWO

National Mental Health
Clinical Programmes

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

There are currently five Mental Health Clinical Programmes:

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

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

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

Impact of the clinical programme in 2017

- A National Clinical Lead took up post in February 2017
- A review report of the National Clinical Programme was published in October 2017 following site visits' to each service
- The standard operating procedure (SOP) was revised and published
- Two training seminars were facilitated for CNS clinicians, the themes included needs of minority groups presenting with self-harm, patient feedback on service experience and new and emerging research. CPD points were awarded
- The data collected each month from each emergency department was refined with conjunction with ICT. An individual interactive data sheet was developed and will be in place from January 2018.

2. Early Intervention in Psychosis

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

- The early detection of psychosis (first episode and at risk mental state (ARMS)) through detailed assessment and engagement.
- The provision of standardised evidence based bio psychosocial interventions in a timely manner.

Model of Care

The National Working Group established in 2016, completed its draft report and submitted it to the Clinical Advisory Group of the College of Psychiatrists' of Ireland in September 2017.

Demonstration sites

The clinical programme secured funding to establish three demonstration sites for first episode psychosis across the country using "Hub and Spoke" structure. Mental Health Services were invited to submit applications in October 2017. It is expected that the services will be established in 2018.

Behavioural Family Therapy (BFT)

In 2017 monthly data was collected from individual services on the number of families offered Behavioural Family Therapy (BFT) and engaged in the process.

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

In October 2017 the National Clinical Programme for Early Intervention in Psychosis facilitated a one day conference titled *Implementing Behavioural Family Therapy in local services – the opportunities and challenges in Ireland*. The conference brought together over 120 people from service users, families members, voluntary agencies, academic institutions and clinicians in mental health services to reflect on the achievements to date and look forward to developments in family work.

The standard operating procedure for BFT was revised and published in October 2017.

Cognitive Behavioural Therapy for psychosis (CBTp)

A sub group was formed to draft a standard operating procedure for CBTp. The membership was based on clinical expertise in the area and across disciplines.

Individual Placement Support (IPS)

A sub group was formed to draft a standard operating procedure for IPS. The clinical programme further developed links with the Department of Employment and Social affairs and EmployAbility to advance the employment needs of young people with first episode psychosis.

Research Award

The National Clinical Programme was successful in its application for funding as part of the RCQPS research programme in July 2017. The research in partnership in University College Dublin will address how can mental health services and primary care best collaborate to enhance physical health outcomes among patients presenting with first episode of psychosis?

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

Model of Care

The MOC was completed and signed off by the HSE in December 2017. The MOC is a comprehensive and evidenced based road-map for the future development of HSE eating disorder service in Ireland. It includes recommendations for local and national delivery of ED treatment and care pathways, and outlines the resource implications. It will be officially launched in January 2018.

Eating Disorders Specialist Teams

Funding was received to commence recruitment of three specialist teams covering populations in excess of 500,000 based in Dublin (one adult and one CAMHS) and Cork.

Family based therapy: Building on the work of 2016, a supervision group network of 5 FBT groups was established. A clinical psychologist facilitates the groups and is receiving training as an FBT supervisor.

Cognitive behavioural therapy – enhanced (CBTE)

CBTE supervision structure provided via an external provider continued to be supported in 2017. A one day seminar was facilitated in November 2017 and approximately 100 clinicians attended from across all disciplines and services.

MARSIPAN (Management of Really Sick Inpatients with Anorexia Nervosa) training

Training was provided in Dublin and Cork in November 2017. Over 200 clinicians from mental health, acute adult hospitals, paediatrics and emergency medicine attended the training.

Bodywhys

The National Clinical Programme continued to partner with Bodywhys to deliver a 4 week family education programme called PiLaR. In 2017: 8 programmes were delivered and 178 people attended.

We commenced discussions to partner with UCC to develop pathways for GPs when assessing patients with eating disorders.

4. ADHD in Adults National Clinical Programme

The assessment and treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults was prioritised by the Health Service Executive (HSE) in conjunction with the College of Psychiatrists of Ireland (COPI) for development as a Clinical Programme. This was reflected in the HSE's Strategy in 2016.

Attention Deficit Hyperactivity Disorder (ADHD) in the European Consensus Statement on Diagnosis and Treatment of Adult ADHD is described as one of the most common psychiatric disorders of childhood. It occurs in 5% - 7% of children and persists into adulthood in 3.4% (Faraone 2005; Kessler 2006). The HSE set up a multidisciplinary Working Group including a nominee from HADD-ADHD Ireland to represent the perspective of adults with ADHD. It began its work in Autumn 2016.

Terms of Reference

The terms of reference of this Working Group are to design and develop a model of care for the strategic and operational delivery of services for adults with ADHD taking into consideration:

- The interests of adults aged 18 years and over
- Relevant national and international policy documents and reports
- Relevant national and international research, evidence based practice and standards.

Tasks completed in 2017 included

- A comprehensive literature review
- Review of existing Irish research
- The perspective of adults with ADHD in Ireland
- Invited presentations on:
  - The role of a specialist ADHD Occupational Therapist
  - ADHD specific cognitive behavioural therapy
  - The assessment process.

Model of Care

Based on the above, the first draft of the Model of Care for the National Clinical Programme has been circulated to the National Working Group for consideration and feedback will be incorporated into the second draft before submission to the College of Psychiatrists of Ireland and its ADHD in Adults Clinical Advisory Group. Its role is to ensure that what the Clinical Programme is recommending is in line with best evidenced based practice.

Actions undertaken

1. Forging links with ADHD Ireland and with other ADHD groups in the country
2. Clinical lead presented information to date at the National ADHD HADD-Ireland meeting in Trinity College
3. Submissions have taken place to HSE Mental Health for funding in 2016/2017. In this context the resources required to provide for assessment and treatment are estimated based as the proposed structure of service delivery. Programme for Government Funding of €1m was obtained in 2017
4. A data set to record activity has been drawn up. This has been piloted by the only public service in Ireland based in the Sligo-Leitrim Mental Health Service
5. Likewise data on treatment outcomes are being considered with the aim of including these as a routine part of data collection. This data will assist in evaluating the interventions that will be implemented by the Clinical Programme
6. Education and training required is also being actively explored.

This National Clinical Programme is addressing an important clinical service deficit. It is known that symptomatic ADHD in adults is associated with distress and functional impairments with life-long consequences for adults with ADHD, their families and partners. Given the now recognised positive impact of diagnosis and intervention, it will require funding but the government allocation in 2017 is indicative of commitment at the highest level to remedy this service deficit.

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

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

Scope of the program

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

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

Terms of Reference

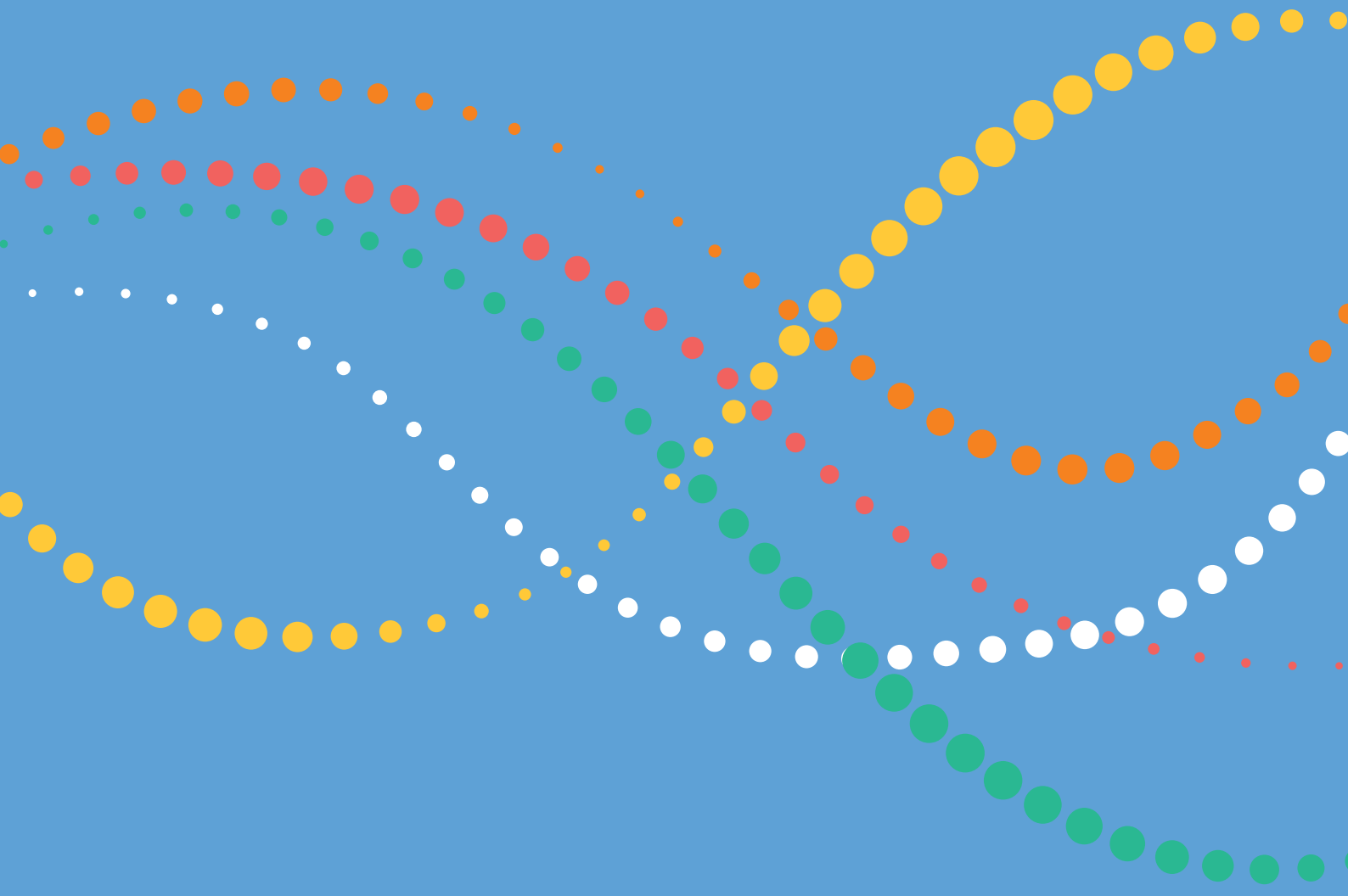
The aims of the Programme are to develop a standardised evidence based approach to the identification, assessment and treatment of people with both moderate to severe mental illness and substance use disorder.

Tasks completed in 2017 included

- Continue to lead the Working Group in designing a Model of Care for HSE Dual Diagnosis services based on international best practice – first meeting October 2017
- Establish links with other key clinical programmes and in particular Primary Care
- Commence scoping exercise on resource requirements and begin to define staff competencies and training requirements
- Commence work to define a core clinical outcome dataset.

CHAPTER THREE

Investing in Mental Health Services



This Chapter will provide an overview of the investment in mental health services including the additional allocations under the Programme for Government. Mental Health Services adopts a multi-year approach to budgeting the key aim of which is the delivery and development of safe and responsive services across the country, in line with the recommendations of VFC and with an increased use of an equitable evidence-based approach. The 2017 final budget for Mental Health, inclusive of 2012-2017 Programme for Government (PfG) funding was €869.7 million.

Between 2012 and 2017, €195m in ring-fenced new development funding was allocated under the PfG to invest in modern mental health services which are recovery focused and community- based. On a year-by-year basis, however, the HSE mental health budget has also been subject to restrictions which have applied to health expenditure generally, including downward adjustments for public service pay reductions and procurement savings similar to other HSE service areas. In addition, in 2013 and 2014 only, unspent development funds due to recruitment restrictions were used to meet unavoidable costs in other areas on a once-off basis only with all funds available on a recurring basis at the start of the next year. In total, taking account of the various movements, an additional €158.7million increase in the Mental Health budget is identified in the HSE Service Plans between 2012 and 2017 inclusive. It should be noted that minimal/no development funding has been re-directed to non-mental health services in 2015, 2016, 2017 and 2018 to date as underspends in PFG allocations were used towards other mental health related costs.

Net Mental Health Funding 2012 to 2017

NET MENTAL HEALTH FUNDING 2012 TO 2017

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

New Development Posts 2012 to 2017 (at February 2018)

NEW DEVELOPMENT POSTS 2012 TO 2017 (AT FEBRUARY 2018)

Type of Post	2012	2013	2014	2015	2016	2017	Total
New Development Posts:							
- Approved (WTE)	416	477	251	376	305	239	2,064
- Filled at Feb 2018 (WTE)	403	465	210	188	94	8	1,366
- % Filled at Feb 2018	97%	97%	83%	50%	31%	3%	66%

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

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

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

- 210 or 83% of the 251 development posts for 2014 have started. Over one third of the remaining unfilled posts are medical and remain difficult to recruit.

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

- 188 or 50% of the approximate 376 development posts for 2015 have started.

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

- 94 or 31% of the approximate 305 development posts for 2016 have started
- A further 134 posts relate to the Assistant Psychology in Primary Care initiative
- A further approximate 120 posts for Eating Disorders, the opening of new units, enhanced perinatal mental health services and specialist rehabilitation services have also been approved.

The 2017 PFG funding of €35m will fund the enhancement of mental health nursing capacity (€2m), provide for a recurring fund to continue to invest in the safety and compliance of mental health service infrastructure (€3m fund), considerably provide for out of hours service responses (€4.5m) as well as the further investment in community teams (€4.65m), in-patient services (€3m) and clinical programmes (€1m).

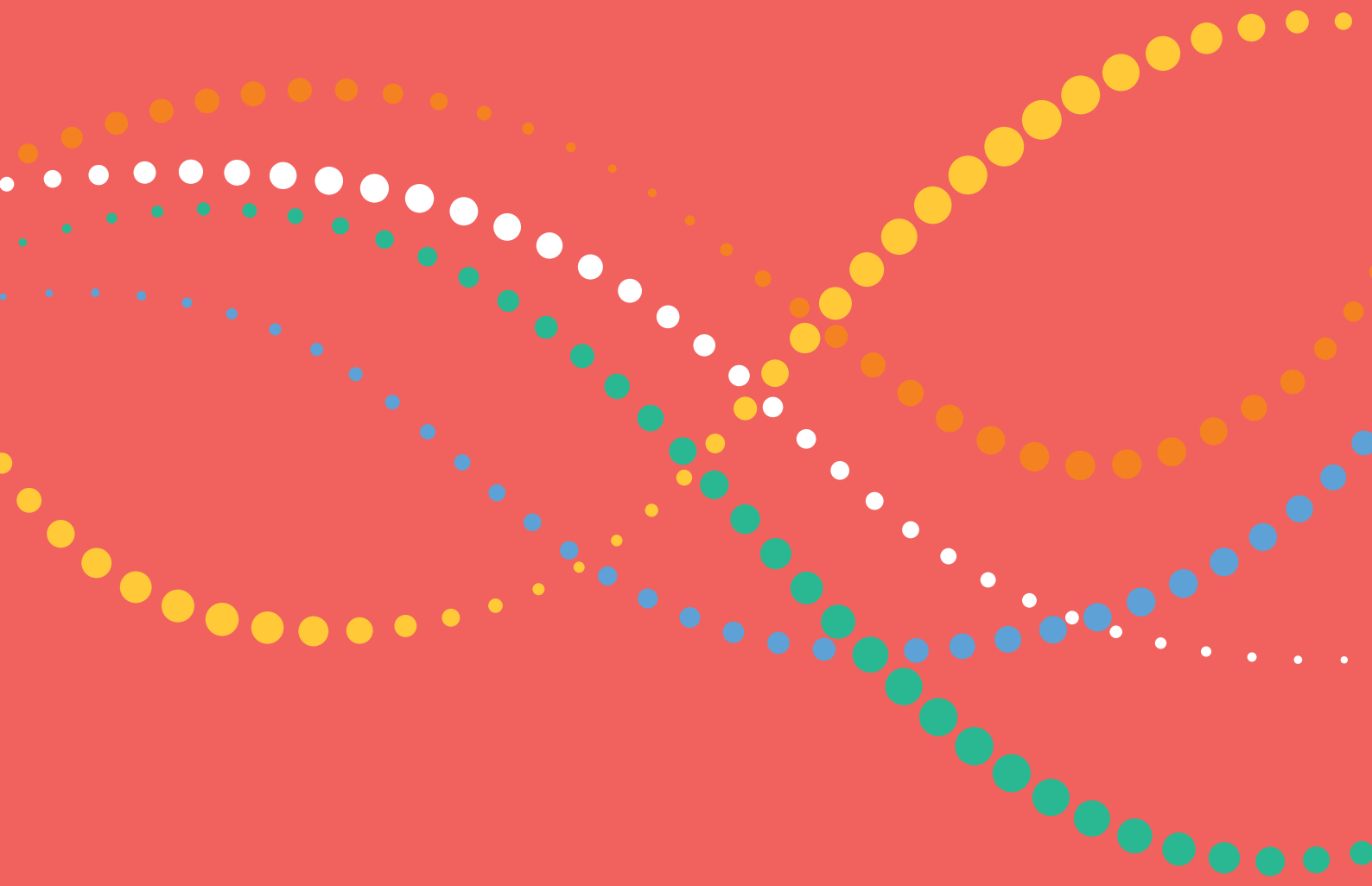
- 8 or 3% of the approximate 239 development posts for 2017 have started.

Allocation of Programme for Government Funding 2012 to 2017							
Funding Use	**2012 €**	**2013 €**	**2014 €**	**2015 €**	**2016 €**	**2017 €**	**Total €**
Service Staff for Community Teams, Specialist services and supports (in- patient below)	22,838,338	31,129,426	20,000,000	21,520,000	12,710,000	22,330,000	130,527,764
Counselling in Primary Care (CIPC)	5,000,000	2,465,299					7,465,299
National Office for Suicide Prevention & CFL	3,000,000	1,000,000		2,750,000	550,000		7,300,000
In Patient Capacity/Placements				6,330,000	8,970,000	4,170,000	19,470,000
Jigsaw & Limerick Youth Service & SHIP Counselling				3,200,000	5,300,000		8,500,000
Genio & Misc	2,102,662						2,102,662
Enhanced Teamworking	1,547,000						1,547,000
Advancing Recovery & Service User Engagement				1,000,000		1,000,000	2,000,000
Information Systems		405,275			1,500,000		1,905,275
Clinical Programs	402,000				270,000	1,000,000	1,672,000
Specialist Rehabilitation Services					3,000,000		3,000,000
Homeless funding					2,000,000	1,000,000	3,000,000
Stigma Reduction				200,000			200,000
Advocacy in Mental Health	110,000						110,000
Minor Works fund to meet compliance and safety requirements						3,000,000	3,000,000
Clinical Psychology Training & Post Graduate/Under Graduate Nursing					700,000	2,500,000	3,200,000
Total	35,000,000	35,000,000	20,000,000	35,000,000	35,000,000	35,000,000	195,000,000

2012–2017 Investment In Posts Specifically For Community Teams

Teams	2012 WTE	2013 WTE	2014 WTE	2015 WTE	2016 WTE	2017 WTE	Total WTE
General Adult Community Mental Health Teams	254	180	38	88	-	123	683
Child and Adolescent Community Mental Health Teams	150	80	53	42	21	33	379
POA Community Mental Health Teams	-	100	25	30	-	4	159
MHID Community Mental Health Teams	-	40	24	41	-	4	109
Forensic Teams (In-reach, MHID and CAMHS)	-	28	-	39	-	11	78
Homeless MH Teams	-	-	7	-	-	15	22
Liasion Teams	-	-	10	5	-	-	15
In-Patient & Continuing Care	-	-	-	31	100	23	154
Primary Care Assistant Psychology Under 18s	-	-	-	-	134	-	134
Mental Health Engagement	-	-	-	-	18	-	18
Physical Health	-	-	-	8	-	8	16
Traveller Mental Health	-	-	-	9	-	-	9
Peer Support	-	-	-	-	20	-	20
Transgender funding						2	
Clinical Programmes	-	-	-	32	-	15	47
ICT/E-Rostering	-	-	-	23	10	-	33
Sub Total	404	428	157	348	303	237	1,876
National Support/NOSP/CFL	12	49	94	28	2	2	187

CHAPTER FOUR
Mental Health
Workforce



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

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

Child and Adolescent Mental Health Services Workforce

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

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

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

A survey of the staffing of the Child and Adolescent Mental Health Services including Community CAMHS teams, Day service programmes, Hospital Liaison teams, and Inpatient services was carried out at various stages in 2017. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in CAMHS services in 2017 was 940.70.

Vision for Change Recommendations v. Actual Staffing (2017)

CAMHS Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2017
Staff Community MHTs	1 : 50,000	79	69	1,238	677.28
Adolescent Day Service Teams		16	4*		22.74
Hospital Liaison MHTs	1 : 300,000	16	3	208	33.16
Total		111	76	1,446	733.19
Inpatient Services				4 Units	207.51
				Total Staff	940.70

**Dunfillan Young Person's Unit is located at the St. John of God Lucena clinic in Rathgar: This Adolescent Day service was fully operated up until September 2017 and after this date for operational reasons some staff were reallocated within the St. John of God's Community Child & Adolescent Services. The current service is focused on delivering an Eating Disorder Programme, Cognitive Behavior Therapy and OT interventions. It is hoped the full acute day hospital service will resume in mid - 2018. Staff for this not recorded under Day service totals.*

Staffing of CAMHS Acute Inpatient Units

The total number of staff at the four inpatient units was 207.51 (December 2017). The table below shows the breakdown of the inpatient staffing by profession between 2013 and 2017.

Staffing of Child and Adolescent Inpatient Units by profession 2013-2017

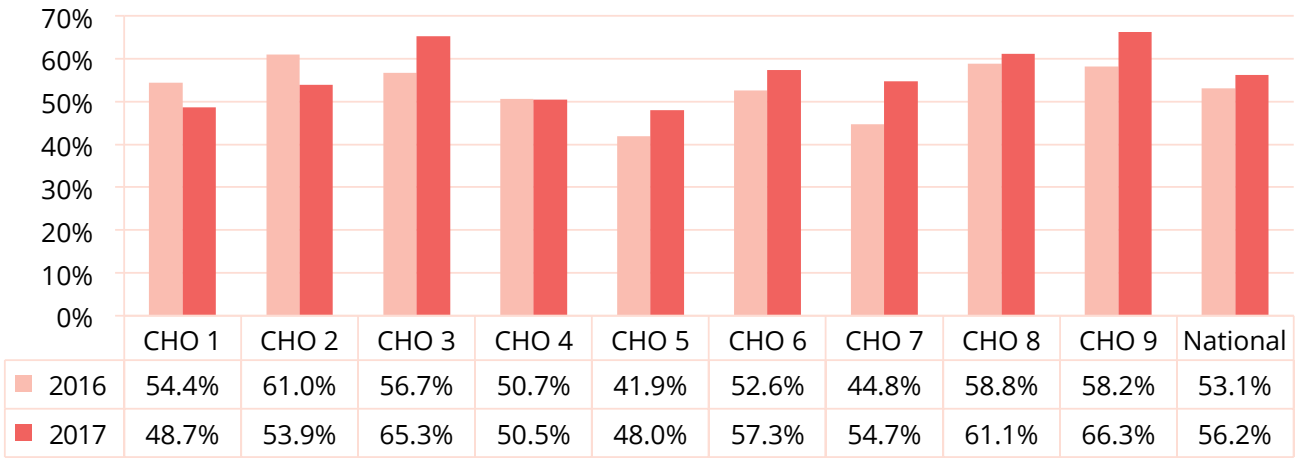
	2013	2014	2015	2016	2017
Consultant Psychiatrist	5.75	5.10	6.00	6.40	6.40
Senior Registrar	4.00	3.00	4.00	2.50	4.00
Registrar/SHO	3.80	3.00	4.00	9.50	7.00
Director of Nursing	2.00	1.00	1.00	1.50	3.00
Assistant Director of Nursing / CNM III	5.70	2.70	4.70	4.20	6.70
CNM II	6.90	6.00	12.00	11.00	12.00
CNM I	8.50	7.50	7.50	7.50	8.00
Clinical Nurse Specialist	2.00	2.00	2.50	3.50	3.00
Staff Nurse	78.08	94.00	84.50	84.50	90.00
Clinical Psychologist	4.50	4.00	3.81	6.61	6.41
Occupational Therapist	2.90	4.30	2.80	4.30	4.20
Speech and Language Therapist	3.00	2.70	2.90	2.30	1.00
Social Worker	4.31	6.30	6.20	6.30	6.80
Childcare Worker	2.00	1.00	1.00	2.00	2.00
Dietician	0.80	1.70	1.20	1.70	2.10
Physiotherapy	0.00	0.00	0.30	0.00	0.00
Other Therapist	0.00	0.00	0.00	0.00	0.00
Administrative Support staff	7.60	7.75	7.75	6.50	8.50
Non-Nursing Care Assistant/Multi Task Attendant	7.50	9.00	9.00	11.00	11.00
Non-Nursing Chef (Household)	1.00	1.00	1.00	1.00	1.00
Non-Nursing Catering Assistant	4.19	2.50	5.19	5.69	3.00
Non-Nursing Driver/Porter	2.00	2.00	2.00	4.00	4.00
Teaching Staff	7.00	4.00	10.00	11.30	12.30
Teaching Support Staff	2.00	2.00	2.00	3.60	3.60
Other Staff	0.40	0.00	2.00	2.40	2.00
Total	165.93	172.55	183.35	199.30	207.51

Staffing of CAMHS Community Mental Health Teams

In Ireland, 25% of the population is under 18 years of age and in December 2017 there was a total of 677.3 staff in the Child and Adolescent Community Mental Health Teams nationally (589.14 Clinical). This represents 56.2% of the clinical staffing levels recommended in A Vision for Change which is an increase of 3% nationally on the 2016 position. The largest increase was in CHO 7 at 10%.

