HSE Mental Health Division

Delivering Specialist Mental Health Services

2019

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. It is also a very valuable tool in allowing scarce resources to be allocated to areas of greatest need.

Over the course of 2018/19, the HSE incorporated structures to support strategic and operational planning. The structure for the Mental Health Strategy & Planning function includes a planning and commissioning team with membership including representation across key functions of mental health service planning e.g. Community Operations, Strategy and Planning, Finance, HR, NCAGL and Mental Health Engagement and Recovery. The team has overall responsibility for the management of Programme for Government funding, and is responsible for the effective planning, development and implementation oversight of all strategic approaches to mental health delivery.

This report details the work in mental health service delivery across a range of specialist services. Mental Health Services are increasingly focused on recovery and on facilitating active partnerships between service users, carers and mental health professionals. It is important to note that the continued investment of Programme for Government funds plays a key role in allowing mental health services to develop and provide additional recovery orientated services.

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 consistent work of frontline staff in mental health services nationally.

The work of the Planning and Business Information (PBI) Unit of the Deputy Director General's Office for supporting the Service 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, Philip Flanagan Mental Health Service, Dr Siobhan Ni Bhrian (to March 2020) National Clinical Advisor and Group Lead for Mental Health, Dr Amir Niazi (from March 2020) National Clinical Advisor and Group Lead for Mental Health and Professor Harry Kennedy National Forensic Mental Health Services.

Jim Ryan
Head of Mental Health Services
June 2020

FOREWORD Specialist Mental Health Report 2019

On behalf of the HSE Mental Health Services, I am delighted to present the report on delivering Specialist Mental Health Services, 2019.

The vision for the mental health services is to support the population to achieve 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, through the development of clinical leadership at all levels in the organisation, and through fit for purpose infrastructure.

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

Now *Sharing the Vision – A mental health policy for everyone* (June 2020) is using the same approach but focusing on promotion, prevention and early intervention and also strengthening the relationship between the mental health service, primary care, and other integrated services.

The strategy for mental health services is also informed by policy 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"*. Sláintecare is a ten-year programme to transform our health and social care services, and plans to:

- Promote the health of our population to prevent illness
- Provide the majority of care at or closer to home
- Create a system where care is provided on the basis of need, not ability to pay
- Move our system from long waiting times to a timely service – especially for those who need it most
- Create an integrated system of care, with healthcare professionals working closely together

In Mental Health Services, we have managed to achieve a number of these aims in that care is community- oriented and delivered as close to home as possible; waiting lists in many parts of the country do not exceed three months for the majority of patients; and we work for the most part in multi-disciplinary teams that are well integrated. We will continue to improve on these services and work with our colleagues in other specialties to develop services that are integrated across the spectrum of care needs, including physical healthcare. Mental Health Services will play a key role in delivering on the Slaintecare agenda over the next ten years.

The spectrum of services provided through the Mental Health Services 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.

These services are further supported by the Clinical Care programmes in Self-harm, Eating disorders and Early Intervention Psychosis. Two more clinical programmes in perinatal psychiatry and Adult ADHD will improve the service delivery in these areas.

The National Office for Suicide Prevention (NOSP) is a core part of the Mental Health Service 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, community settings such as day hospitals, and acute settings. 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 community/voluntary sector partners.

Mental Health Services are fully committed to, and play an active part in, internal service improvement processes both within mental health and in the wider health system reform agenda.

Regionally the 9 Community Healthcare Organisations (CHOs) 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 CHOs. The Forensic Mental Health Service operates on a national basis. Details of CHOs and area population are provided in Appendix 1.

Dr Amir Niazi

National Clinical Advisor and Group Lead for Mental Health
June 2020

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 analyse the data generated by services to inform continuous quality improvement. The focus on data collection is both to drive service improvement and to inform service users and other stakeholders on activities in mental health services. This report is one strand in ensuring that activity data is disseminated as widely as possible and that the good practice, and the challenges in mental health services are 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 Reports 2014 to 2018, this 2019 report will provide an overview of the work of the specialist mental health services by describing the services delivered, detailing the resources available to the services and showing the activity of those services in 2019.

The Service 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.

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 Healthcare 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 Later Life, etc.), day hospitals, out-patient clinics, continuing care settings and community residential services. Also included is 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 services are coordinated and delivered through Community Mental Health Teams (CMHTs), which are designed to serve the needs of particular care groups across the lifespan from childhood to later life.

Within this multidisciplinary team, 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 2019 there was a total of 698 staff in the Child and Adolescent Community Mental Health Teams nationally (602 Clinical). This represents 57.5% of the clinical staffing levels recommended in *A Vision for Change* which is an increase of 0.6% nationally on the 2018 position
- In December 2019 there was a total of 1,753 staff in the General Adult Community Mental Health Service (1,541 Clinical), which represents 77.1% of the clinical staffing levels recommended in *A Vision for Change*
- In December 2019, there were 362 staff (clinical 319) working in 32 Psychiatry of Later Life Service teams, which represents 61% of the clinical staffing level as recommended in *A Vision for Change*

Child and Adolescent Mental Health Services

- In 2008 there were 49 CAMHS Community Mental Health Teams. There are 71 teams in place in 2019
- There has been a 23% increase in referrals accepted between 2012 and 2019
- 12,174 new appointments were offered in 2019
- 48% of new appointments were seen within 4 weeks
- A quarter of new cases seen were aged over 16 years
- 8.5% of new patients did not attend their first appointment
- In 2007, 3,609 individuals were waiting to be seen; in 2019, 2,327 individuals were waiting to be seen.

General Adult Mental Health Services

- There are 111 Community General Adult Mental Health Teams
- There has been a 0.3% decrease in referrals accepted from 2018 to 2019
- 34,792 new appointments were offered in 2019
- Almost one fifth of new appointments were seen within 1 week
- 30.3% were seen within 2 weeks & 47.7% were seen within 4 weeks
- Over 1 in 5 new patients did not attend their first appointment.

Psychiatry of Later Life Mental Health Services

- In 2013 there were 22 POLL teams; there were 32 POLL teams in place in 2019
- There has been an 8.5% increase in referrals from 2014 to 2019
- 9,134 new appointments were offered in 2019
- 36.9% new appointments were seen within 1 week
- 78.3% new appointments were seen within 4 weeks
- 2.3% new patients did not attend their first appointment.

Child and Adolescent Acute Inpatient Services

- In 2008, there were 16 CAMHS Acute Inpatient beds. By the end of 2019, there were 72 CAMHS Acute Inpatient beds
- In 2008, 25% of admissions of children were to CAMHS acute inpatient beds. By the end of 2019, 86% of admissions of children were to CAMHS acute inpatient beds
- There was a 46% decrease in the number of bed used in adult approved centres
- 96% of the total bed days used by children who were admitted were in Child and Adolescent Acute Inpatient Units
- Of the 14% (50) admitted to Adult Approved Centres, 94% (47) were 16/17 years old with 48% (24) of these discharged either the same day or within 3 days and 82% (41) 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 there were 16,293 admissions in 2007 to acute units - in 2019, there were 12,134 admissions
- In 2007 there was a 72% re-admission rate; in 2019 this rate reduced to 69%
- Median length of stay was 11.3 days.

Chapter 1

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.

The Mental Health Services place 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.

All Community Health Services including Mental Health Services remain challenged in providing detailed information about 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. Mental Health Services are fully committed to providing ICT enabled solutions to meet their information and decision support requirements, and are working to develop a business case for a national electronic health record (EHR) that will capture the interaction between patients and clinicians and provide detailed information on activities on mental health services. Pending the implementation of an EHR, Mental Health services are committed to extracting maximum value from the current information system.

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 services and how they are accessed by service users. Chapter three describes the investment made in mental health services including the Programme for Government funding available to mental health since 2012.

Chapter four 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 five to ten 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 eleven of the Report provides an overview of the development of specialist and subspecialist mental health services including National Forensic Mental Health Services, 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 is 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.

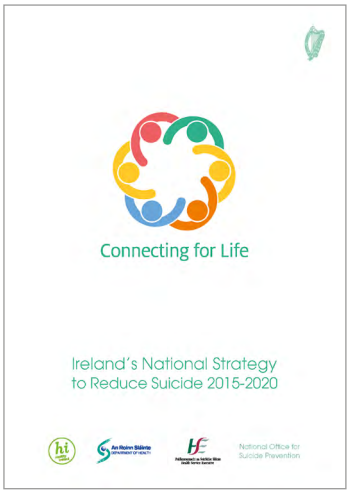
CMHTs have a number of core functions. They are there to:

- 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.

The Strategic Context for Suicide Prevention



Connecting for Life, Ireland's National Strategy to Reduce Suicide, was published in 2015 and continues to inform targeted suicide prevention initiatives and services across the country. The strategy was developed in line with national and international evidence associated with effective suicide prevention strategies.

Connecting for Life is designed to coordinate and focus the efforts of a broad range of government departments, state agencies, non-statutory organisations and local communities in suicide prevention. In addition to the national strategy, a further 17 Local Action Plans have been developed. Local planning builds capacity at a community level to respond to suicide and encourages community engagement on the delivery of other Connecting for Life actions. Key responsibility for local plans lies within the HSE Mental Health and Healthcare Areas structures and the more than 20 Resource Officers for Suicide Prevention (ROSPs) nationwide.

The work of the HSE National Office for Suicide Prevention (NOSP) is underpinned by the Connecting for Life strategy, which has influenced the core functions of the office, namely;

- The NOSP is a lead agency for 16 Connecting for Life actions - driving improvement initiatives that advance efforts to deliver on the actions assigned to it, in the strategy.
- In addition, the NOSP is a joint lead on two further actions and a supporting partner on 21 actions. The office supports or resources projects related to these actions, in collaboration with the lead agencies who are assigned to them.
- The NOSP has a pivotal role to play in driving the implementation of Connecting for Life. The strategy mandates NOSP to support, inform, coordinate and monitor the implementation of Connecting for Life across the HSE, government departments, statutory agencies and NGOs (non-governmental organisations). As a whole-of government strategy, Connecting for Life requires the office to provide a strategic view of progress against agreed milestones and outputs as well as to evaluate specific activities and to report on these to the National Cross-Sectoral Steering and Implementation Group, on a quarterly basis.
- The NOSP also works in synergy with colleagues across the HSE, government departments and within the NGO and community sector, in an advisory and supportive role on activities or projects aligned with the Connecting for Life Strategy or on suicide and self-harm prevention and awareness.

Key Developments in 2019

1. The publication of the Interim Strategy Review of Connecting for Life:

The NOSP invited the Connecting for Life Evaluation Advisory Group (EAG) to undertake an independent Interim Review of the strategy, which was published in early 2019. The aims of the review were to examine the extent to which the key actions of the strategy are on-track to being achieved (by 2020), to help identify what is working well and where the challenges lie, and to help set strategic priorities for the next two years and beyond.

2. The development of the Education and Training Plan 2019-2020:

Education and training is one of the key components of work to achieve the vision of Connecting for Life. The NOSP is the national coordinator for suicide prevention and self-harm awareness training across Ireland and supports the delivery of a comprehensive suite of evidence-informed training programmes in suicide prevention, intervention and postvention. Delivery has been expedited by

the advancement of strong links and partnerships with agencies such as the Defence Forces, Garda Training College Templemore and ICGP.

In 2019, approximately 14,500 individuals completed programmes such as safeTALK, ASIST (Applied Suicide Intervention Skills Training), STORM, Understanding Self-harm and Suicide Bereavement.

3. Investment in services:

In 2019, the NOSP spend was over €12.2m, representing a significant increase in suicide-prevention-specific funding over the last 10 years. For example, the budget for the office in 2012 was €5.2m.

Over €7.1m of the office's expenditure in 2019 was to agencies and front-line services making coordinated efforts to meet Connecting for Life objectives and actions, across seven overarching strategic goals. Some key recipients were Samaritans, Pieta House, the National Suicide Research Foundation, Aware, Exchange House Ireland and BelonG To. This high level of investment is reflective of the abundance of suicide prevention initiatives aligned with Connecting for Life that are underway nationally.

For more information;

- Visit www.connectingforlifeireland.ie for updates on the strategy and its implementation, upcoming training, publications and reports.

Connecting for Life

Chapter 2

National Mental Health Clinical Programmes

Clinical Design & Innovation

Office of Chief Clinical Officer

The National Clinical Programmes for Mental Health established in 2011 are part of a family of health related programmes established in the HSE to develop high quality health services that are based on best international practice aimed at improving patient safety, value and equity.

All of the programmes are now at various stages of implementation. The NCAGL office for Mental Health works very closely with Mental Health operations to deliver the programmes in line with each model of care. We continue to work with our partners including the College of Psychiatrists of Ireland, health and social care professionals, nursing office, service users and family members and voluntary partners to ensure full implementation.

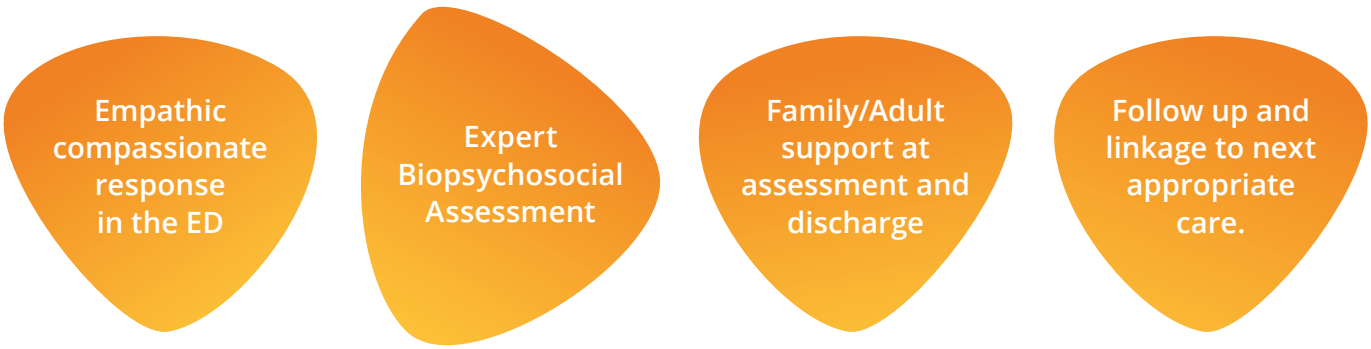
There are currently five Mental Health Clinical Programmes:

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

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

People who self-harm are known to present an increased risk of completing suicide. This Clinical Programme aims to provide a standardised specialist response to individuals presenting to the Emergency Department (ED) following self-harm and, by so doing, reduce the numbers leaving ED without receiving a biopsychosocial assessment; it aims to involve family members at assessment and discharge and to ensure people are linked to appropriate next care. (Diagram 1. The overall aim is to improve engagement with appropriate care and thereby reduce repetition of self-harm. The Mental Health Service funds Clinical Nurse Specialists (CNS) to work within EDs in Model 3 and Model 4 hospitals. The CNS ensures the clinical programme is implemented and data is collected on each mental health assessment completed. CNSs receive clinical support and leadership from Consultant Psychiatrists in Liaison and General Adult Psychiatry.

Diagram 1. Four components of the Clinical Programme.



Impact of the clinical programme in 2019

- The programme is delivered in 24 of the 26 Adult Emergency Departments (ED) that are open 24/7.
- The recommended staffing is one CNS per 200 self-harm presentations per annum. At the end of 2019 there were 25 CNS in post with 19 vacant posts. In total 44 posts are required. Recruitment of staff has been challenging with the same pool of staff competing for many Clinical Nurse Specialist posts. The provision of the programme in paediatric hospitals (3 CNS posts) was not progressed due to recruitment issues. Strategies to address the recruitment of staff are in place. These include supporting nurses who are training towards CNS level and expanding the liaison team to include other disciplines.
- Additional expertise was added to the national team through the appointment of a national nurse lead (one day per week) and a data analyst (2 days per week).
- Addition of GP expertise of one session a month is currently under discussion with the ICGP. (Funded through the National Office for Suicide Prevention (NOSP)).
- The Implementation Advisory Group (IAG) and a Research and Audit Group (RAG) established in 2018 met on 4 occasions during 2019. The composition of the groups represents all stakeholders in the process.
- The IAG is reviewing the Model of Care – with emphasis on identifying improved pathways to care in the following situations: those who present to their GP as the first port of call; access to crisis care in the Community Mental Health team; and that the programme should be delivered to all ages, including children.
- The RAG has continued to work closely with the National Suicide and Research Foundation (NSRF) and the universities in improving standards in practice. Specific audit focus has been placed on Assessment Rooms in the ED and the delivery of an Emergency Care Plan.
- The national clinical lead conducted quarterly reviews with each service, including with the CNS, Consultant Clinical Lead, ECD, Director of Nursing and Head of service for Mental Health.
- Two training seminars were facilitated for Clinical Nurse Specialist (CNS) clinicians in April and October. Continuing Professional Development (CPD) points were awarded from the relevant professional training bodies.
- Joint training on safety planning was facilitated with NOSP in January. Non-consultant hospital doctors (NCHDs) and Clinical Nurse Specialists attended this one day training.
- Meetings with Assistant Directors of Nursing ADON were held in June and August

The programme continues to report on relevant objectives in Connecting for Life.

Data in 2019

The data collected every month from each emergency department during 2019 was collated and analysed through SPSS statistical software.

Key findings from data show an improvement in responses to patients presenting to the ED, with a higher percentage receiving written emergency care plans, next of kin involvement and follow up.

Table 1 on the following page outlines the data.

Table 1.
Attendances to 24 emergency department hospitals for self-harm related behaviors

	ED attendances 2019 n (%) No. of Patients Presenting
No. of Patients Presenting	13,125
Number of Patients Assessed (ED and Medical Wards)	11,622 (89%)
No. of patients leaving the ED Without biopsychosocial ass.	1,110 (8.5%)
Age groups	
<15	376 (2.9%)
16-17	573 (4.4%)
20-29	3,852 (29.5%)
30-39	2,802 (21.3%)
40-49	2,130 (16.2%)
60-64	359 (2.7%)
>65	478 (3.6%)
Self-harm act	
1st episode of self-harm	4,084 (31%)
Overdose	3,229 (24.6%)
Poison (non-accidental)	393 (3%)
Cutting	1,491 (11.4%)
Attempted Hanging	395 (3%)
Shooting	5 (<1%)
Attempted Drowning	167 (1.3%)
Other	364 (2.8%)
Multiple methods	229 (1.7%)
Suicidal or Self-Harm Ideation only – no self-harm act	5,655 (45.6%)
Emergency Care Plan (ECP)**	6,692 (70%)
Next of kin involvement	
Given Advice on suicide prevention**	7,424 (63.9%)
Follow up of patients assessed	
Letter sent to GP within 24 hours of discharge from ED**	8,120 (69.9%)
Number followed up with a phone call to the patient	4,192 (36.1%)

** For 78 presentations the age was unknown*

*** ECP given to those who were assessed but not admitted to an approved centre (n=9556).*

Training and Education

Every 6 months all CNSs (Clinical Nurse Specialists) are invited to two days training. This training provides opportunities for networking, along with providing expert presentations for continuous professional development. Non Consultant Hospital Doctors (NCHD) in psychiatry are invited to attend one of the training days. The opportunity to provide interdisciplinary training has proved invaluable.

- April 2019 – 30 CNS and SCAN (Suicide Crisis Assessment Nurse) staff attended 1 day's training on the Clinical Programme which included an overview of implementation of the programme; presentations from the services; and a presentation from a service development advocate/family member. Participants then conducted a brainstorming exercise providing material for the Implementation Advisory Group and revision of the Model of Care.
- April 2019 – 36 CNS, SCAN and ADONs (Assistant Directors of Nursing) and 53 NCHDs attended 1 day's training on Clinician Connections from the staff of DBT Ireland. This day used principles from Dialectical Behavior Therapy for use in self-care for staff working with people with challenging presentations.
- November 2019 - 46 CNS, SCAN and ADONs, and 63 NCHDs attended 1 day's training which included: Screening and Brief Interventions for Drug and Alcohol Problems; Introduction to SAMAGH (Suicide Assessment and Management at the General Hospital); Information from the National Office for Suicide Prevention (NOSP); and Emergency Care Planning.
- November 2019 - 33 CNS and SCAN staff attended 1 day's training on Mindfulness, Data collection, and presentation from the services.

National Audit and Research Group

In 2019 *An Audit of Mental Health Assessment Rooms in Irish Emergency Departments* was accepted for publication in the Irish Journal of Psychological Medicine.

An Audit of Emergency Care Plans was completed in September 2019. All CNSs and Clinical Leads within the Clinical Programme were sent an Audit Tool and requested to complete an Audit on 10 Emergency Care Plans (ECP) by choosing consecutive notes from the previous two months until 10 ECPs were audited. 22 out of 24 services completed the audit. Table 2 on the following page outlines the key results.

Table 2.
Audit of Emergency Care Plans September 2019

No	Item Audited	National Average
1	There is a written ECP in the patient's notes.	87%
2	The date of assessment is on the ECP	97%
3	There is evidence (either in the notes or on the ECP) that the ECP was written in collaboration with the patient	93%
4	The development of the ECP has input from the family/chosen adult. (Evidence in the notes or on the ECP).	65%
5	The ECP is signed by the assessing mental health professional (MHP)	89%
6	The name of the MHP is written legibly on the form	90%
7	There is evidence in the notes the individual was given a written copy of the ECP	73%
8	The ECP details the individual discharge plan.	88%
9	The ECP details triggers for Self-Harm/Suicidal/Self-Harm Ideation	52%
10	The ECP identifies warning signs for Self-Harm/Suicidal/Self-Harm Ideation	52%
11	The ECP identifies internal coping strategies.	53%
12	The ECP identifies ways to keep the environment safe.	62%
13	The ECP identifies time and date for next care appointment	34%
14	The ECP identifies supportive family/friends.	65%
15	The ECP identifies contact numbers for emergency support.	88%
16	The ECP states the patients will receive a follow up phone call within 24 hours.	49%
19	All items on the ECP were completed	77%
20	There is evidence in the notes that a copy of the ECP was sent to the patient's GP.	54%

Following discussion with the IAG and the RAG, a template with identifying mandatory inclusions has been agreed. This includes ways to keep the environment safe, emergency numbers, and linkage to next appropriate appointment. An ECP should be completed for all patients, GPs should be sent a copy and there should be clear evidence that the ECP was written in collaboration with the patient with every effort made to include family members and supportive adults.

The National Clinical Programme clinical lead was one of the collaborators in a successful bid for HRB funding and research commenced in 2019: *Providing improved care for self-harm: A mixed-methods study of intervention, implementation and economic outcomes from a national clinical programme – PRISM.* (Lead investigator Dr. Eve Griffen NSRF.)

2. Early Intervention in Psychosis

Early Intervention in Psychosis (EIP) Clinical Programme aims to deliver:

- 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 in line with the Model of Care

Model of Care

The Model of Care was approved by the HSE National Working Group and the Clinical Advisory Group of the College of Psychiatrists of Ireland in December 2018. It was launched by Minister Jim Daly TD on 6th June 2019. Dr. Katherine Brown stood down from the role of Clinical Lead in March 2019, the post was advertised and subsequently recruited to, with the expectation that Dr. Karen O'Connor will start in post in January 2020.

Demonstration sites for First Episode Psychosis

3 HSE sites were selected to test the delivery of EIP programme using a Hub and Spoke Model. The sites are based in South Lee Cork, Meath and Sligo/Leitrim. Funding was approved for 25 posts to be allocated across the 3 sites. In May 2019 the RISE (Responsive Early Intervention Service) team in Cork commenced clinical delivery of the programme. The other 2 sites continued to plan and recruit clinicians to the various posts. A process evaluation of the demonstration sites by Trinity College Dublin led by Dr. Catherine Dracker recruited a researcher to the project. The NCP collaborated with ORYGEN in Australia. They gained access to their online modules and funded the RISE team to access a range of modules over 12 months.

Behavioural Family Therapy (BFT)

BFT is delivered across the HSE by trained clinicians. In 2019 monthly data was collected from individual services on the number of families offered Behavioural Family Therapy (BFT) and engaged in the process.