In the period from 2011 to 2017, arising from the Programme for Government investment in CAMHS services from 2012, staffing in the community CAMHS teams had a net gain of 213.07 whole time equivalents over this period, exclusive of staff leaving and retiring etc.

Community CAMHS Teams Staffing vs. VFC recommendations in 2016 – 2017

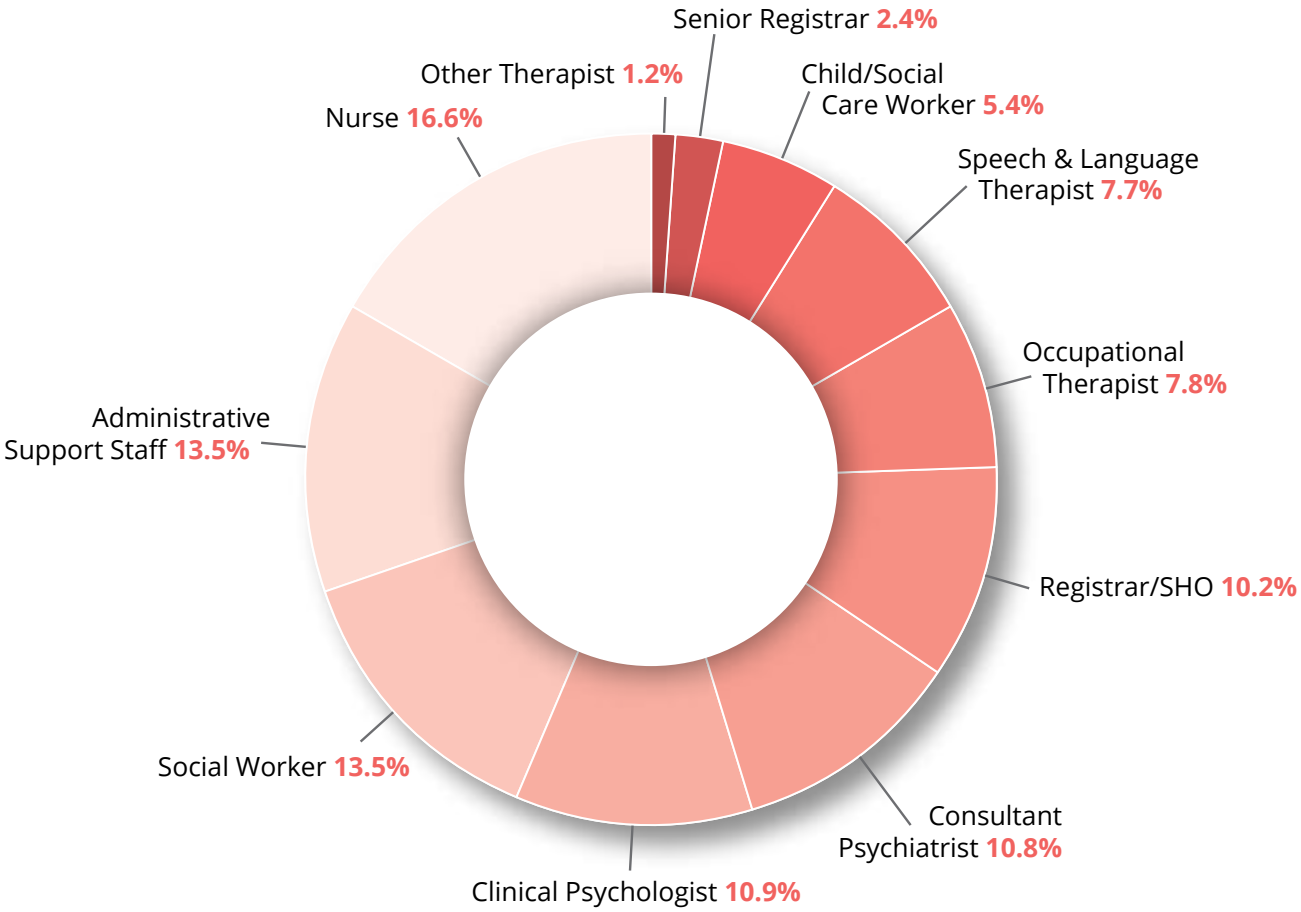


	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2016	54.4%	61.0%	56.7%	50.7%	41.9%	52.6%	44.8%	58.8%	58.2%	53.1%
2017	48.7%	53.9%	65.3%	50.5%	48.0%	57.3%	54.7%	61.1%	66.3%	56.2%

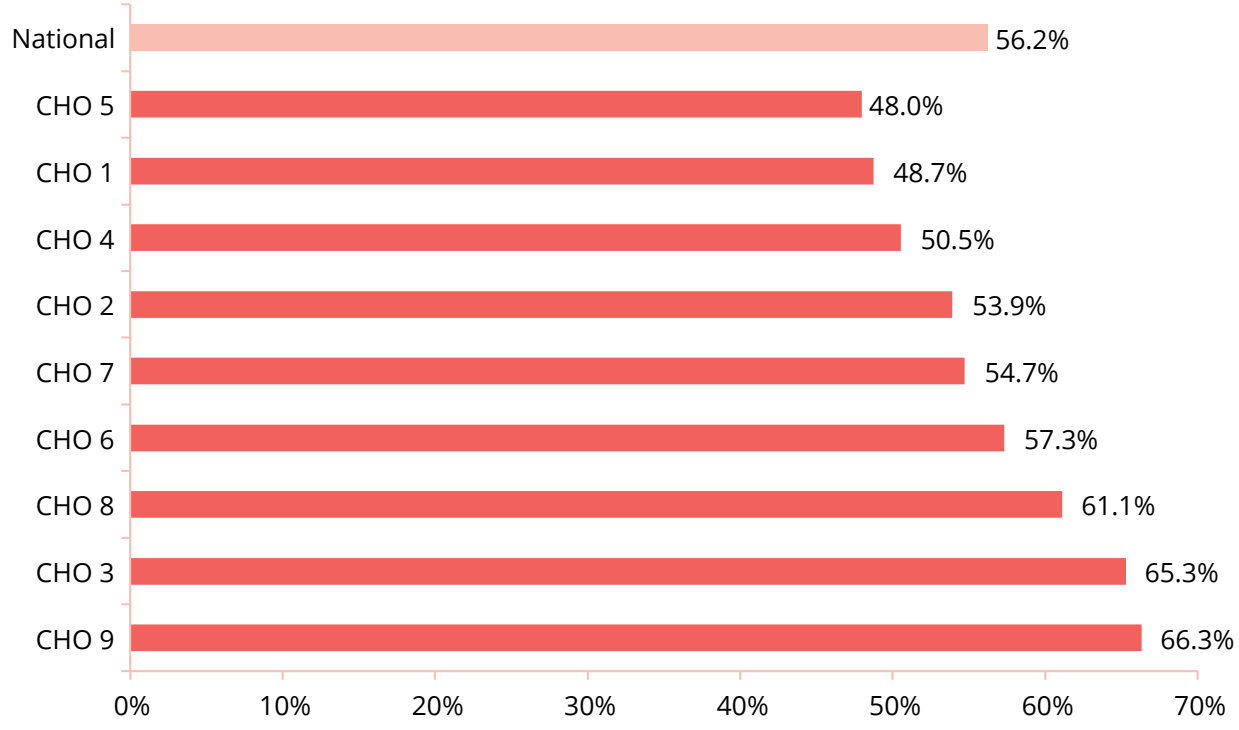
In December 2017, there was 677.3 staff (clinical 589.14) working in 69 Community CAMHS teams, with an average of 9.82 staff, 8.54 of which were clinical staff. The range of team size varies from the smallest team of 5 (4 clinical) to the largest which comprises of 15.3 (14.3 clinical). The variation in team size can arise due to team development or population size etc.

	2011	2012	2013	2014	2015	2016	2017	Change +/-
Consultant Psychiatrist	57.69	60.44	60.37	65.39	64.15	68.2	72.9	15.16
Senior Registrar	19.8	20.6	10.4	13.30	10.70	13.2	16.3	-3.49
Registrar/SHO	43.49	45.2	47.03	48.58	59.52	67.0	69.3	25.79
Social Worker	68.01	67.29	72.09	76.47	77.60	78.5	91.6	23.58
Clinical Psychologist	57.78	57.78	55.75	61.61	66.54	68.8	74.0	16.22
Nurse	61.33	59.64	68.77	88.37	98.27	105.4	112.2	50.91
Occupational Therapist	26.7	25.72	50.53	47.99	52.19	50.9	52.7	25.96
Speech & Language Therapist	29.22	29.72	46.14	51.61	42.61	50.6	52.1	22.84
Child/Social Care Worker	15.74	12.74	33.54	41.35	41.13	39.5	36.9	21.15
Other Therapist	9	6.45	6.6	5.70	8.70	13.7	11.3	2.26
Administrative Support Staff	75.48	76.36	80.54	79.83	82.54	87.6	88.2	12.67
Total	464.24	461.94	531.76	580.20	603.95	643.50	677.29	213.05

Community Child & Adolescent workforce by profession 2017



Community CAMHS Teams Staffing vs. VFC recommendation by Community Healthcare Organisations 2017



Staffing of CAMHS Day Services and CAMHS Liaison Teams

Each of the three Dublin paediatric hospitals have a liaison team and the total number of staff on these teams is 33.16 (clinical 27.66).

There are two adolescent day services in Dublin and one in Galway with a total staff of 22.74 (clinical 18.66).

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

Staffing of Day Services and Liaison Teams

Dec-17	Day Service	Paediatric Hospital Liaison	Total
Medical	5.00	9.56	14.56
Nursing	6.80	6.80	13.60
Health Care Professional	6.06	11.30	17.36
Support Staff	4.88	5.50	10.38
Total	22.74	33.16	55.90

1. This service was fully operated up until September 2017 and after this date for operational reasons some staff were reallocated within the St. John of God's Community Child & Adolescent Services. The current service is focused on delivering an Eating Disorder Programme, Cognitive Behavior Therapy and OT interventions. It is hoped the full acute day hospital service will resume in mid - 2018. Staff for this service is not recorded under Day service totals.

Staffing of Community General Adult Mental Health Services

A survey of the staffing of community general adult mental health teams was carried out in December 2017. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 1,713.59

Vision for Change recommendations – actual staffing (2017)

Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2017
Staff Community MHTs	1 : 50,000	95	114	2,185	1,714

Community GAMHT staffing compared against Vision for Change recommendations

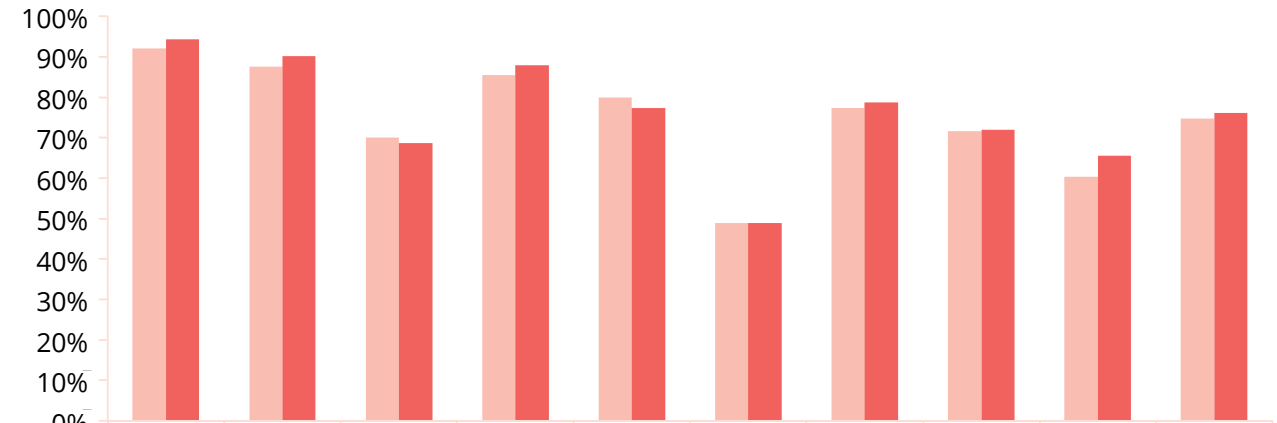
Vision for Change (2006) recommends that there should be one General Adult Community Mental Health Team for each sector of 50,000 population with individual General Adult Community Mental Health Team comprising of the following:

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

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

In December 2017 there was a total of 1,713.59 staff in situ (1,521.69 Clinical), which represents 78.2% (76.1% clinical) of the staffing levels recommended in a Vision for Change.

Community GAMHS Teams Clinical Staffing vs. VFC recommendations for 2016 - 2017



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2016	92.1%	87.5%	70.1%	85.4%	79.9%	48.8%	77.3%	71.5%	60.4%	74.8%
2017	94.3%	90.2%	68.6%	87.9%	77.4%	48.9%	78.8%	72.0%	65.5%	76.1%

In 2017 the clinical staffing level as recommended in a Vision for Change had increased by 1.3% nationally on the 2016 position. The largest increase was in the CHO 9 which was 5.1%

Community General Adult Mental Health teams

In the period from December 2016 to December 2017, the clinical staff of the Community General Adult Mental Health Teams increased by 26.42. Variations in staffing numbers can occur due to staff retiring and or changing role and the posts can remain unfilled due to various factors including shortage of qualified applications etc.

Community General Adult Mental Health Teams (2016 to 2017)

	Clinical Staff 2017	Clinical Staff 2017	Change +/- 2017
CHO 1	156.10	152.58	3.53
CHO 2	171.57	166.52	5.05
CHO 3	110.96	113.37	-2.42
CHO 4	254.87	247.75	7.12
CHO 5	165.91	171.25	-5.34
CHO 6	91.54	91.42	0.12
CHO 7	213.5	209.5	4.00
CHO 8	186.34	185.18	1.16
CHO 9	170.90	157.7	13.20
Total Clinical	1,521.69	1,495.27	26.42
Admin/support	191.90	211.49	-19.59
Total Staff	1,713.59	1,706.76	6.83

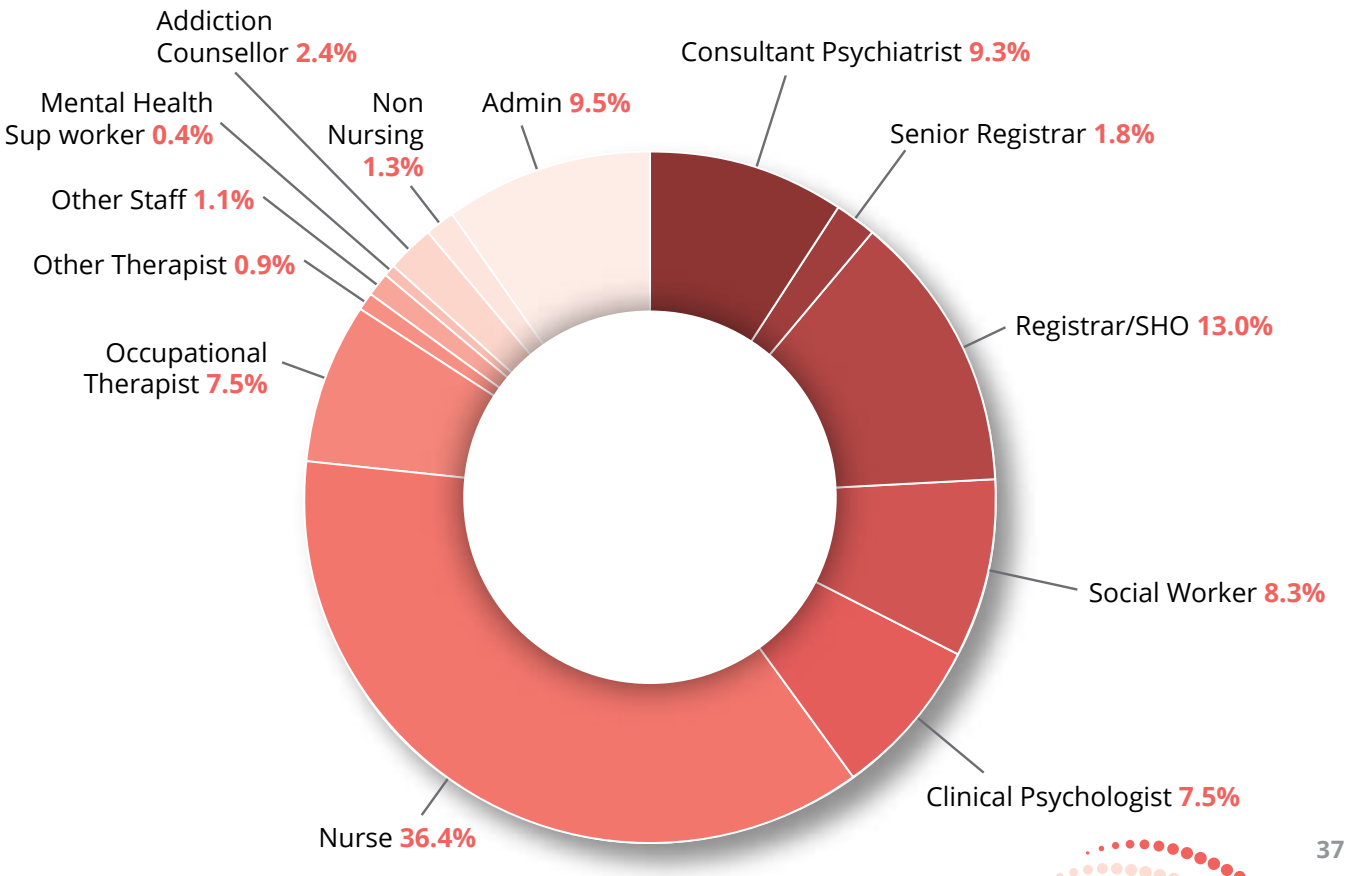
In December 2017 there was 1,713.59 staff (clinical 1,521.69) working in 114 Community General Adult Mental Health teams, with an average of 15.03 staff per team, of which 13.35 were clinical staff.

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

Community General Adult Mental Health Teams Staffing by discipline 2013 to 2017

	2013	2014	2015	2016	2017	Change +/-
Consultant Psychiatrist	157.34	157.92	159.97	155.64	159.1	1.79
Senior Registrar	35.40	35.30	30.43	41.23	31.6	-3.82
Registrar/SHO	203.60	208.31	217.60	212.6	223.3	19.70
Social Worker	138.11	132.99	148.73	139.18	141.4	3.27
Clinical Psychologist	110.72	126.26	132.39	128.75	128.7	17.94
Nurse	604.21	613.13	648.92	621.58	623.2	18.99
Occupational Therapist	116.05	123.76	124.48	112.55	128.0	11.90
Other Therapist e.g. SLT Creative/Recreational	12.98	14.58	15.92	14.69	13.6	0.58
Other Staff	14.28	17.78	16.33	16.43	18.5	4.20
Mental Health Support Worker	15.30	17.00	7.00	9.00	13.0	-2.30
Addiction Counsellor	48.58	46.00	46.02	43.62	41.5	-7.13
Non Nursing	32.32	35.61	43.80	40.50	21.8	-10.57
Administrative Support Staff	146.08	159.71	166.79	170.99	170.2	24.07
Total	1,634.97	1,688.35	1,758.38	1,706.76	1,700.59	65.62

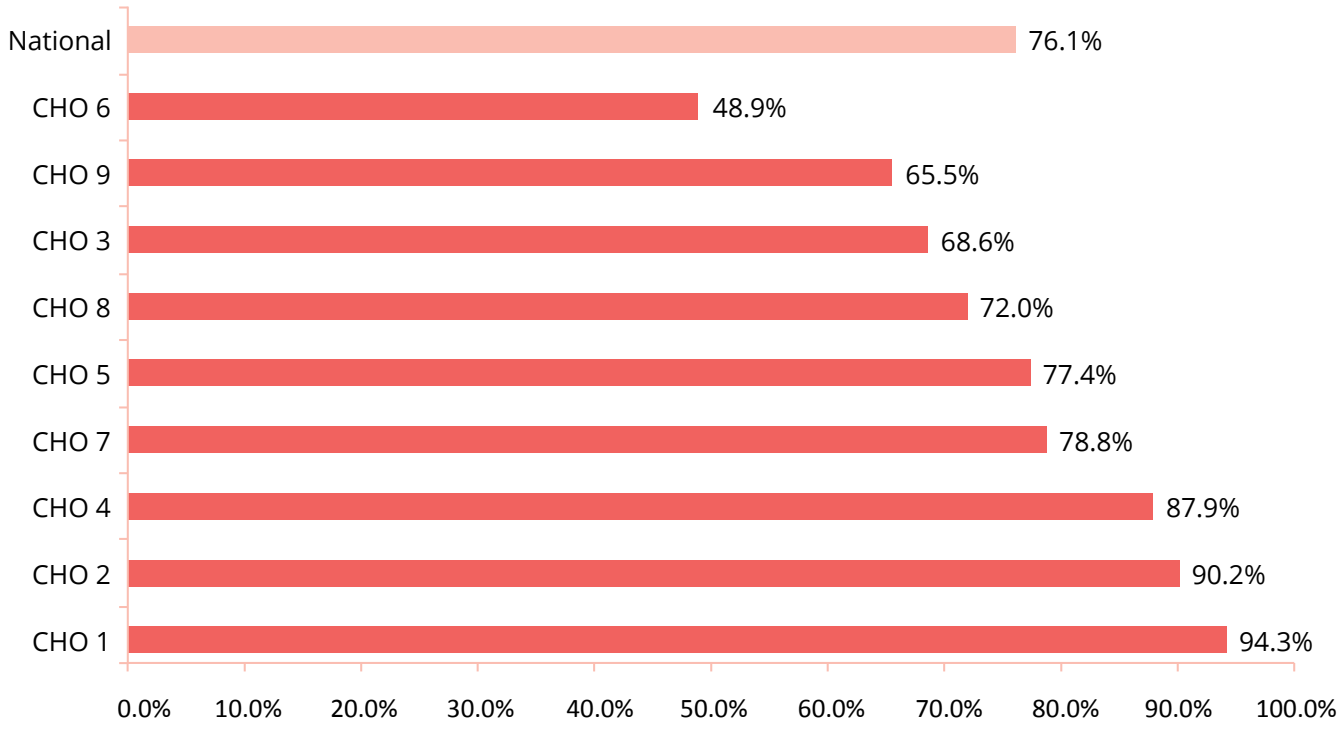
Community GAMHT work force by profession (2017)



Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2016-2017

	Population Census 2016	Clinical Staff 2017	% of VFC rec 2017	Clinical Staff 2016	% of VFC rec 2016
CHO 1	394,333	156.10	94.3%	152.58	92.1%
CHO 2	453,109	171.57	90.2%	166.52	87.5%
CHO 3	384,998	110.96	68.6%	113.37	70.1%
CHO 4	690,575	254.87	87.9%	247.75	85.4%
CHO 5	510,333	165.91	77.4%	171.25	79.9%
CHO 6	445,59 0	91.54	48.9%	91.42	48.8%
CHO 7	645,293	213.50	78.8%	209.5	77.3%
CHO 8	616,229	186.34	72.0%	185.18	71.5%
CHO 9	621,405	170.90	65.5%	157.7	60.4%
National	4,761,865	1,521.69	76.1%	1,495.27	74.8%

Community GAMHS Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2016 - 2017



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

A survey of the staffing of Psychiatry of Later Life (POLL) was carried out in December 2017. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 343.86

Vision for Change recommendations – actual staffing (2017)

Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2017
Staff POA service	1 : 100,000*	48	30	571	343.86

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

Currently there are 30 POLL community teams (December 2017) with a number of teams in development which have been resourced from the Programme for Government investments in recent years. The plan is to move to full resourcing of POLL services which will ensure national coverage.