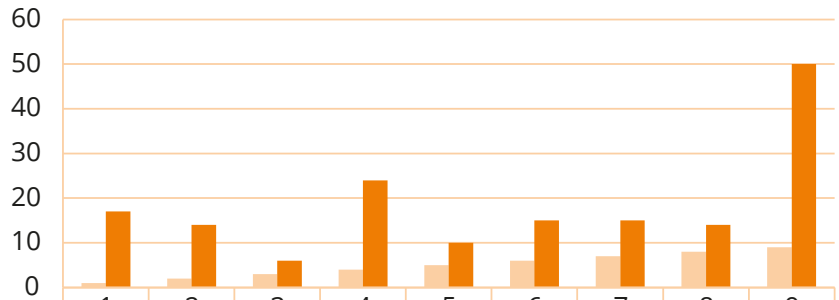
Table 3.
BFT Data 2016 – 2019

BFT - NATIONAL	2019	2018	2017	2016
Number of families contacted and offered BFT	275	252	300	305
% uptake of BFT intervention	60%	65%	68%	67%
Number of mental health professionals on BFT register at year end	111	184	191	199
Number of BFT trainers/Supervisors	26	26	31	31
Number of trainers who completed accreditation of work with Meriden NHS UK	2	2	4	2

The rate of uptake by families remains consistent for the last 4 years at between 60% - 67%. The number of BFT clinicians practicing BFT continues to fall. Our supervisors/leads number has fallen in 2019 due to retirements.

The SOP was updated in May 2019. It recommends that there are 2 clinicians trained in each adult team and one on each CAMHS team to deliver BFT. At the end of 2019 the numbers trained and on the level BFT register by CHO were as follows:

BFT Register by CHO 2019



	1	2	3	4	5	6	7	8	9
CHO	1	2	3	4	5	6	7	8	9
BFT Register	17	14	6	24	10	15	15	14	50

Three business meeting were facilitated by the programme with the CHO BFT leads in 2019. Meriden in NHS UK provided 3 face to face supervision sessions with BFT leads in Dr. Steevens Hospital throughout the year. In turn BFT leads delivered supervision sessions locally for all trained in BFT. This is important to maintain competence and skills in the delivery of BFT.

The programme collaborated with UCD Psychology Department to facilitate a Clinical Psychology Masters student to undertake a piece of research to explore the factors that affect practitioner engagement and delivery of BFT in Ireland. The results will be published in 2020.

Cognitive Behavioural Therapy for psychosis (CBTp)

The SOP was agreed and published in January 2019. A Coping Skills Online Manual for service users was adapted and approved by NALA (National Adult Literacy Agency) for a plain English mark. It is available to download from our webpage www.hse.ie/eng/about/who/cspd/ncps/mental-health/psychosis/resources/

The programme identified the need to commence external training and supervision for CBT leads within demonstration teams in order to build competence and clinical expertise in the delivery of CBTp. 3 Sessions were held in 2019.

Individual Placement Support (IPS)

The agreed SOP for IPS was published in April 2019. IPS workers commenced working as part of the RISE demonstration team in Cork. The workers are employed by Employability and funded by the HSE Clinical Programme.

Established Early Intervention for Psychosis Services in Ireland

There are two established early intervention services in Ireland: DETECT in CHO 6 (Dublin South East, Dun Laoighaire and Wicklow), and EIST in CHO 4 (Cork, North Lee). In 2019, the first of the EIP Demonstration sites launched in Cork, South Lee- RISE.

DETECT Early Intervention in Psychosis Service

The DETECT early intervention for psychosis service is a programme that was set up in 2006 to provide early treatment to those individuals who are experiencing a psychotic illness. The DETECT service operates as an adjunct service to the Community Mental Health Services in CHO Area 6: Dublin South East, Dun Laoghaire and Wicklow, with an adult population of approximately 236,320 between the age of 18 to 65*. The area is predominately urban with a small rural population in the Wicklow region. Census 2016 indicates that approximately 11% of people residing across the area are recognised as being disadvantaged, very disadvantaged, or extremely disadvantaged.*

Rapid Assessment Service & Evaluation of Service

DETECT provide access to rapid, expert assessment for community mental health teams. In 2019 the service received 133 referrals from the community mental health service teams. On completion of the assessment, 55% (n=73) had a confirmed diagnosis of first episode psychosis (FEP), 9% (n=12) received a diagnosis of 'At Risk Mental State' and 10% (n=13) were diagnosed as psychotic but not first episode. 13.5% of the people referred were not experiencing a first episode psychosis, 10.5% of people referred did not engage with the service at initial referral and 1% of referrals were ongoing at 31st December, 2019. DETECT also provides access to evidence-based interventions including Cognitive Behavioural Therapy for psychosis (primarily delivered as a group intervention) and a group family intervention - the 'DETECT 6-week Information and Support Course' (DISC).

DETECT Team Staffing 2019

- The staffing for the DETECT service has reduced from 8.5 WTEs in 2011 to 5.5 WTEs in 2019 as shown on the next page.
- A particular challenge for DETECT during 2019 was the five month period between June and November when the Senior Social Worker post was vacant. This required the service to place the DISC Family Intervention on hold and family members of patients newly diagnosed with FEP were wait-listed for the programme. The new Senior Social Worker came on board in November and commenced contacting families and arranging individual meetings. The first 2020 group DISC programme was delivered in January 2020.

Table 4.
Staffing: Original and Current Staffing and Staff Roles

Original Staffing	WTE	2019 Staffing	WTE	Role
Consultant Psychiatrist	0.5 WTE	Consultant Psychiatrist	0.5 WTE	Education Assessment Interventions Outcome evaluation
Principal Clinical Psychologist	0.5 WTE	Clinical Psychologist	0. 41 WTE	Psychology input & CBT programme facilitation
Senior Social Worker	0.5 WTE	Senior Social Worker (Sen Social Worker appointed Nov 2019)	0.4 WTE	Family assessment and BFT
Assessors				
Psychiatric Registrars	3 WTEs	Psychiatric Registrar	1 WTE	Clinical Assessor
CMHN (Community Mental Health Nurse)	1.5 WTE	CMHN	2 WTEs	Clinical Assessors* 1 CMHN – also providing individual CBT-p intervention. 1 CMHN also running Physical Health Programme
Administrator	0.5 WTE	Administrator	0.5 WTE	Service Administration, Co-ordination of programme Data/record management & statistical reporting Programmes development
Total	**8.5 WTEs**	**Total**	**4.8 WTEs**	
Current Unfilled Posts				
Principal Clinical Psychologist	0.5 WTE	*Post vacant since May 2017 due to sick leave*		
CMHN/Registrar	1 WTE	*Assessor Post – vacant from end 2016*		
Occupational Therapist	1 WTE	*Vacant*		
CMHN	0.5	*Psychosis Education Programme -Vacant*		
Project Manager/Clinical Team Co-ordinator	1 WTE	*Project Manager/Clinical Team Co-0rdinator – currently vacant*		

Table 5.
2019 Data: DETECT

Metric	Number	
1. Access		
No. of new cases of FEP seen in 2019	73 39 Male 34 Female	Incidence rate of ~ 31/100,000
No. offered assessment within 72 hours	59	82% of total assessed
2. Number who received/took up the following interventions		
Keyworker assigned on entry to service	NA	NA
Medication started		
Metabolic monitoring at baseline recorded	-	-
CBTp uptake rate **Delivered primarily as a group intervention	54	93% of a total of 58 people offered the intervention
BFT/family – uptake rate for Individual family meeting 2019 DETECT 6 week Information & Support Course (Delivered as a group intervention) 2020 Detect 6 week information & Support Course (Delivered as a group intervention)	29 5 + 19	44% of a total of 65 families offered the intervention* 37% of a total of 65 families offered the intervention*
IPS – uptake rate	NA	NA
3. Outcomes		
• No. in open employment • No. in full-time education • No. in full-time homecare	28 14 6	**39%** **19%** **8%**

**Intervention did not run between June and December 2019 due to vacant Social Worker position.*

Nineteen families whose relative received a diagnosis in 2019 attended the DISC course in January 2020.

EIST, North Lee Mental Health Services

EIST is an early intervention in psychosis service on the North Side of Cork City set up in 2012. The service provides access and interventions to people living in three sectors of the North Lee Mental Health Services: City North East, City North West and Cobh (population of about 100,000 people). The EIST service provides rapid access to expert assessment for General Practitioners and Community Mental Health Teams. In 2019 the service received 53 referrals. After assessment 31 people met criteria for a diagnosis of a First Episode of Psychosis. Each of these individuals was assigned to a dedicated EIP keyworker for six months, after which they are assigned to the caseload of a member of the relevant community mental health team and are co-keyworked with the EIST EIP keyworker for the following 2.5 years. The EIST programme runs for 3 years and clinical responsibility remains with the Consultant Psychiatrist of the EIST service during this time.

Table 6.
2019 Data - EIST

Metric	Total Number
1. Access	
No. of new cases of FEP seen in 2019	31 (Incidence of ~ 31/100,000)
No. offered ax within 72 hours	31 (100%)
2. Number who received/took up the following interventions	
Keyworker assigned on entry to service	31 (100%)
Medication started	31 (100%)
Metabolic monitoring at baseline recorded	19 (62%)
CBTp uptake rate	22 (72%)
BFT – uptake rate	14 (44%)
IPS – uptake rate	N/A
3. Outcomes	
No. in open employment/full-time education	13 (41%)

Demonstration Site- RISE, South Lee Cork

The RISE (Responsive Early Intervention for Psychosis Service) in South Lee Mental Health Services, Cork, is one of the three EIP demonstration sites in Ireland funded by the HSE. The service launched in May 2019. In 2019 the service was only available to 55% of the South Lee population (~110,000 population). Since February 2020, the service is available to all people presenting with a first episode of psychosis in South Lee Mental Health Services (200,000 population).

The service covers both an urban and a rural population on the south side of Cork city and county. The RISE service has a Hub and Spoke model of service delivery. This means that some interventions (e.g. keyworker support, psychiatrist appointments, occupational therapy support, social worker support, and individual placement supports) will be provided at the 'spoke' in the community mental health team. Other interventions (e.g. psychological interventions, physical health and lifestyle interventions, and some family interventions) are provided at the central 'Hub'. Clinical responsibility for care remains in the spokes (i.e. with the psychiatrist in the community mental health team). However, weekly RISE clinical meetings are held at the Hub, which all RISE staff (Hub and Spoke based staff) attend. This supports fidelity to the EIP model across the service and ensures good team communication.

Table 7.
RISE Team staffing in 2019

Role	WTE	Staffing
Lead for Psychological interventions	0.5 WTE	Principal Psychologist (0.5)
Clinicians delivering psychological interventions	2.0 WTE	Psychologist (0.5) Clinical Nurse Specialist (0.5) Senior Occupational Therapist
BFT clinicians	0.5 WTE	Clinical Nurse Specialist
IPS workers	2.0 WTE	
EIP Keyworkers	2.0 WTE	Clinical Nurse Specialist Senior Occupational Therapist
Physical Health Lead	0.5 WTE	Advanced Nurse Practitioner (0.5)

Table 8.
RISE 2019 Data (May 2019 - December 2019)

Metric	Total Number			
1. Access		**Males**	**Females**	
No. of new cases of FEP in 2019 (May- December 2019)	**28** Incidence rate of ~ 38/100,000	**15**	**13**	
No. offered assessment within 72 hours	**23 (82%)**	**13**	**10**	82 % of total assessed
2. Number who received/took up the following interventions				
Keyworker assigned on entry to service	**100%**	**15**	**13**	100%
Medication prescribed and commenced	**27 (96%)**	**14**	**13**	96%
Metabolic monitoring at baseline recorded	**25 (89%)**	**13**	**12**	89%
CBTp (individual)	**24 (86%)**	**12**	**11**	86%
Behavioural Family Therapy (delivered to families individually)	**21 (71%)**	**11**	**10**	71%
Individual Placement Support (IPS)	**9 (32%)**	**5**	**4**	32%
3. Outcomes. 3 year programme therefore no one in RISE near point of discharge yet.				
• No. in open employment	13	7	5	42%
• No. in full-time education	6	3	3	21%
• No. in full-time homecare	2	0	2	7%

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

HSE Clinical Programme for **Eating Disorders**

Model of Care

The MOC is a comprehensive and evidenced based road-map for the development of HSE eating disorder services in Ireland. It includes recommendations for regional and national delivery of Eating Disorder treatment and care pathways, and outlines the resource implications. It was launched in January 2018 with an approved implementation plan. The webpage has access to all the resources developed.

The programme is part of the Office of the National Group Advisor for Mental Health. A National Oversight Group for the Implementation of the Model of Care chaired by the Clinical Lead meets monthly to progress implementation. The purposed new Regional Health Areas (RHA) will impact on some of our team boundaries in the Dublin area and the programme will need to agree a new structure in 2020. The core values are:

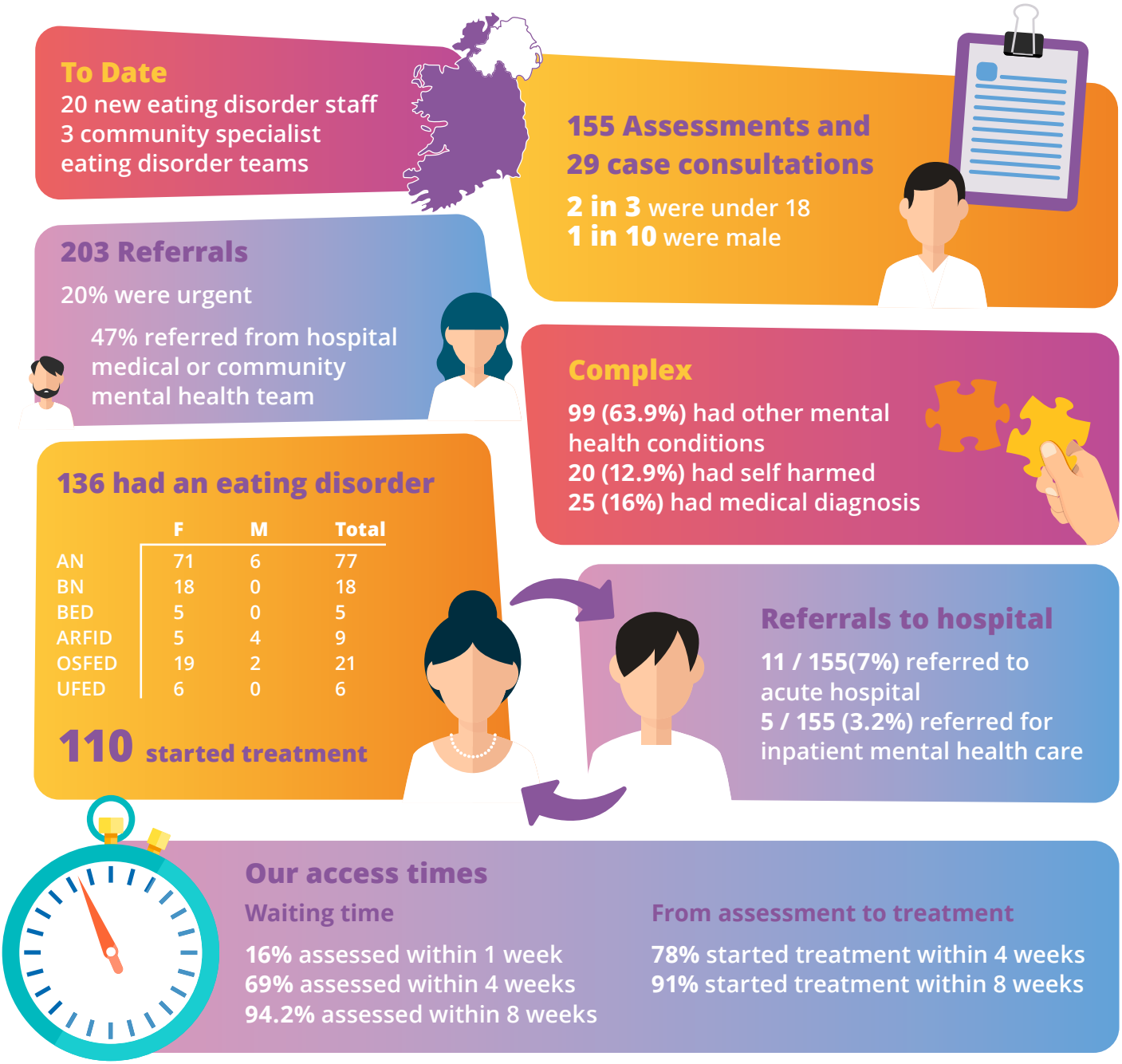
Our Core Values

Eating Disorders Specialist Teams

At the end of 2019 there were 3 Eating Disorders Specialist Teams in operation, 2 Eating Disorders CAMHS teams serving CHO4 and CHO7 and an adult team based in CHO6. No team was serving its full population due to recruitment challenges and lack of dedicated office and clinical space for teams.

Funding received for additional posts and teams in 2019 was not progressed.

Despite the lack of full team membership the data below represents the combined activity of the 3 Eating Disorder teams. In 2020 the teams will report on service users and family satisfaction with services.



Developing a specialist, skilled workforce

The National Clinical Programme continued to support the development of a skilled workforce. Specialist CAMHS eating disorder teams continued specialist Family Therapy (FBT) and Multifamily Group Therapy training programmes. The adult team had access to MANTRA training, CBTE training and early intervention for eating disorders (FREED). In addition named clinicians with an interest in eating disorders were also included in some training opportunities.

The service continues to develop relationships with eating disorders colleagues in the NHS and USA to share learning and education sessions.

Table 9.
Numbers who attended training programmes

2019 Dates	Programme	Numbers who attended
January	MANTRA	6
February	FBT training	8
February	AFT training	4
March	CBT-E Network day	70
September	FT/AN	30
October	FBT Introduction Day	30
October	FBT: Seminar 2019	100
November	FREED	30

Family Based Therapy (FBT)

Building on the work since 2016 the supervision group network of 5 Family Based Therapy groups was facilitated on a monthly basis with 66 CAMHS clinicians attending from a range of CAMHS teams. An FBT national training seminar took place in October 2019 attended by 100 clinicians.

Cognitive Behavioural therapy – enhanced (CBTe)

CBTe group supervision was provided monthly via phone to 4 groups across the country. They are Dublin, Kildare, South East, Mid-West/West.

HSE Library: Lib Guide

In partnership with the regional librarian in Dr. Steeven's Hospital a library guide for eating disorders is being developed. The library guide will provide all clinicians with up to date information and evidence on eating disorders. This guide will be available in early 2020.

Eating Disorders Hub Development Days

The MOC recommended the development of Hub teams across CAMHS and adult services that would share learning as services are developed. The programme facilitated 2 Eating Disorder hub days in 2019 (February and November), and the days were attended by the Eating Disorder team members.

Patient Self-Management and self help

This is a key action within the model of care as patient education and shared decision making have been associated with patient satisfaction and better adherence to treatment. During 2019 the National Clinical Lead commenced work with the National Oversight Group for the implementation of the MOC to develop an active waiting pack for service users and families. During the development and with feedback from families it was agreed to change the written pack to an app that is readily accessible to all members of the public. Filming of clips for the app commenced in November. The app will be launched in early 2020.

Primary Care

The National Clinical Programme continued to engage a GP one day per month to work with the programme and as a member of the national oversight group for the implementation of the MOC. During 2019 the main objectives achieved were

- Irish National Eating Disorder Conference in Dublin February 2019: participated in an interactive talk with patients and families of those with Eating Disorders, feedback from which led to the development of the "Active Waiting" concept which then led to development of a new Eating Disorder App.
- March 2019: presentation at the CBTE Seminar Day discussing Eating Disorders from a GP perspective.
- In Spring of 2019 a Bibliotherapy guide was developed. This was a collaborative process incorporating feedback from clinicians and patients. It is available to view on the Eating Disorders webpage.
- In June 2019 a poster on "Active Waiting" was presented at the Student Affairs Ireland Annual Conference in UCC.
- From September 2019: Quality in Practice Guideline for Eating Disorders with the ICGP was completed. This was first reviewed in November 2019 and will be published in early 2020.
- Linked in with "GP Buddy", a popular GP educational/information website, and arranged filming for their "Ask the Expert" series with National Clinical Lead www.gpbuddy.ie/go/education/psychiatry/eating_disorders

Bodywhys – PiLAR Programme

The Clinical Programme continued to partner with Bodywhys to deliver a 4 week family education programme called PiLaR. In 2019, the Bodywhys PiLaR programme was delivered 10 times to 288 carers supporting a loved one with an eating disorder, across the country. Bodywhys has two trained facilitators. The demand for support is ever increasing, especially as service provision improves and becomes more focused through the dedicated teams.

The content of the PiLaR programme supports the clinical work of the treating teams, benefitting all. This model of support has been noted by specialised clinicians as important because carers come with a level of knowledge that equips them to make the most out of treatment services. The collaboration between Bodywhys and the HSE NCP- ED has meant that key messages are reinforced, repeated, and explained. The programme is open to all and free to attend, while also specifically supporting those families engaged in mental health services.

Table 10.
Pilar Programme 2019

Location	Mental Health Service	Dates	Numbers
Kerry	HSE Kerry Mental Health Services	Jan 2019	17
Laois	Laois HSE CAMHS	Feb 2019	23
Mullingar	HSE Longford/Westmeath Mental Health Services	March 2019	20
Dublin	St Vincent University Hospital	May 2019	71
Limerick	HSE Limerick Mental Health Services	May 2019	20
Cork	HSE Cork Mental Health Services	June 2019	41
Donegal	HSE Donegal Mental Health Services	September 2019	16
Dublin	HSE Linn Dara CAMHS	November 2019	79
Waterford	HSE Waterford Mental Health Services	November 2019	22
Total:10 sites			288

Webpage: www.hse.ie/eng/about/who/cspd/ncps/mental-health/eating-disorders/

4. ADHD in Adults National Clinical Programme

The HSE National Clinical Programme for ADHD is a joint initiative between the HSE and the College of Psychiatrists of Ireland. A Clinical Lead and Programme Manager were appointed and a key priority for the HSE National Service Plan in 2018 was the development of the clinical programme for ADHD in Adults. A Working Group was established to develop a National Model of Care for ADHD in Adults. This working group was multidisciplinary with service user representation from ADHD Ireland.

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 is now known to persist into adulthood (Kooij 2010), with approximately 65% of children continuing to have symptoms in adulthood and 15% meeting the full diagnostic criteria (Barkley 2002; Faraone 2006).

The three core features of the disorder are inattention, hyperactivity and impulsivity (DSMV:APA 2013). The symptoms related to inattention are those most often complained of and these include forgetfulness, difficulties in organisation particularly of routine tasks, being easily distracted by thoughts or external events.

The 2019 HSE National Service Plan included the continued development of the clinical programme for ADHD in Adults and the completion and sign off of the Model of Care with the College of Psychiatry of Ireland and Clinical Design and Innovation in the HSE and these were achieved. Work on the recruitment of staff for the Clinical Programme commenced in two of the three demonstration sites, Community Healthcare Organisations (CHO) 1 and 3.

The three demonstration sites are:

1. CHO3 – Limerick, Clare and North Tipperary – 1 full team
2. CHO1 – Sligo/Leitrim/Donegal – 1 half team.
3. CHO7 – Dublin – 1 full team.

Actions undertaken 2019

1. The College of Psychiatrists of Ireland, following consideration by its Clinical Advisory Group, approved the Model of Care.
2. The ADHD in Adults National Clinical Programme Model of Care was then subsequently approved by the HSE.
3. Joint funding proposals were developed and agreed with ADHD Ireland for a number of research projects including the development of a psycho-education programme and patient information app.
4. Clinical Lead presented information to date at the National ADHD Ireland meetings in Trinity College and met with service users through ADHD Ireland
5. A dataset to record activity has been developed and revised on implementation. This has been piloted by the only public service in Ireland based in the Sligo-Leitrim MHS and will be reviewed on commencement of the demonstration sites.
6. Likewise data on treatment outcomes was considered with the aim of including these as a routine part of data collection. This data will assist in evaluating the interventions implemented by the National Clinical Programme.
7. Specific education and training requirements for staff working in the ADHD in Adults service was also actively explored.

This National Clinical Programme is addressing an important clinical service need. It is known that symptomatic ADHD in adults is associated with significant distress and functional impairments with life-long consequences for adults with ADHD, their families and partners.

The Youth Mental Health Taskforce emphasised the need for improved and timely access to the appropriate level of mental health care with clear referral pathways across and between services for the 0-25yr age range. It particularly focuses on transition between child and adult mental health services at 18yrs, stating this requires oversight and coordination. In recognition of this, the HSE in association with the College of Psychiatrists of Ireland has included in the national MOC a pathway for transition for those approaching their 18th birthday for the assessment and management of young adults with ADHD where continued support is necessary.

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 programme

An integral part of the Dual Diagnosis (DD) NCDI 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 services nationally. *A Vision for Change* (VFC) 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 Clinical Programme National Working Group (NWG) was established in October 2017. It is multidisciplinary and includes representation from service users. 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.

Updates from 2019 included

- The post of Clinical Lead for Dual Diagnosis National Clinical Programme was vacant during 2019 despite a recruitment campaign.
- A draft Model of Care was developed which takes account of service user views, and describes the clinical pathway for patients with substance misuse and significant (moderate to severe) mental illness, including connectivity with primary care substance misuse services, community mental health service and acute services. This has been informed by international best practice and the experience of the National Working Group.
- Links were established with the National Clinical Lead for the Drugs Strategy and Social Inclusion, to ensure that a comprehensive approach is taken to the care of those with Dual Diagnosis, bearing in mind that they can present to any part of the health service.

Chapter 3

Investing in Mental Health Services

This Chapter will provide an overview of the investment in mental health services including the additional allocations under the Programme for Government. Mental Health Services adopt 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 2019 final budget for Mental Health, inclusive of 2012-2019 Programme for Government (PFG) funding was €987.3 million.

Between 2012 and 2019, €265m 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 €276.3 million increase in the Mental Health budget is identified in the HSE Service Plans between 2012 and 2019 inclusive.

It should be noted that minimal/no development funding has been re-directed to non-Mental Health services in 2015, 2016, 2017, 2018 and 2019 as underspends in PFG allocations were used towards other mental health related costs.

Net Mental Health Funding 2012 to 2019

NET MENTAL HEALTH FUNDING 2012 TO 2019

Heading	2012 €m	2013 €m	2014 €m	2015 €m	2016 €m	2017 €m	2018 €m	2019 €m
Budget per NSP	711.0	737.0	766.0	791.6	826.6	867.8	917.8	987.3
Spend in MH		723.1	746.3	784.5	822.9	867.4	920.3	987.1

New Development Posts 2012 to 2019 (as at 31st Jan 2020)

NEW DEVELOPMENT POSTS 2012 TO 2019 (as at 31st Jan 2020)

Type of Post	2012	2013	2014	2015	2016*	2017	2018	2019	Total
New Development Posts:									
Approved (WTE)	416	477	251	334	293	228	170	253	2,422
Filled at Jan 2020 (WTE)	416	473	237	269	258	158	29	82	1,921
Unfilled at Jan 2020 (WTE)	-	4	14	65	36	70	141	171	500
% Filled at Jan 2020	100%	99%	94%	81%	88%	69%	17%	32%	79%

**PFG 2016 recruitment includes 134 WTE Psychologists who are funded through Mental Health but employed through Primary Care.*

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 (CIPC) service.

- 416 or 100% of the 416 development posts for 2012 have commenced.
- 473 or 99% of the 477 development posts for 2013 have started where 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.

- 237 or 94% 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 services of €3m. It embedded the role of the 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.

- 269 or 81% of the 334 development posts for 2015 have started.

The funding of €35m in 2016, enabled the consolidation and on-going development of services arising from this previous investment in teams and acute/continuing care in-patient provision and included the opening of the Drogheda Unit, Station C in Galway & Deerlodge in Killarney as well as increased capacity for CHO 6 , SJOG and Portlaoise respectively(€5m). Funding of €3m was provided that year to begin to develop responses to those with severe mental illness and challenging behaviour. 2016 funding also provided 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 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 (€0.5m) and additional clinical psychology training places (€0.2m.) It also provided for the introduction of Peer Support Workers in mental health (€1.0m.)

- 258 or 88% of the 293 development posts for 2016 have started.
- 114 of these recruited posts relate to the Assistant Psychology in Primary Care initiative.

The funding of €35m in 2017: PFG has continued the multi annual plan for the enhancement of existing models of service such as community adult, child and older age teams, further development of newer models of care and teams such as MHID, Perinatal, etc., as well as stabilising the overall provision of services through investment in capacity building of staffing and improved and safer service infrastructure. This includes the following specific allocations:

- Mental Health nursing capacity and retention of €5.8m through increased undergraduate, post graduate and ANP capacity.
- Provision of a recurring fund of €3m to continue to invest in the safety and compliance of mental health service infrastructure.
- Considerable provision for out of hours service responses through enhancement of 7/7 services of €4.5m and 45 new posts.

- Further investment in community teams of €5m and 48 posts across all CHOs.
- Further investment in in-patient services of €4.5m including Linn Dara and Deerlodge and provision for opening of new unit in Galway.
- Investment in new Clinical programmes of €1m for Adult ADHD.
- Enhancement of services for those who are homeless with mental illness of €1m.
- Improved responses to the physical health needs of those with mental illness of €1m.
- Funding to support delivery of the recommendations from the youth mental health task force report of €1m.
- Investment in Psychological/Talking Therapies of €1m through enhanced Behavioural Family Therapy (BFT) and CIPC.
- Implementation of the agreed new Perinatal Mental Health model of care through funding of a further 15 posts at a cost of €1m.
- Funding of €1m to support reimbursement of involvement of mental health service users in design and delivery of services.
- Investment of over €1m in development of Forensic Community In-Reach teams.
- 158 or 69% of the 228 development posts for 2017 have commenced.

The 2018 PFG funding of €35m with maximum expenditure in 2018 of €15m was allocated in a way that continued to build on the agreed models of care and service stabilisation priorities that had been the feature in the PFG investment programme since 2015. Further funding was agreed and aligned to the headings as outlined in the above previous years providing for a further 177 posts including the following:

- Further investment in community teams of €10.5m and over 130 posts across all CHOs including CAMHs, general adult, POA, MHID and Rehabilitation.
- Enhancement of a recurring fund to continue to invest in the safety and compliance of mental health service infrastructure of €3m.
- Mental Health nursing capacity and retention of €2.4m
- Further investment of €2.5m in enhanced responses to those with severe mental illness and challenging behaviour building on 2016 investment.
- Further development of perinatal mental health services of €2m building on 2016 investment and recently launched new model of care.
- Enhanced development of Eating Disorder services of €1.5m building on 2016 investment and recently launched new model of care.
- Funding for more expensive and more effective drug therapies of €1m.
- Further provision for out of hours service responses through enhancement of 7/7 services of €1m
- Funding to support delivery of the recommendations from the youth mental health task force report of €1m
- Investment in Psychological/Talking Therapies of €1m
- Funding of €1m to develop recovery pathways for specific Forensic patients.
- The start of the required additional investment for the opening of the new National Forensic Service through allocation of €1m.

- Investment of €1m to support NOSP to meet training and research needs, coronial data management and development of outcomes indicators, etc.
- Enhancement of services for those who are homeless with mental illness (€0.5m).
- Investment in Self Harm Clinical programmes of €0.5m through appointment of further self-harm nurses in both adult and paediatric hospitals.
- 29 or 17% of the 170 development posts for 2018 have commenced with the remaining posts at recruitment stage.

The 2019 PFG funding of €35m was allocated in a way that continued to build on the agreed models of care and service stabilisation priorities that had been the feature in the PFG investment programme since 2015. Funding was allocated to the new National Forensics Hospital in Portrane, while further funding was agreed/aligned to the headings as outlined in the above previous years providing for a further 253 posts including the following:

- New National Forensics Hospital, Portrane (€4.7m)
- Acute Inpatient Unit CHO5 (€1.3)
- Placements for people with complex mental health difficulties where their needs cannot be met by existing HSE CAMHS, General Adult or Psychiatry of Later Life services (€7m)
- Nurse undergraduate training costs (€1.5m)
- Rent & leasing costs (€1.5m)
- Counselling in Primary Care (€0.5m)
- Talk Therapies Model of Care for Community Mental Health Teams (€1 m)
- Mental Health Peer Support Service- Integration of Peer Support Workers onto Multi-Disciplinary Teams (€0.7m)
- Mental Health Engagement and Recovery- Research and Evaluation function development (€0.1 m)
- Clinical Programme: Early Intervention in Psychosis (€0.4 m)
- Clinical Programme: Adult ADHD (€0.3 m)
- Progress development and implementation of Specialist Perinatal Mental Health Services (€0.6 m)
- National Clinical Programme for the Assessment and Management of Patients presenting to the Emergency Department following self-harm (€0.6 m)
- National Clinical Programme for Eating Disorders (€1.6 m)
- Mental Health of Intellectual Disabilities (MHID) for Adults and Children (€0.7 m)
- Mental Health/Social Inclusion Integrative Project Development (€2.4 m)

82 or 32% of the 253 development posts for 2019 have commenced with the remaining posts at recruitment stage.

Allocation of Programme for Government Funding 2012 to 2019

Funding Use	2012 €m	2013 €m	2014 €m	2015 €m	2016 €m	2017 €m	2018 €m	2019 €m	Total €m
Service Staff for Community Teams, Specialist services and supports	24.5	31.1	20.0	15.8	3.8	7.9	8.1	3.9	115.0
Counselling in Primary Care (CIPC)	5.0	2.5	-	-	-	-	-	0.5	8.0
National Office for Suicide Prevention & CFL	3.0	1.0	-	2.8	-	-	1.0	0.3	8.1
In Patient Capacity/Placements	-	-	-	6.3	9.0	4.2	4.6	8.7	32.7
Jigsaw & Limerick Youth Service & SHIP Counselling	-	-	-	3.2	5.3	-	-	0.6	9.1
Genio & Misc	2.1	-	-	-	-	-	-	-	2.1
Community Nurse Allowances	-	-	-	-	-	1.8	-	-	1.8
Advancing Recovery & Service User Engagement	-	-	-	1.0	-	1.0	0.5	0.1	2.6
Peer support workers & CHO service user engagement leads	-	-	-	-	2.0	-	-	0.7	2.7
Information Systems/Digital Projects	-	0.4	-	1.0	2.5	-	-	3.0	6.9
Clinical Programs - Self Harm	0.4	-	-	-	-	-	0.5	0.6	1.5
Clinical Programs - Eating Disorders	-	-	-	-	1.5	1.0	1.5	1.6	5.6
Clinical Programs - Early Intervention in Psychosis	-	-	-	1.4	-	0.5	-	0.4	2.3
Clinical Programs - ADHD	-	-	-	-	0.3	1.0	-	0.3	1.6
Perinatal	-	-	-	-	-	1.0	2.0	0.6	3.6
MHID	-	-	-	3.2	-	0.5	2.0	1.7	7.4
Specialist Rehabilitation Services	-	-	-	-	3.0	-	2.9	-	5.9
Homeless funding	-	-	-	-	2.0	1.0	0.5	-	3.5
7 Day Services	-	-	-	-	-	4.5	1.0	-	5.5
Service improvement & Quality	-	-	-	-	-	-	1.0	-	1.0
Minor Works fund to meet compliance and safety requirements	-	-	-	-	-	3.0	3.0	-	6.0
Clinical Psychology Training & Post/ Under Graduate Nursing	-	-	-	-	0.7	2.5	2.4	1.5	7.1
Primary Care based Mental Health supports - Psychologists	-	-	-	-	5.0	-	-	-	5.0
Forensic Service	-	-	-	-	-	1.2	1.0	4.7	6.9
Drugs & Medicines increased costs for Improved Regimes	-	-	-	-	-	-	1.0	-	1.0
Youth Mental Health	-	-	-	-	-	1.0	1.0	-	2.0
Advanced Nurse practitioners	-	-	-	-	-	2.0	-	1.0	3.0
Physical Health	-	-	-	0.4	-	0.5	-	-	0.9
Talk therapies	-	-	-	-	-	0.5	1.0	1.0	2.5
Rental/Upgrade costs	-	-	-	-	-	-	-	1.5	1.5
Social Inclusion based Mental Health supports	-	-	-	-	-	-	-	2.4	2.4
Total	35.0	35.0	20.0	35.0	35.0	35.0	35.0	35.0	265.0

Note: There has been some additional detail included in relation to splitting out Clinical Programmes & other funding headings which required changes to the headings across previous years. It should be noted that in previous years this funding was incorporated under the "Community Teams" heading however the current iteration is more detailed and will give the reader a more accurate understanding of where funding was allocated.

2012–2019 Investment In Posts Specifically For Community Teams

Teams	2012 WTE	2013 WTE	2014 WTE	2015 WTE	2016 WTE	2017 WTE	2018 WTE	2019 WTE	Total WTE
General Adult Community Mental Health Teams	254	180	38	83	-	104	19	51	729
Child and Adolescent Community Mental Health Teams	150	80	53	41	-	20	62		406
POA Community Mental Health Teams	-	100	25	30	-	4	16		174
MHID Community Mental Health Teams	-	40	24	41	-	4	19	22	150
Forensic Teams (In-reach, MHID and CAMHS)	-	28	-	38	-	12	-	81	159
Homeless MH Teams	-	-	7	-	-	-	-		7
Liaison Teams	-	-	10	5	-	2	-		17
In-Patient & Continuing Care	-	-	-	30	98	23	-	5	156
Primary Care Assistant Psychology Under 18s	-	-	-	-	134	-	-		134
Mental Health Engagement	-	-	-	-	18	-	-	1	19
Physical Health	-	-	-	7	-	8	-		15
Traveller Mental Health	-	-	-	9	-	-	-		9
Peer Support	-	-	-	-	20	-	-	10	30
Transgender funding						2	1		3
Clinical Programs - Self Harm	-	-	-	-	-	-	7	8	15
Clinical Programs - Eating Disorders				3	21	12	16	20	72
Clinical Programs - Early Intervention in Psychosis				20		6		5	31
Clinical Programs - ADHD						12		2	13
Perinatal						8	28	7	43
ICT/E-Rostering	-	-	-	-	-	-	-	8	8
Youth Mental Health						10			10
Social Inclusion Projects								34	34
Sub Total	404	428	157	306	291	225	168	253	2,232
National Support/NOSP/CFL	12	49	94	28	2	3	2	-	190
Grand Total	416	477	251	334	293	228	170	253	2,422

Chapter 4

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 each team 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 Team 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 2019. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in CAMHS services in 2019 was 937.4.

Vision for Change Recommendations vs Actual Staffing (2019)

CAMHS Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2019
Staff Community MHTs	1 : 50,000[1]	79[2]	71	1,238	698.2
Adolescent Day Service Teams		16[2]	2		13.56
Hospital Liaison MHTs	1 : 300,000	16	3	208	36.26
Total		111	77	1,446	748.04
Inpatient Services				4 Units	189.4
				Total Staff	937.44

[1]Equates to 1: 12,500 under 18 year old population based on 2016 census.

[2]Vision for Change recommends the following

"Child and adolescent mental health services should be provided by multidisciplinary CMHTs. Two teams should be provided for each sector of approximately 100,000 population. These teams should serve all children and adolescents in the sector population, providing multidisciplinary assessment and a comprehensive range of interventions in a variety of settings such as home, outpatient and day hospital settings as appropriate.

The teams should also cover the child and adolescent day hospital in the catchment area. One additional team per catchment area of 300,000 population should also be provided, to provide liaison cover to paediatric, general hospitals and maternity units in their area."

The ratio for day teams is 1 per 300,000. As VFC recommendation means these teams are to be covered by the CMHTs, this equates to 79 Community teams and 16 Adolescent Day Service teams.

Staffing of CAMHS Acute Inpatient Units

The total number of staff at the four Inpatient Units was 189.4 (December 2019). The table below shows the breakdown of the inpatient staffing by profession between 2014 and 2019.

Staffing of Child and Adolescent Inpatient Units by profession 2014-2019

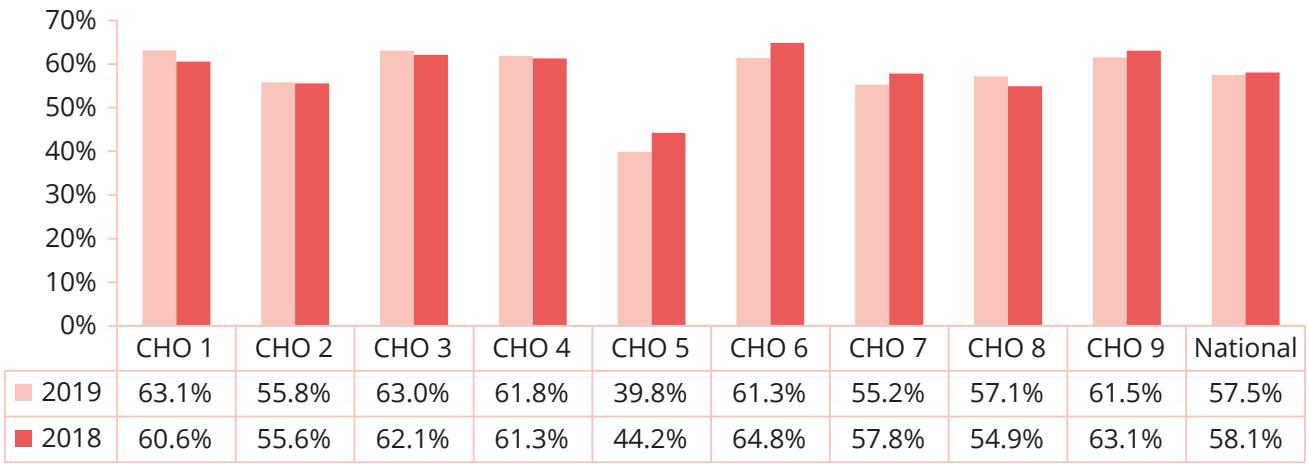
	2014	2015	2016	2017	2018	2019	Change +/-
Consultant Psychiatrist	5.1	6.0	6.4	6.4	7.4	6.7	1.6
Senior registrar	3.0	4.0	2.5	4.0	5.0	6.0	3.0
Registrar/SHO	3.0	4.0	9.5	7.0	6.0	5.0	2.0
Other Staff (Interns)	0.0	2.0	2.0	2.0	2.0	2.0	2.0
Director of Nursing	1.0	1.0	1.5	3.0	1.4	1.0	0.0
Assistant Director of Nursing	2.7	4.7	4.2	3.7	3.2	2.7	0.0
CNM III	0.0	1.0	1.0	3.0	3.0	4.0	4.0
CNM II	6.0	12.0	11.0	12.0	11.0	9.5	3.5
CNM I	7.5	7.5	7.5	8.0	8.0	9.0	1.5
Clinical Nurse Specialist	2.0	2.5	3.5	2.5	3.5	4.5	2.5
Staff Nurse	94.0	84.5	84.5	90.0	84.6	76.0	-18.0
Clinical Psychologist	4.0	3.8	6.6	6.4	6.6	5.7	1.7
Occupational Therapist	4.3	2.8	4.3	4.2	4.0	3.5	-0.8
Speech and Language Therapist	2.7	2.9	2.3	1.0	2.0	2.5	-0.2
Social Worker	6.3	6.2	6.3	6.8	6.5	4.8	-1.5
Childcare Worker	1.0	1.0	2.0	2.0	1.0	1.0	0.0
Dietitian	1.7	1.2	1.7	2.1	2.2	2.5	0.8
Clinical Specialist Dietitian	0.0	0.0	0.0	0.0	1.0	1.0	1.0
Physiotherapy	0.0	0.3	0.0	0.0	0.0	0.0	0.0
Other Therapist	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Administrative Support staff	7.8	7.8	6.5	8.5	7.5	6.7	-1.1
Non Nursing Care Assistant/ Multi Task Attendant	9.0	9.0	11.0	11.0	9.0	12.0	3.0
Non Nursing Chef (Household)	1.0	1.0	1.0	1.0	1.0	1.0	0.0
Non Nursing Catering Assistant	2.5	5.2	5.7	3.0	3.0	3.0	0.5
Non Nursing Driver/Porter	2.0	2.0	4.0	4.0	5.0	4.0	2.0
Teaching Staff	4.0	10.0	11.3	12.3	12.7	13.7	9.7
Teaching Support Staff	2.0	2.0	3.6	3.6	1.6	1.6	-0.4
Other Staff	0.0	0.0	0.4	0.0	0.0	0.0	0.0
Total	172.6	184.4	200.3	207.5	198.2	189.4	16.9

Staffing of CAMHS Community Mental Health Teams

In Ireland, 25% of the population is under 18 years of age and in December 2019 there was a total of 698.2 staff in the Child and Adolescent Community Mental Health Teams nationally (602 Clinical). This represents 57.5% of the clinical staffing levels recommended in *A Vision for Change* which is a decrease of -0.6% nationally on the 2018 position. The largest increase was in CHO 1 at 2.5% and the largest decrease was in CHO 5 at -4.4%.

In the period from 2014 to 2019, arising from the Programme for Government investment in CAMHS services, staffing in the community CAMHS teams had a net gain of 118 whole time equivalents over this period, exclusive of staff leaving and retiring, etc.