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

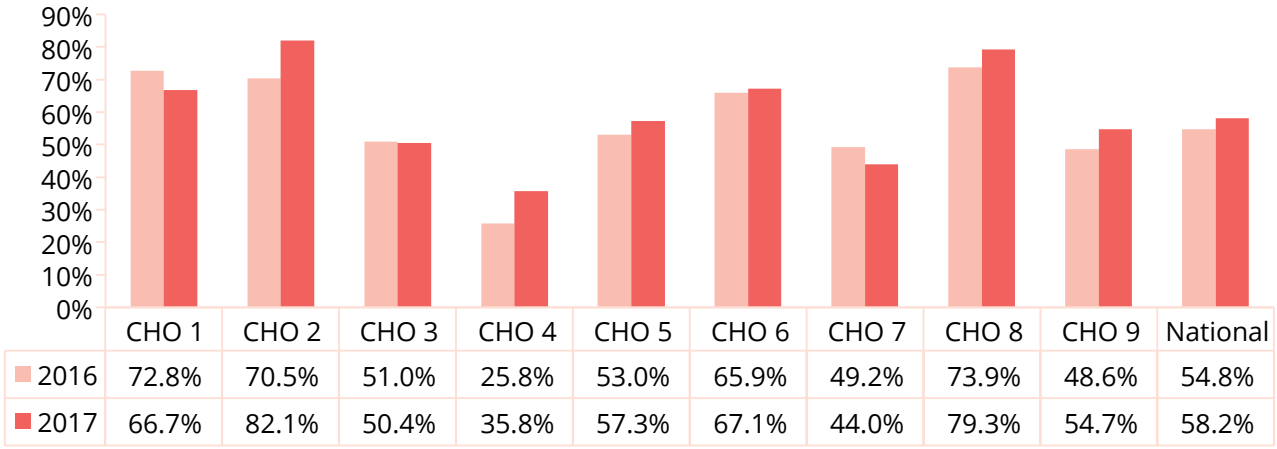
A Vision for Change (2006) recommends that there should be one Psychiatry of Later Life Service team for each sector of 100,000 population. The staff complement for a Psychiatry of Later Life team is 12 per 100,000 head of population, (11 clinical and 1 administrative support staff) and is comprised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

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

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

In December 2017, there were 343.86 staff (clinical 304.77) working in 30 Psychiatry of Later Life Service teams, with an average of 11.46 staff (of which 10.12 were clinical staff) per team. This represents 60.2% (58.2% clinical) of the staffing level as recommended in a Vision for Change.

Community POLL Team Staffing vs. VFC recommendations in 2016 - 2017



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2016	72.8%	70.5%	51.0%	25.8%	53.0%	65.9%	49.2%	73.9%	48.6%	54.8%
2017	66.7%	82.1%	50.4%	35.8%	57.3%	67.1%	44.0%	79.3%	54.7%	58.2%

In 2017 the staffing level as recommended in a Vision for Change had increased by 3.4% nationally on the 2016 position. The largest increase was in the CHO 2 which saw an increase of 11.6%

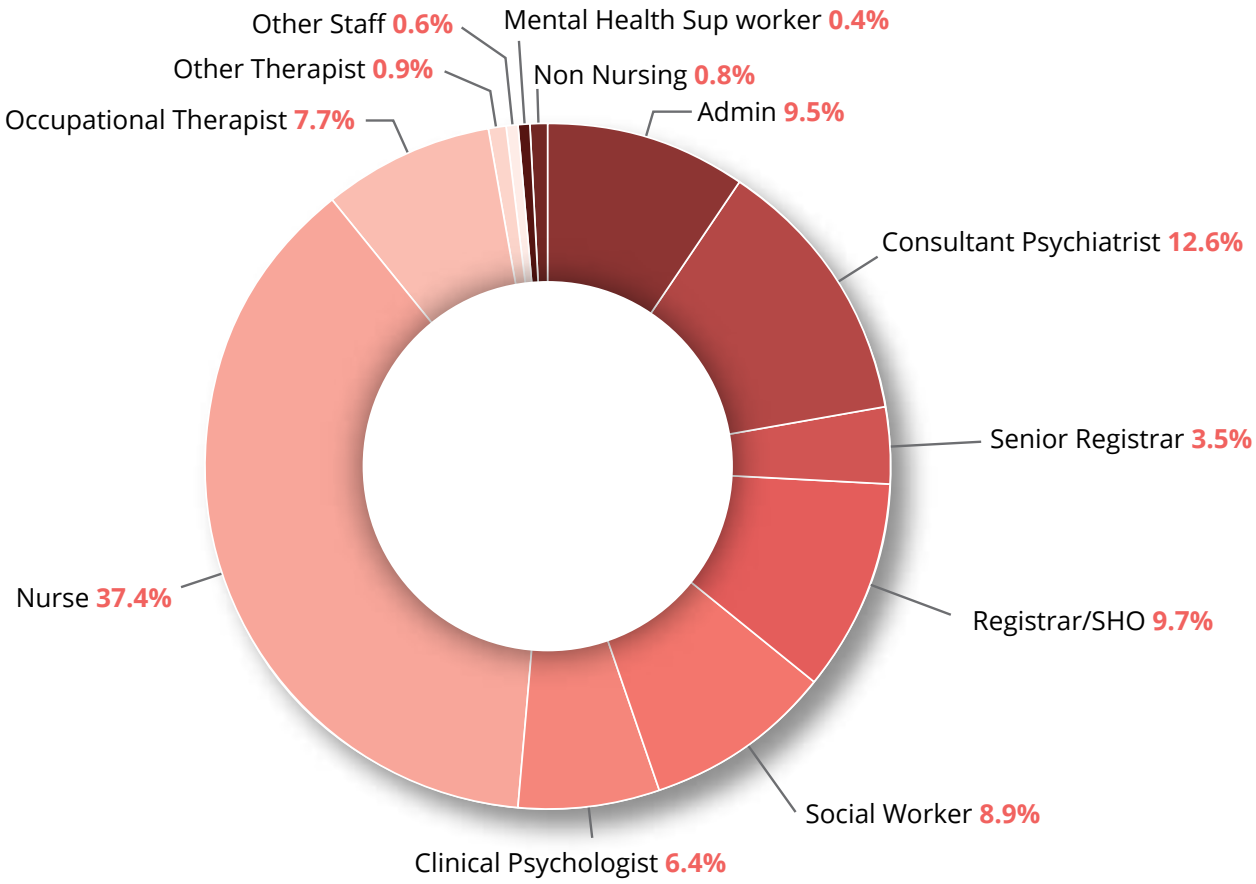
Psychiatry of Later Life Service Teams

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

Psychiatry of Later Life Service Teams (2016 to 2017)

	Clinical Staff 2017	Clinical Staff 2016	Change +/-
CHO 1	32.9	35.90	-3.00
CHO 2	46.2	39.70	6.50
CHO 3	23.16	23.40	-0.24
CHO 4	29.03	20.90	8.13
CHO 5	34.96	32.40	2.56
CHO 6	28	27.50	0.50
CHO 7	30	33.50	-3.50
CHO 8	48.32	45.00	3.32
CHO 9	32.2	28.60	3.60
Total Clinical	304.77	286.90	17.87
Admin/support	39.1	37.8	1.29
Total	343.86	324.70	19.16

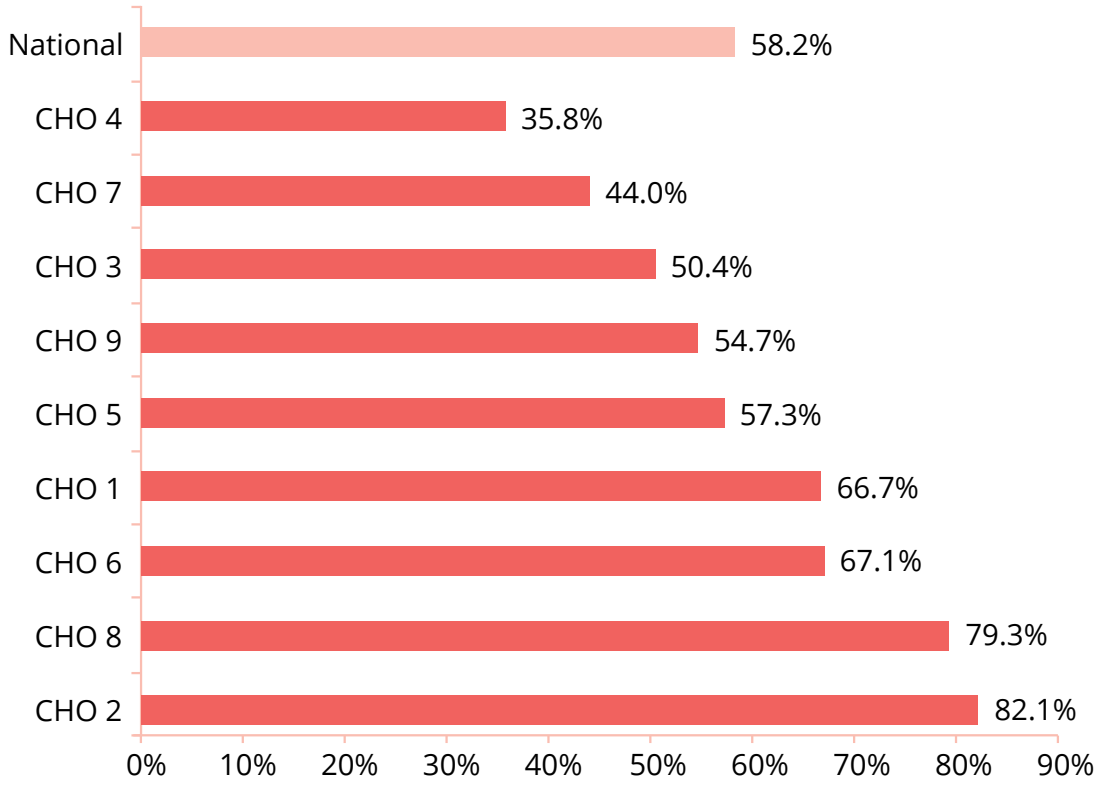
Psychiatry of Later Life Service Workforce by discipline (2017)



Psychiatry of Later Life Service Staffing by discipline 2013 to 2017

	2013	2014	2015	2016	2017	Change +/-
Consultant Psychiatrist	32.30	36.30	36.95	40.2	43.5	11.19
Senior Registrar	10.00	11.00	10.55	15	12.0	2.00
Registrar/SHO	27.00	26.00	26.50	32	33.4	6.39
Social Worker	16.00	25.00	26.90	26.8	30.7	14.67
Clinical Psychologist	10.85	16.50	17.80	22.1	22.0	11.10
Nurse	102.12	114.83	119.12	123.3	128.6	26.50
Occupational Therapist	20.32	24.22	23.27	23	26.6	6.31
Other Therapist e.g. SLT Creative/Recreational	1.20	2.00	1.30	1.6	3.2	1.96
Other Staff	1.00	0.88	2.63	1.9	2.0	1.03
Mental Health Support Worker	3.00	3.00	1.00	1	2.8	-0.17
Addiction Counsellor	0.40	0.40	0.20	0	0.0	-0.40
Non Nursing	3.29	6.32	2.91	2.9	2.9	-0.38
Administrative Support Staff	30.31	35.24	33.41	34.9	36.2	5.87
Total	257.79	301.69	302.54	324.70	343.86	86.07

POLL Team Staffing vs. VFC recommendation by Community Healthcare Organisations 2017



CHAPTER FIVE

Child and Adolescent
Mental Health Services

Key Facts

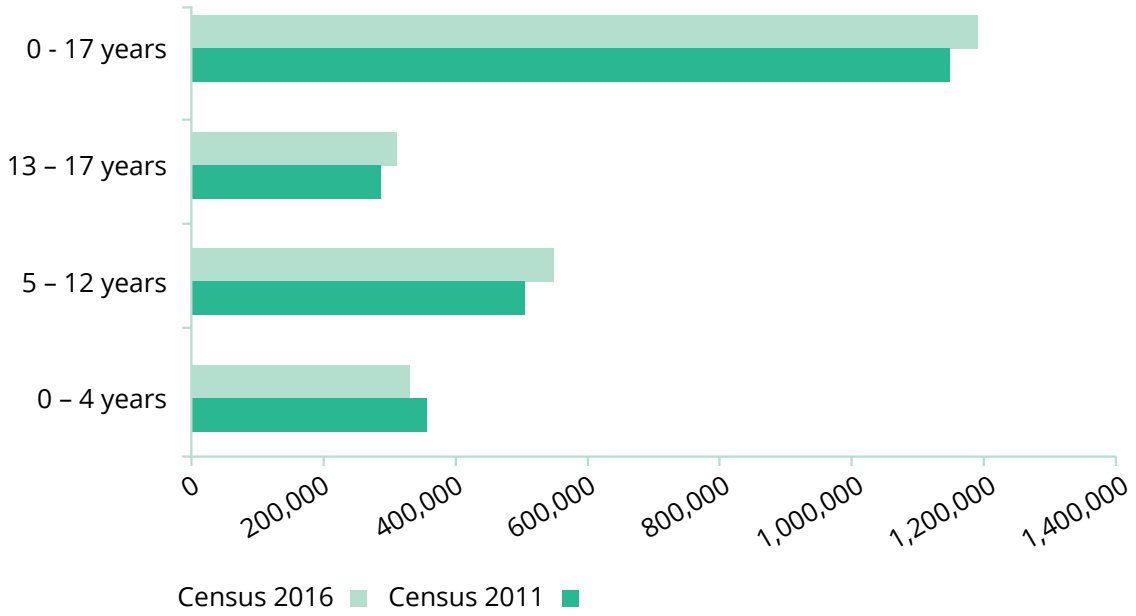
- 2008 - 49 CAMHS teams; 2017 – 69 CAMHS Teams
- 2008 – 351.63 Clinical WTE's; 2017 – 589.14 Clinical WTE's
- 56.2% of the Clinical staffing levels recommended in A Vision for Change
- -4% decrease in referrals accepted from 2016 to 2017
- 11,498 new appointments offered in 2017
- 48.8% new appointments seen within 4 weeks
- A quarter of new cases seen are aged over 16 years
- 10.4% of new patients did not attend their first appointment
- 2007 – 3,609 individuals were waiting to be seen; 2017 – 2,419 individuals were waiting to be seen.

Children in the Population

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

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

2016 & 2011 Census by Age



2016–2011 Census by Age

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

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

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

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

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

2016 Census by Age 0 – 17 years by CHO Area

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

Prevalence of Childhood Psychiatric Disorders

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

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

1 in 10 children and adolescents suffer from mental disorders that are associated with "considerable distress and substantial interference with personal functions" such as family and social relationships, their capacity to cope with day-to-day stresses and life challenges, and their learning.

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

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

Children Attending CAMHS

The total population under 18 years in the 2016 census was 1,190,502 and in Quarter 3 of 2017 the number of active open cases recorded by CAMHS Community Mental Health Teams was 18,462 or 1.6% of the child population nationally.

Number of children attending CAMHS by year and CHO

	2017		2016		2015	
	Q1	Q3	Q1	Q3	Q1	Q3
CHO 1	1,782	1,645	1,973	1,842	2,109	1,947
CHO 2	2,437	2,441	2,328	2,291	2,324	2,232
CHO 3	2,258	2,527	2,380	2,366	2,351	2,399
CHO 4	2,376	2,309	2,412	2,447	2,266	2,208
CHO 5	1,499	1,459	1,538	1,562	1,572	1,544
CHO 6	3,145	2,908	3,274	3,150	3,363	2,801
CHO 7	2,136	2,005	1,870	1,955	2,408	2,106
CHO 8	1,541	1,864	1,905	1,814	1,657	1,760
CHO 9	1,467	1,304	1,518	1,461	1,711	1,584
National	18,641	18,462	19,198	18,888	19,761	18,581

Percentage of CHO Population under 18 years old attending CAMHS 2017

	<18 years Population	Caseload 2017	Percentage
CHO 1	103,778	1,645	1.6%
CHO 2	111,880	2,441	2.2%
CHO 3	96,266	2,527	2.6%
CHO 4	168,542	2,309	1.4%
CHO 5	131,522	1,459	1.1%
CHO 6	116,264	2,908	2.5%
CHO 7	144,296	2,005	1.4%
CHO 8	172,373	1,864	1.1%
CHO 9	145,581	1,304	0.9%
National	1,190,502	18,462	1.6%

Referral Process and Criteria for Child and Adolescent Mental Health Services

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

The referral criteria to Community CAMHS are as follows:

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

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

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

The Referring Agents are:

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

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

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

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

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

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

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

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

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

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

Access to Child and Adolescent Community Mental Health Services

In 2017, there were 12,988 referrals accepted by the Community Child and Adolescent Mental Health service which is a - 4% decrease on 2016. In the period from 2012, the number of referrals accepted has increased overall by 21% nationally.

Referrals accepted 2012 – 2017

	2017	2016	+/- Variance 16 vs. 17	2015	+/- Variance 15 vs. 17	2014	+/- Variance 14 vs. 17	2013	+/- Variance 13 vs. 16	2012	+/- Variance 12 vs. 16
CHO 1	837	957	-13%	1,026	-18%	1,005	-17%				
CHO 2	1109	1,049	6%	1,064	4%	1,035	7%				
CHO 3	1994	1,941	3%	1,813	10%	1,866	7%				
CHO 4	1466	1,566	-6%	1,578	-7%	1,539	-5%				
CHO 5	1210	1,458	-17%	1,502	-19%	1,283	-6%				
CHO 6	1604	1,639	-2%	1,625	-1%	1,670	-4%				
CHO 7	1689	1,688	0%	1,694	0%	1,955	-14%				
CHO 8	2093	2,094	0%	1,881	11%	1,642	27%				
CHO 9	986	1,107	-11%	1,173	-16%	1,067	-8%				
National	12,988	13,499	-4%	13,356	-3%	13,062	-1%	12,319	5%	10,705	21%

Length of time waiting to be seen

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

At the end of December 2017, 1,162 individuals were expected to be seen within three months and a further 1,257 individuals were on the waiting list. This represented a decrease of 94 (-4%) from the total number of 2,513 waiting at the end of 2016.

In the context of an overall 21% increase in the number of referrals accepted, between 2012 and 2017, the Child and Adolescent Mental Health Service waiting list has remained static decreasing by 3 cases since 2012.

At the end of 2017 there were 2,419 cases waiting to be seen. This is a decrease of 94 cases on the same period in 2016. Those waiting over 12 months rose by 102 to 320 in 2017. The Mental Health Services set up a CAMHS Waiting List Initiative to focus on reducing waiting lists with a particular focus on those waiting >12 months. The CHOs with individuals waiting over 12 months are taking focused actions to ensure no child is waiting more than 12 months. However these increases are attributed to the challenges presented by the increase in population, increase in referrals, staffing retention and challenges in recruiting.

Length of Wait time by CHO - December 2016 vs. December 2017

	2017						2016					
	0-3 months	3-6 months	6-9 months	9-12 months	12+ months	TOTAL	0-3 months	3-6 months	6-9 months	9-12 months	12+ months	TOTAL
CHO 1	118	36	27	12	10	203	123	73	72	61	93	422
CHO 2	33	2	1	0	0	36	23	5	3	2	2	35
CHO 3	91	59	41	21	43	255	120	53	50	31	30	284
CHO 4	196	103	118	115	205	737	231	112	110	70	75	598
CHO 5	81	26	19	11	3	140	87	46	11	1	0	145
CHO 6	264	56	23	28	2	373	236	81	48	1	0	366
CHO 7	169	39	24	8	1	241	170	34	6	0	0	210
CHO 8	137	42	25	43	52	299	144	70	40	9	1	264
CHO 9	73	23	25	10	4	135	100	38	19	15	17	189
National	1,162	386	303	248	320	2,419	1,234	512	359	190	218	2,513

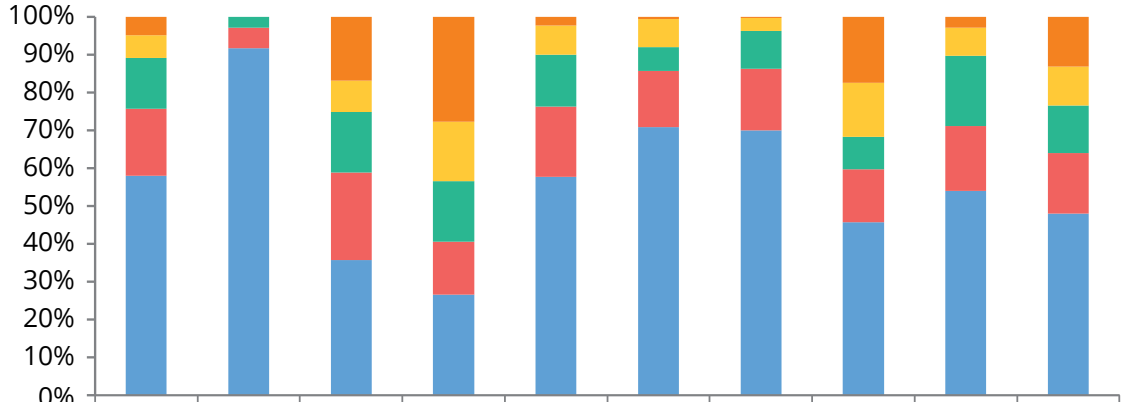
Referrals Accepted Trend vs. Waiting List trend

Referrals accepted		+/- Trend on previous year	Wait List	+/- Trend on previous year
2011	8,663		1,983	
2012	10,705	24%	2,422	22%
2013	12,319	15%	2,602	7%
2014	13,062	6%	2,869	10%
2015	13,356	2%	2,319	-19%
2016	13,499	1%	2,513	8%
2017	12,988	-4%	2,419	-4%
2012 v 2017	2,283	21%	-3	0%

Numbers waiting by length of time per CHO in 2017

The numbers waiting to be seen varied by Child and Adolescent Community Mental Health Team and 74% (51) of teams had less than 50 on the waiting list with 94% (65) having waiting lists below 100.

Breakdown of Waiting Lists by CHO Area 2017



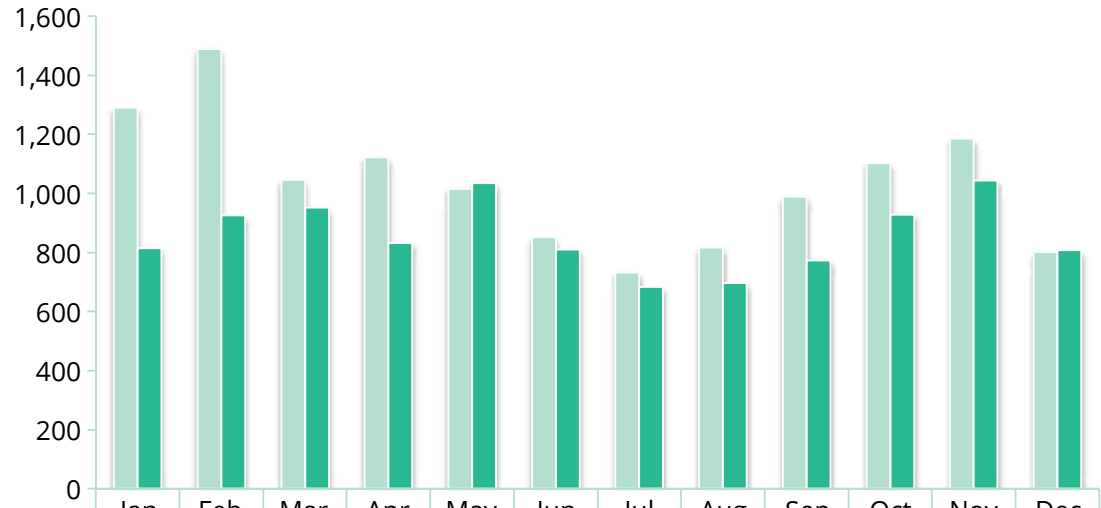
	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
12+ months	10	0	43	205	3	2	1	52	4	320
9-12 months	12	0	21	115	11	28	8	43	10	248
6-9 months	27	1	41	118	19	23	24	25	25	303
3-6 months	36	2	59	103	26	56	39	42	23	386
0-3 months	118	33	91	196	81	264	169	137	73	1,162

New (including re-referred) cases seen by Community CAMHS teams in 2017

In 2017, 11,498 new cases were offered an appointment by Community CAMHS Teams compared to 14,193 cases in 2016.