Community CAMHS Teams Staffing vs VFC recommendations in 2018 – 2019

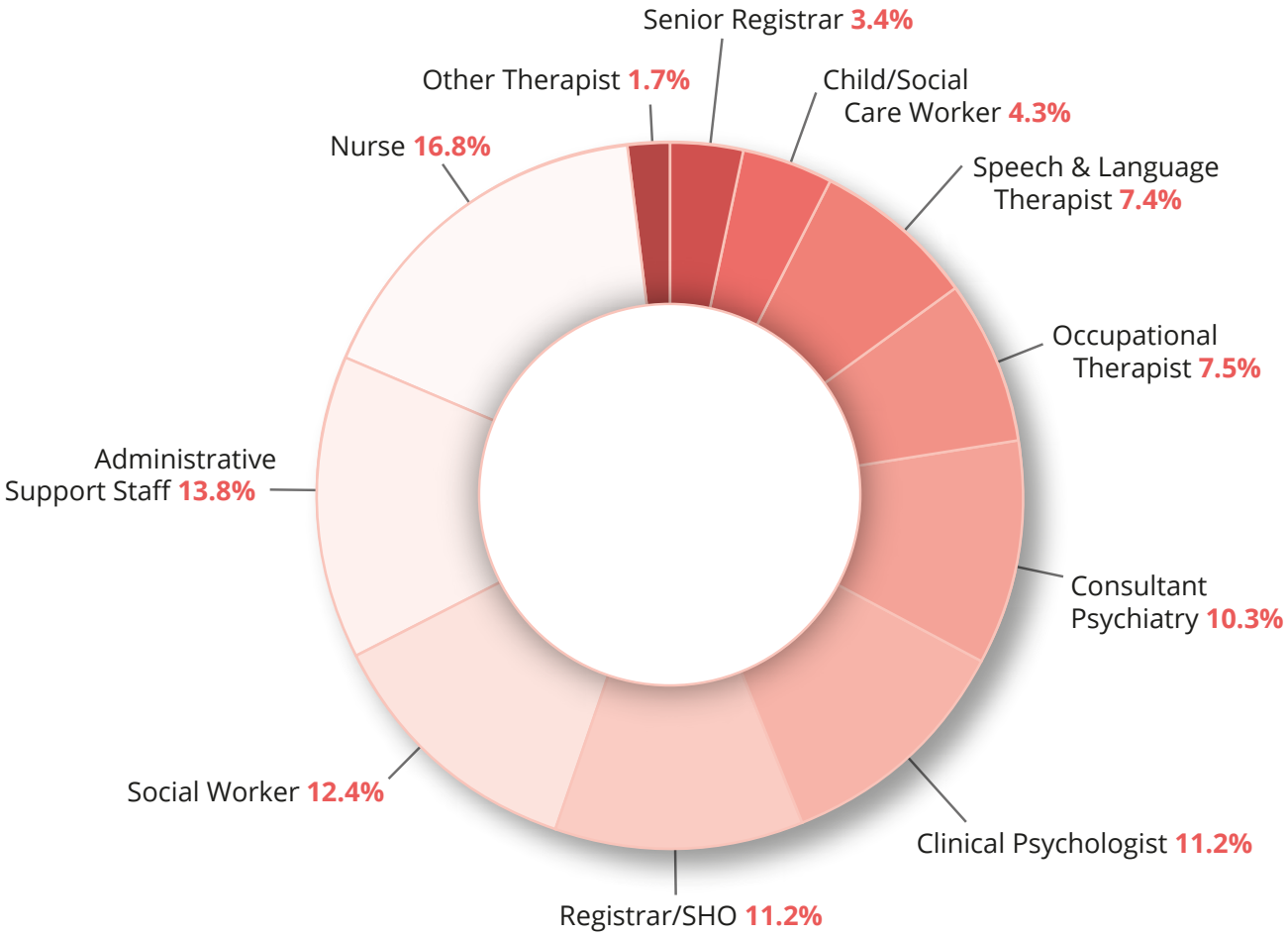


	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2019	63.1%	55.8%	63.0%	61.8%	39.8%	61.3%	55.2%	57.1%	61.5%	57.5%
2018	60.6%	55.6%	62.1%	61.3%	44.2%	64.8%	57.8%	54.9%	63.1%	58.1%

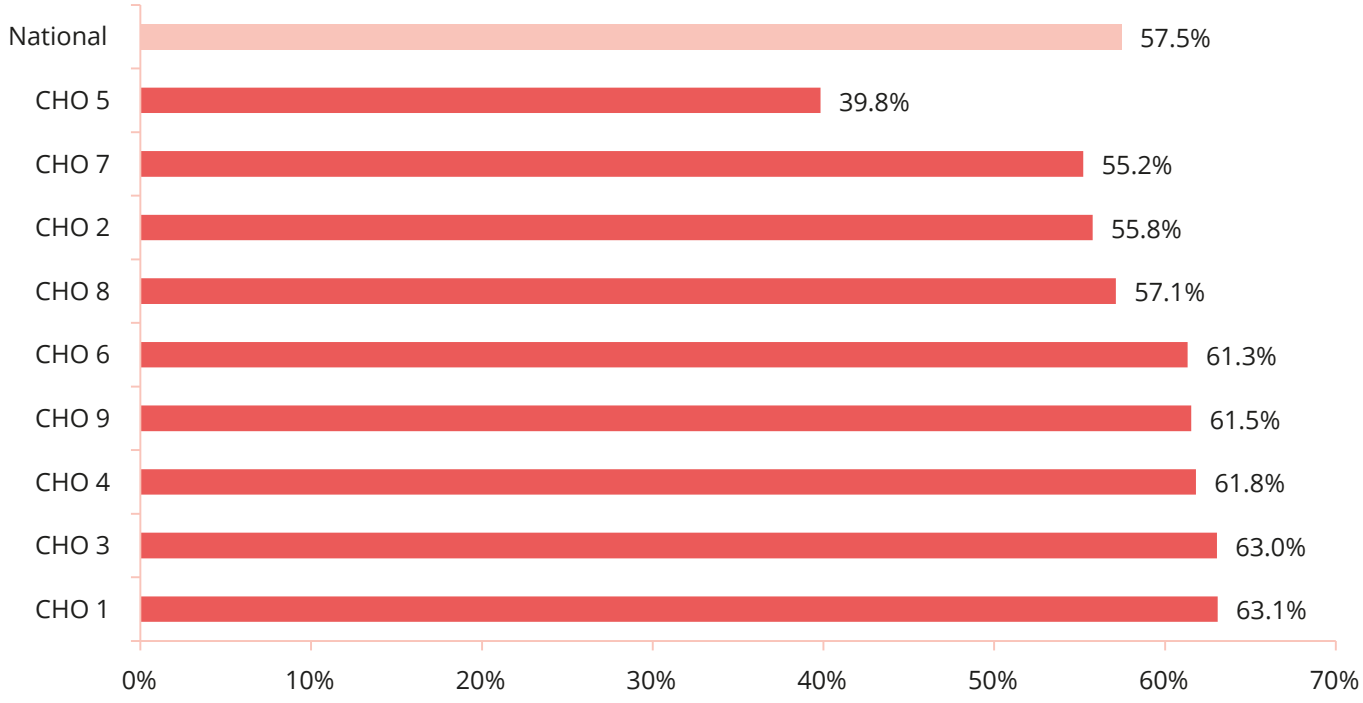
In December 2019, there was a total of 698.2 staff (clinical 602) working in 71 Community CAMHS teams, with an average of 9.83 staff per team, 8.48 of which were clinical staff. The range of team size varies from the smallest team of 5.2 staff (3.8 clinical) to the largest which comprises of 16.7 staff (14 clinical). The variation in team size can arise due to team development or population size, etc.

	2014	2015	2016	2017	2018	2019	Change +/-
Consultant Psychiatrist	65.39	64.15	68.22	72.85	71.70	71.60	6.21
Senior Registrar	13.30	10.70	13.22	16.31	21.98	24.08	10.78
Registrar/SHO	48.58	59.52	66.99	69.28	78.50	78.00	29.42
Social Worker	76.47	77.60	78.54	91.59	89.60	86.60	10.13
Clinical Psychologist	61.61	66.54	68.81	74.00	77.70	77.86	16.25
Nurse	88.37	98.27	105.41	112.24	114.90	117.52	29.15
Occupational Therapist	47.99	52.19	50.92	52.66	56.90	52.60	4.61
Speech & Language Therapist	51.61	42.61	50.57	52.06	50.50	51.85	0.24
Child/Social Care Worker	41.35	41.13	39.47	36.89	35.20	30.21	-11.14
Other Therapist	5.70	8.70	13.72	11.26	11.50	11.70	6.00
Administrative Support Staff	79.83	82.54	87.63	88.15	96.00	96.18	16.35
Total	580.20	603.95	643.50	677.29	704.48	698.20	118.00

Community Child & Adolescent workforce by profession 2019



Community CAMHS Teams Clinical Staffing vs VFC recommendation by Community Healthcare Organisations 2019



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 36.26 (clinical 30.76).

There are two adolescent day services, one in Dublin and one in Galway, with a total staff of 13.56 (clinical 11.56).

1. St. Joseph's Adolescent and Family Service at St. Vincent's Hospital, Fairview
2. Merlin Park Adolescent Day Programme located in Galway.

Staffing of Day Services and Liaison Teams

Dec-19	Day Service	Paediatric Hospital Liaison	Total
Medical	2.00	13.16	15.16
Nursing	8.50	6.30	14.80
Health Care Professional	1.06	11.30	12.36
Support Staff	2.00	5.50	7.50
Total	13.56	36.26	49.82

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 2019. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 1,752.69

Vision for Change recommendations – actual staffing (2019)

General Adult Mental Health Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2019
Staff Community MHTs	1 : 50,000	95	111	2,185	1,752.69

Community GAMHT staffing compared against Vision for Change recommendations

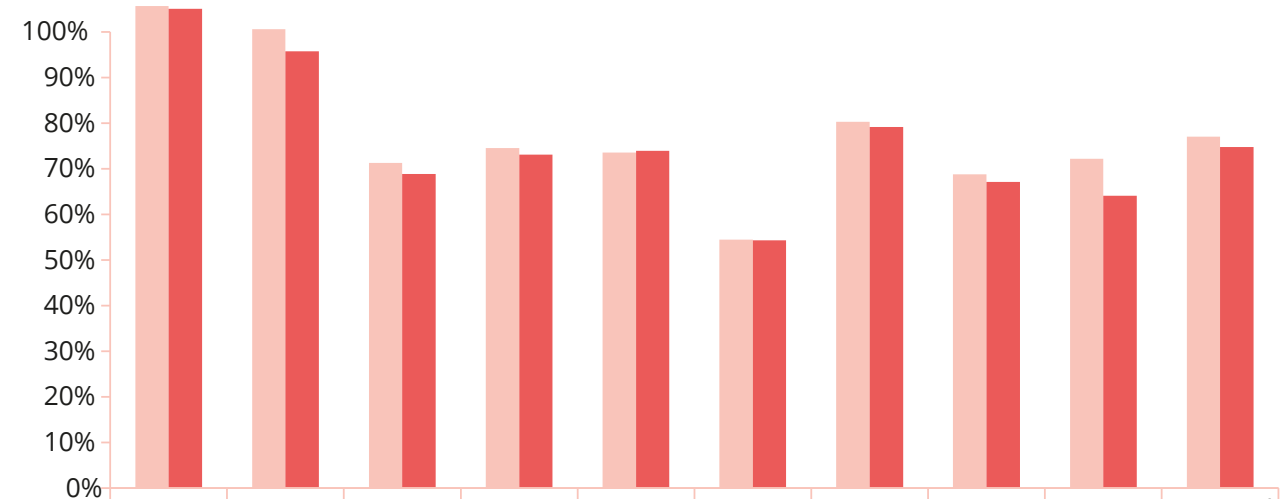
Vision for Change (2006) recommends that there should be one General Adult Community Mental Health Team for each sector of 50,000 population with each Team comprising of the following:

- 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 2019 there was a total of 1,752.69 staff in situ (1,541.22 Clinical), which represents 80% (77.1% clinical) of the staffing levels recommended in *A Vision for Change*.

Community GAMHS Teams Clinical Staffing vs VFC recommendations for 2018 – 2019



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2019	105.7%	100.6%	71.2%	74.5%	73.6%	54.5%	80.3%	68.8%	72.1%	77.1%
2018	105.0%	95.7%	68.8%	73.1%	73.9%	54.3%	79.1%	67.1%	64.1%	74.8%

In 2019 the clinical staffing level as recommended in *A Vision for Change* had increased by 2.3% nationally on the 2018 position.

The largest increase was in CHO 9 at 8% and the largest decrease was in CHO 5 at -0.4%.

Community General Adult Mental Health teams

In the period from December 2018 to December 2019, the clinical staff of the Community General Adult Mental Health Teams increased by 46.22 WTEs. 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 applicants, etc.

Community General Adult Mental Health Teams (2018 to 2019)

	Clinical Staff 2019	Clinical Staff 2018	Change +/- 2019
CHO 1	175.0	173.9	1.11
CHO 2	191.4	182.2	9.19
CHO 3	115.2	111.3	3.90
CHO 4	216.2	212.0	4.16
CHO 5	157.7	158.5	-0.81
CHO 6	102.0	101.6	0.38
CHO 7	217.5	214.5	3.00
CHO 8	178.0	173.7	4.29
CHO 9	188.3	167.3	21.00
Total Clinical	1,541.22	1,495.00	46.22
Admin/support	211.47	191.70	19.77
Total Staff	1,752.69	1,686.70	65.99

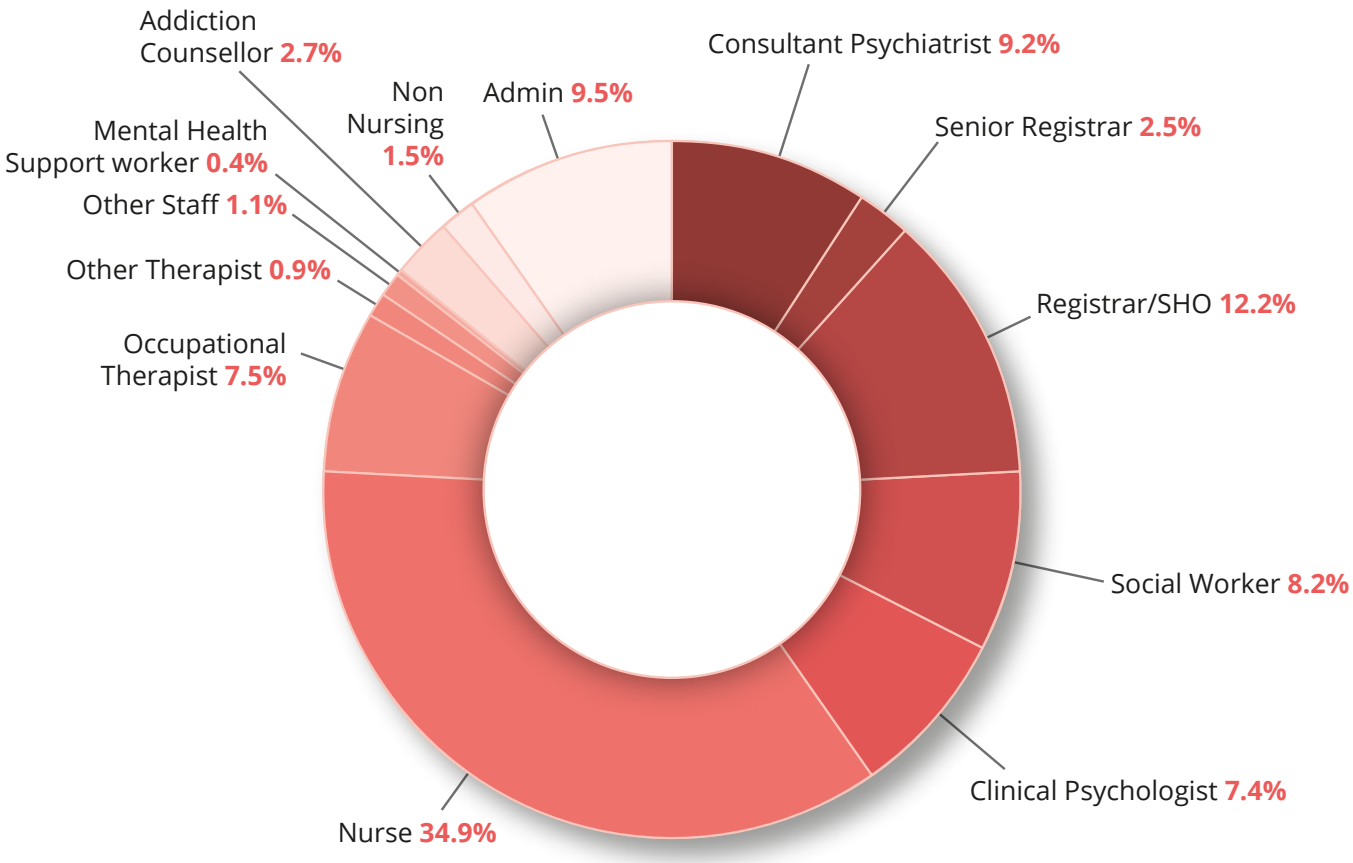
In December 2019 there was 1,752.69 staff (clinical 1,541.22) working in 111 Community General Adult Mental Health teams, with an average of 15.8 staff per team, of which 13.9 were clinical staff.

The General Adult Community Mental Health Teams as shown in the table opposite had a net gain of 64.35 whole time equivalents over the period 2014 to 2019, exclusive of staff leaving and retiring, etc.

Community General Adult Mental Health Teams Staffing by discipline 2014 to 2019

	2014	2015	2016	2017	2018	2019	Change +/-
Consultant Psychiatrist	157.92	159.97	155.64	159.1	159.5	161.6	3.68
Senior Registrar	35.30	30.43	41.23	31.6	41.7	43.7	8.40
Registrar/SHO	208.31	217.60	212.6	223.3	219.0	214.45	6.14
Social Worker	132.99	148.73	139.18	141.4	136.0	143.39	10.40
Clinical Psychologist	126.26	132.39	128.75	128.7	121.1	130.5	4.24
Nurse	613.13	648.92	621.58	623.2	595.5	610.95	-2.17
Occupational Therapist	123.76	124.48	112.55	128.0	135.1	131.27	7.51
Other Therapist e.g. SLT Creative/Recreational	14.58	15.92	14.69	13.6	15.9	20.54	5.96
Other Staff	17.78	16.33	16.43	18.5	12.6	19.76	1.98
Mental Health Support Worker	17.00	7.00	9	13.0	13.2	18	1.00
Addiction Counsellor	46.00	46.02	43.62	41.5	45.4	47.06	1.06
Non Nursing	35.61	43.80	40.50	21.8	18.6	26.66	-8.95
Administrative Support Staff	159.71	166.79	170.99	170.2	173.1	184.81	25.10
Total	1,688.35	1,758.38	1,706.76	1,713.59	1,686.70	1,752.69	64.35

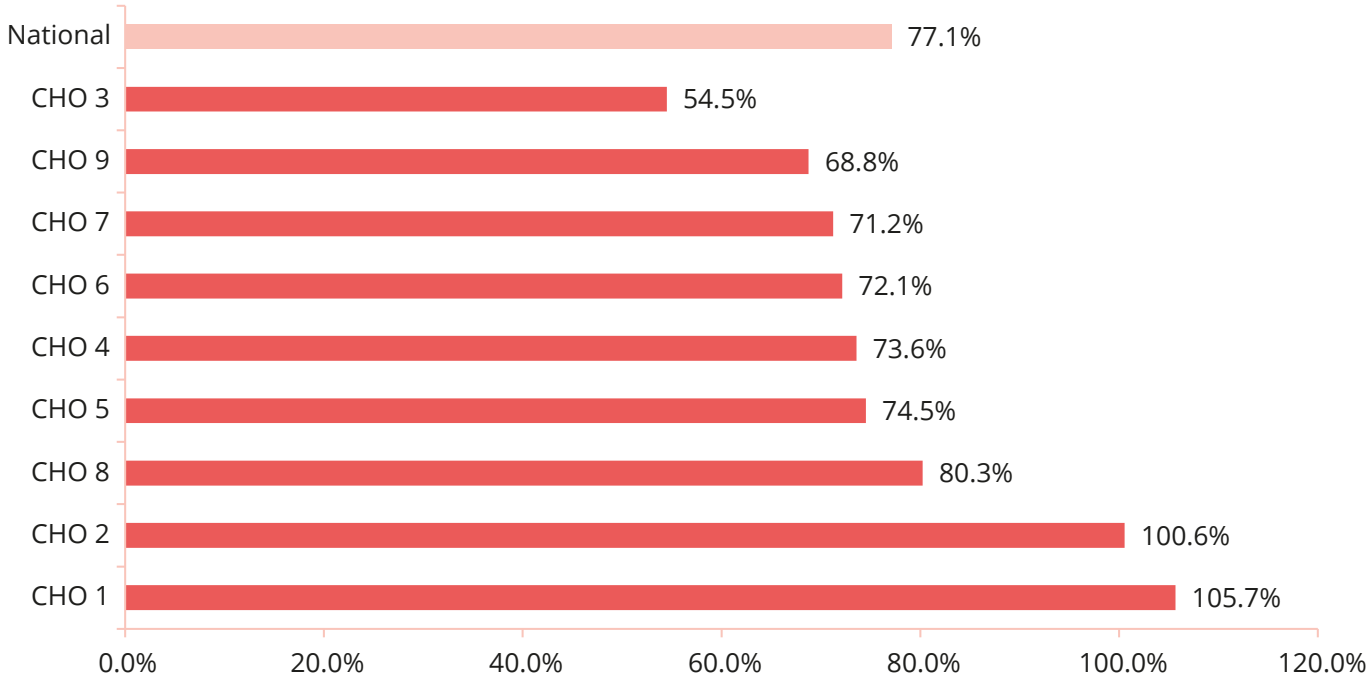
Community GAMHT workforce by profession (2019)



Community GAMHS Teams Clinical Staffing vs VFC recommendation by Community Healthcare Organisations 2018-2019

	Population Census 2016	Clinical Staff 2019	% of VFC rec 2019	Clinical Staff 2018	% of VFC rec 2018
CHO 1	394,333	175.0	105.7%	173.9	105.0%
CHO 2	453,109	191.4	100.6%	182.2	95.7%
CHO 3	384,998	115.2	71.2%	111.3	68.8%
CHO 4	690,575	216.2	74.5%	212.0	73.1%
CHO 5	510,333	157.7	73.6%	158.5	73.9%
CHO 6	445,590	102.0	54.5%	101.6	54.3%
CHO 7	645,293	217.5	80.3%	214.5	79.1%
CHO 8	616,229	178.0	68.8%	173.7	67.1%
CHO 9	621,405	188.3	72.1%	167.3	64.1%
National	4,761,865	1,541.2	77.1%	1,495.0	74.8%

Community GAMHS Teams Clinical Staffing vs VFC recommendation by Community Healthcare Organisations 2019



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 2019. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing was 362.1

Vision for Change recommendations – actual staffing (2019)

Psychiatry of Later Life Services	Vision for Change (2006)	No. of recommended teams	Teams In place	Rec. Staff	Staffing levels in 2019
Staff POLL service	1 : 100,000*	48	32	571	362.1

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

Currently there are 32 POLL community teams (December 2019) with a number of teams in development which have been resourced from the Programme for Government investments in recent years.

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

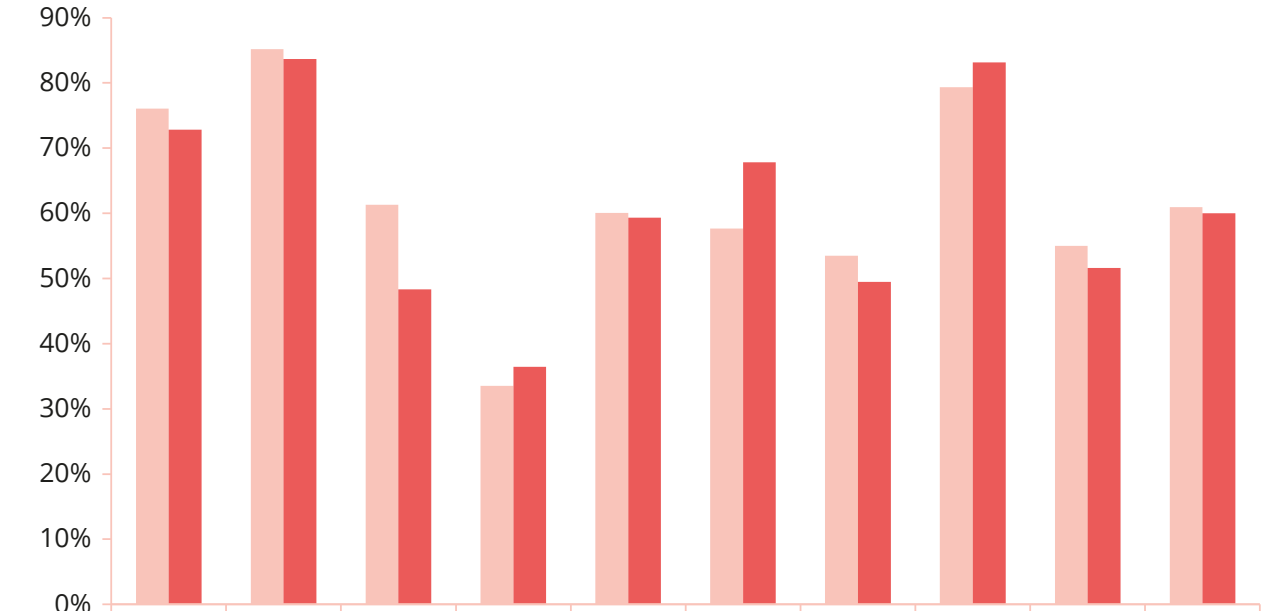
A Vision for Change (2006) recommends that there should be one Psychiatry of Later Life Service team for each sector of 100,000 population. The staff complement for a Psychiatry of Later Life team is 12 per 100,000 head of population, (11 clinical and 1 administrative support staff) and is comprised 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 2019, there were 362.11 staff (clinical 319.01) working in 32 Psychiatry of Later Life Service teams, with an average of 11.32 staff (of which 9.97 were clinical) per team. This represents 63.4% (61% clinical) of the staffing level as recommended in *A Vision for Change.*

Community POLL Team Staffing vs VFC recommendations in 2018 – 2019



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2019	76.1%	85.2%	61.3%	33.5%	60.1%	57.7%	53.5%	79.3%	55.0%	61.0%
2018	72.8%	83.7%	48.3%	36.5%	59.3%	67.8%	49.5%	83.2%	51.6%	60.0%

In 2019 the Clinical staffing level as recommended in *A Vision for Change* had increased by 0.9% nationally on the 2018 position. The largest increase was in CHO 3 which saw an increase of 13%; and the largest decrease was in CHO 6 at -10.2%

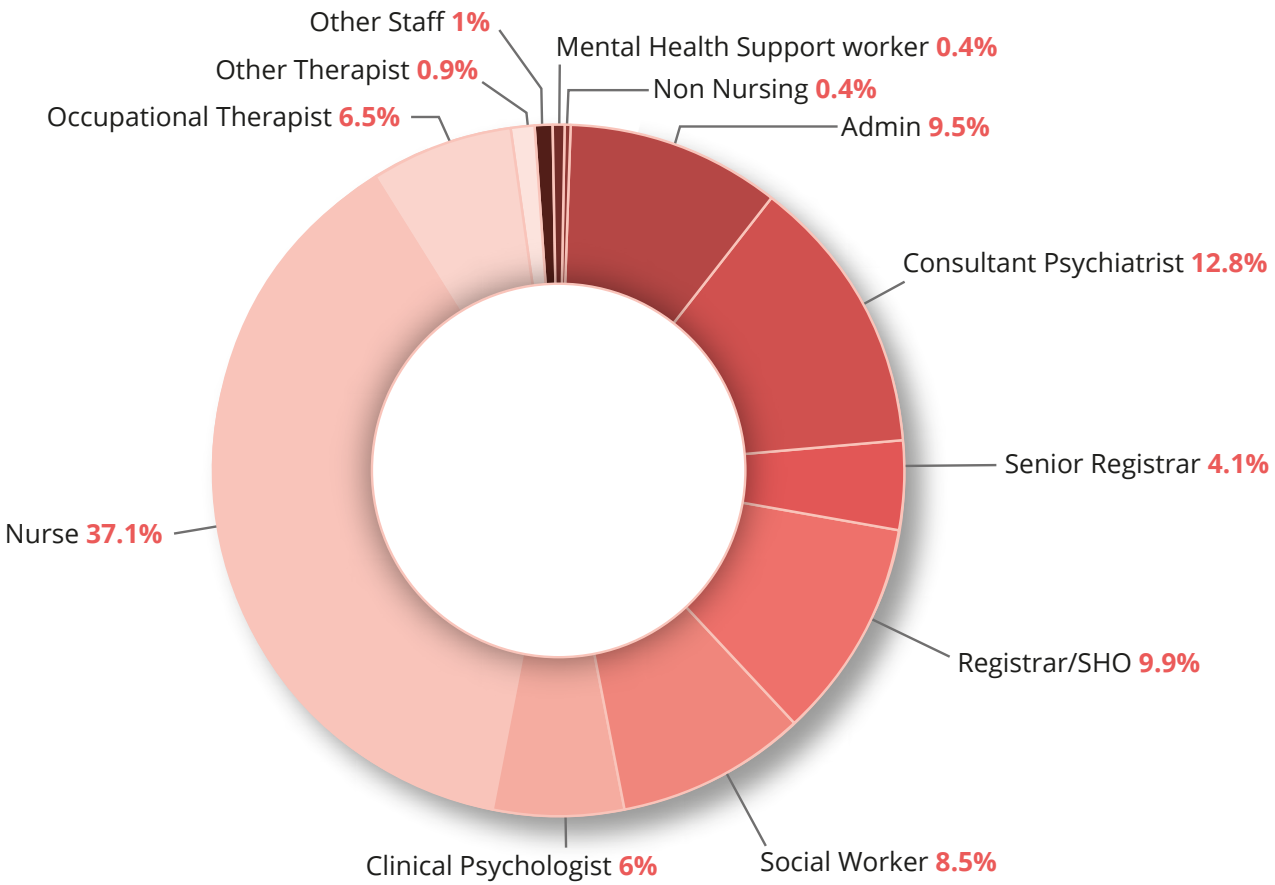
Psychiatry of Later Life Service Teams

The staffing of Psychiatry of Later Life Service increased by 19.16 WTEs in the period from December 2016 to December 2017. In the period from 2013 to 2017, Community Psychiatry of Later Life Services 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 (2018 to 2019)

	Clinical Staff 2018	Clinical Staff 2019	Change +/-
CHO 1	35.9	37.5	1.60
CHO 2	47.1	47.95	0.85
CHO 3	22.2	28.16	5.96
CHO 4	29.6	27.2	-2.40
CHO 5	36.2	36.63	0.43
CHO 6	28.3	28.3	0.00
CHO 7	33.7	32.5	-1.20
CHO 8	50.7	48.37	-2.33
CHO 9	30.4	32.4	2.00
Total Clinical	314.10	319.01	4.91
Admin/support	40.5	43.1	2.63
Total	354.57	362.11	7.54

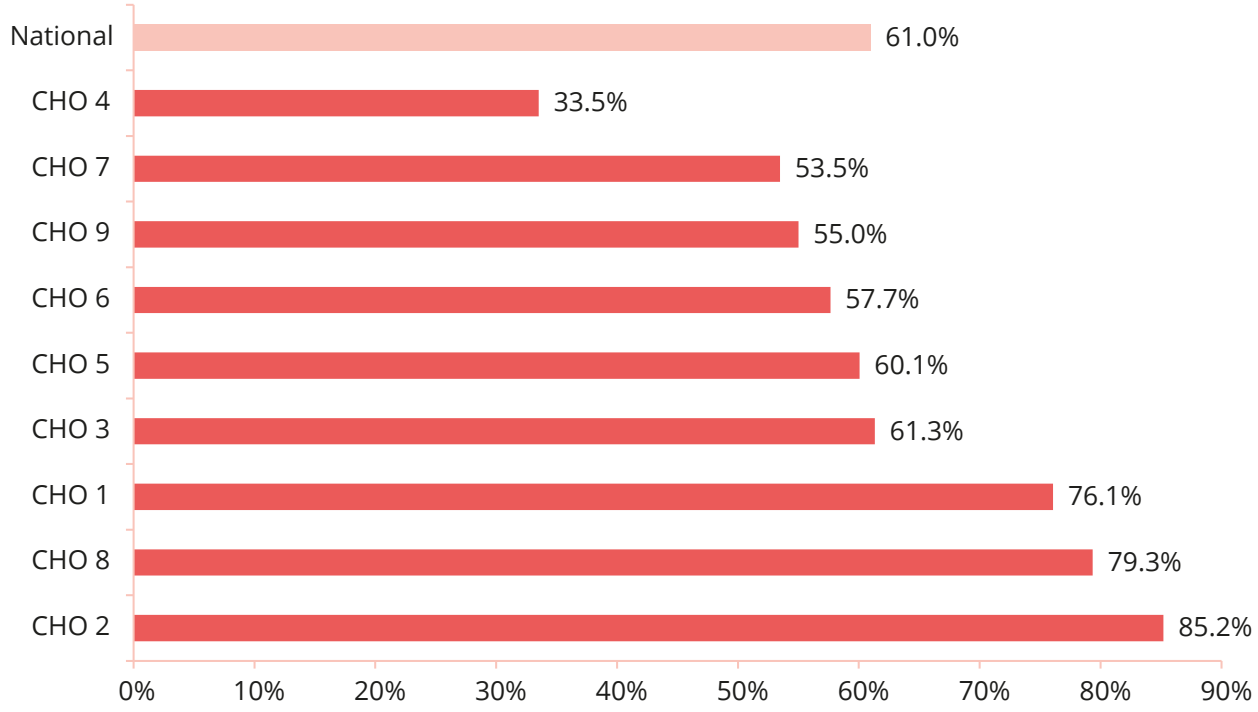
Psychiatry of Later Life Service Workforce by discipline (2019)



Psychiatry of Later Life Service Staffing by discipline 2014 to 2019

	2014	2015	2016	2017	2018	2019	Change +/-
Consultant Psychiatrist	36.30	36.95	40.2	43.5	44.0	46.3	10.00
Senior Registrar	11.00	10.55	15	12.0	13.0	14.7	3.70
Registrar/SHO	26.00	26.50	32	33.4	37.8	36	10.00
Social Worker	25.00	26.90	26.8	30.7	30.2	30.65	5.65
Clinical Psychologist	16.50	17.80	22.1	22.0	23.2	21.55	5.05
Nurse	114.83	119.12	123.3	128.6	133.0	134.52	19.69
Occupational Therapist	24.22	23.27	23	26.6	26.3	23.7	-0.52
Other Therapist e.g. SLT Creative/Recreational	2.00	1.30	1.6	3.2	3.2	5.89	3.89
Other Staff	0.88	2.63	1.9	2.0	1.4	3.7	2.82
Mental Health Support Worker	3.00	1.00	1	2.8	2.0	2	-1.00
Addiction Counsellor	0.40	0.20	0	0.0	0.0	0	-0.40
Non Nursing	6.32	2.91	2.9	2.9	2.4	2.9	-3.42
Administrative Support Staff	35.24	33.41	34.9	36.2	38.0	40.2	4.96
Total	301.69	302.54	324.70	343.86	354.50	362.11	60.42

POLL Team Clinical Staffing vs VFC recommendation by Community Healthcare Organisations 2019



Chapter 5

Community Child and Adolescent Mental Health Services

Key Facts

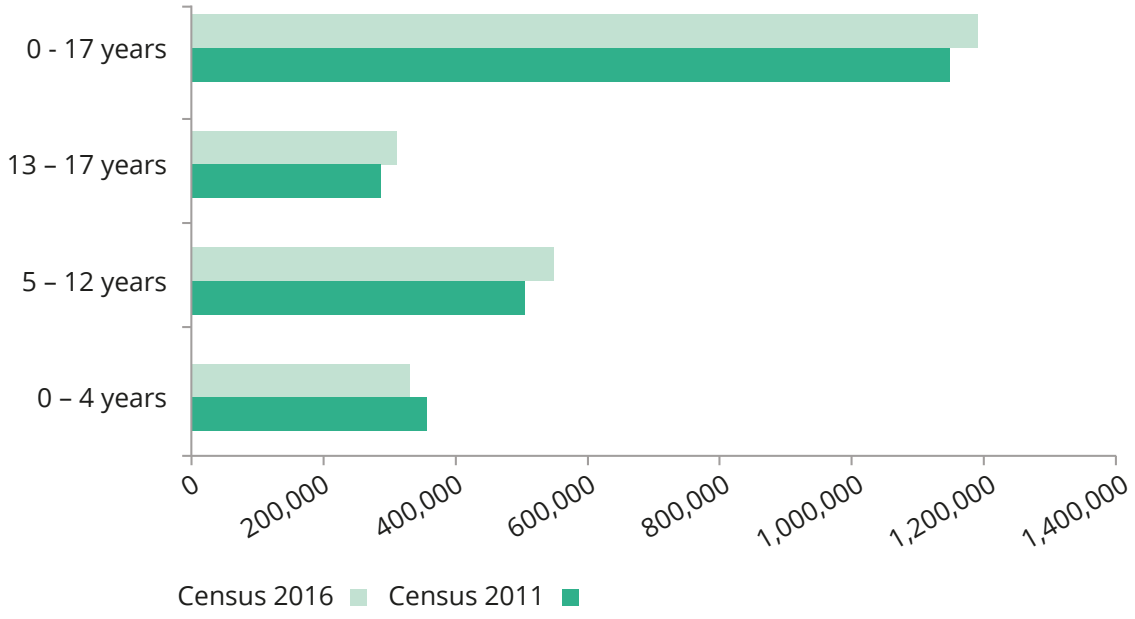
- 2008 - 49 CAMHS teams; 2019 – 71 CAMHS Teams
- 2008 – 351.63 Clinical WTEs; 2019 – 602 Clinical WTEs
- 57.5% of the Clinical staffing levels recommended in *A Vision for Change*
- 2% increase in referrals accepted from 2017 to 2019
- 12,174 new appointments offered in 2019
- 48.4% new appointments seen within 4 weeks
- A quarter of new cases seen are aged over 16 years
- 8.5% of new patients did not attend their first appointment
- 2007 – 3,609 individuals were waiting to be seen; 2019 – 2,327 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 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 lowest increase 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, undermine compliance with health regimens, and reduce 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 populations of Irish adolescents aged 12-15 years in a defined geographical area found that 15.6% of the total population met the criteria for a current psychiatric disorder, including 2.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide.

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

Children Attending CAMHS

The total population under 18 years in the 2016 census was 1,190,502 and in Quarter 3 of 2019 the number of active open cases recorded by CAMHS Community Mental Health Teams was 18,719 or 1.6% of the child population nationally.

Number of children attending CAMHS by year and CHO

	2019		2018		2017	
	Q1	Q3	Q1	Q3	Q1	Q3
CHO 1	1,828	1,758	1,733	1,737	1,782	1,645
CHO 2	2,549	2,356	2,523	2,512	2,437	2,441
CHO 3	2,358	2,161	2,222	2,239	2,258	2,527
CHO 4	2,579	2,567	2,416	2,487	2,376	2,309
CHO 5	1,237	1,118	1,396	1,421	1,499	1,459
CHO 6	3,245	2,994	3,160	3,079	3,145	2,908
CHO 7	2,129	2,163	2,025	2,059	2,136	2,005
CHO 8	2,344	2,270	2,209	2,222	1,541	1,864
CHO 9	1,352	1,332	1,368	1,337	1,467	1,304
National	19,621	18,719	19,052	19,093	18,641	18,462

Percentage of CHO Population under 18 years old attending CAMHS 2019

	<18 years Population	Caseload 2019	Percentage
CHO 1	103,778	1,758	1.7%
CHO 2	111,880	2,356	2.1%
CHO 3	96,266	2,161	2.2%
CHO 4	168,542	2,567	1.5%
CHO 5	131,522	1,118	0.9%
CHO 6	116,264	2,994	2.6%
CHO 7	144,296	2,163	1.5%
CHO 8	172,373	2,270	1.3%
CHO 9	145,581	1,332	0.9%
National	1,190,502	18,719	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 Operational Guidelines* set out the referral criteria to Community CAMHS as follows:

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

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

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

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

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

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

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

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

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

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

** Child and Adolescent Mental Health Services Operational Guidelines effective from September 2019 www.hse.ie/eng/services/list/4/mental-health-services/camhs/operational-guideline/*

*** 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 2019, there were 13,190 referrals accepted by the Community Child and Adolescent Mental Health service which is on par with 2018. In the period from 2015 the number of referrals accepted has slightly decreased overall by -1% nationally.

Referrals accepted 2015 – 2019

	2019	2018	+/- Variance 18 vs 19	2017	+/- Variance 17 vs 19	2016	+/- Variance 16 vs 19	2015	+/- Variance 15 vs 19
CHO 1	1,095	1,030	6%	837	31%	957	14%	1,026	7%
CHO 2	1,257	1,247	1%	1,109	13%	1,049	20%	1,064	18%
CHO 3	1,391	1,593	-13%	1,994	-30%	1,941	-28%	1,813	-23%
CHO 4	1,520	1,573	-3%	1,466	4%	1,566	-3%	1,578	-4%
CHO 5	1,393	1,178	18%	1,210	15%	1,458	-4%	1,502	-7%
CHO 6	1,641	1,650	-1%	1,604	2%	1,639	0%	1,625	1%
CHO 7	1,642	1,796	-9%	1,689	-3%	1,688	-3%	1,694	-3%
CHO 8	2,294	2,319	-1%	2,093	10%	2,094	10%	1,881	22%
CHO 9	957	869	10%	986	-3%	1,107	-14%	1,173	-18%
National	13,190	13,255	0%	12,988	2%	13,499	-2%	13,356	-1%

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 to 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 2019, 1,157 individuals were expected to be seen within three months and a further 1,170 individuals were on the waiting list. This represented a decrease of -199 (-8%) from the total number of 2,526 waiting at the end of 2018.

In the context of an overall 23% increase in the number of referrals accepted, between 2012 and 2019 the Child and Adolescent Mental Health Service waiting list has decreased by -4% (-95 cases).

At the end of 2019 there were 2,327 cases waiting to be seen. This is a decrease of 199 cases on the same period in 2018. The number of cases waiting over 12 months decreased by 102 to 212 in 2019. 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 dedicated 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 issues and challenges in recruiting.

Length of Wait time by CHO - December 2018 vs December 2019

	2019						2018					
	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	162	61	45	22	39	329	156	40	33	21	13	263
CHO 2	32	2	1	0	0	35	27	2	0	0	0	29
CHO 3	115	43	17	9	4	188	63	34	42	32	68	239
CHO 4	203	89	93	89	145	619	220	109	140	120	163	752
CHO 5	99	23	12	7	3	144	82	31	22	20	31	186
CHO 6	160	106	69	58	19	412	163	102	38	45	5	353
CHO 7	111	20	11	2	0	144	134	34	12	3	0	183
CHO 8	152	53	42	19	2	268	183	58	41	16	31	329
CHO 9	123	38	21	6	0	188	108	31	33	17	3	192
National	1,157	435	311	212	212	2,327	1,136	441	361	274	314	2,526

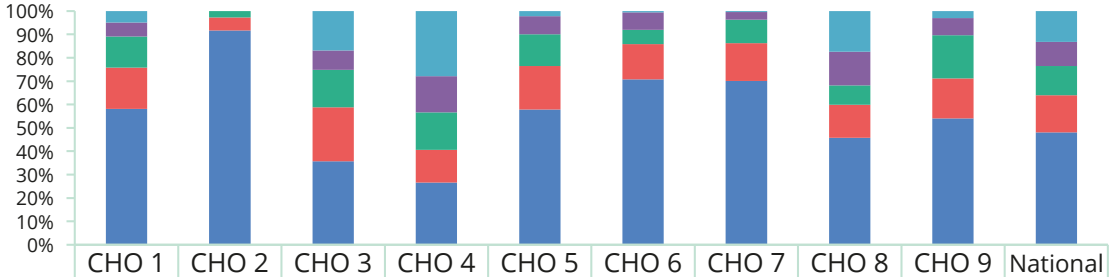
Referrals Accepted Trend vs Waiting List trend

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%
2018	13,255	2%	2,526	4%
2019	13,190	0%	2,327	-8
2012 v 2019	2,485	23%	-95	-4%

Numbers waiting by length of time per CHO in 2019

The number of cases waiting to be seen varied in Child and Adolescent Community Mental Health Teams. 79% (56) of the teams had less than 50 cases on the waiting list, with 93% (66) having a waiting lists below 100.

Breakdown of Waiting Lists by CHO Area 2019



	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
9-12months	12	0	21	115	11	28	8	43	10	248
6-9months	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

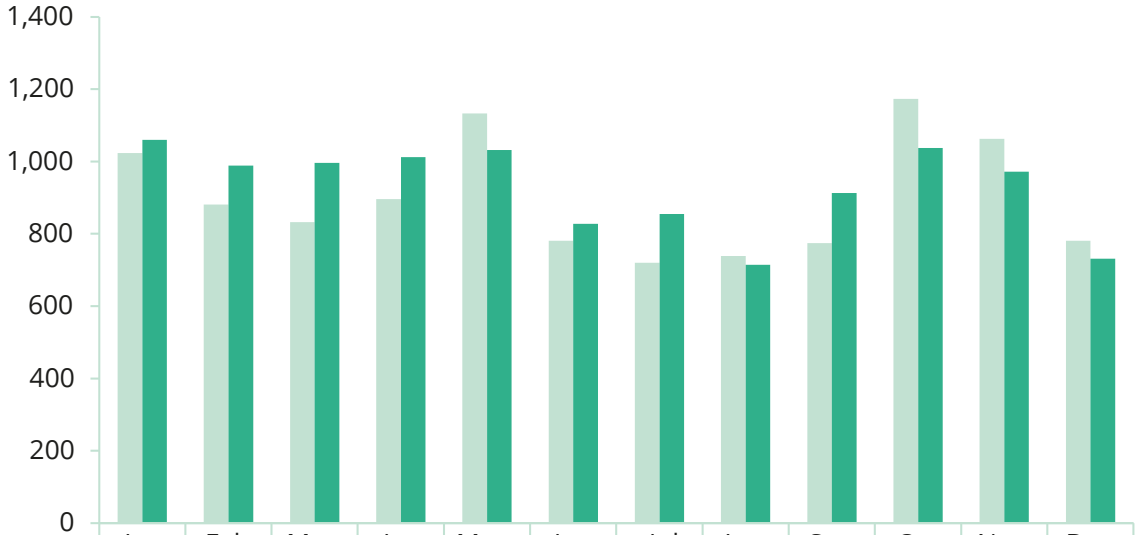
New (including re-referred) cases seen by Community CAMHS teams in 2019

In 2019, 12,174 new cases were offered an appointment by Community CAMHS Teams compared to 11,954 cases in 2018.

Of these, 11,139 (10,796 in 2018) were seen and 1,035 (1,158 in 2018) did not attend (DNA).

This shows a slight decrease in the non-attendance rate to 8.5% nationally (9.7 % in 2018).

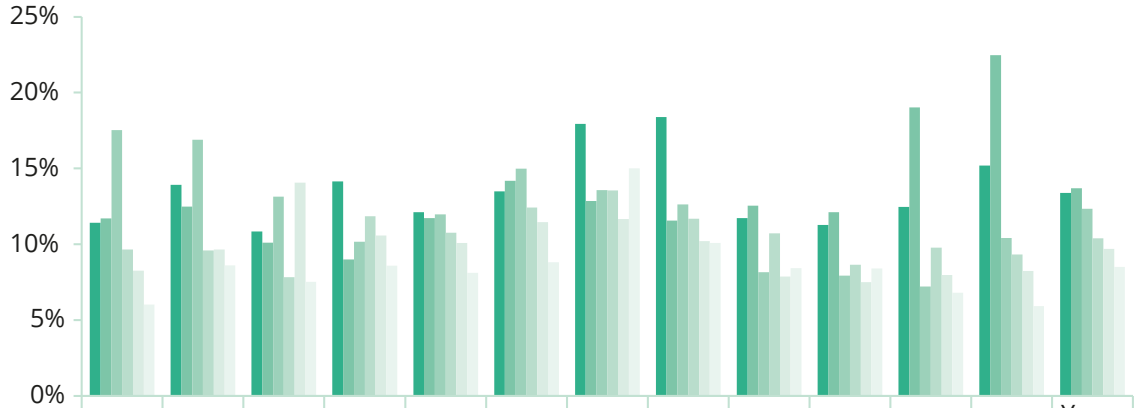
Number of New (including re-referred) cases seen 2018 vs 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen -2018	1,023	881	832	896	1,133	781	720	739	774	1,173	1,063	781
Seen -2019	1,060	989	996	1,012	1,032	828	855	714	913	1,037	972	731

Figures below shows the variation by month in the DNA rates, reflecting the seasonal impact on attendance, as the rates range from 15% (July) to 5.9% (December) across 2019. This compares to 14% (March) to 7.5% (October) in 2018 with 13.5% (July) to 7.8% (March) in 2017 and 17.5% (January) to 7.2% (November) in 2016.

DNA rates 2014 to 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2014	11.4%	13.9%	10.8%	14.1%	12.1%	13.5%	17.9%	18.4%	11.7%	11.3%	12.5%	15.2%	13.4%
2015	11.7%	12.5%	10.1%	9.0%	11.7%	14.2%	12.9%	11.6%	12.5%	12.1%	19.0%	22.5%	13.7%
2016	17.5%	16.9%	13.1%	10.2%	12.0%	15.0%	13.6%	12.6%	8.2%	7.9%	7.2%	10.4%	12.3%
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%
2018	8.3%	9.6%	14.0%	10.6%	10.1%	11.5%	11.7%	10.2%	7.9%	7.5%	8.0%	8.2%	9.7%
2019	6.0%	8.6%	7.5%	8.6%	8.1%	8.8%	15.0%	10.1%	8.4%	8.4%	6.8%	5.9%	8.5%

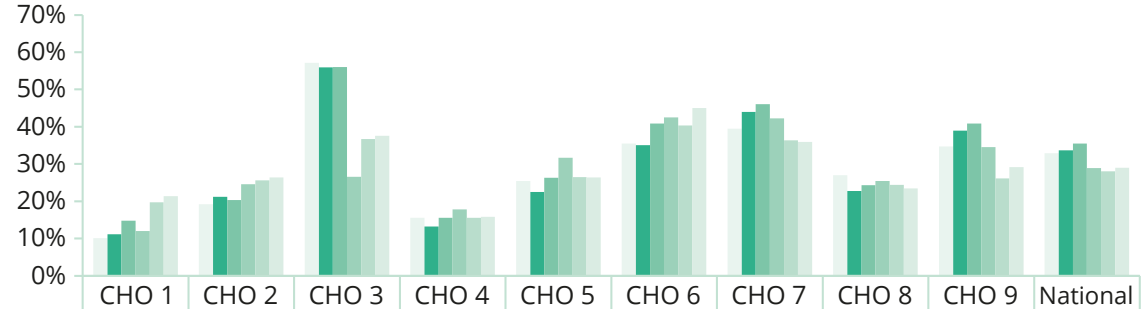
Breakdown of New Cases (New vs Re-referred Cases)

A proportion of the new cases seen will have previously attended the service, been discharged and are re-referred back to the service for a new episode of care.