Of these, 10,304 (12,442 in 2016) were seen and 1,194 (1,751 in 2016) did not attend (DNA). This gives slight decrease in the non-attendance rate to 10.4% nationally from 12.3% in 2016.

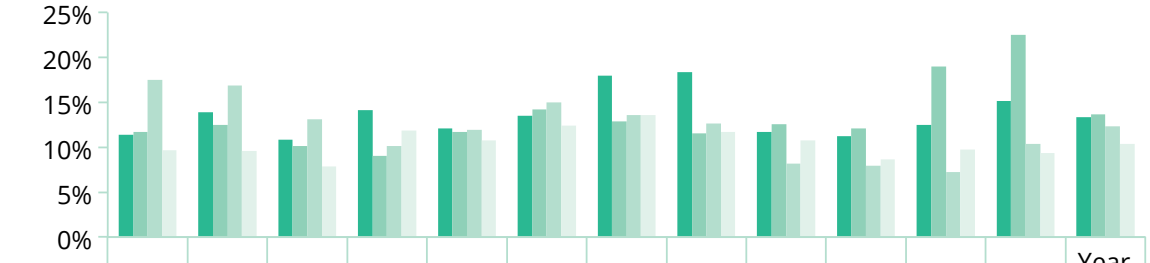
Number of New (including re-referred) cases seen 2017 vs. 2016



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2016	1,290	1,490	1,045	1,122	1,016	851	732	817	990	1,103	1,185	801
Seen - 2017	814	925	953	833	1,036	811	683	696	774	929	1,043	807

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

DNA rates 2014 to 2017



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

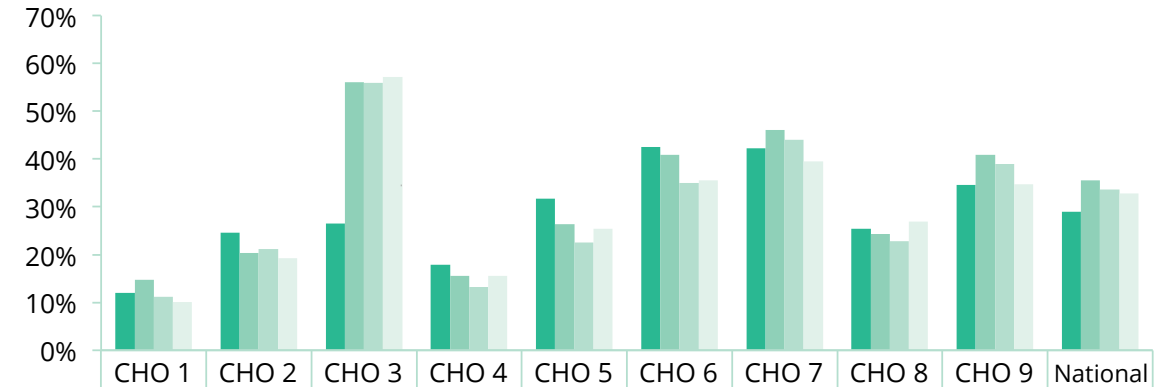
Breakdown of New Cases (New vs. Re-referred Cases)

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

In 2017, of the 10,304 cases seen, a total of 2,979 had been re-referred to the service. In 2016, of the 12,442 cases seen, a total of 4,417 had been re-referred to the service. This reflects an increase in re-referral rate from 35.6% in 2016 to 28.9%.

The proportion of re-referred cases seen in the CHOs over the two years varied from 12% in CHO 1 to 42.5% in CHO 6 (see figures below).

Percentage of Re- referred cases between 2017 and 2014



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

Breakdown of new cases (New vs. Re- referred cases) 2017

New and re-referred Cases seen by age profile

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

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

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

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

2017	Total No. of New (including re- referred) cases seen	No. of New (including re-referred) cases seen aged 16 years and over	% of teams who have seen new (including re-referred) cases aged 16 years and over
CHO 1	842	164	19.5%
CHO 2	1,041	290	27.9%
CHO 3	1,571	411	26.2%
CHO 4	1,008	297	29.5%
CHO 5	1,079	298	27.6%
CHO 6	1,185	317	26.8%
CHO 7	1,214	242	19.9%
CHO 8	1,658	387	23.3%
CHO 9	706	195	27.6%
National	10,304	2,601	25.2%

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

2016	Total No. of New (including re- referred) cases seen	No. of New (including re-referred) cases seen aged 16 years and over	% of teams who have seen new (including re-referred) cases aged 16 years and over
CHO 1	817	177	21.7%
CHO 2	989	272	27.5%
CHO 3	2,731	601	22.0%
CHO 4	1,176	258	21.9%
CHO 5	1,169	380	32.5%
CHO 6	1,813	481	26.5%
CHO 7	1,349	256	19.0%
CHO 8	1,614	500	31.0%
CHO 9	784	184	23.5%
National	12,442	3,109	25.0%

Timeliness of access to CAMHS Community Mental Health Teams

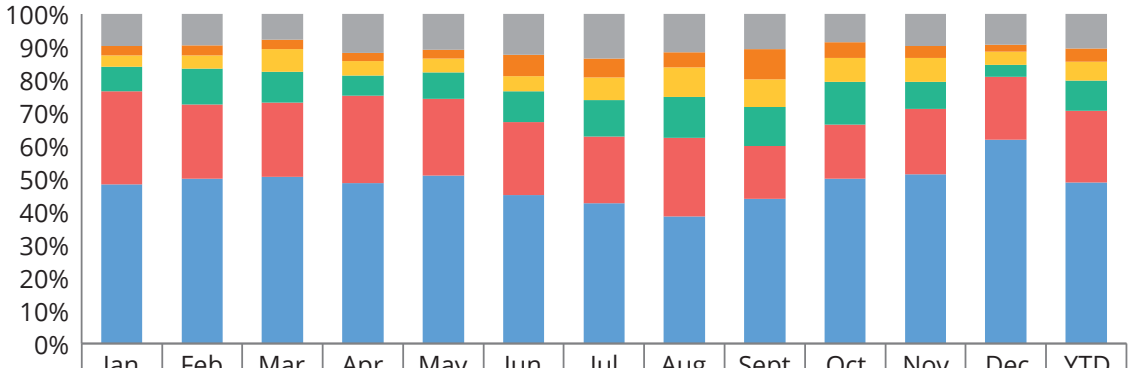
In 2017, a total of 14,193 individuals were offered an appointment of which 10,304 new cases were seen by Community CAMHS teams.

The expectation is that the CAMHS Community Mental Health Teams will offer an appointment and see an individual within three months. In 2017, 70.6% of new cases were seen within three months and of these, 48.8% were seen within one month.

The breakdown is as follows:

- 48.8% of new cases were seen within 1 month of referral.
- 70.6% seen within 3 months.
- 9.2% of new cases had waited between 3 to 6 months.
- 5.8% had waited between 6 and 12 months.
- 4.1% had waited more than 1 year.
- 10.4% did not attend their appointment.

Timeframe for 1st appointment to be seen in 2017



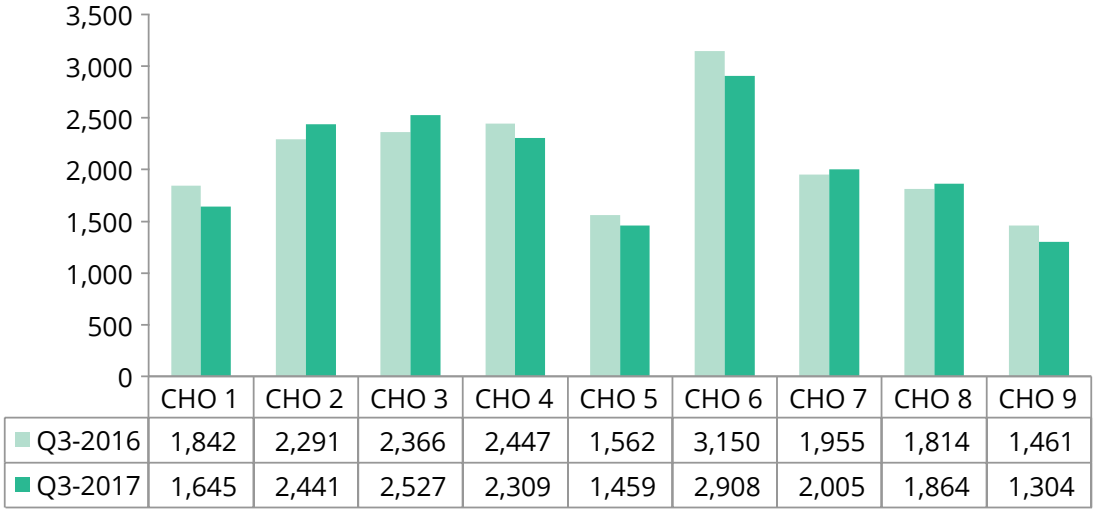
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
DNA	9.7%	9.6%	7.8%	11.9%	10.8%	12.4%	13.5%	11.7%	10.7%	8.7%	9.8%	9.3%	10.4%
>12 mth	3.0%	2.9%	2.8%	2.4%	2.8%	6.4%	5.7%	4.6%	9.1%	4.6%	3.6%	2.1%	4.1%
6-12 mth	3.3%	4.1%	6.9%	4.4%	4.1%	4.8%	7.0%	9.0%	8.3%	7.4%	7.3%	4.0%	5.8%
3-6 mth	7.5%	10.9%	9.3%	6.1%	8.0%	9.3%	11.0%	12.3%	11.9%	12.9%	8.0%	3.5%	9.2%
1-3 mth	28.1%	22.6%	22.6%	26.5%	23.3%	22.1%	20.3%	23.9%	16.0%	16.5%	20.0%	19.2%	21.8%
<1 mth	48.4%	50.0%	50.6%	48.7%	51. 0%	45.0%	42.5%	38.6%	43.9%	50.0%	51.3%	61.8%	48.8%

Timeframe for 1st appointment by CHO

Length of wait to 1st appointment by CHO						
	<1 month	**1 - 3 months**	**3 -6 months**	**6 - 12 months**	**>12 months**	**DNA**
CHO 1	39.2%	19.6%	8.3%	8.7%	15.8%	8.5%
CHO 2	83.6%	7.9%	1.9%	0.8%	0.4%	5.4%
CHO 3	59.4%	21.1%	4.4%	3.1%	7.0%	4.9%
CHO 4	47.3%	16.7%	8.3%	9.7%	8.3%	9.8%
CHO 5	46.6%	26.8%	6.1%	7.3%	0.4%	12.9%
CHO 6	41.8%	29.4%	13.5%	9.0%	0.4%	6.0%
CHO 7	39.1%	30.3%	15.4%	3.2%	1.5%	10.5%
CHO 8	45.4%	19.4%	10.4%	6.2%	1.0%	17.7%
CHO 9	32.5%	23.3%	15.3%	6.1%	7.2%	15.8%
National	48.8%	21.8%	9.2%	5.8%	4.1%	10.4%

Community CAMHS Caseload

The number of active open cases in Q3 2017 vs. Q3 2016 for the Community CAMHS Service by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
Q3-2016	1,842	2,291	2,366	2,447	1,562	3,150	1,955	1,814	1,461
Q3-2017	1,645	2,441	2,527	2,309	1,459	2,908	2,005	1,864	1,304

Discharge from the CAMHS Community Mental Health Teams

In 2017, 12,923 individuals were discharged by Community CAMHS Teams compared to 13,284 cases in 2016.

88.2% (88.8% in 2016) of the individuals were discharged to the care of their general practitioner or Primary Care Team (PCT), 5.1% (5.1% in 2016) to a Community Based Service, 2.8% (3.1% in 2016) to another CAMHS service, and 3.8% (3% in 2016) to an Adult Mental Health Service.

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

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service
CHO 1	90.4%	5.9%	0.8%	2.9%
CHO 2	93.3%	0.8%	1.6%	4.3%
CHO 3	89.6%	3.7%	1.2%	5.4%
CHO 4	87.1%	3.4%	3.6%	5.9%
CHO 5	83.7%	7.0%	2.7%	6.6%
CHO 6	92.6%	2.2%	3.8%	1.4%
CHO 7	82.3%	9.0%	6.0%	2.7%
CHO 8	90.9%	3.6%	2.2%	3.2%
CHO 9	88.1%	6.5%	0.6%	4.8%
National	88.2%	5.1%	2.8%	3.8%

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

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service	Total
CHO 1	1,066	69	10	34	1,179
CHO 2	779	7	13	36	835
CHO 3	647	27	9	39	722
CHO 4	1,064	42	44	72	1,222
CHO 5	1,070	90	35	84	1,279
CHO 6	1,793	42	74	28	1,937
CHO 7	1,851	202	135	60	2,248
CHO 8	1,447	58	35	51	1,591
CHO 9	1,682	125	12	91	1,910
National	11,399	662	367	495	12,923

CHAPTER SIX
General Adult Mental Health Services

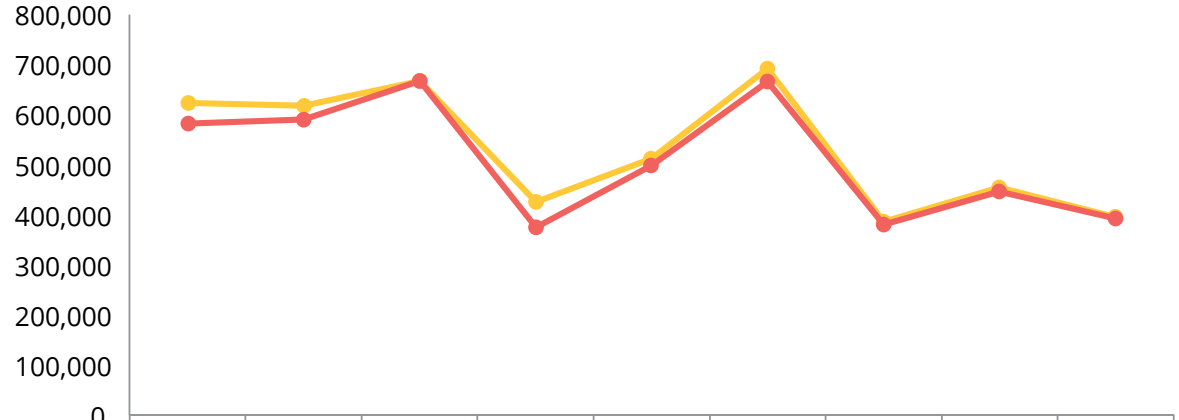
Key Facts

- 114 Community General Adult Mental Health Teams
- 2013 – 1,456.57 Clinical WTE's; 2017 – 1,521.69 Clinical WTE's
- 75.5% of the Clinical staffing levels recommended in *A Vision for Change*
- -2.2% decrease in referrals accepted from 2016 to 2017
- 36,277 new appointments offered in 2017
- 21.6% new appointments seen within 1 week
- Over one third are seen within 2 weeks & 50.6% seen within 4 weeks
- Over 1 in 5 new patients did not attend their first appointment.

Adults in the Population

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

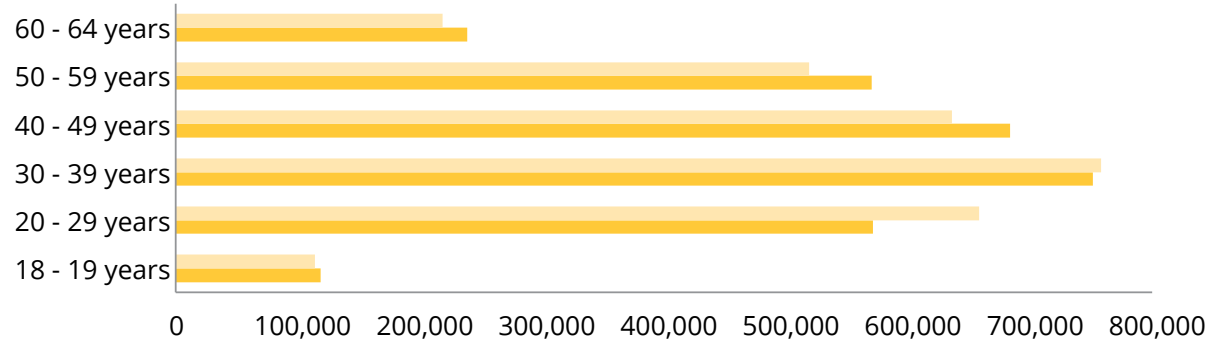
2016 & 2011 Census by CHO*



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

**NB CHO Areas not in place until 2014*

2016 census by Age



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

Access to Community General Adult Mental Health Teams

Referrals

Between 2014 and 2017, there has been a decrease of -1.9% nationally in the number of referrals accepted by the community general adult mental health service. From 2016 to 2017 there was a -2.2% decrease as outlined in the table below.

Referrals accepted 2014 vs. 2017

Referrals Accepted

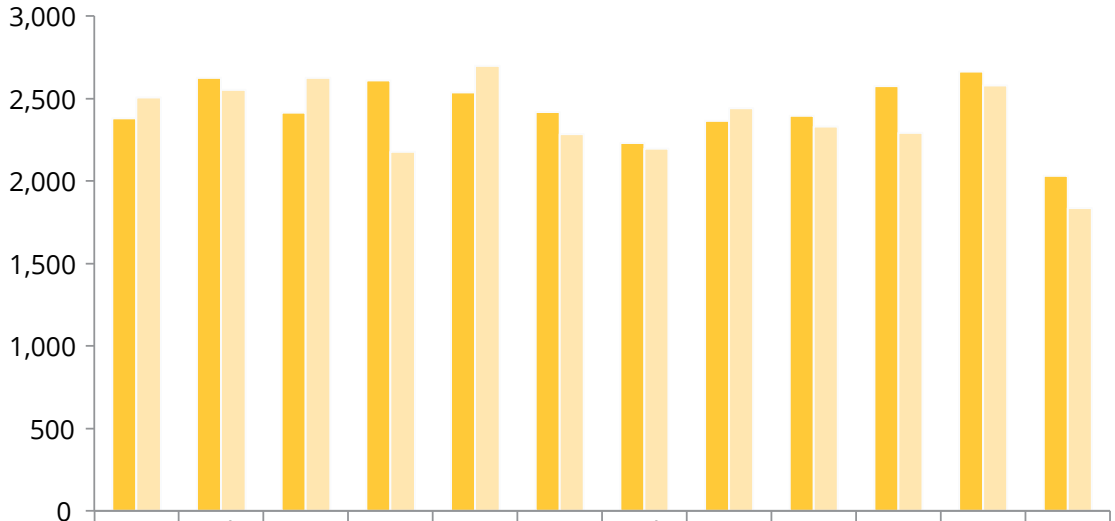
	2017	2016	+/- Variance 2016/2017	2015	+/- Variance 2015/2017	2014	+/- Variance 2014/2017
CHO 1	3,412	3,334	2.3%	3,264	4.5%	3,889	-12.3%
CHO 2	5,865	6,463	-9.3%	6,551	-10.5%	6,537	-10.3%
CHO 3	3,798	3,701	2.6%	3,738	1.6%	3,523	7.8%
CHO 4	5,926	6,471	-8.4%	6,202	-4.5%	5,906	0.3%
CHO 5	3,910	4,078	-4.1%	3,917	-0.2%	3,984	-1.9%
CHO 6	2,186	2,214	-1.3%	2,240	-2.4%	2,275	-3.9%
CHO 7	4,354	4,033	8.0%	3,745	16.3%	3,967	9.8%
CHO 8	5,331	5,278	1.0%	5,417	-1.6%	5,118	4.2%
CHO 9	3,519	3,591	-2.0%	3,678	-4.3%	3,828	-8.1%
National	38,301	39,163	-2.2%	38,752	-1.2%	39,027	-1.9%

New cases seen by Community General Adult Mental Health Teams 2017

In 2017 a total number of 36,277 new cases were offered an appointment by community general adult mental health teams which compares to 37,536 cases in 2016.

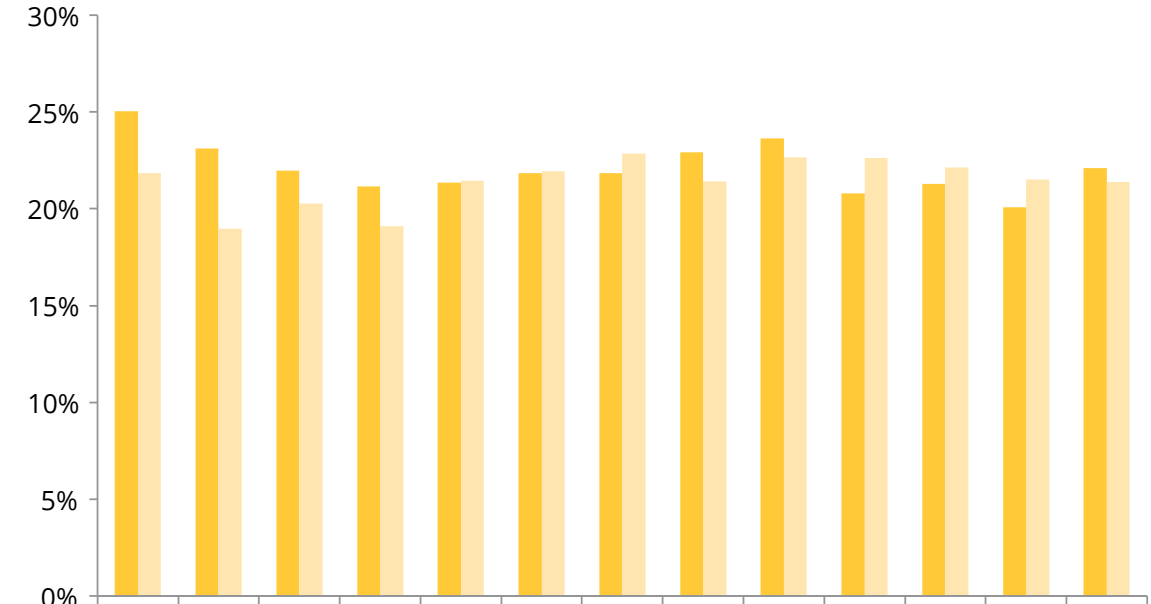
A total of 28,513 (29,235 in 2016) were seen and 7,764 (8,301 in 2016) did not attend (DNA). This gives a non-attendance rate of 21.4% compared with 22.1% in 2016.