In 2019, of the 11,139 cases seen, a total of 3,230 had been re-referred to the service. In 2018, of the 10,796 cases seen, a total of 3,026 had been re-referred to the service. This reflects an increase in the re-referral rate from 28% in 2018 to 29%.

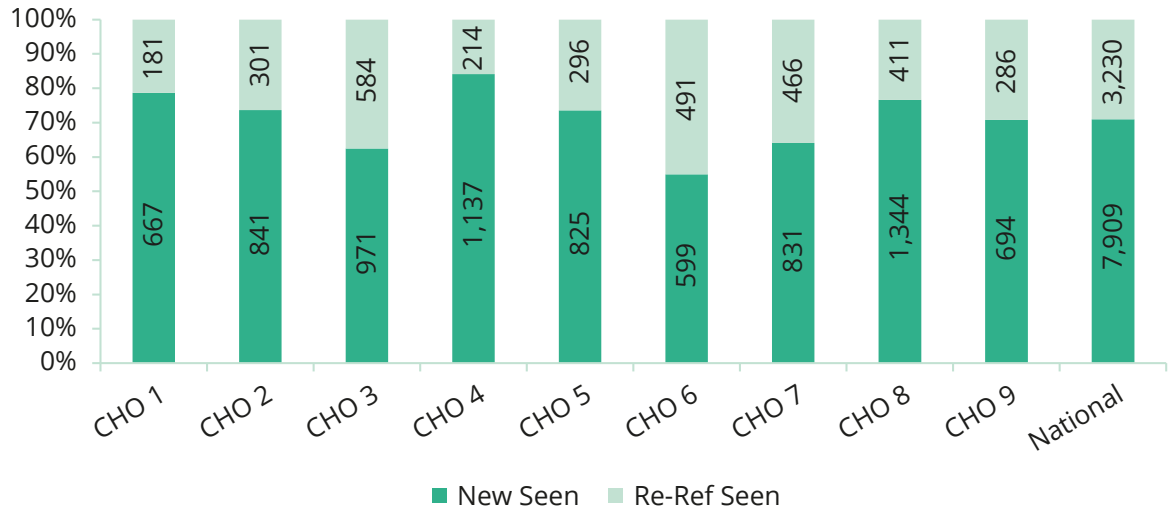
The proportion of re-referred cases seen in the CHOs over 2019 varied from 21.3% in CHO 1 to 45% in CHO 6 (see figures below).

Percentage of Re-referred cases between 2014 and 2019



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2014	10.1%	19.2%	57.2%	15.6%	25.4%	35.5%	39.5%	27.0%	34.7%	32.9%
2015	11.2%	21.2%	55.9%	13.3%	22.5%	35.1%	44.0%	22.7%	39.0%	33.6%
2016	14.8%	20.3%	56.0%	15.6%	26.3%	40.8%	46.0%	24.3%	40.8%	35.5%
2017	12.0%	24.6%	26.5%	17.9%	31.7%	42.5%	42.3%	25.5%	34.6%	28.9%
2018	19.7%	25.6%	36.7%	15.6%	26.5%	40.4%	36.3%	24.4%	26.2%	28.0%
2019	21.3%	26.4%	37.6%	15.8%	26.4%	45.0%	35.9%	23.4%	29.2%	29.0%

Breakdown of new cases (New vs Re-referred cases) 2019



New and re-referred Cases seen by age profile

In 2019, a total number of 11,139 new and re-referred cases were seen by Community CAMHS teams. Of these, 75% (8,321) were under 16 years of age and 25% (2,818) were over 16 years of age.

In 2018, a total number of 10,796 new and re-referred cases were seen by Community CAMHS teams. Of these, 75% (8,100) were under 16 years of age and 25% (2,696) were over 16 years of age.

There are a small number of service users who will transition from community child and adolescent mental health services to adult mental health services before their 18th birthday and in some cases it may be appropriate that they are provided with treatment by both services whilst transition occurs.

Number of new (including re-referred) cases seen aged 16 years and over 2019

2019	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	848	207	24.4%
CHO 2	1,142	285	25.0%
CHO 3	1,555	335	21.5%
CHO 4	1,351	318	23.5%
CHO 5	1,121	282	25.2%
CHO 6	1,090	268	24.6%
CHO 7	1,297	327	25.2%
CHO 8	1,754	464	26.5%
CHO 9	981	332	33.8%
National	11,139	2,818	25.3%

Number of new (including re-referred) cases seen aged 16 years and over 2018

2018	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	863	164	19.0%
CHO 2	1,172	289	24.7%
CHO 3	1,352	336	24.9%
CHO 4	1,449	386	26.6%
CHO 5	869	248	28.5%
CHO 6	1,224	295	24.1%
CHO 7	1,271	290	22.8%
CHO 8	1,751	447	25.5%
CHO 9	845	241	28.5%
National	10,796	2,696	25.0%

Timeliness of access to CAMHS Community Mental Health Teams

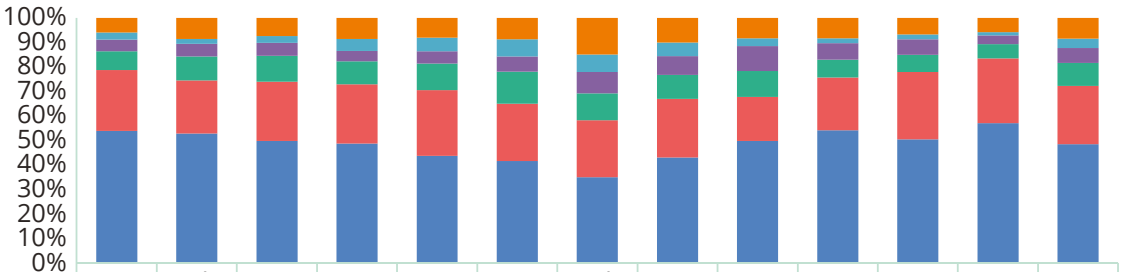
In 2019, a total of 12,174 individuals were offered an appointment of which 11,796 new cases were seen by Community CAMHS teams.

The expectation is that the CAMHS Community Mental Health Teams will offer an appointment and see an individual within three months. In 2019, 72.2% of new cases were seen within three months and of these, 48.4% were seen within one month.

The breakdown is as follows:

- 48.4% of new cases were seen within 1 month of referral.
- 72.2% seen within 3 months.
- 9.4% of new cases had waited between 3 to 6 months.
- 6.1% had waited between 6 and 12 months.
- 3.8% had waited more than 1 year.
- 8.5% did not attend their appointment.

Timeframe for 1st appointment to be seen in 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DNA	6.0%	8.6%	7.5%	8.6%	8.1%	8.8%	15.0%	10.1%	8.4%	8.4%	6.8%	5.9%	8.5%
>12 Mth	2.9%	2.0%	2.7%	5.0%	5.6%	6.9%	7.2%	5.5%	3.1%	2.0%	1.9%	1.3%	3.8%
6-12 mth	4.7%	5.2%	5.3%	4.2%	5.0%	6.3%	8.6%	7.7%	10.2%	6.6%	6.4%	3.6%	6.1%
3-6 mth	7.7%	9.8%	10.6%	9.4%	10.9%	13.0%	11.0%	9.8%	10.5%	7.2%	7.0%	5.8%	9.4%
1 -3 mth	24.8%	21.5%	24.1%	24.2%	26.7%	23.3%	23.2%	23.8%	18.0%	21.6%	27.4%	26.4%	23.7%
<1 Month	53.8%	52.9%	49.8%	48.7%	43.7%	41.6%	35.0%	43.1%	49.7%	54.1%	50.4%	57.0%	48.4%

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	40.7%	25.0%	15.2%	7.6%	4.0%	7.4%
CHO 2	72.1%	19.6%	1.4%	0.1%	0.1%	6.7%
CHO 3	62.7%	19.3%	5.5%	3.2%	5.0%	4.4%
CHO 4	41.4%	18.6%	8.4%	9.1%	12.0%	10.4%
CHO 5	52.9%	21.6%	7.4%	3.1%	5.4%	9.5%
CHO 6	37.0%	28.8%	16.6%	11.2%	2.1%	4.2%
CHO 7	39.1%	36.2%	9.3%	3.3%	1.1%	11.0%
CHO 8	44.2%	22.4%	10.6%	8.8%	1.4%	12.6%
CHO 9	43.6%	23.9%	13.7%	8.8%	2.7%	7.3%
National	48.4%	23.8%	9.4%	6.1%	3.8%	8.5%

Discharge from the CAMHS Community Mental Health Teams

In 2019, 12,660 individuals were discharged by Community CAMHS Teams compared to 12,201 cases in 2018.

88.3% (88.9% in 2018) of the individuals were discharged to the care of their general practitioner or Primary Care Team (PCT), 2.6% (3.4% in 2018) to a Community Based Service, 5.2% (4.5% in 2018) to another CAMHS service, and 3% (3.1% in 2018) 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	87.7%	4.5%	1.7%	6.1%
CHO 2	93.9%	0.7%	0.6%	4.9%
CHO 3	86.3%	3.4%	4.6%	5.8%
CHO 4	86.6%	3.6%	6.4%	3.4%
CHO 5	91.1%	2.7%	3.3%	2.9%
CHO 6	92.6%	1.5%	4.1%	1.7%
CHO 7	93.2%	1.7%	3.7%	1.4%
CHO 8	77.3%	4.8%	15.4%	2.5%
CHO 9	97.2%	0.6%	0.5%	1.7%
National	89.3%	2.6%	5.2%	3.0%

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

	GP/PCT	Other Community Service	Other CAMHS Service	Adult Mental Health Service	Total
CHO 1	864	44	17	60	985
CHO 2	1,139	8	7	59	1,213
CHO 3	584	23	31	39	677
CHO 4	1,333	56	98	53	1,540
CHO 5	1,100	33	40	35	1,208
CHO 6	1,753	29	78	33	1,893
CHO 7	1,814	33	73	27	1,947
CHO 8	1,515	95	302	49	1,961
CHO 9	1,202	7	6	21	1,236
National	11,304	328	652	376	12,660

Chapter 6

Community General Adult Mental Health Services

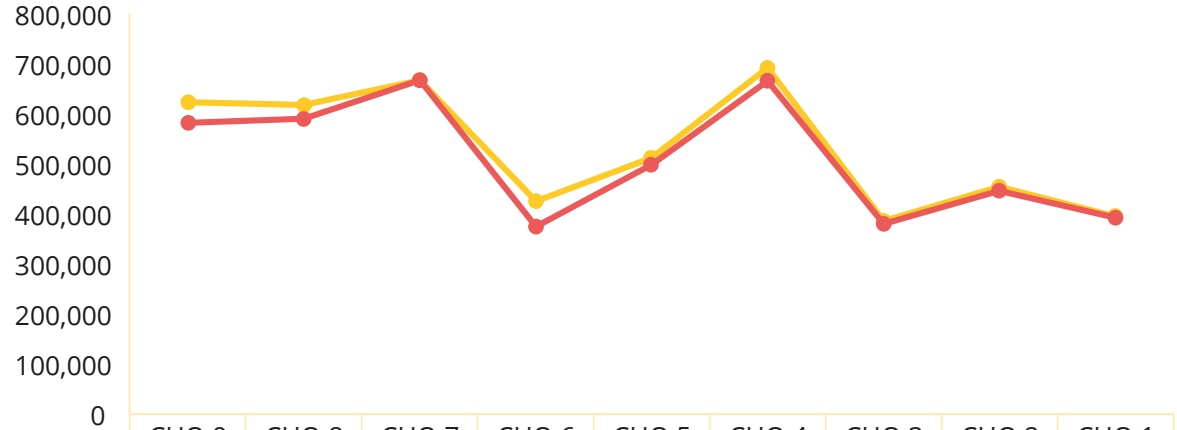
Key Facts

- 111 Community General Adult Mental Health Teams
- 2013 – 1,456.57 Clinical WTEs; 2019 – 1,541.2 Clinical WTEs
- 77.1% of the Clinical staffing levels recommended in *A Vision for Change*
- 0.3% decrease in referrals accepted from 2018 to 2019
- 34,792 new appointments offered in 2019
- 19.1% of new appointments seen within 1 week
- 30.3% are seen within 2 weeks & 47.7% 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%.

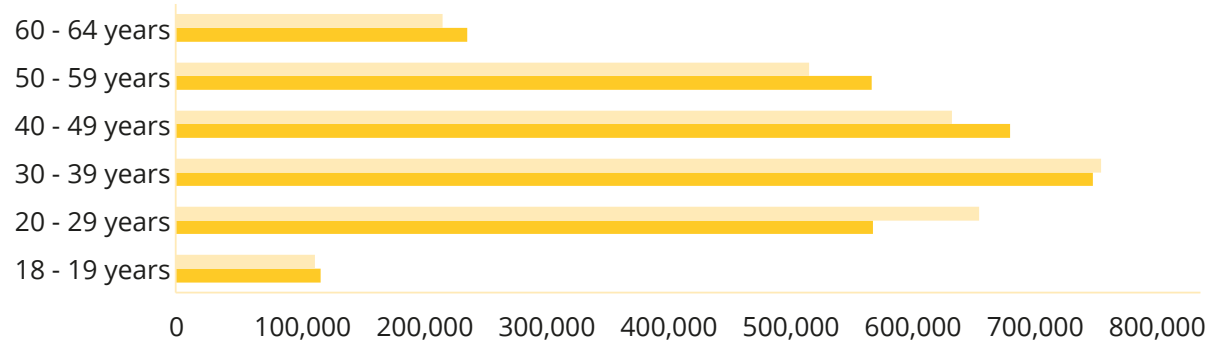
2016 & 2011 Census by CHO*



	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 2019, there has been a decrease of -3.6% nationally in the number of referrals accepted by the community general adult mental health service. From 2018 to 2019 there was a 0.3% increase as outlined in the table below.

Referrals accepted 2014 vs 2019

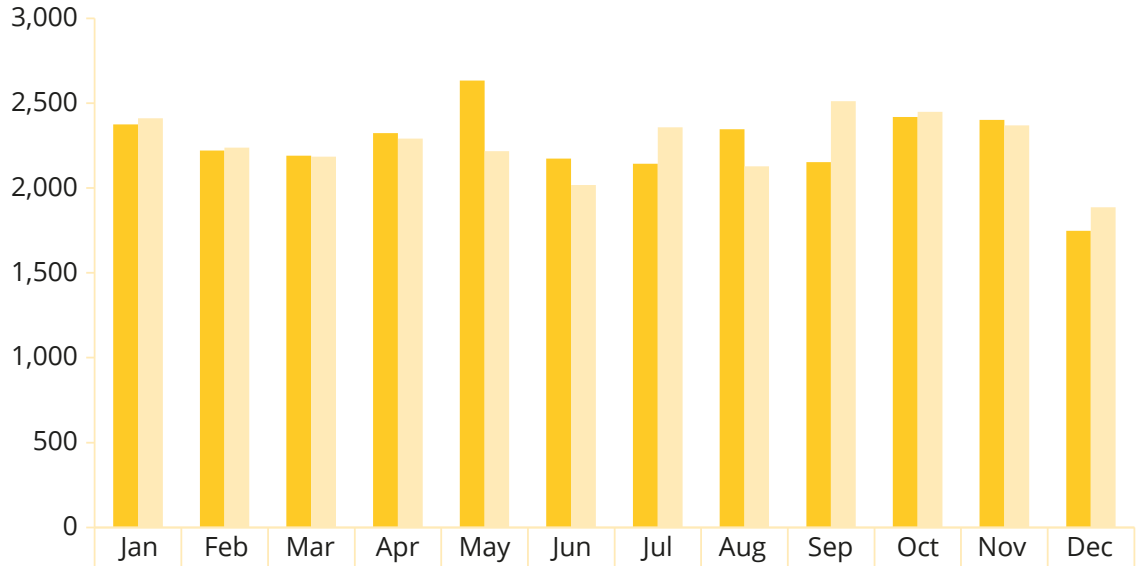
Referrals Accepted											
	2019	2018	+/- Variance 19 vs 18	2017	+/- Variance 19 vs 17	2016	+/- Variance 19 vs 16	2015	+/- Variance 19 vs 15	2014	+/- Variance 19 vs 14
CHO 1	3,305	3,095	6.8%	3,412	-3.1%	3,334	-0.9%	3,264	1.3%	3,889	-15.0%
CHO 2	6,037	5,594	7.9%	5,865	2.9%	6,463	-6.6%	6,551	-7.8%	6,537	-7.6%
CHO 3	3,717	3,595	3.4%	3,798	-2.1%	3,701	0.4%	3,738	-0.6%	3,523	5.5%
CHO 4	5,617	5,703	-1.5%	5,926	-5.2%	6,471	-13.2%	6,202	-9.4%	5,906	-4.9%
CHO 5	3,587	3,873	-7.4%	3,910	-8.3%	4,078	-12.0%	3,917	-8.4%	3,984	-10.0%
CHO 6	2,177	2,411	-9.7%	2,186	-0.4%	2,214	-1.7%	2,240	-2.8%	2,275	-4.3%
CHO 7	4,360	4,426	-1.5%	4,354	0.1%	4,033	8.1%	3,745	16.4%	3,967	9.9%
CHO 8	5,464	5,396	1.3%	5,331	2.5%	5,278	3.5%	5,417	0.9%	5,118	6.8%
CHO 9	3,365	3,427	-1.8%	3,519	-4.4%	3,591	-6.3%	3,678	-8.5%	3,828	-12.1%
National	37,629	37,520	0.3%	38,301	-1.8%	39,163	-3.9%	38,752	-2.9%	39,027	-3.6%

New cases seen by Community General Adult Mental Health Teams 2019

In 2019 a total number of 34,792 new cases were offered an appointment by community general adult mental health teams which compares to 35,002 cases in 2018.

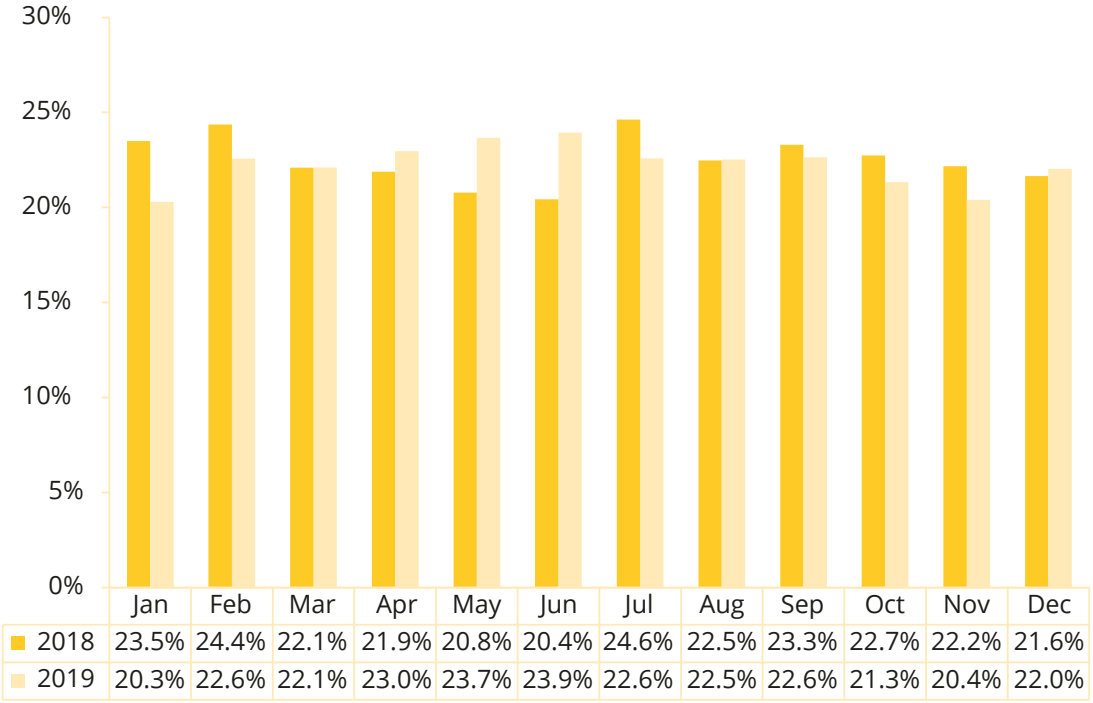
A total of 27,056 (27,124 in 2018) were seen and 7,736 (7,878 in 2018) did not attend (DNA). This gives a non-attendance rate of 22.5% compared with 22.2% in 2018.

New (including re-referred) cases seen 2018 vs 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2018	2,374	2,220	2,190	2,324	2,633	2,173	2,143	2,346	2,153	2,419	2,401	1,748
Seen - 2019	2,411	2,237	2,184	2,291	2,216	2,018	2,358	2,127	2,511	2,448	2,369	1,886

DNA Rate 2018 vs 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	23.5%	24.4%	22.1%	21.9%	20.8%	20.4%	24.6%	22.5%	23.3%	22.7%	22.2%	21.6%
2019	20.3%	22.6%	22.1%	23.0%	23.7%	23.9%	22.6%	22.5%	22.6%	21.3%	20.4%	22.0%

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

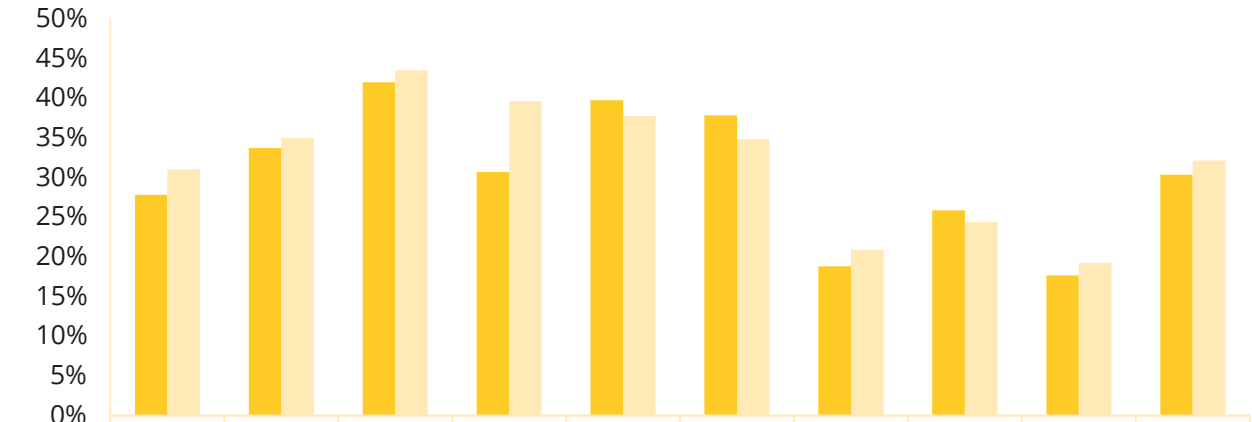
A proportion of the new cases seen will have previously attended the service, been discharged and been re-referred back to the service for a new episode of care.

In 2019 of the 27,056 cases seen, a total of 8,696 had been re-referred to the service. This represents a 32.1% re-referral rate.

In 2018 of the 27,124 cases seen, a total of 8,238 had been re-referred to the service. This represents a 30.4% re-referral rate.

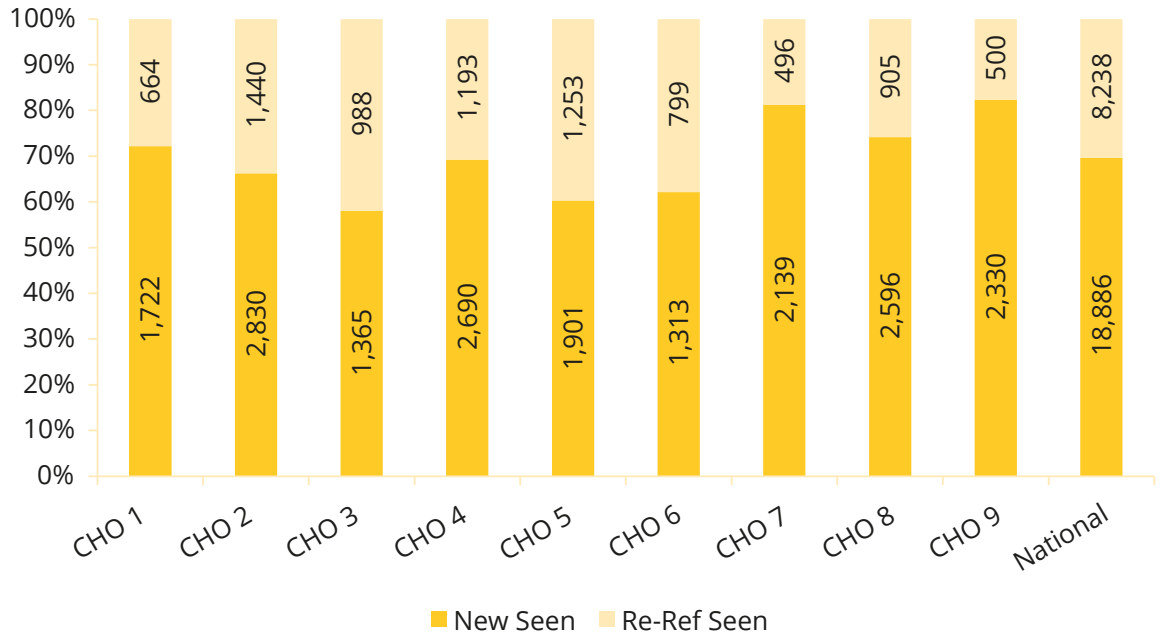
The proportion of re-referred cases in 2019 varied from 19.2% in CHO 9 to 43.5% in CHO 3 (see figures below).

Percentage of Re-referred cases 2018 vs 2019



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2018	27.8%	33.7%	42.0%	30.7%	39.7%	37.8%	18.8%	25.8%	17.7%	30.4%
2019	31.0%	35.0%	43.5%	39.6%	37.7%	34.8%	20.9%	24.4%	19.2%	32.1%

Breakdown of New Cases Seen (New vs Re-referred cases) 2019



New Cases including re-referred seen by age profile

In 2019 a total number of 27,056 new cases were seen by Community General Adult Mental Health Teams. Of these, 0.2% (54) were under 18 years of age and 99.8% (27,002) were over 18 years of age. This compares to 0.4% (102) of cases in 2018.

There are a small number of service users who will transition from community child and adolescent mental health services to adult mental health services before their 18th birthday and in some cases it may be appropriate that they are provided with treatment by both services whilst transition occurs.

Waiting Times for New Cases Seen

In 2019 a total number of 34,792 were offered an appointment of which 27,056 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	30.1%	8.5%	7.8%	6.1%	20.1%	7.9%	4.1%	15.3%
CHO 2	35.6%	15.1%	11.4%	10.1%	11.5%	4.7%	1.6%	10.0%
CHO 3	21.1%	9.4%	8.8%	6.3%	15.8%	6.8%	1.0%	30.7%
CHO 4	13.9%	11.1%	8.6%	10.2%	17.6%	8.7%	4.4%	25.5%
CHO 5	18.5%	13.9%	11.0%	9.4%	20.0%	9.1%	5.1%	12.9%
CHO 6	21.7%	14.3%	12.0%	9.4%	14.7%	3.7%	1.6%	22.6%
CHO 7	9.9%	8.2%	6.6%	6.9%	19.8%	14.9%	10.9%	22.8%
CHO 8	9.8%	9.1%	8.4%	8.2%	16.5%	12.0%	5.0%	31.0%
CHO 9	11.9%	10.5%	7.9%	6.8%	13.4%	9.9%	9.4%	30.1%
National	19.1%	11.1%	9.1%	8.3%	16.5%	8.8%	4.8%	22.2%

Cases Closed or Discharged

In 2019, 25,299 cases were closed and discharged by Community General Adult Mental Health Teams. This compares to 25,133 cases closed in 2018. Of these, 87.1% of the cases closed were discharged to care of the General Practitioner or Primary Care Team (PCT), 6.5% to General Practitioner and other primary/community care services, 4.1% to another Adult Mental Health Service, 0.7% to other services and 1.6% were due to death.

No. of Cases closed and discharged by Community General Adult teams in 2019

	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	2,787	118	224	17	30	3,176
CHO 2	2,107	215	125	31	46	2,524
CHO 3	2,158	111	76	36	65	2,446
CHO 4	4,101	133	74	10	87	4,405
CHO 5	2,037	136	33	6	44	2,256
CHO 6	1,429	342	51	60	32	1,914
CHO 7	1,476	299	364	2	29	2,170
CHO 8	3,390	273	9	0	36	3,708
CHO 9	2,550	21	78	6	45	2,700
National	22,035	1,648	1,034	168	414	25,299

Percentage of Cases closed and discharged by Community General Adult teams in 2019

	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	87.8%	3.7%	7.1%	0.5%	0.9%
CHO 2	83.5%	8.5%	5.0%	1.2%	1.8%
CHO 3	88.2%	4.5%	3.1%	1.5%	2.7%
CHO 4	93.1%	3.0%	1.7%	0.2%	2.0%
CHO 5	90.3%	6.0%	1.5%	0.3%	2.0%
CHO 6	74.7%	17.9%	2.7%	3.1%	1.7%
CHO 7	68.0%	13.8%	16.8%	0.1%	1.3%
CHO 8	91.4%	7.4%	0.2%	0.0%	1.0%
CHO 9	94.4%	0.8%	2.9%	0.2%	1.7%
National	87.1%	6.5%	4.1%	0.7%	1.6%

Chapter 7

Psychiatry of Later Life
Mental Health Services

Key Facts

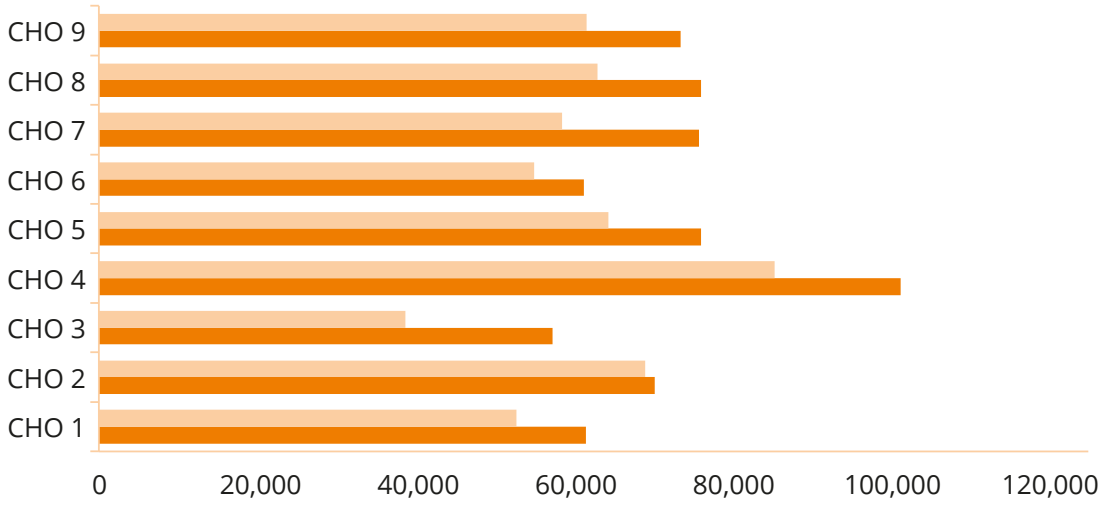
- 2013 – 22 POLL teams; 2019 – 32 POLL teams
- 2013 – 224.19 Clinical WTEs; 2019 – 319 Clinical WTEs
- 61% of the Clinical staffing levels recommended in *A Vision for Change*
- 8.5% increase in referrals received from 2014 to 2019
- 9,134 new appointments offered in 2019
- 36.9% new appointments seen within 1 week
- 78.3% new appointments seen within 4 weeks
- 2.3% new patients did not attend their first appointment.

Over 65 year of age population

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

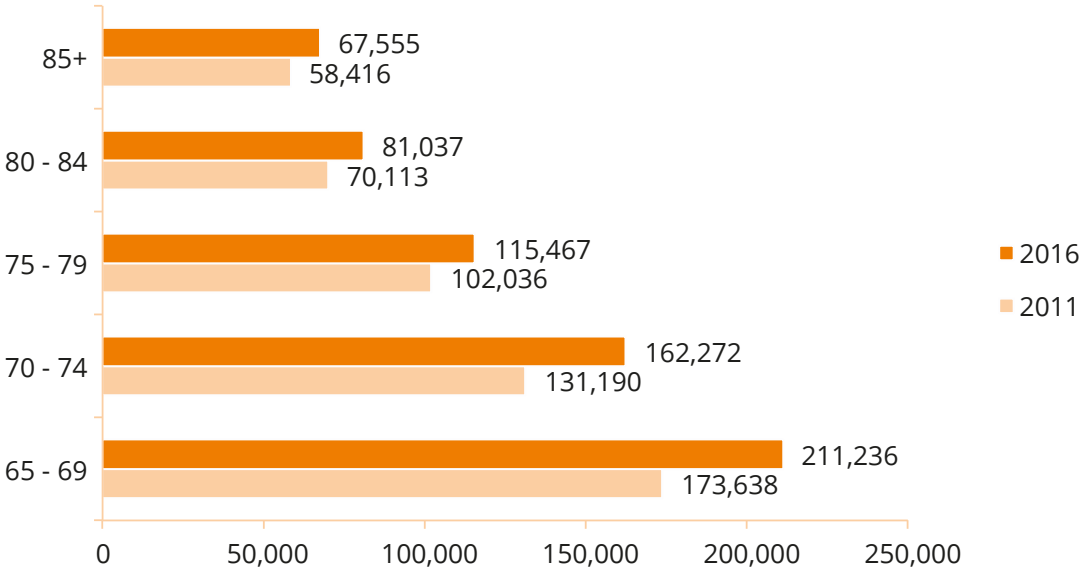
In line with other European countries, the population over 65 years is increasing in Ireland and now forms 13.4% of the total population. From 2011 to 2016 there was a 19% increase in the over 65 years population. This significant increase in population will result in increased demand for POLL services.

2016 & 2011 Census – Number over 65 years



	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 that 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 increased morbidity and mortality (RCPsych, 2005).

Psychiatry of Later Life Services

Psychiatry of Later Life services have been 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 Services 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 accepting a 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, assisting 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 require 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 2019, there was an increase of 8.5% nationally in the number of referrals accepted by the Psychiatry of Later Life Service as outlined in the table below.

	2019	2018	+/- Variance 19 vs 18	2017	+/- Variance 19 vs 17	2016	+/- Variance 19 vs 16	2015	+/- Variance 19 vs 15	2014	+/- Variance 19 vs 14
CHO 1	1,326	1,188	11.6%	1,297	2.2%	1,296	2.3%	1,380	-3.9%	1,494	-11.2%
CHO 2	1,651	1,668	-1.0%	1,633	1.1%	1,748	-5.5%	1,807	-8.6%	1,375	20.1%
CHO 3	1,087	1,140	-4.6%	1,016	7.0%	1,021	6.5%	965	12.6%	989	9.9%
CHO 4	717	700	2.4%	551	30.1%	647	10.8%	339	111.5%	454	57.9%
CHO 5	1,344	1,270	5.8%	1,360	-1.2%	1,416	-5.1%	1,487	-9.6%	1,439	-6.6%
CHO 6	1,027	1,042	-1.4%	975	5.3%	1,035	-0.8%	1,031	-0.4%	957	7.3%
CHO 7	864	768	12.5%	867	-0.3%	856	0.9%	839	3.0%	980	-11.8%
CHO 8	1,712	1,620	5.7%	1,675	2.2%	1,625	5.4%	1,523	12.4%	1,514	13.1%
CHO 9	1,390	1,637	-15.1%	1,255	10.8%	1,181	17.7%	1,073	29.5%	1,046	32.9%
National	11,118	11,033	0.8%	10,629	4.6%	10,825	2.7%	10,444	6.5%	10,248	8.5%

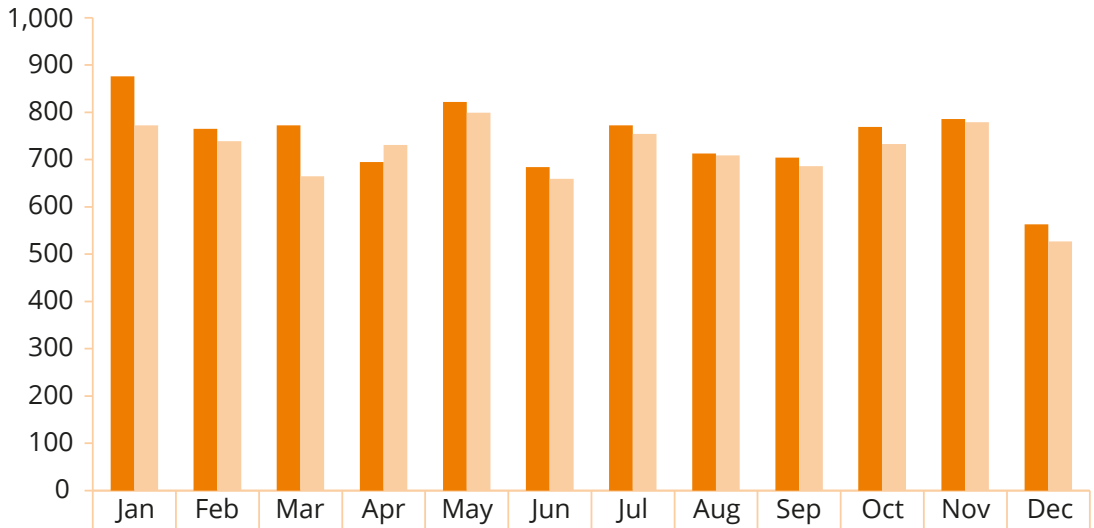
New cases seen by Psychiatry of Later Life Service 2019

In 2019 a total number of 9,134 new cases were offered an appointment by Psychiatry of Later Life Services. This compares to 8,804 cases in 2018.

A total of 8,921 (8,553 in 2018) were seen and 213 (251 in 2018) did not attend (DNA).

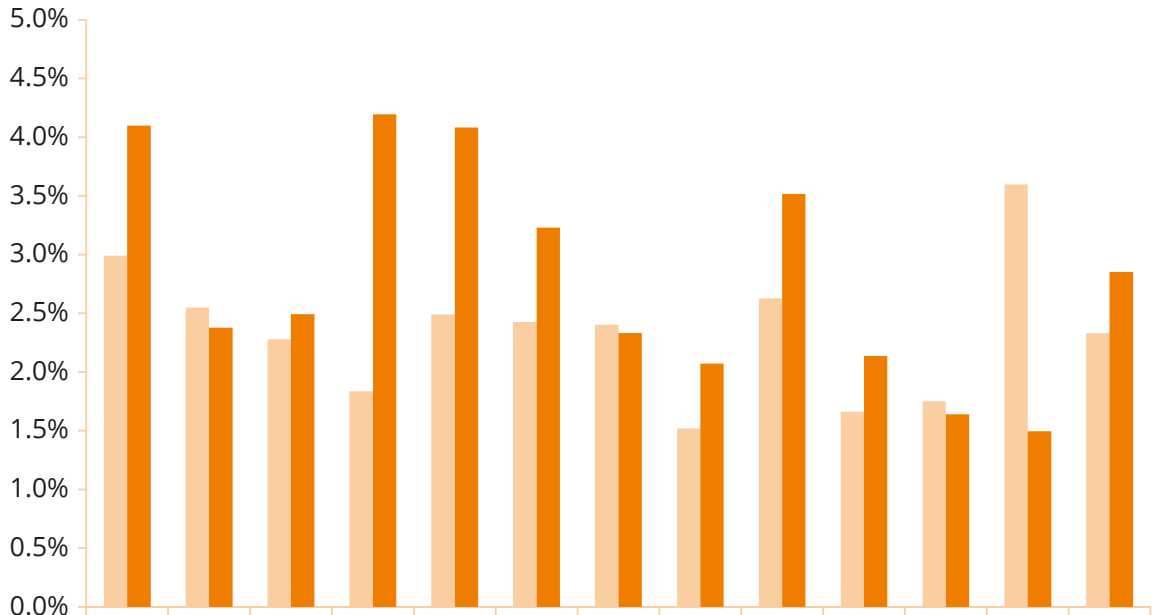
This gives a non-attendance rate of 2.3% (2.9% in 2018) ranging from 1.5% to 3.6% across the 12 month period.

New (including re-referred) Cases Seen 2018 vs 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Seen - 2019	876	765	772	695	822	684	772	713	704	769	786	563
Seen - 2018	772	739	665	731	799	659	754	709	686	733	779	527

New (including re-referred) DNA 2018 vs 2019



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year-end
2019	3.0%	2.5%	2.3%	1.8%	2.5%	2.4%	2.4%	1.5%	2.6%	1.7%	1.8%	3.6%	2.3%
2018	4.1%	2.4%	2.5%	4.2%	4.1%	3.2%	2.3%	2.1%	3.5%	2.1%	1.6%	1.5%	2.9%

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

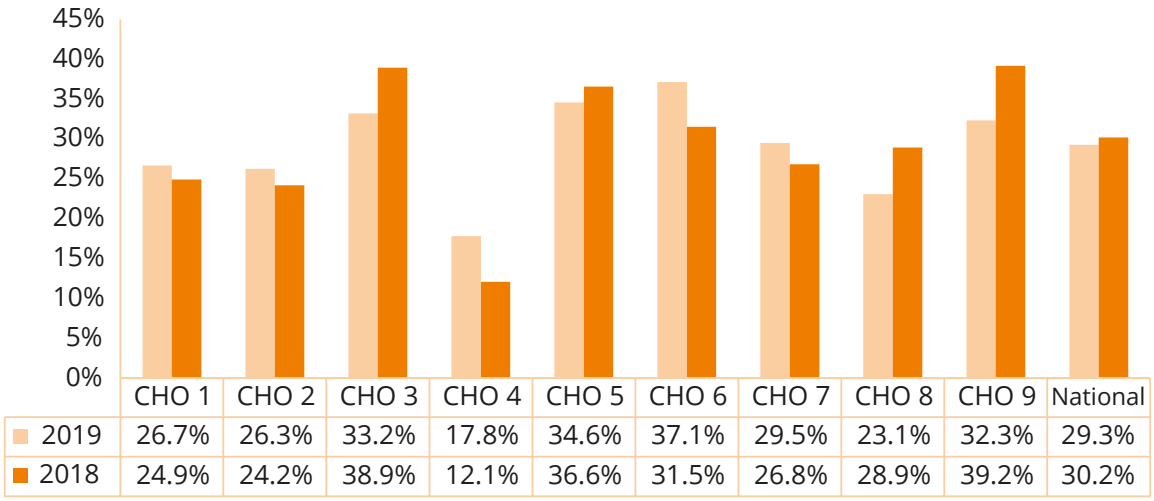
A proportion of the new cases seen will have previously attended the service, been discharged and been re-referred back to the service for a new episode of care.

In 2019, of the 8,921 cases seen, a total of 2,613 had been re-referred to the service. This represents a 29.3% re-referral rate.

In 2018, of the 8,553 cases seen, a total of 2,583 had been re-referred to the service. This represents a 30.2% re-referral rate.

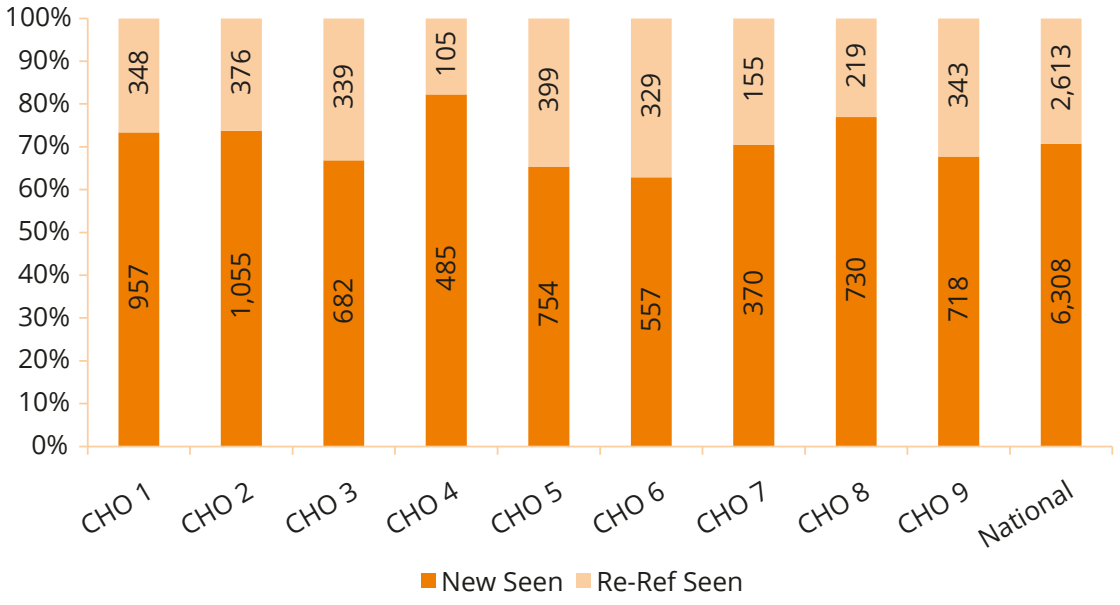
The proportion of re-referred cases varied in 2019 from 17.8% in CHO 4 to 37.1% in CHO 6 (in figure below).

Percentage of re-referred cases 2018 vs 2019



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2019	26.7%	26.3%	33.2%	17.8%	34.6%	37.1%	29.5%	23.1%	32.3%	29.3%
2018	24.9%	24.2%	38.9%	12.1%	36.6%	31.5%	26.8%	28.9%	39.2%	30.2%

Breakdown of New Cases Seen (new vs re-referred cases) 2019



Waiting Times for New Cases Seen

In 2019, a total number of 9,134 patients were offered an appointment, of which 8,921 new cases were seen by Psychiatry of Later Life Services.

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

Length of wait to 1st appointment seen 2019 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	58.9%	16.4%	8.0%	3.1%	6.2%	3.3%	3.3%	0.8%
CHO 2	32.6%	26.1%	18.4%	13.2%	8.4%	0.2%	0.0%	1.0%
CHO 3	39.6%	24.4%	16.7%	10.5%	6.0%	1.7%	0.0%	1.2%
CHO 4	29.3%	15.8%	8.9%	11.9%	15.9%	7.1%	6.1%	5.0%
CHO 5	39.2%	23.7%	15.5%	8.0%	9.4%	2.0%	1.2%	1.0%
CHO 6	26.5%	10.5%	6.3%	8.8%	22.2%	16.1%	7.4%	2.2%
CHO 7	20.6%	18.8%	8.5%	6.4%	22.8%	10.5%	9.0%	3.5%
CHO 8	26.6%	26.3%	11.2%	7.5%	11.3%	4.5%	7.3%	5.3%
CHO 9	41.3%	15.5%	12.1%	10.1%	8.6%	4.4%	4.3%	3.7%
National	36.9%	20.3%	12.3%	8.8%	11.0%	4.7%	3.6%	2.3%

Cases Closed or Discharged

In 2019, 7,000 cases were closed and discharged by Psychiatry of Later Life Services. This compares to 7,019 cases closed in 2018.