New (including re-referred) cases seen 2017 vs. 2016



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2016	2,378	2,625	2,413	2,611	2,537	2,417	2,229	2,363	2,393	2,574	2,663	2,032
Seen - 2017	2,507	2,552	2,626	2,175	2,697	2,282	2,196	2,441	2,331	2,292	2,577	1,837

DNA Rate 2017 vs. 2016



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2016	25.1%	23.1%	22.0%	21.1%	21.4%	21.8%	21.8%	22.9%	23.6%	20.8%	21.3%	20.1%	22.1%
2017	21.8%	19.0%	20.3%	19.1%	21.4%	22.0%	22.9%	21.4%	22.7%	22.6%	22.1%	21.5%	21.4%

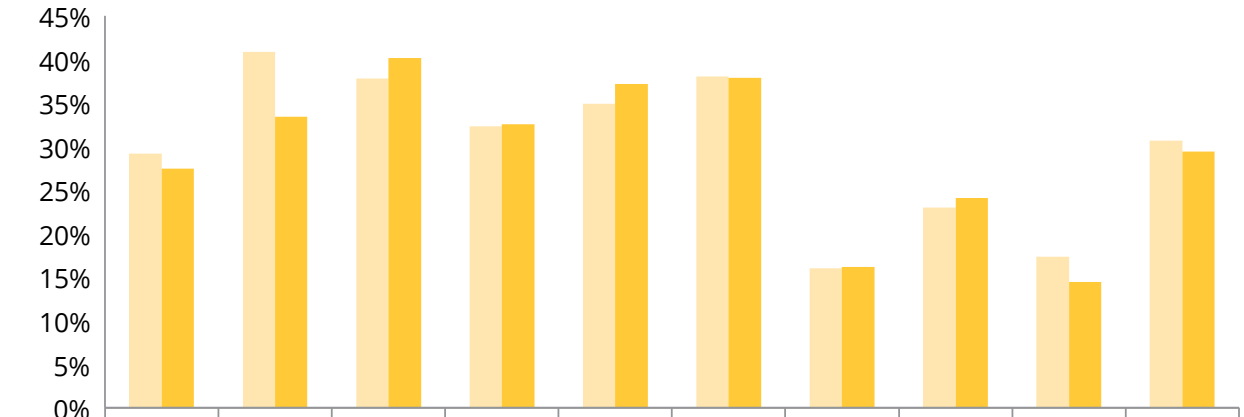
Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen, a proportion will have previously attended the service and been discharged. In 2017of the 28,513 cases seen, a total of 8,377 had been re-referred to the service. This represents a 29.4% re-referred rate.

In 2016 of the 29,235 cases seen, a total of 8,964 had been re-referred to the service representing a 30.7% re-referred rate.

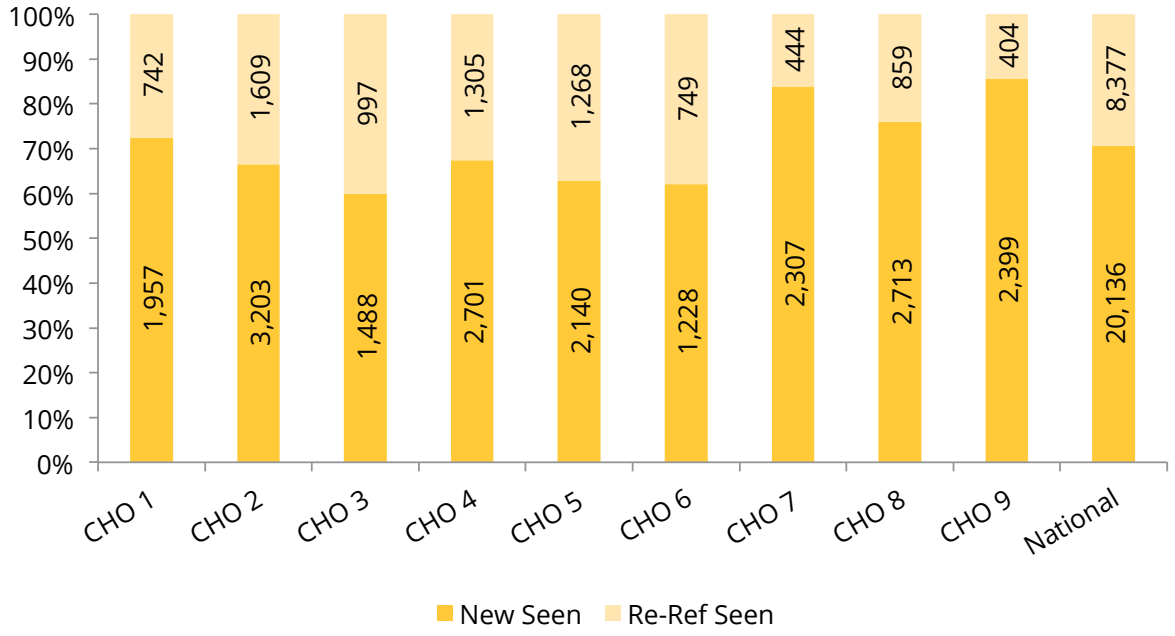
The proportion of re-referred cases in 2017 varied from 14.4% in CHO 9 to 40.1% in CHO 3 (see figures below).

Percentage of Re-referred cases 2017 vs. 2016



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2016	29.2%	40.9%	37.8%	32.3%	34.9%	38.1%	16.0%	23.0%	17.4%	30.7%
2017	27.5%	33.4%	40.1%	32.6%	37.2%	37.9%	16.1%	24.0%	14.4%	29.4%

Breakdown of New Cases Seen (New vs. Re-referred cases) 2017



New Cases including re-referred seen by age profile

In 2017 a total number of 28,513 new cases were seen by Community General Adult Mental Health Teams. Of these, 0.5% (156) were under 18 years of age and 99.5% (28,357) were over 18 years of age. This compares to 0.7% (213) of cases in 2016.

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

Waiting Times for New Cases Seen

In 2017 a total number of 36,277 were offered an appointment of which 28,513 new cases were seen by Community General Adult Mental Health Teams. The waiting time to be seen was recorded for each case.

Length of wait to 1st appointment by CHO

	< 1 week	> 1 to 2 weeks	> 2 to 3 weeks	> 3 to 4 weeks	> 4 to 8 weeks	> 8 to 12 weeks	> 12 Weeks	DNA
CHO 1	28.8%	9.9%	8.3%	7.1%	16.4%	6.0%	6.2%	17.2%
CHO 2	35.4%	17.4%	13.5%	8.4%	12.0%	3.8%	0.6%	8.9%
CHO 3	23.9%	12.6%	11.3%	7.8%	11.7%	4.6%	2.0%	26.1%
CHO 4	16.1%	8.9%	7.8%	9.0%	17.0%	7.9%	3.6%	29.6%
CHO 5	21.4%	9.4%	12.6%	9.0%	26.2%	7.9%	2.8%	10.7%
CHO 6	32.2%	15.2%	11.1%	8.6%	15.1%	1.3%	0.7%	15.8%
CHO 7	13.2%	6.9%	7.1%	6.4%	19.6%	14.6%	11.4%	20.9%
CHO 8	15.1%	9.7%	9.7%	8.2%	16.3%	6.6%	4.1%	30.2%
CHO 9	12.7%	9.7%	7.1%	7.5%	16.1%	8.8%	9.6%	28.5%
National	21.6%	11.0%	9.9%	8.1%	16.6%	7.0%	4.5%	21.4%

Cases Closed or Discharged

In 2017 – 25,035 cases were closed and discharged by Community General Adult Mental Health Teams. This compares to 24,206 cases closed in 2016. Of these, 90.9% of the cases closed were discharged to care of the General Practitioner or Primary Care Team (PCT), 3.5% to General Practitioner and other primary / community care services, 3.4% to another Adult Mental Health Service, 0.7% to other services and 1.5% were due to death.

No. of Cases closed and discharged by Community General Adult teams in 2017

	Closed / Discharged to GP/Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed / Discharged to other Adult Mental Health Service	Closed / Discharged to other Service	Closed due to Death	Total Closed Discharged
CHO 1	2,690	71	188	12	37	2,998
CHO 2	2,183	126	259	46	42	2,656
CHO 3	2,232	185	131	30	49	2,627
CHO 4	3,798	75	112	25	84	4,094
CHO 5	2,218	176	29	17	45	2,485
CHO 6	1,689	100	33	9	28	1,859
CHO 7	2,162	33	9	24	29	2,257
CHO 8	3,334	47	14	10	19	3,424
CHO 9	2,461	53	83	2	36	2,635
National	22,767	866	858	175	369	25,035

Percentage of Cases closed and discharged by Community General Adult teams in 2017

	Closed / Discharged to GP/Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed / Discharged to other Adult Mental Health Service	Closed / Discharged to other Service	Closed due to Death
CHO 1	89.7%	2.4%	6.3%	0.4%	1.2%
CHO 2	82.2%	4.7%	9.8%	1.7%	1.6%
CHO 3	85.0%	7.0%	5.0%	1.1%	1.9%
CHO 4	92.8%	1.8%	2.7%	0.6%	2.1%
CHO 5	89.3%	7.1%	1.2%	0.7%	1.8%
CHO 6	90.9%	5.4%	1.8%	0.5%	1.5%
CHO 7	95.8%	1.5%	0.4%	1.1%	1.3%
CHO 8	97.4%	1.4%	0.4%	0.3%	0.6%
CHO 9	93.4%	2.0%	3.1%	0.1%	1.4%
National	90.9%	3.5%	3.4%	0.7%	1.5%

CHAPTER SEVEN

Psychiatry of Later Life
Mental Health Services

Key Facts

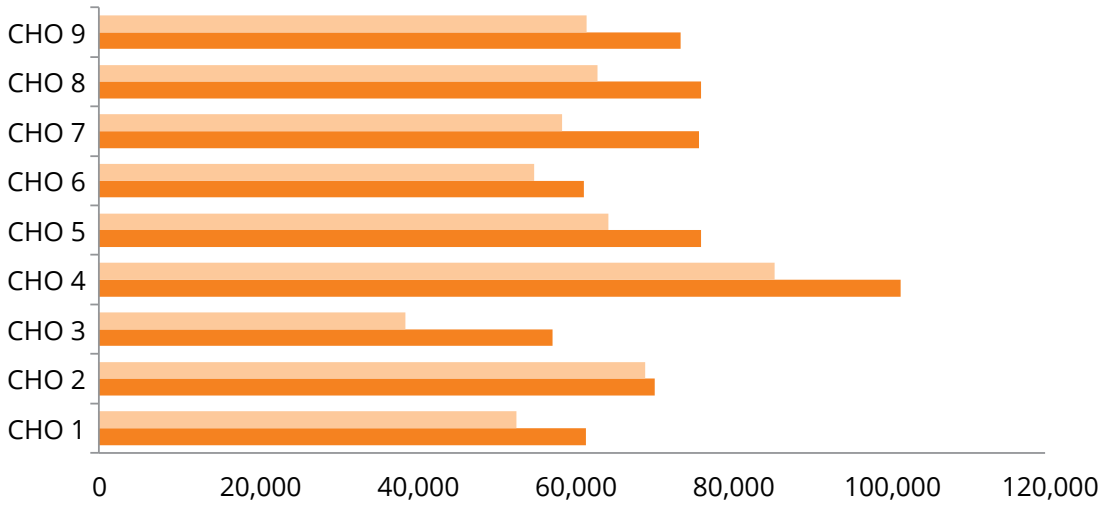
- 2013 – 22 POLL teams; 2017 – 30 POLL teams
- 2013 – 224.19 Clinical WTE's; 2017 – 304.77 Clinical WTE's
- 58.2% of the Clinical staffing levels recommended in *A Vision for Change*
- 1.8% decrease in referrals received from 2016 to 2017
- 8,829 new appointments offered in 2017
- 40% new appointments seen within 1 week
- 83.3% new appointments seen within 4 weeks
- 2.4% new patients did not attend their first appointment.

Over 65 year of age population

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

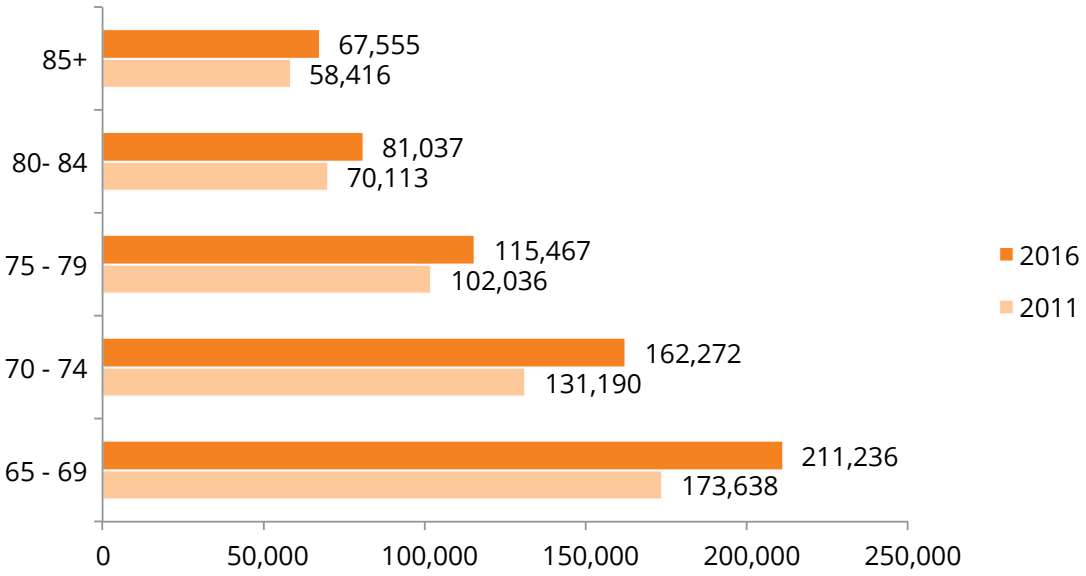
In line with other European countries, the population over 65 years is increasing in Ireland and now forms 13.4% of the total population. From 2011 to 2016 there was a 19% increase in the over 65 year's population. This significant increase in population will result in increased demand for POLL services.

2016 & 2011 Census – Number over 65



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

2016 Census by Age



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

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

Prevalence of mental disorders in later life

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

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

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

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

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

Psychiatry of Later Life Services

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

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

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

Psychiatry of Later Life Team - Assessment

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

The rationale for this approach is:

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

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

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

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

Access to Psychiatry of Later Life Services

Between 2014 and 2017, there was an increase of 3.7% nationally in the number of referrals accepted by the Psychiatry of Later Life Service as outlined in the table below.

	2017	2016	+/- Variance 2015/2016	2015	+/- Variance 2016/2017	2014	+/- Variance 2014/2017
CHO 1	1,297	1,296	0.1%	1,380	-6.0%	1,494	-13.2%
CHO 2	1,633	1,748	-6.6%	1,807	-9.6%	1,375	18.8%
CHO 3	1,016	1,021	-0.5%	965	5.3%	989	2.7%
CHO 4	551	647	-14.8%	339	62.5%	454	21.4%
CHO 5	1,360	1,416	-4.0%	1,487	-8.5%	1,439	-5.5%
CHO 6	975	1,035	-5.8%	1,031	-5.4%	957	1.9%
CHO 7	867	856	1.3%	839	3.3%	980	-11.5%
CHO 8	1,675	1,625	3.1%	1,523	10.0%	1,514	10.6%
CHO 9	1,255	1,181	6.3%	1,073	17.0%	1,046	20.0%
National	10,629	10,825	-1.8%	10,444	1.8%	10,248	3.7%

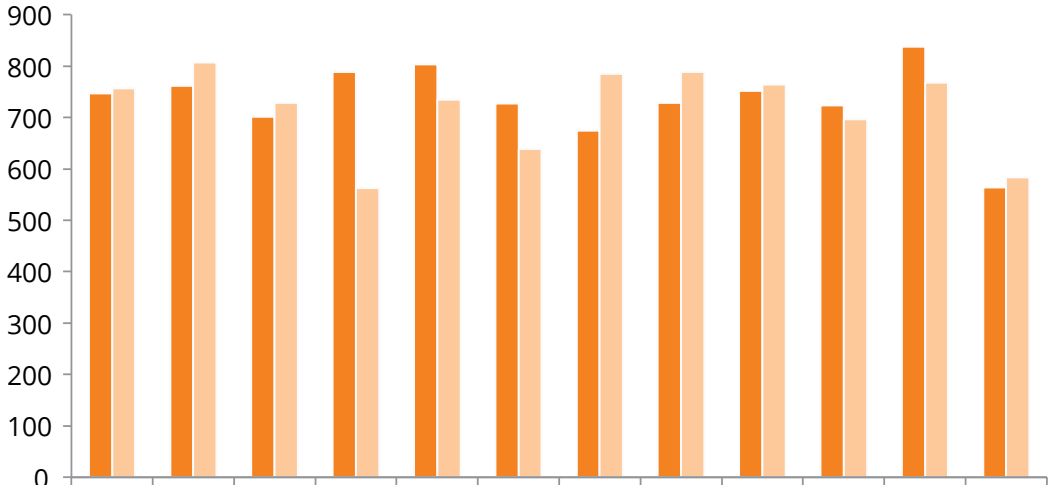
New cases seen by Psychiatry of Later Life Service 2017

In 2017 a total number of 8,829 new cases were offered an appointment by Psychiatry of Later Life Services. This compares to 9,012 cases in 2016.

A total of 8,614 (8,806 in 2016) were seen and 215 (206 in 2016) did not attend (DNA).

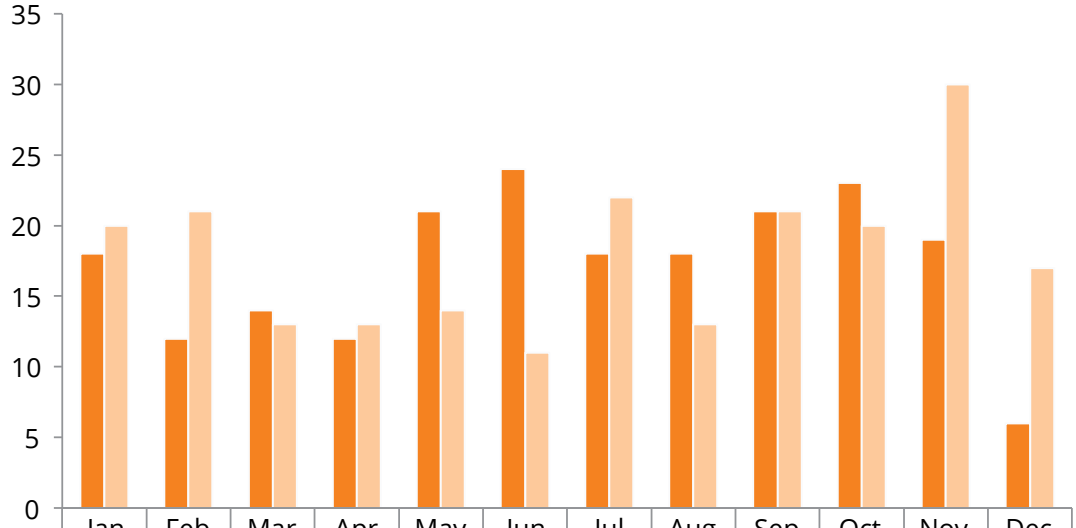
This gives a non-attendance rate of 2.4%, ranging from 1.6% to 3.8% across the 12 month period. The national DNA rate is impacted by particular challenges experienced by one area over this period, which have been addressed with planned improvement in 2017.

New (including re-referred) Cases Seen 2017 vs. 2016

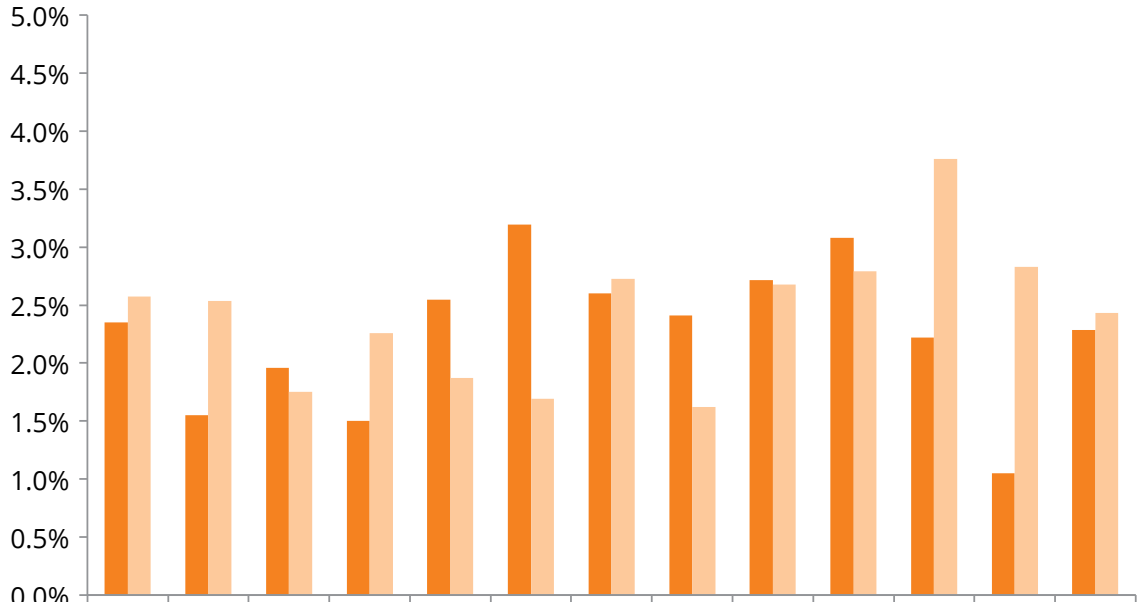


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2016	747	761	701	788	803	727	674	728	752	724	837	564
Seen - 2017	757	807	728	562	734	639	785	789	764	697	768	584

New (including re-referred) DNA 2017 vs. 2016



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
DNA - 2016	18	12	14	12	21	24	18	18	21	23	19	6
DNA - 2017	20	21	13	13	14	11	22	13	21	20	30	17



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2016	2.4%	1.6%	2.0%	1.5%	2.5%	3.2%	2.6%	2.4%	2.7%	3.1%	2.2%	1.1%	2.3%
2017	2.6%	2.5%	1.8%	2.3%	1.9%	1.7%	2.7%	1.6%	2.7%	2.8%	3.8%	2.8%	2.4%

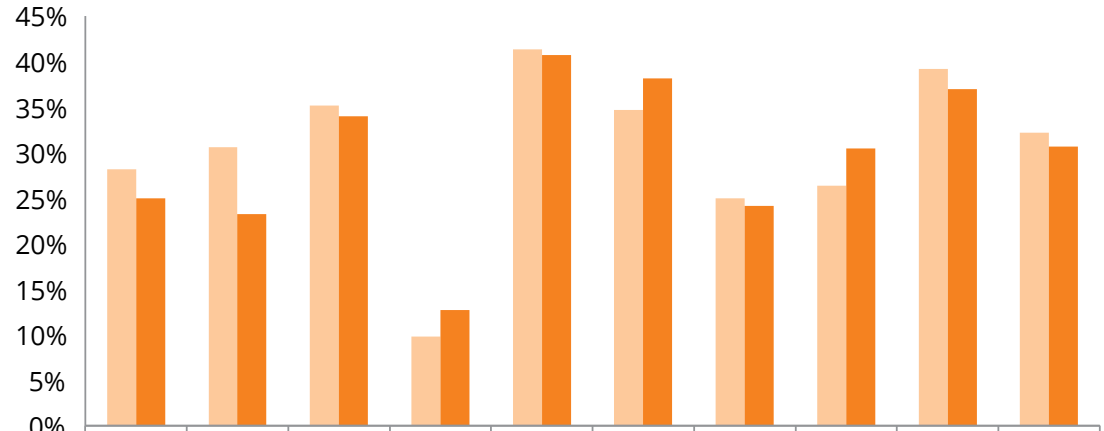
Breakdown of New Cases (New vs. Re-referred Cases)

Of the new cases seen, a proportion will have previously attended the service and been discharged. In 2017 of the 8,614 cases seen a total of 2,634 had been re-referred to the service. This represents a 30.7% re-referred rate.

In 2016 of the 8,806 cases seen, a total of 2,835 had been re-referred to the service representing a 32.2% re-referred rate.

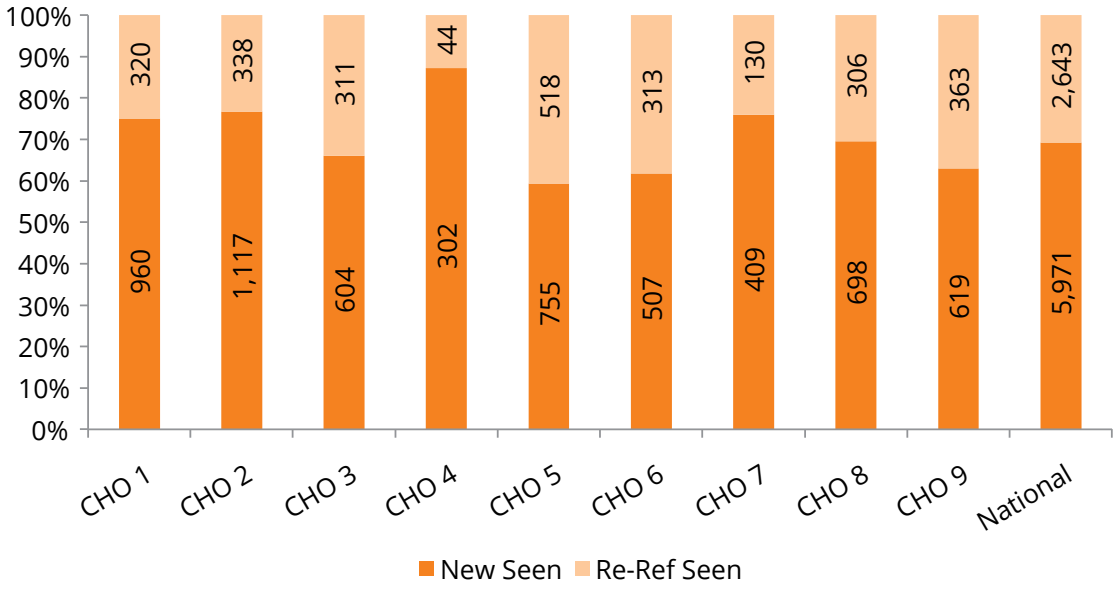
The proportion of re-referred cases varied in 2017 from 12.7% in CHO 4 to 37% in CHO 9 (in figure below).

Percentage of re-referred cases 2017 vs. 2016



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2016	28.1%	30.6%	35.1%	9.8%	41.3%	34.7%	25.0%	26.3%	39.2%	32.2%
2017	25.0%	23.2%	34.0%	12.7%	40.7%	38.2%	24.1%	30.5%	37.0%	30.7%

Breakdown of New Cases Seen (new vs. re-referred cases) 2017



Waiting Times for New Cases Seen

In 2017, a total number of 8,829 patients were offered an appointment, of which 8,614 new cases were seen by Psychiatry of Later Life Service.

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

Length of wait to 1st appointment seen 2017 by CHO

	< 1 week	> 1 to 2 weeks	> 2 to 3 weeks	> 3 to 4 weeks	> 4 to 8 weeks	> 8 to 12 weeks	> 12 Weeks	DNA
CHO 1	62.1%	15.6%	5.8%	3.2%	6.0%	2.8%	2.4%	2.1%
CHO 2	42.3%	24.6%	15.8%	10.8%	5.6%	0.0%	0.0%	1.0%
CHO 3	44.2%	24.5%	15.8%	9.2%	4.0%	0.6%	0.0%	1.6%
CHO 4	41.8%	18.0%	12.5%	4.4%	6.5%	2.1%	5.0%	9.7%
CHO 5	44.1%	21.8%	14.7%	10.4%	7.5%	0.5%	0.1%	0.9%
CHO 6	37.8%	20.8%	9.6%	11.7%	18.1%	1.0%	0.7%	0.4%
CHO 7	31.5%	20.6%	11.6%	9.9%	16.6%	5.4%	1.8%	2.5%
CHO 8	23.5%	34.0%	13.3%	8.9%	11.2%	4.4%	1.6%	3.1%
CHO 9	22.4%	15.0%	12.7%	9.6%	18.2%	6.0%	10.5%	5.8%
National	40.0%	21.9%	12.5%	8.8%	9.8%	2.3%	2.2%	2.4%

Cases Closed or Discharged

In 2017, 6,963 cases were closed and discharged by Psychiatry of Later Life Service. This compares to 7,012 cases closed in 2016.

88.7% of the cases closed were discharged to the care of the General Practitioner or Primary Care Team (PCT) / Community Care Service and 13.2% due to death.

	Closed / Discharged to GP/ Primary Care Team	Closed/ Discharged to GP and other primary / community care service	Closed due to Death	Total Closed Discharged
CHO 1	739	227	92	1,058
CHO 2	856	168	122	1,146
CHO 3	310	77	97	484
CHO 4	280	0	60	340
CHO 5	939	1	253	1,193
CHO 6	524	0	64	588
CHO 7	307	79	24	410
CHO 8	919	11	156	1,086
CHO 9	562	45	51	658
National	5,436	608	919	6,963

Percentage of Cases closed and discharged by CHO

	Closed / Discharged to GP/Primary Care Team / community care service	Closed due to Death
CHO 1	91.3%	8.7%
CHO 2	89.4%	10.6%
CHO 3	80.0%	20.0%
CHO 4	82.4%	17.6%
CHO 5	78.8%	21.2%
CHO 6	89.1%	10.9%
CHO 7	94.1%	5.9%
CHO 8	85.6%	14.4%
CHO 9	92.2%	7.8%
National	86.8%	13.2%

CHAPTER EIGHT

Child and Adolescent Mental Health Acute Inpatient Services

Key Facts

- 2008 – 16 CAMHS Acute Inpatient beds; 2017 – 74 CAMHS Acute Inpatient beds
- 2008 – 25% admissions to CAMHS inpatient beds; 2017 – 73.7% admission to CAMHS inpatient beds
- 1.3% decrease in bed days used in 2017
- 97% bed days used in Child Adolescent Acute Inpatient Units as a total of bed days.

In 2007 there were a total of 12 beds available for the admission of children under the age of 18 years. Over the last number of years significant investment in the construction of new age appropriate inpatient facilities has resulted in significant progress being made in achieving the targets set out in A Vision for Change (2006). With regard to the provision of child and adolescent inpatient facilities, 74 CAMHS Acute Inpatient beds were provided at the end December 2017.

HSE inpatient services and bed capacity (2008 to 2017)

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

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

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

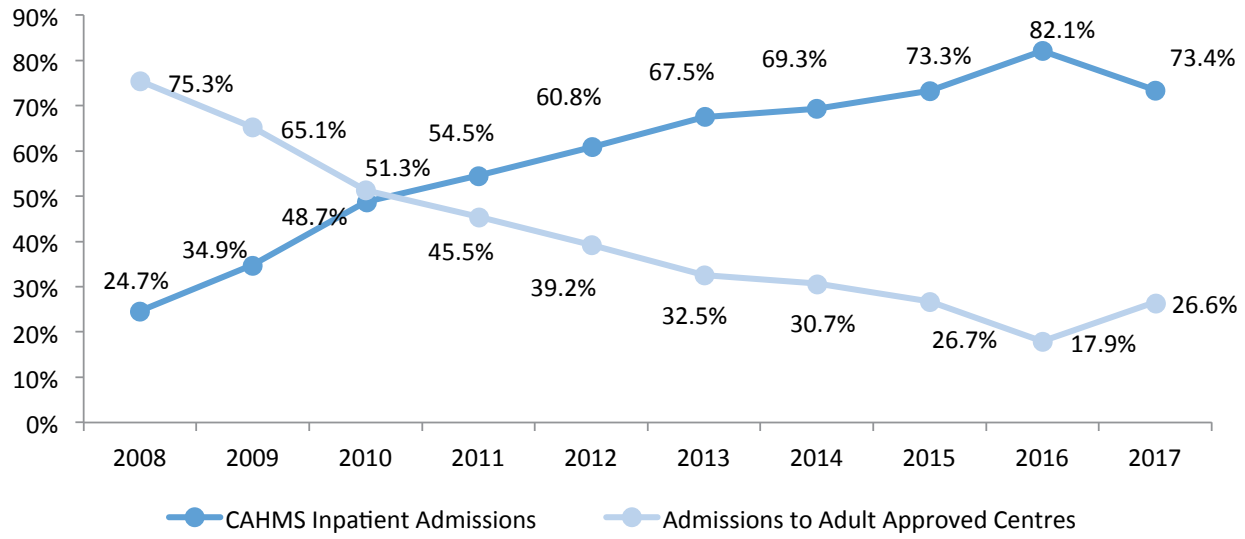
The increase in the availability of age appropriate CAMHS acute inpatient facilities has enabled the CAMHS service to ensure, in so far as possible, that when a child is admitted, that admission is to age appropriate inpatient facilities.

In 2017, there were 308 children and adolescents admitted and of these, 226 (73.4%) were admitted to child and adolescent inpatient units and 82 (26.6%) to adult units. Of these 308 admissions, 91%

(280) of these were voluntary admissions with parental consent with a very small number under Section 25 of the Mental Health Act 2001. Of the 82 admitted to Adult Approved Centres, 60 or 93.9% were 16/17 years old with 45.1% (37) of these discharged either the same day or within 3 days and 74.4% (61) within a week.

Admissions of children to Acute Inpatient Units 2008-2017

Figure below shows the increase in the percentage of admissions of children to age appropriate units in the period from 2008 to 2017.



Number of admissions by Unit/Unit Type*

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

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

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

How long are children staying in Acute Inpatient Units?

The length of stay of child admissions is longer than adults due to the greater complexity in assessing and treating the clinical presentations of children. In 2017, the total number of bed days used by the admission of children was 20,646, a decrease of -1.3% (-278) on the 2016 position of 20,924.

In 2017, 96.9% (20,013) of bed days used were in the age appropriate Child and Adolescent Acute Inpatient Units with 3.1% (633) used in adult approved centres. These figures are comparable with 2016 position of 97.4% (20,373) in CAMHS inpatient and 2.6% (551) in adult approved centres.

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

Bed Days used by CHO

Bed Days Used	2016					2017				
	Total Days Used	CAMHS	IP	Adult	IP	Total Days Used	CAMHS	IP	Adult	IP
CHO 1	2,427	2,381	98.1%	46	1.9%	1,569	1,547	98.6%	22	1.4%
CHO 2	2,455	2,453	99.9%	2	0.1%	3,396	3,379	99.5%	17	0.5%
CHO 3	2,160	2,139	99.0%	21	1.0%	2,899	2,754	95.0%	145	5.0%
CHO 4	3,351	3,281	97.9%	70	2.1%	3,705	3,656	98.7%	49	1.3%
CHO 5	928	895	96.4%	33	3.6%	1,370	1,162	84.8%	208	15.2%
CHO 6	2,137	2,135	99.9%	2	0.1%	1,474	1,474	100.0%	0	0.0%
CHO 7	2,514	2,497	99.3%	17	0.7%	1,879	1,807	96.2%	72	3.8%
CHO 8	2,615	2,348	89.8%	267	10.2%	2,810	2,763	98.3%	47	1.7%
CHO 9	2,337	2,244	96.0%	93	4.0%	1,544	1,471	95.3%	73	4.7%
National	20,924	20,373	97.4%	551	2.6%	20,646	20,013	96.9%	633	3.1%

The following table compares the percentage of admissions of children by length of stay in the Adult Approved Centres between 2014, 2015, 2016 and 2017.

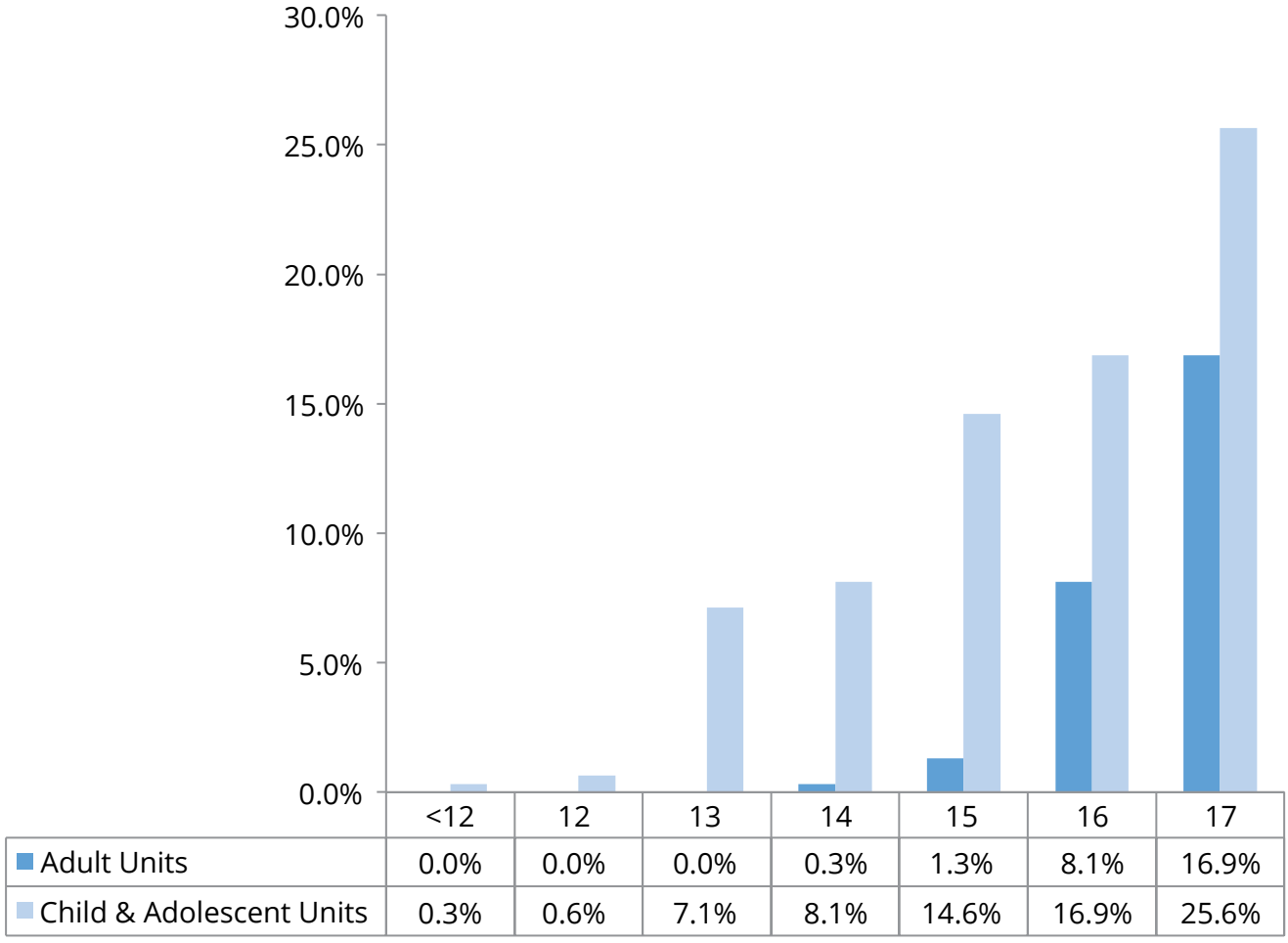
Percentage of admissions by Length of Stay in Adult Approved Centres

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

Age of admissions (2017)

Of the 308 admissions of children and adolescents in 2017, 42.5% were aged 17 years or over on admission, 25% were aged 16 years, 15.9% were aged 15 years, 8.4% were aged 14 years, 7.1% were aged 13 years, 0.6% aged 12 years and 0.3% less than 12 years of age.

Age of admissions (2017)



	<12	12	13	14	15	16	17
Adult Units	0.0%	0.0%	0.0%	0.3%	1.3%	8.1%	16.9%
Child & Adolescent Units	0.3%	0.6%	7.1%	8.1%	14.6%	16.9%	25.6%

Planned Development for Child and Adolescent Mental Health Services

New Children's Hospital of Ireland

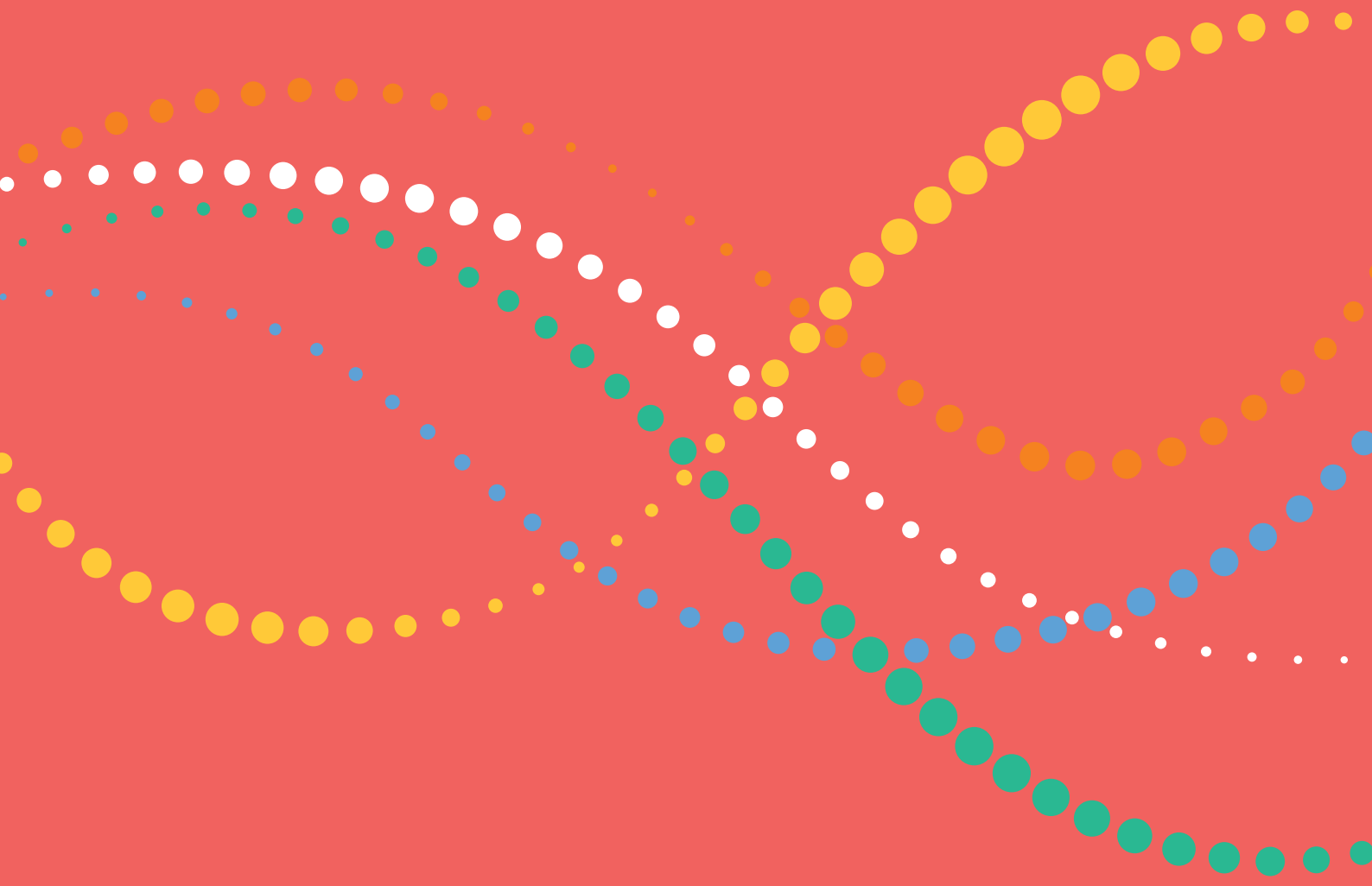
Construction started at the end of 2016 on the New Children's Hospital which will be developed at the campus of St. James's Hospital in Dublin. The St. James's site ensures that the planned co-location with an adult hospital and, ultimately, tri-location with a maternity hospital, will be delivered.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

New National Forensic Hospital

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

CHAPTER NINE

Adult Acute Inpatient Services



Key Facts

- 29 Acute Inpatients units
- 2007 – 16,293 admissions;- 2017 – 12,155 admissions
- 2007 – 72% re- admission rate;- 2017 – 64% re- admission rate

Mental Health Adult Acute Inpatient Services

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

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

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

Individuals may be admitted voluntarily, or as an involuntary patient within the provisions of the Mental Health Act, 2001. In 2017 84.11% of admissions were voluntary admissions.

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

Table 40: 2017 Adult Acute Inpatient Units by CHO

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

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

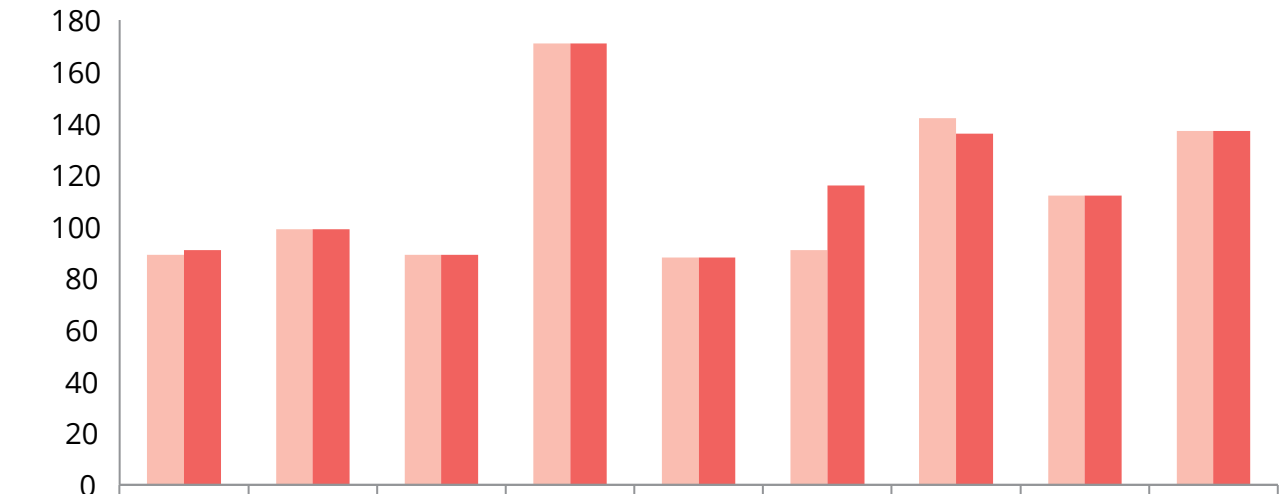
Adult Mental Health Acute inpatient Beds

There are 29 adult acute inpatient units nationally. At the end of 2017, the number of adult acute inpatient places was 1,039 (1,018 at the end of 2016) or 21.8 beds per 100,000 population. The information provided below includes General Adult Psychiatry acute admissions and Psychiatry of Later Life acute admissions.

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

	2017					2016			
	Total Population	Units	Beds	Bed Rate per 100,000		Units	Beds	Bed Rate per 100,000
CHO 1	394,333	3	91	23.1	CHO 1	3	89	22.6
CHO 2	453,109	3	99	21.8	CHO 2	3	99	21.8
CHO 3	384,998	2	89	23.1	CHO 3	2	89	23.1
CHO 4	690,575	5	171	24.8	CHO 4	5	171	24.8
CHO 5	510,333	2	88	18.3	CHO 5	2	88	17.2
CHO 6	549,531	3	116	25.9	CHO 6	3	91	16.6
CHO 7	541,352	3	136	20.2	CHO 7	3	142	26.2
CHO 8	616,229	4	112	18.2	CHO 8	4	112	18.2
CHO 9	621,405	4	137	22.0	CHO 9	4	137	22.0
National	4,761,865	29	1,039	21.8	National	29	1,018	21.4

Adult Acute Inpatient Beds 2016/2017 by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2016	89	99	89	171	88	91	142	112	137
2017	91	99	89	171	88	116	136	112	137

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

Adult Acute Inpatient Units with separate POLL Provision

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

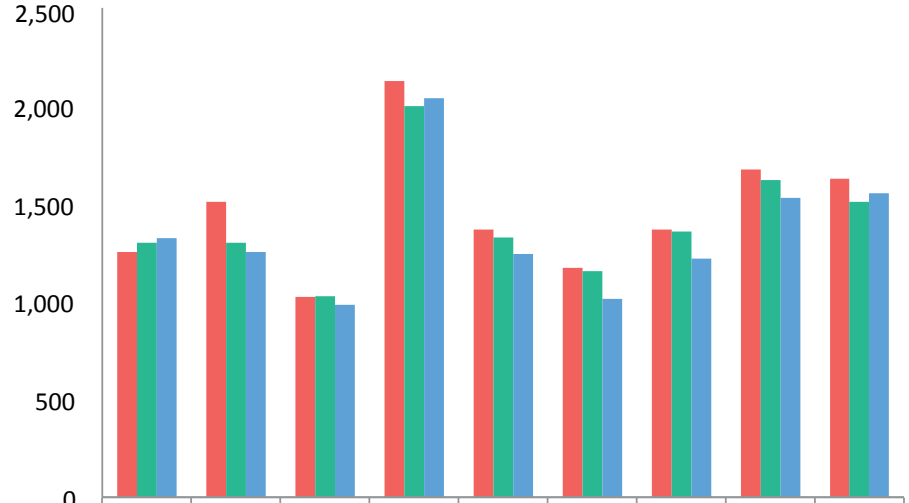
Admissions to Adult Acute Inpatient Units

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

At the end of 2017 the number of admissions was 12,155 compared to 12,590 at the end of 2016.

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

Adult Acute Admissions 2015 - 2017 by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	1,254	1,510	1,024	2,127	1,366	1,172	1,369	1,675	1,626
2016	1,299	1,300	1,026	1,997	1,327	1,156	1,356	1,621	1,508
2017	1,323	1,252	984	2,039	1,242	1,012	1,218	1,531	1,554

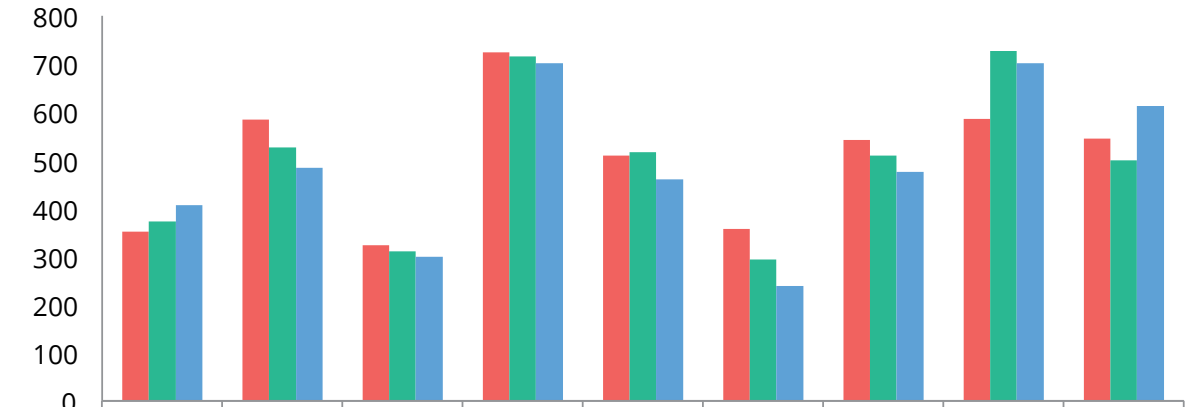
Adult Acute First Admissions

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

At the end of 2017 the number of First admissions was 4,379 this is compared to 4,471 at the end of 2016. First admissions accounted for 36% of admissions in 2017.

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

Adult Acute First admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	352	584	324	724	509	357	542	586	545
2016	373	527	311	715	516	293	510	727	499
2017	406	484	299	702	460	238	476	702	612

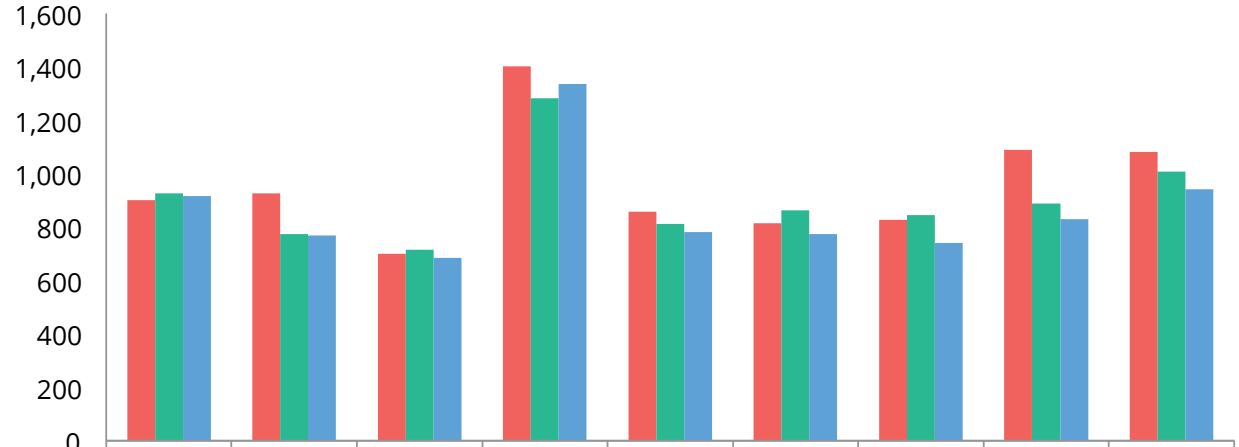
Adult Acute Re-admissions

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

At the end of 2017 the number of re-admissions was 7,776. This is compared to 8,111 at the end of 2016. Re-admissions accounted for 64.0% of admissions in 2017.

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

Adult Acute Re-Admissions by CHO

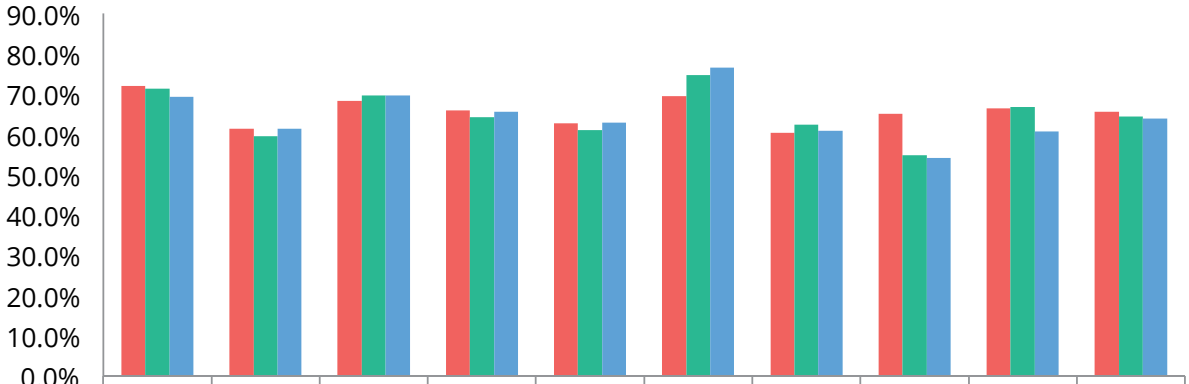


	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	902	926	700	1,403	857	815	827	1,089	1,081
2016	926	773	715	1,282	811	863	846	887	1,008
2017	917	768	685	1,337	782	774	742	829	942

Percentage of Re-admissions

	2015		2016		2017	
CHO 1	902	71.9%	926	71.3%	917	69.3%
CHO 2	926	61.3%	773	59.5%	768	61.3%
CHO 3	700	68.4%	715	69.7%	685	69.6%
CHO 4	1,403	66.0%	1,282	64.2%	1,337	65.6%
CHO 5	857	62.7%	811	61.1%	782	63.0%
CHO 6	815	69.5%	863	74.7%	774	76.5%
CHO 7	827	60.4%	846	62.4%	742	60.9%
CHO 8	1,089	65.0%	887	54.7%	829	54.1%
CHO 9	1,081	66.5%	1,008	66.8%	942	60.6%
National	8,600	65.5%	8,111	64.4%	7,776	64.0%

Percentage of Adult Acute Re-Admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	71.9%	61.3%	68.4%	66.0%	62.7%	69.5%	60.4%	65.0%	66.5%	65.5%
2016	71.3%	59.5%	69.7%	64.2%	61.1%	74.7%	62.4%	54.7%	66.8%	64.4%
2017	69.3%	61.3%	69.6%	65.6%	63.0%	76.5%	60.9%	54.1%	60.6%	64.0%

Length of Stay

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

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

At the end of 2017 the median length of stay was 12 days.

Median Length of stay

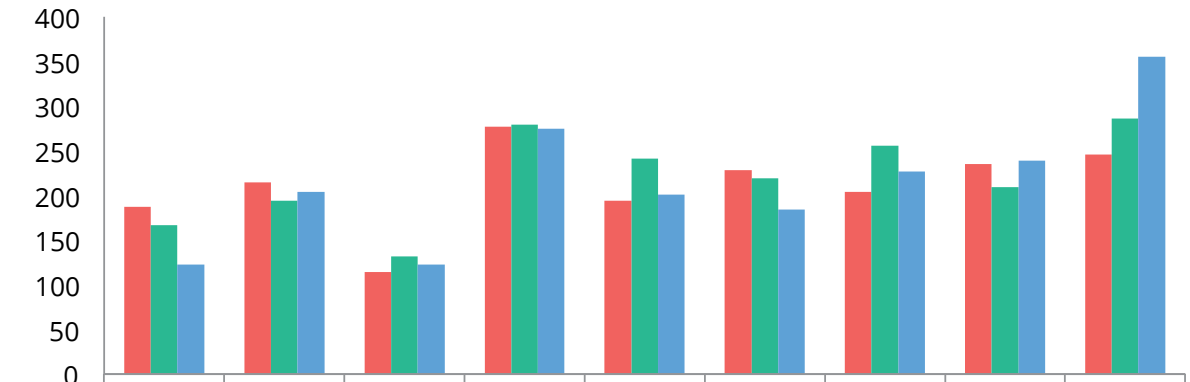
	2013	2014	2015	2016	2017
CHO 1	12	10.4	9.8	8.3	9.0
CHO 2	13.2	12.7	11.1	11.1	10.0
CHO 3	12.3	13.3	12.9	14.8	14.0
CHO 4	13.2	13.5	13.4	14.5	12.0
CHO 5	10.1	9.8	9.3	9.5	10.0
CHO 6	16.5	14.0	14.3	11.5	14.0
CHO 7	8.1	9.3	11.2	10.3	14.0
CHO 8	14.7	11.7	11.4	9.3	11.0
CHO 9	17.3	23.9	16.1	10.3	11.0
National	13.0	13.2	12.2	11.0	12.0

Involuntary Admissions to Adult Acute Inpatient Units

An involuntary admission refers to the legal status of each admission as recorded at the time of admission to acute units/hospitals in each CHO. At the end of 2017 the number of involuntary admissions was 1,931 (1,958 at the end of 2016). Involuntary admissions accounted for 15.9% of both first and re-admissions to adult acute inpatient units in 2017.

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

Involuntary admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2015	187	215	114	277	194	228	204	235	246
2016	167	194	132	279	241	219	256	209	286
2017	123	204	123	275	201	184	227	239	355

Data Notes

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

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

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

CHAPTER TEN
National Forensic Mental Health Service

Definition of the specialty:

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

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

Overview of the National Service

The National Forensic Mental Health Service (NFMHS) is the only forensic mental health service for the population of Ireland. It is currently located in Dundrum, Dublin, in the original building which was built in 1850. The Central Mental Hospital (CMH) provides secure hospital services at high, medium and pre- discharge levels. It is an Approved Centre under the Mental Health Act 2001 and the only designated centre under the Criminal Law (Insanity) Act 2006. The National Forensic Mental Health Service also provides forensic rehabilitation and recovery teams that meet the requirements of Section 13A of the Criminal Law (Insanity) Act 2010 concerning the supervision of patients who are conditionally discharged when found not guilty by reason of insanity. The National Forensic Mental Health Service and Central Mental Hospital is therefore subject to all the protections, rules and regulations that follow, including inspection by the Inspectorate of Mental Health Services

Currently the hospital has 93 inpatient beds and a number of community supported residences. The NFMHS also provides in-reach clinics at Cloverhill, Mountjoy, Dochas Centre, Wheatfield, the Midlands, Portlaoise, Castlerea, and Arbour Hill Prisons. It also provides a service to Oberstown Children Detention Centre. The prison in-reach clinics are provided in close cooperation with the Irish Prison Service primary care teams so that a system of two stage reception screening is used to ensure early intervention. Weekly multi- disciplinary multi-agency meetings are held to ensure continuity of care and monitoring across prisons and through-care pathways back to community services.

Following a successful planning application and the provision of funding, construction has commenced on the building of a new hospital on the Portrane site in North Dublin. It is expected to be completed in Quarter 3 2019. This new facility will increase the current bed capacity from 93 inpatient beds to 170. The 170 beds include 10 specialist FMHID beds, 10 Forensic Child and Adolescent (FCAMHS) beds and a 30 bedded ICRU and additional bed capacity for women which will allow for the development of a care pathway for women. The transition programme is been actively developed and will constitute a major project for the HSE and the NFMHS over the next 2 years

Who is referred?

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

Referred by whom

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

Where assessed

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

Recovery

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

Special Needs Groups

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

Service Activity Levels of Prison In-Reach Teams

Trends in committals to Irish prisons by gender and total, 2007-2017 as per Irish Prison Service Annual Report 2017.

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

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

Prison In-reach Service 2017

Prison	New Referrals	Patient Reviews	Transfer to other In-reach teams	Transfer from other In-reach teams	Total discharges	Avg. % Met Clinics
Arbour Hill	19	206	3	5	21	95%
Cork (Nov + Dec only)	41	107	2	2	15	100%
Clover Hill	321	1,556	73	1	221	86%
Castlerea	65	201	11	8	44	97%
Dochas	115	438	2	0	105	97%
Midlands	122	711	17	47	122	92%
Mountjoy	127	1340	16	24	127	95%
Portlaoise	14	105	0	0	2	100%
Shelton Abbey	3	10	0	0	0	100%
Wheatfield Place of Detention	61	680	18	16	58	99%
Oberstown Children Detention Campus	38	69	0	0	35	100%
Total	926	5,423	142	103	750	96%

Service Activity Levels of Central Mental Hospital

The number of persons found not guilty by reason of insanity has increased year on year since the law reforms of 2006 and 2010. The obligation on the Mental Health (Criminal Law) Review Board and on clinicians to act in the best interests of the patient and in the public interest means that length of stay is no longer falling. There were a total of 196 Mental Health Review Boards and 17 Mental Health Tribunals in 2017.

Admissions and Discharges 2007 to 2017

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

Waiting List

The numbers admitted and discharged each year are therefore falling while demand from the prison population and local approved centres is increasing. Over the past 3 years there has been a large increase in the number of patients found Not Guilty for Reason of Insanity (NGRI) (see table below). The waiting list for admission to the Central Mental Hospital is therefore an increasingly prolonged one, leading to admissions driven almost exclusively by crisis and worsening psychosis while on the waiting list and an increase in NGRI verdicts. For 'legacy' reasons the NFMHS has 2 secure forensic beds per 100,000 population while most modern European states have in excess of 7 secure forensic beds per 100,000. It is intended to open ten additional beds at the Central Mental Hospital as part of the transition to the new Central Mental Hospital in Portrane in 2020.

NGRI Verdicts

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
NGRI	7	4	3	1	2	5	6	5	16	7	56

Length of Stay

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

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

Cross-sectional length of stay in bands.

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

Service Activity Levels of Forensic Rehabilitation and Recovery Teams

Patient Numbers 2017

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

Community Consultation and Liaison Work

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

Community Consultation and Liaison Clinics 2017

	Referrals	Referrals Seen
Referrals received from HSE Community Mental Health Teams conducted in our outpatient clinic in Usher's Island and Approved Centres nationally	76	54
Referrals seen for the purpose of reports at request of Judges of District and Circuit Courts, DPP, Solicitors, and Prison Referrals from prison with no inreach	250	250
Prison in-reach team Cloverhill Prison Voluntary & Requested reports to District & Circuit Courts	152	152
Requests for psychiatric reports for inpatients.	16	16
Total	494	472

CHAPTER ELEVEN

Other Specialty and Subspecialty Mental Health Services

Mental Health Intellectual Disability

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

A Vision for Change recommends that specialist Mental Health Intellectual Disability (MHID) services are required for those with moderate or greater degrees of intellectual disability and co-morbid mental illness/behavioural problems. These individuals need to be responded to based on age related mental health service i.e. Child and Adolescent Intellectual Disability Mental Health Services (CAMHS-ID) and Adult MHID services.

In addition, approximately a third of those with mild learning disability who develop a co-morbid mental illness may be better served by specialist age related MHID services.

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

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

Mental Health Service provision is more complicated for people with intellectual disability as many MHID services are provided directly by the HSE and also by voluntary agencies. These voluntary agencies provide holistic ID services and in addition have a number of Consultant Psychiatrists and some multi-disciplinary staff specialising in the area of MHID. These agencies are funded by the HSE through annually negotiated Service Level Agreements.

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

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

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

The National MHID Service Development programme's aim is to operationalise Vision for Change and provide specialist, multi-disciplinary, community MHID services for adults and children, across Ireland. In 2017 the programme specifically looked at:

- Mapping all existing resources, including pre 2013 posts, in both the HSE and voluntary ID agencies. A specific focus was on looking at allocated posts, to determine which are in place and which remain to be filled.
- Establishing Community Health Operations (CHOs) MHID Service plans which detail MHID service development per CHO and clarify access to services based on governance and catchment area agreements between the HSE and local voluntary agencies
- Planning "Baseline" teams where they are needed across the country, to ensure equitable access for service users
- Developing a national Model of Service to support service delivery and ensure consistency and high standards in practice.
- Establishing a national Clinical Activity Data Collection Process for MHID

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

Mental Health and Intellectual Disability Services Workforce

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

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

Vision for Change Recommendations v. Actual Staffing (2017)

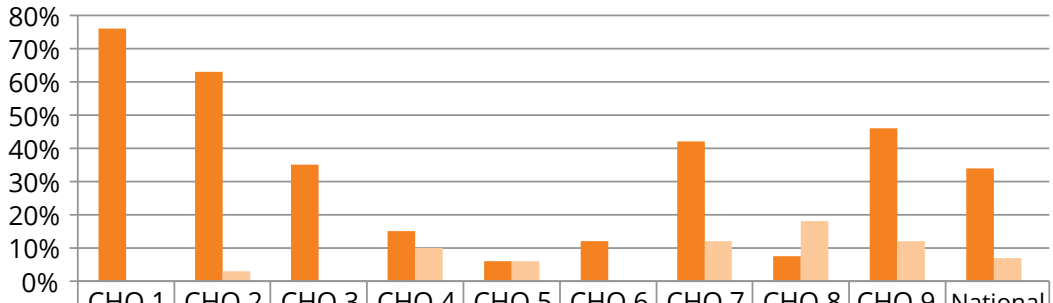
MHID Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2017
Adult MHID teams	1 : 150,000	31	17	310	99.6
CAMHS-ID	1 : 300,000	16	3	160	12
Total		47	20	470	112.6
				Total Staff	111. 6

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

Staffing of Mental Health and Intellectual Disability Teams

In December 2017 there was a total of 110.6 staff in Adult MHID Teams nationally (91.8 Clinical). This represents 31% of the clinical staffing levels recommended in A Vision for Change. CAMHS-ID had a total of 12 staff nationally, all clinical. This represents 7% of the clinical staffing levels recommended in a Vision for Change.

Adult MHID and CAMHS-ID Teams Staffing vs. VFC recommendations in 2017



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
Adult MHID	76%	63%	35%	15%	6%	12%	42%	7.50%	46%	34%
CAMHS-ID	0%	3%	0%	10%	6%	0%	12%	18%	12%	7%

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

A mapping exercise of the staffing of Mental Health and Intellectual Disability Services including CAMHS –ID teams, was carried out in various stages in 2017. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in MHID services in 2017 was 111.6.

In December 2017, there was 98.6 staff (clinical 91.8) working in 16 MHID teams, with an average of 6.16 staff, 5.73 of which were clinical staff. The range of team size varies from the smallest team of 1.3 (1.3 clinical) to the largest which comprises of 8.2 (7.2 clinical). The variation in team size can arise due to team development and ability to fill posts, posts can remain unfilled due to various factors including shortage of qualified applications, geographic catchment areas etc.

In December 2017, there was 12 staff all clinical working in CAMHS-ID nationally. Of that total, 8.3 clinical staff were working in 3 CAMHS-ID, with an average of staff, 2.7. The range of team size varies from the smallest team of 2.3 to the largest which comprises of 3.5. The remainder 3.7 clinical staff are Consultant Psychiatrists working on their own, without a team.

Adult MHID and CAMHS-ID Teams Staffing and VFC recommendations per CHO in 2017

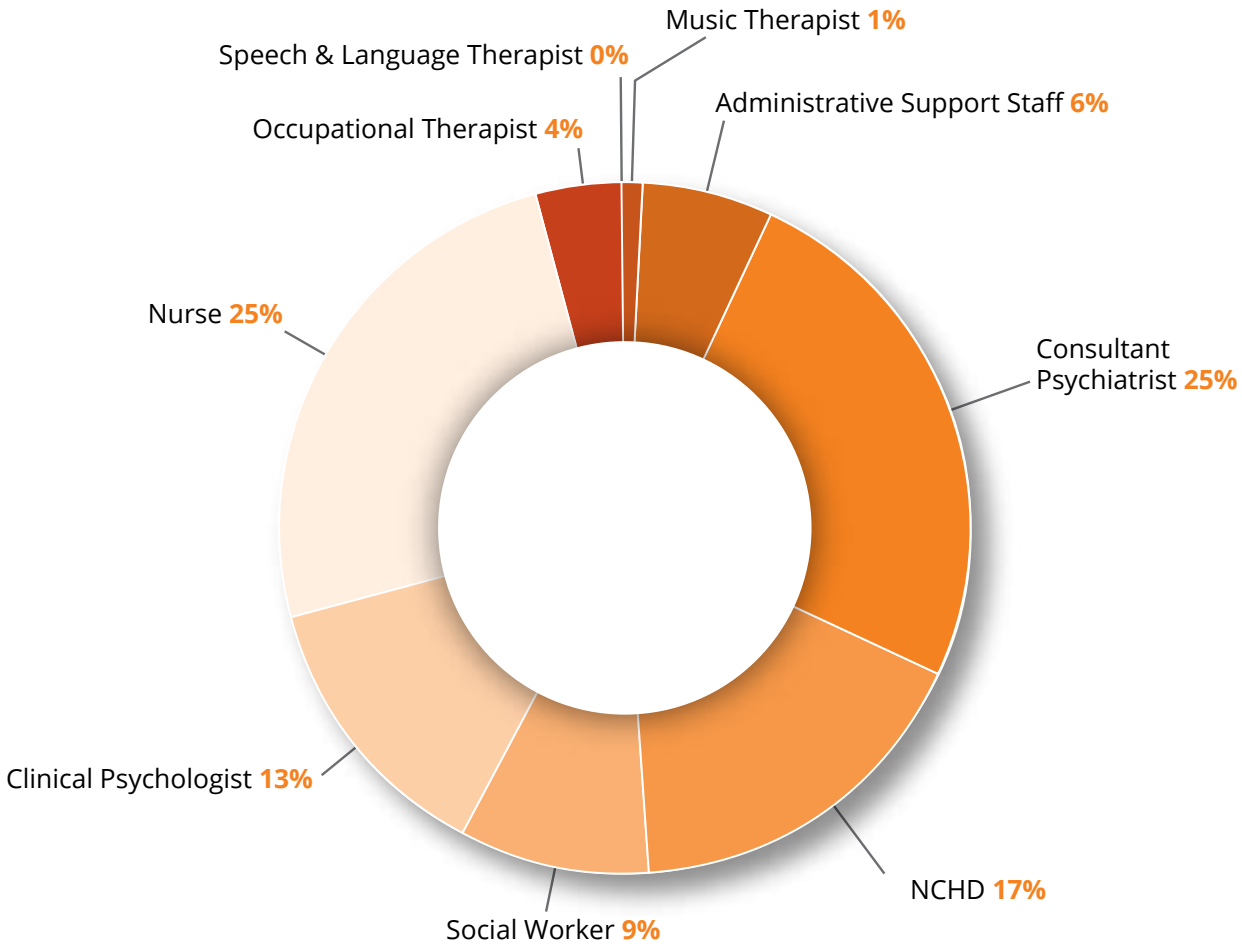
	Population Census 2016	Adult MHID Staffing 2017	% of VFC rec 2017	CAHMS-ID Staffing 2017	% of VFC rec
CHO 1	394,333	19.8	76%	0	0%
CHO 2	453,109	19	63%	0.5	3%
CHO 3	384,998	9	35%	0	0%
CHO 4	690,575	7	15%	2.25	10%
CHO 5	510,333	2	6%	1	6%
CHO 6	445,590	3.5	12%	0	0%
CHO 7	645,293	18.1	42%	2.5	12%
CHO 8*	616,229	3	7.5%	3.5	18%
CHO 9	621,405	18.2	46%	2.3	12%
National	4,761,865	99.6	34%	12	7%

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

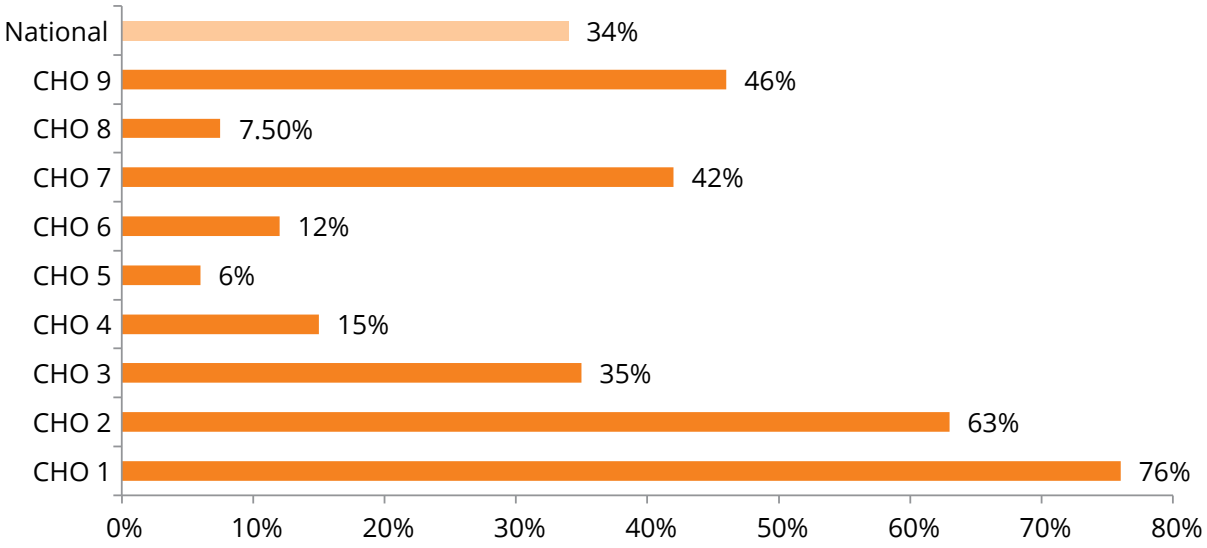
MHID Teams Staffing by discipline 2017

2017	Adult	CAMHS-ID
Consultant Psychiatrist	20.3	7.25
NCHD(Senior Registrar & Registrar/SHO	17.1	1.8
Social Worker	10	0
Clinical Psychologist	12.8	2
Nurse	26.4	1
Occupational Therapist	5	0
Speech & Language Therapist	0.4	0
Music Therapist	0.8	0
Administrative Support Staff	6.8	0
Total	99.6	12

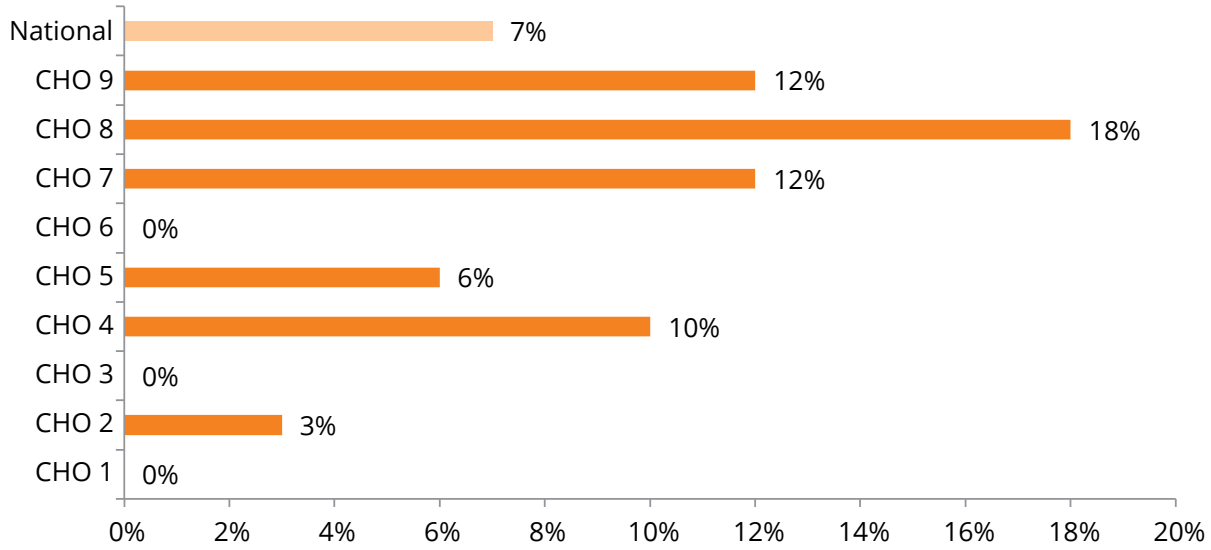
Workforce of Adult MHID and CAMHS-ID Teams by profession 2017



Adult MHID Teams Staffing vs. VFC recommendation by Community Healthcare Organisations 2017



CAMHS-ID Teams Clinical Staffing vs. VFC recommendation by Community Healthcare Organisations 2017



Liaison Psychiatry

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

These services are designed to operate away from traditional mental health settings in Acute Hospital Emergency Departments and wards and medical and surgical outpatients. The teams are multidisciplinary and clinically led by a consultant liaison psychiatrist who will have higher specialty training in General Adult Psychiatry with subspecialty endorsement in Liaison Psychiatry. Many liaison psychiatrists will also have Higher Specialty Training in General Medicine or General Practice.

The multidisciplinary team should include specialist Mental Health Nurses, Clinical Psychologists, Occupational Therapists and Social Workers together with high quality administrative support.

The rationale for developing the subspecialty is as follows:

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

Hence, liaison psychiatry provides a key link between physical and mental health care providers thereby ensuring people using acute hospitals have access to mental health services. An important task of hospital based liaison psychiatry services is to ensure that there are strong links with other mental health services particularly those based in the community.

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

Specialist Perinatal Mental Health Services

Background

Perinatal Mental Health Disorders are those which complicate pregnancy and year post-partum. They can be new onset, re-occurrence or relapse of pre-existing disorder. The unique aspect is the potential negative impact on mother/child relationship, which can lead to significant emotional/behavioural/cognitive problems in the child. A National Working group began work in October 2016, it was multidisciplinary and had service user input from AIMs Ireland.

Specialist perinatal mental health services are vital because of the very negative consequences of perinatal mental health disorders for the mother, the baby, their relationship and that with the partner and other children. The specific circumstances of pregnancy, birth and early mother/infant bonding requires staff who are knowledgeable, skilled, sensitive and experienced.

Hence the philosophy underpinning this model of care is its focus on: the mother, the baby, their relationship in the context of the family.

Integrated Model

- In line with maternity networks and developed within hospital groups hub and spoke model with those hospitals who have the largest number of deliveries – the hub, one in each hospital group. Hubs will host multidisciplinary specialist perinatal mental health teams.
- Links are being developed between maternity services and mental health services in the maternity settings. At the same time links with community mental health teams and maternity perinatal services are being established to provide an integrated response to women who require mental health support services in the perinatal period.
- Work is continuing in linking with the Department of Health (DOH) and the National Women and Infants' Health Programme (NWIHP) in particular on the development of Mental Health midwife posts and other clinical areas to support this integrated care model for women.

Outcome

The Specialist Perinatal Mental Health Service Model of Care was formally approved and launched by the HSE in November, 2017.

The Department of Health allocated €1m in Programme for Government (PFG) funding in 2017 to initiate this implementation.

From December 2017 onwards the focus of the Clinical Lead and Programme Manager has been on supporting local services to recruit the staff through the 2017 funding allocation. Together with the existing staff this will ensure each of the six perinatal hubs has a consultant psychiatrist with special responsibility for perinatal psychiatry and a mental health nurse at CNS level.

Rehabilitation and Recovery Mental Health Services

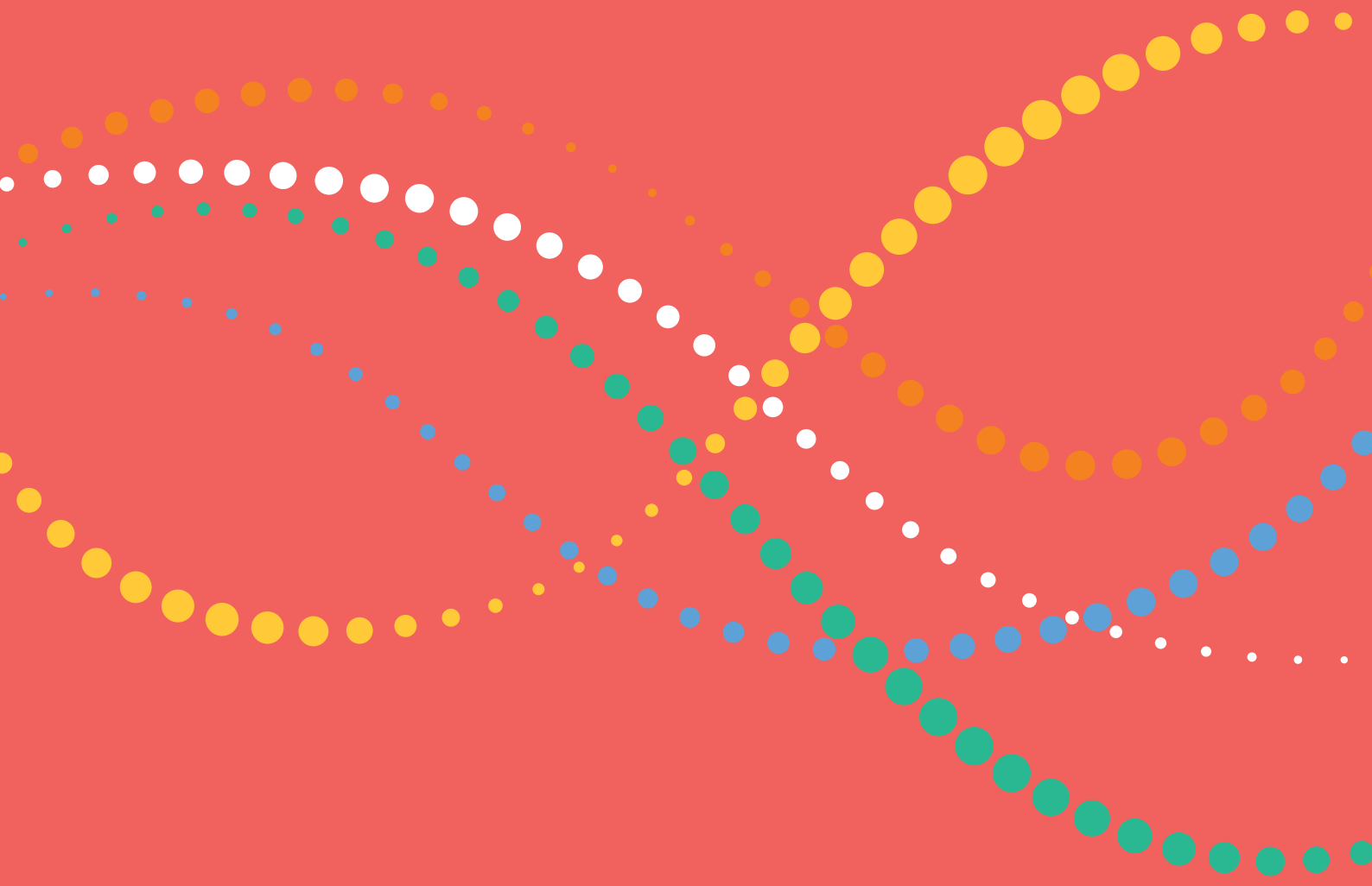
Killaspy et al., 2005 defines this area of practice as "a whole systems approach to recovery from mental illness that maximises a known individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future leading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

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

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

The Mental Health Division has provided for the development of rehabilitation services by allocating investment funding for the development of these services where they have not existed to date. Additionally the Mental Health Division published a National Framework for Recovery in Mental Health in 2017.

CHAPTER TWELVE
Conclusion



As can be seen from the foregoing, Mental Health Services have continued the journey of transformation from hospital to community based services, and in many areas have gone further in developing multi-disciplinary, community-based alternatives to hospital than any other part of the health system. This transformation of services has been guided by the Mental Treatment Act 2001 and the associated regulations and the Government Policy document "A Vision for Change" Report of the Expert group on Mental health Policy (Government of Ireland 2006). The strategic direction of mental health policy will be further informed by the 'Evidence Review to Inform the Parameters for a Refresh of A Vision for Change' report published in February 2017 and by the implementation of the Slaintecare Report.

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

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

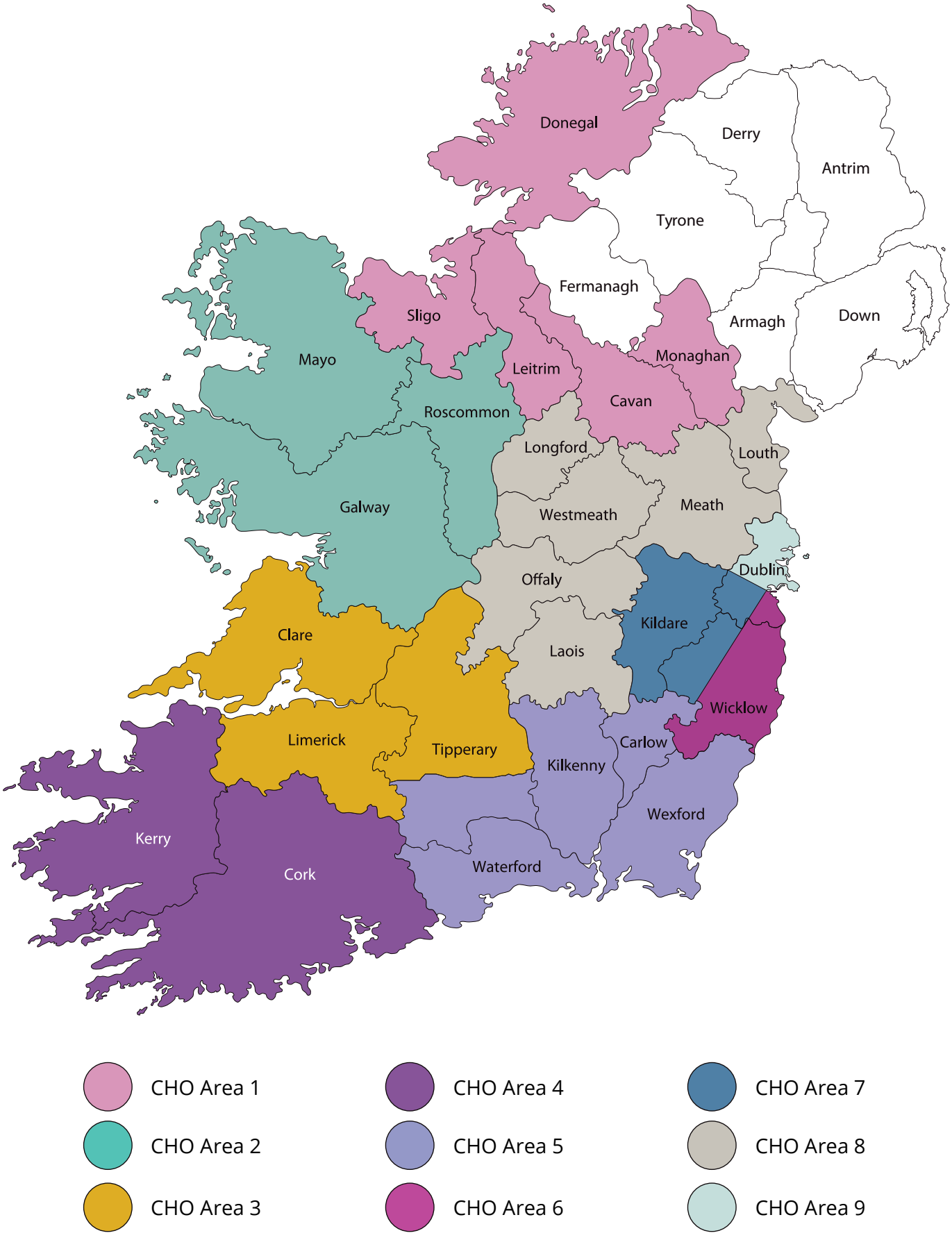
The Report has provided up to date information on activities in Acute Inpatient Units, Child and Adolescent Mental Health, General Adult, Psychiatry of Old Age and the National Forensic Mental Health Service. Information on sub-specialities including MHID, Liaison Psychiatry, and other specialist mental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

In reporting on activity in 2017, Mental Health Services are cognisant and supportive of the planned changes in the H.S.E. in 2018. These changes will see a move from the divisional structure to and integrated community model of service delivery. The move to a community model is essential to ensure that services can be provided to patients and service users in primary and community settings reducing over-reliance on more costly, hospital-based care. Significant work will be undertaken in Mental Health Services in 2018, in line with Sláintecare, to plan for the changes required. For 2018, our objective is to maintain quality, deliver good outcomes and recognise that there are opportunities, even in a constrained financial environment, to provide excellent health and social care services to the population. The system will ensure that the resources available to health and social care are targeted towards providing care and support for those patients and clients most in need, and ensuring that these services are delivered efficiently and effectively, consistent with best available evidence.

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

Appendix 1

Community Health Organisations (CHOs)



Community mental health service populations by CHO

	CAMHS		GAMHT		POA	
CHO Areas	0 - < 18 years	Total pop	>=18 years to <64 years	Total pop	> = 65 years	Total pop
CHO 1	103,778	394,333	230,492	394,333	60,063	394,333
CHO 2	111,880	453,109	272,671	453,109	68,558	453,109
CHO 3	96,266	384,998	232,797	384,998	55,935	384,998
CHO 4	168,542	690,575	423,156	690,575	98,877	690,575
CHO 5	131,522	510,333	304,509	510,333	74,302	510,333
CHO 6	116,264	549,531	274,412	424,772	59,799	424,772
CHO 7	144,296	541,352	422,098	666,111	74,014	666,111
CHO 8	172,373	616,229	369,598	616,229	74,258	616,229
CHO 9	145,581	621,405	404,063	621,405	71,761	621,405
Total	1,190,502	4,761,865	2,933,796	4,761,865	637,567	4,761,865
Percentage	**25.00%**		**61.60%**		**13.40%**	

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

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

Appendix 2 Mental Health Service Improvement Projects 2017

2017 Service Improvement Projects

Project No.	Project Name	Executive Sponsor	Project Manager	Strategic Prog.	RAG status	Status Report	*Change Board approval required
AOE002	National Mental Health e-Rostering Project	Yvonne O'Neill	Lily Connolly	AO & E	Green	Pg 13	None - remains in Planning
AOE003	MHD ICT Infrastructure Improvement Project (Phase 1)	Yvonne O'Neill	Fearghal Duffy	AO & E	Green	Pg 16	None - remains in Implementation
AOE004	Standardised Management of first/ re-referred appointment DNA's in the Community Mental Health setting	Yvonne O'Neill	Philip Flanagan	AO & E	Green	Pg 18	Approval to close the project
AOE006	Integrated Mental Health System	Yvonne O'Neill	Mike McInerney	AO & E	Green	Pg 21	Approval to close the project
AOE007	Standardised process for Service User Journey within General Adult Community Mental Health Teams	Yvonne O'Neill	Ciara Latimer	AO & E	Green	Pg 23	Approval to move from Discovery to Initiation
AOE008	Mental Health Services Workforce Plan Programme Phase 1 – Assessing the Supply and Future Demand	Yvonne O'Neill	Adrienne Doherty	AO & E	Green	Pg 25	None – remains in Implementation
SIQ003	Development of a Framework for Recovery in Mental Health 2018-2020	Yvonne O'Neill	Michael Ryan	SIQ	Green	Pg 28	Approval to close the project
SIQ005	National Peer Support Worker Implementation	Jim Ryan	Michael Ryan	SIQ	Green	Pg 33	Approval to move from Implementation to Closure

SIQ006	Implementation of Team Coordinators for Community Mental Health Teams	Jim Ryan	Patricia O'Neill	SIQ	Green	Pg 36	None - remains in Implementation
SIQ007	Develop a Stepped Model of Mental Health Care for the Homeless Population in Dublin (CHO 6,7,9)	Jim Ryan	Una Twomey	SIQ	Red	Pg 38	In Exception - Feasibility report with Steering Committee
SIQ008	Review of the CAMHS SOP	Jim Ryan	Sarah Hennessy	SIQ	Green	Pg 42	None – remains in Implementation
SIQ009	Choice and Partnership Approach (CAPA)	Jim Ryan	Sarah Hennessy	SIQ	Green	Pg 47	None – remains in Discovery
SIQ010	Developing Weekend Community Mental Health Services in Ireland	Jim Ryan	Patricia O'Neill	SIQ	Green	Pg 50	None - remains in Implementation
SIQ011	Implementation of the HSE Best Practice Guidance for Mental Health Services	JP Nolan	Linda Moore	SIQ	Green	Pg 52	Approval to move from Discovery to Initiation and from Initiation to Planning
IAD001	Develop a model of care for people with Severe and Enduring Mental Health Illnesses and Challenging Behaviours	Jim Ryan	Anne Callanan Cahill	IAD	Green	Pg 56	None – remains in Implementation
IAD002	MHID	Jim Ryan	Ciara Latimer	IAD	Green	Pg 60	None – remains in Implementation
IAD003	Transfer of National Forensic Mental Health Service Inpatient beds from CMH to Portrane	Jim Ryan	TBC	IAD	N/A	Pg 63	N/A
SUE001	Mental Health Engagement - Research & Evaluation	Liam Hennessy	Gerry Maley	SUE	Amber	Pg 64	None - remains in Initiation
SUE002	Implementation of the roles and structures to support mental health engagement through local and area for a development and Area Leads posts	Liam Hennessy	Catherine O'Grady	SUE	Green	Pg 66	Approval to move from Implementation to Closure
SUE003	Training and capacity building required to support roles and engagement structures	Liam Hennessy	Catherine O'Grady	SUE	Green	Pg 69	Approval to move from Implementation to Closure
SUE004	Formalization of Service User, Family Member and Carer Engagement Recognition and Reward Procedures	Liam Hennessy	Conor Kennedy	SUE	Green	Pg 72	Approval to move from Initiation to Planning and from Planning to Implementation
SUE005	Development of an Independent Advocacy service in CAMHS	Liam Hennessy	Michael Ryan	SUE	Green	Pg 75	None- remains in Initiation
SUE006	Implementation of the National Recovery Framework in Mental Health 2018-2020	Yvonne O'Neill	Gina Delaney	SUE	Green	Pg 77	None – remains in Discovery
PWB001	Alignment of CHO CFL Action Plans	Jim Ryan	Poul Walsh Olesen	PWB	Green	Pg 79	Approval to move from Implementation to Closure
PWB002	CFL action 4.1.4	Jim Ryan	Una Twomey	PWB	Green	Pg 82	None – remains in Discovery
PWB003	CFL action 4.3.1.	Jim Ryan	Una Twomey	PWB	Green	Pg 84	None – remains in Discovery
PWB004	CFL action 5.2.1	Jim Ryan	Una Twomey	PWB	Green	Pg 86	None – remains in Discovery
PWB005	Physical Health Needs of Mental Health Service Users	Jim Ryan/ Philip Dodd	Laura Molloy	PWB	Green	Pg 88	Approval to move from Discovery to Initiation
PWB006	HSE Best Guidance Suicide Prevention Services	John Meehan	Brid Casey	PWB	Green	Pg 90	Approval to move from Discovery to Initiation and from Initiation to Planning

*Subject to receipt of required documentation and project level approval

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

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

Mental Health Performance Reports can be found at

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

Health Service Executive
Dr Steevens' Hospital
Dublin 8
Tel: +353 (0)1 635 2000
www.hse.ie

HSE Mental Health Services