87.6% of the cases closed were discharged to the care of the General Practitioner or Primary Care Team (PCT)/Community Care Service and 12.4% 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	779	192	91	1,062
CHO 2	868	182	165	1,215
CHO 3	247	124	119	490
CHO 4	356	82	69	507
CHO 5	848	0	166	1,014
CHO 6	462	4	49	515
CHO 7	408	84	25	517
CHO 8	859	0	145	1,004
CHO 9	635	0	41	676
National	5,462	668	870	7,000

Percentage of Cases closed and discharged by CHO

	Closed / Discharged to GP/Primary Care Team / community care service	Closed due to Death
CHO 1	91.4%	8.6%
CHO 2	86.4%	13.6%
CHO 3	75.7%	24.3%
CHO 4	86.4%	13.6%
CHO 5	83.6%	16.4%
CHO 6	90.5%	9.5%
CHO 7	95.2%	4.8%
CHO 8	85.6%	14.4%
CHO 9	93.9%	6.1%
National	87.6%	12.4%

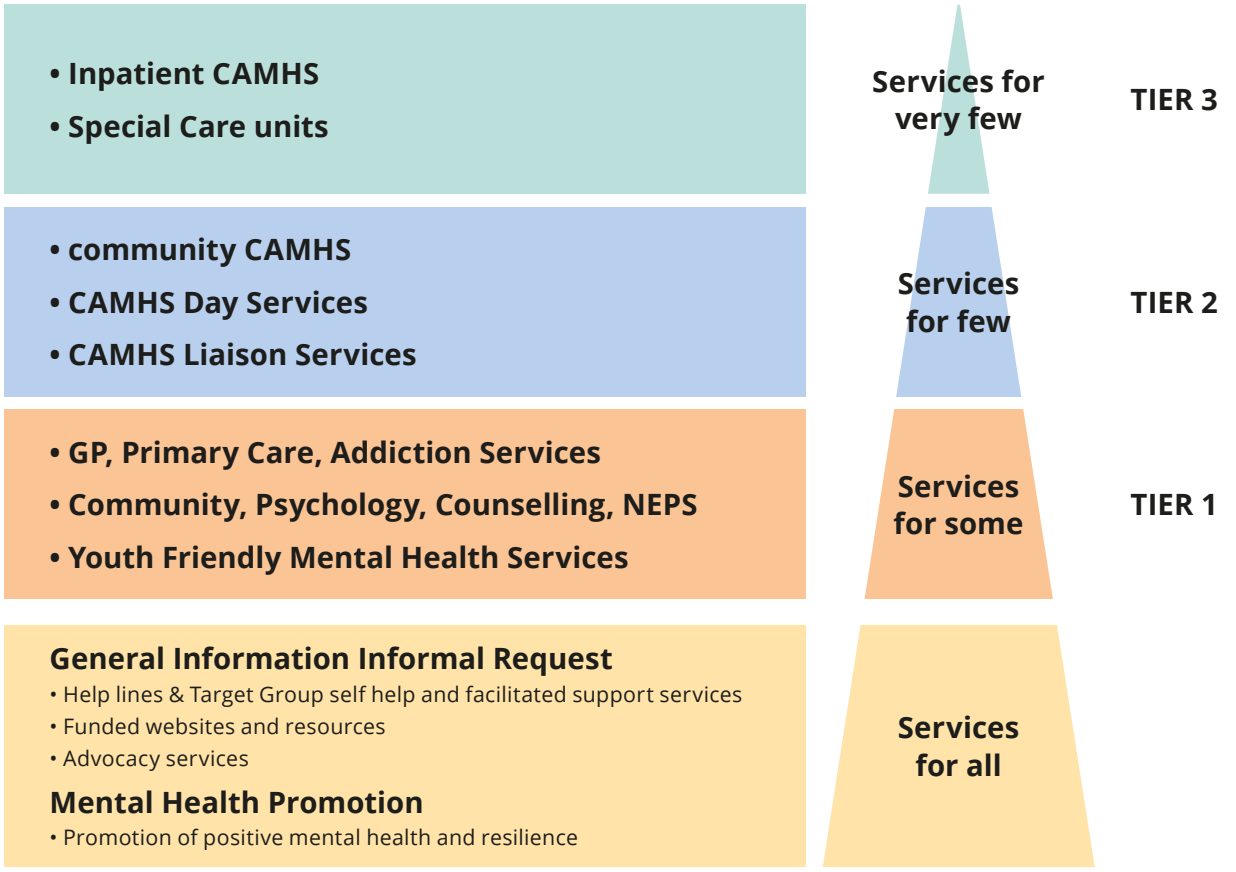
Chapter 8

Child and Adolescent Mental Health Acute Inpatient Services

Inpatient CAMHS

- CAMHS inpatient units offer assessment and treatment to children and adolescents up to the age of 18, with severe and often complex mental health difficulties.
- CAMHS inpatient units are known as "Approved Centres" and they are inspected by the Mental Health Commission. This means there are rules and codes of practice and legislation which must be followed by all CAMHS Inpatient Units. These regulations cover physical examination, physical restraint, risk assessment, admission, transfer and discharge from a CAMHS inpatient unit.
- Currently there are four HSE/HSE funded inpatient CAMHS units provided across the country.

The Graphic below shows where inpatient services fit within the Tiers of Mental Health Care



Inpatient CAMHS Units

Unit Name	Unit Location	Current Number of Registered beds with MHC	Primary Catchment Area
Eist Linn (HSE)	Cork CHO4	16	CHO 4 & CHO 5
Merlin Park (HSE)	Galway CHO2	20	CHO 1(a) Sligo/Leitrim/Donegal, CHO2, CHO3.
Linn Dara (HSE)	West Dublin CHO7	24 (22+2 High Observation Beds)	CHO6, CHO7, CHO8 (a) Laois/ Offaly/Longford/Westmeath.
St. Joseph's (HSE funded)	North Dublin CHO9	12	CHO9, CHO1 (b) (Cavan/ Monaghan), CHO8 (b) (Louth/Meath).
Total		70 (+2 high obs)	

Key Facts

- 2008 – 16 CAMHS Acute Inpatient beds; 2019 – 72 CAMHS Acute Inpatient beds
- 2008 – 25% admissions to CAMHS inpatient beds; 2019 – 86% admission to CAMHS inpatient beds
- -46% decrease in the number of bed days used in adult approved centres in 2019
- 96% bed days used in Child Adolescent Acute Inpatient Units.

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, 72 CAMHS Acute Inpatient beds were funded at the end December 2019.

HSE inpatient services and bed capacity (2008 to 2019)

Child & Adolescent Inpatient Units	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
St. Anne's Inpatient Unit, Galway	10	10	10									
New Unit, Merlin Park Hospital, Galway				20	20	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‡	22‡	24
St. Vincent's Hospital, Fairview, Dublin		6	6	6	12	12	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	20	16
Total No. of Beds	16	30	30	52	60	60	66	74	74	74	74	72

**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

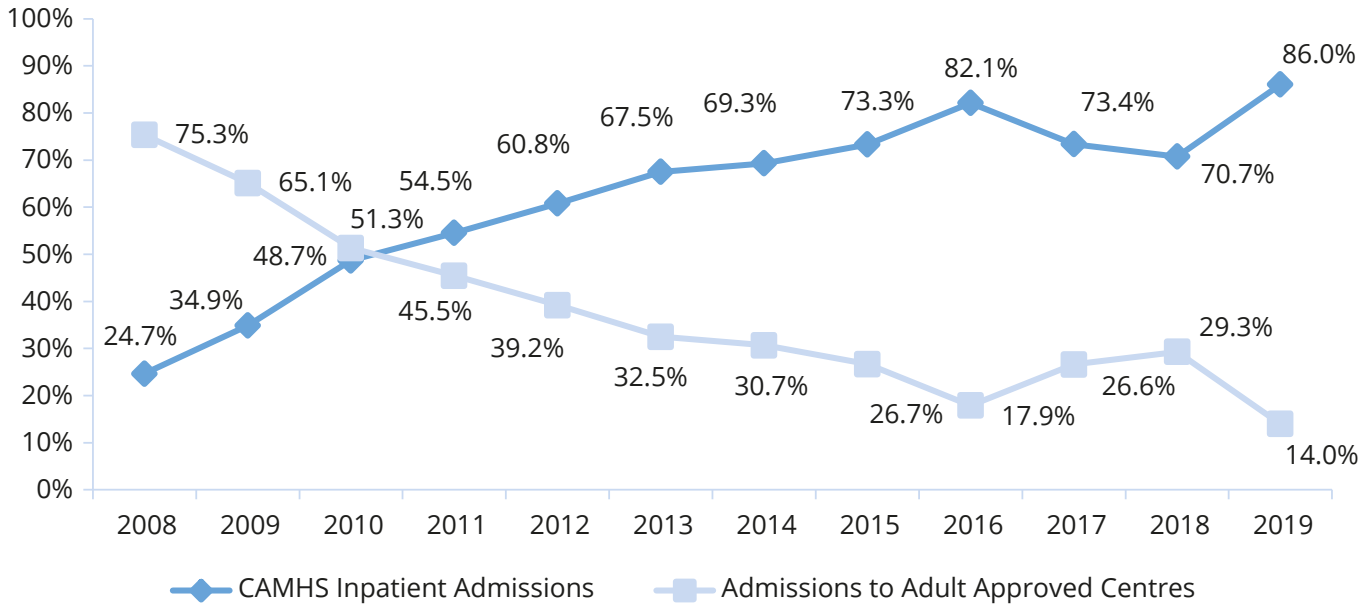
The increase in the availability of age-appropriate CAMHS acute inpatient facilities has enabled the CAMHS service to ensure, as much as possible, that when a child is admitted, that admission is to age appropriate inpatient facilities.

In 2019, there were 358 children and adolescents admitted and of these, 308 (86%) were admitted to child and adolescent inpatient units and 50 (14%) to adult approved centres.

Of these 358 admissions, 93% (333) were voluntary admissions with parental consent with a very small number under Section 25 of the Mental Health Act 2001. Of the 50 admitted to Adult Approved Centres, 47 or 94% were 16/17 years old with 48% (24) of these discharged either the same day or within 3 days and 82% (41) within a week.

Admissions of children to Acute Inpatient Units 2008-2019

Figure below shows the increase in the percentage of admissions of children to age appropriate units in the period from 2008 to 2019.



Number of admissions by Unit/Unit Type*

Child and Adolescent Units	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
St. Anne's, Galway	32	31	29	33									
Merlin Park Inpatient Unit, Galway					38	71	70	68	85	95	60	35	69
St. Vincent's Hospital, Fairview, Dublin			29	34	42	36	38	33	54	67	44	52	57
Warrenstown Unit, Blanchardstown, Dublin	46	42	37	37	39								
Interim Linn Dara Unit, Palmerstown, Dublin						24†	30	46	83	110	66	69	138
Eist Linn, St. Stephen's Hospital, Cork			4	44	5								
Eist Linn, Bessboro, Cork					32	38	49	54	39	40	56	47	44
Total Child	78	73	99	148	156	145	187	201	261	312	226	203	308
Adult Units	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
HSE Adult Units	190	223	185	155	129	109	91	89	95	68	82	84	50
Central Mental Hospital				1	1								
Total Adult	190	223	185	156	130	109	91	89	95	68	82	84	50
Total	268	296	284	304	286	254	278	290	356	380	308	287	358

† 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 2019, the total number of bed days used for the admission of children was 18,321, a decrease of -1% (-110) on the 2018 position of 18,431.

In 2019, 96% (17,595) of bed days used were in the age-appropriate Child and Adolescent Acute Inpatient Units with 4% (726) used in adult approved centres. These figures are comparable with the 2018 position of 92.7% (17,093) in CAMHS inpatient and 7.3% (1,338) in adult approved centres.

There was a -46% (612) reduction in the number of bed days in adult approved centres – 726 compared to 1,338 in 2018. 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 on the statistics.

Bed Days used by CHO

Bed Days Used	2019					2018				
	Total Days Used	CAMHS	IP	Adult	IP	Total Days Used	CAMHS	IP	Adult	IP
CHO 1	1,541	1,393	90.4%	148	9.6%	904	773	85.5%	131	14.5%
CHO 2	1,670	1,670	100.0%	0	0.0%	2,339	2,339	100.0%	0	0.0%
CHO 3	2,148	2,035	94.7%	113	5.3%	2,245	2,218	98.8%	27	1.2%
CHO 4	3,439	3,127	90.9%	312	9.1%	3,211	2,461	76.6%	750	23.4%
CHO 5	1,506	1,468	97.5%	38	2.5%	1,667	1,469	88.1%	198	11.9%
CHO 6	631	631	100.0%	0	0.0%	1,058	1,058	100.0%	0	0.0%
CHO 7	2,991	2,985	99.8%	6	0.2%	2,414	2,383	98.7%	31	1.3%
CHO 8	2,350	2,254	95.9%	96	4.1%	2,787	2,707	97.1%	80	2.9%
CHO 9	2,045	2,032	99.4%	13	0.6%	1,806	1,685	93.3%	121	6.7%
National	18,321	17,595	96.0%	726	4.0%	18,431	17,093	92.7%	1338	7.3%

The following table compares the percentage of admissions of children by length of stay in the Adult Approved Centres between 2014 and 2019.

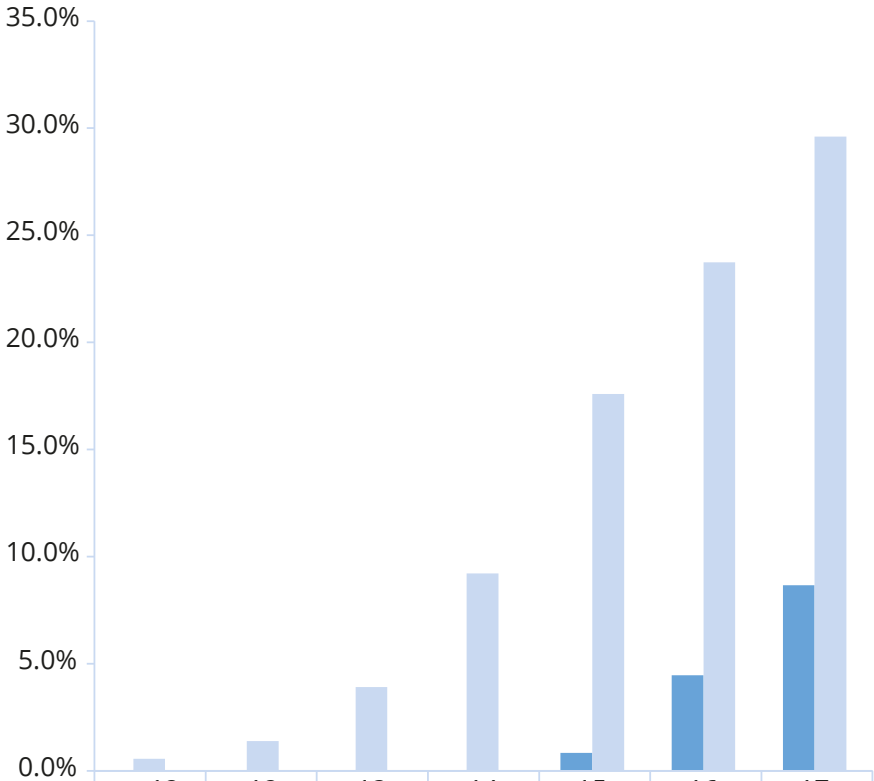
Percentage of admissions by Length of Stay in Adult Approved Centres

	2014	2015	2016	2017	2018	2019
Same day discharged	1.1%	6.3%	14.7%	6.1%	2.4%	10.0%
1-3 days	33.7%	34.7%	48.5%	39.0%	35.7%	38.0%
3-5 days	14.6%	14.7%	13.2%	17.1%	10.7%	24.0%
5-7 days	12.4%	10.5%	7.4%	12.2%	13.1%	10.0%
>7 <=14	21.4%	13.7%	10.3%	14.6%	15.5%	6.0%
2-3 weeks	6.7%	8.4%	2.9%	2.4%	8.3%	0.0%
3-4 weeks	2.3%	3.2%	0.0%	4.9%	6.0%	4.0%
4-8 weeks	6.7%	6.3%	1.5%	2.4%	3.6%	4.0%
8-12 weeks	0.0%	1.1%	1.5%	0.0%	1.2%	0.0%
12-16 weeks	1.1%	0.0%	0.0%	0.0%	1.2%	2.0%
>16 weeks	0.0%	1.1%	0.0%	1.2%	2.4%	2.0%
Admissions	89	95	68	82	84	50

Age of admissions (2019)

Of the 308 admissions of children and adolescents in 2019, 38.3% were aged 17 years or over on admission; 28.2% were aged 16 years; 18.4% were aged 15 years; 9.2% were aged 14 years; 3.9% were aged 13 years; and 2% were aged 12 years or under.

Age of admissions (2019)



	< 12	12	13	14	15	16	17
Adult Units	0.0%	0.0%	0.0%	0.0%	0.8%	4.5%	8.7%
Child & Adolescent Units	0.6%	1.4%	3.9%	9.2%	17.6%	23.7%	29.6%

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 2023.

New National Forensic Hospital

The National Forensic Mental Health Service (NFMHS) will be a new state-of-the-art facility located 22km from Dublin City in Portrane, North County Dublin. The Service will provide care for 170 patients in the facility as well as community and prison in-reach services. The development will also include a 10 bed secure adolescent inpatient unit.

Services are due to move in to the facility in 2020.

Chapter 9

Adult Acute Inpatient Services

Key Facts

- 29 Acute Inpatient Units
- 2007 – 16,293 admissions; 2019 – 12,134 admissions
- 2007 – 72% re-admission rate; 2019 – 62% 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 2018, 83.9% 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.

2019 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.

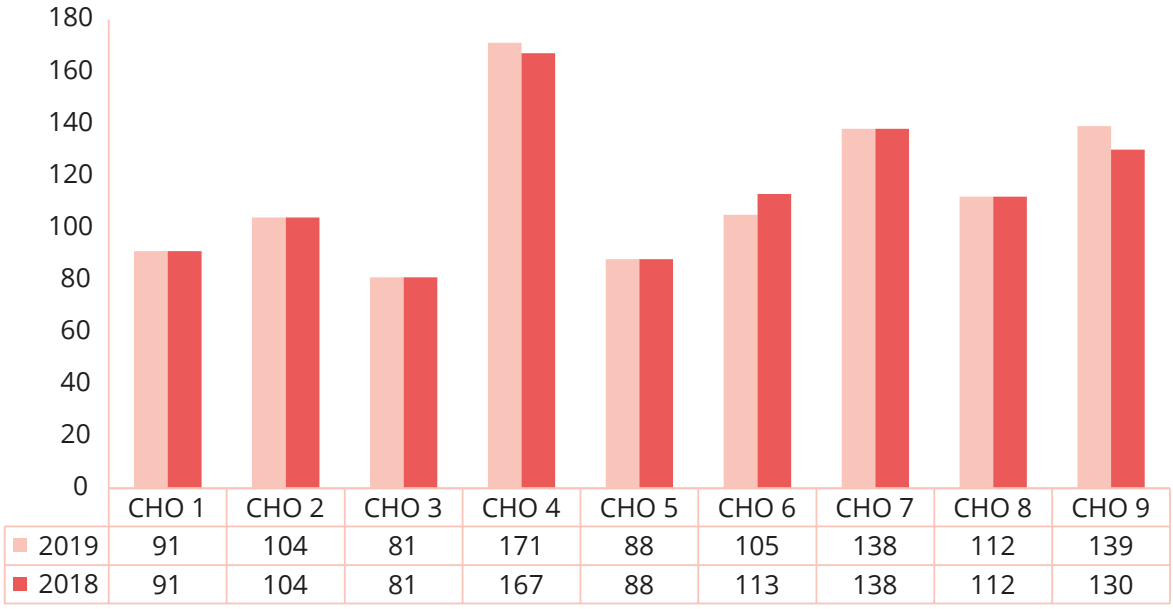
Adult Mental Health Acute inpatient Beds

There are 29 adult acute inpatient units nationally. At the end of 2019, the number of adult acute inpatient places was 1,029 (1,024 at the end of 2018) or 21.6 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

	2019				2018			
	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	91	23.1
CHO 2	453,109	3	104	23.0	CHO 2	3	104	23.0
CHO 3	384,998	2	81	21.0	CHO 3	2	81	21.0
CHO 4	690,575	5	171	24.8	CHO 4	5	167	24.2
CHO 5	510,333	2	88	17.2	CHO 5	2	88	17.2
CHO 6	549,531	3	105	19.1	CHO 6	3	113	20.6
CHO 7	541,352	3	138	25.5	CHO 7	3	138	25.5
CHO 8	616,229	4	112	18.2	CHO 8	4	112	18.2
CHO 9	621,405	4	139	22.4	CHO 9	4	130	20.9
National	4,761,865	29	1,029	21.6	National	29	1,024	21.5

Adult Acute Inpatient Beds 2018/2019 by CHO



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, CUH	•	
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

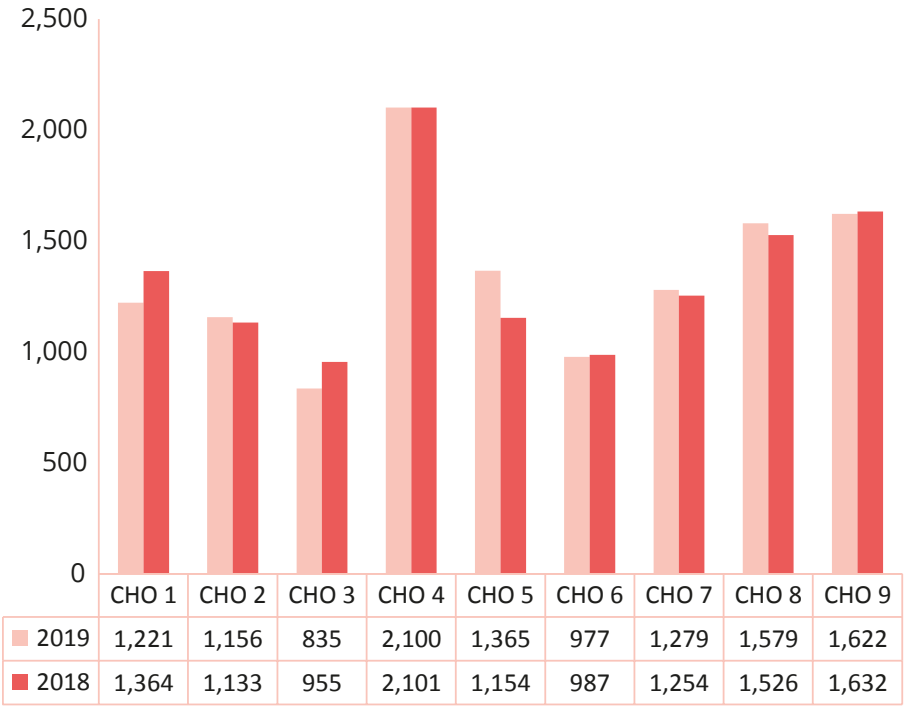
Admissions to Adult Acute Inpatient Units

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 2019 the number of admissions was 12,134 compared to 12,106 at the end of 2018.

	Admissions					
	2014	2015	2016	2017	2018	2019
CHO 1	1,212	1,254	1,299	1,323	1,364	1,221
CHO 2	1,487	1,510	1,300	1,252	1,133	1,156
CHO 3	1,005	1,024	1,026	984	955	835
CHO 4	2,120	2,127	1,997	2,039	2,101	2,100
CHO 5	1,355	1,366	1,327	1,242	1,154	1,365
CHO 6	1,076	1,172	1,156	1,012	987	977
CHO 7	1,486	1,369	1,356	1,218	1,254	1,279
CHO 8	1,607	1,675	1,621	1,531	1,526	1,579
CHO 9	1,632	1,626	1,508	1,554	1,632	1,622
National	12,980	13,123	12,590	12,155	12,106	12,134

Adult Acute Admissions 2018 - 2019 by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2019	1,221	1,156	835	2,100	1,365	977	1,279	1,579	1,622
2018	1,364	1,133	955	2,101	1,154	987	1,254	1,526	1,632

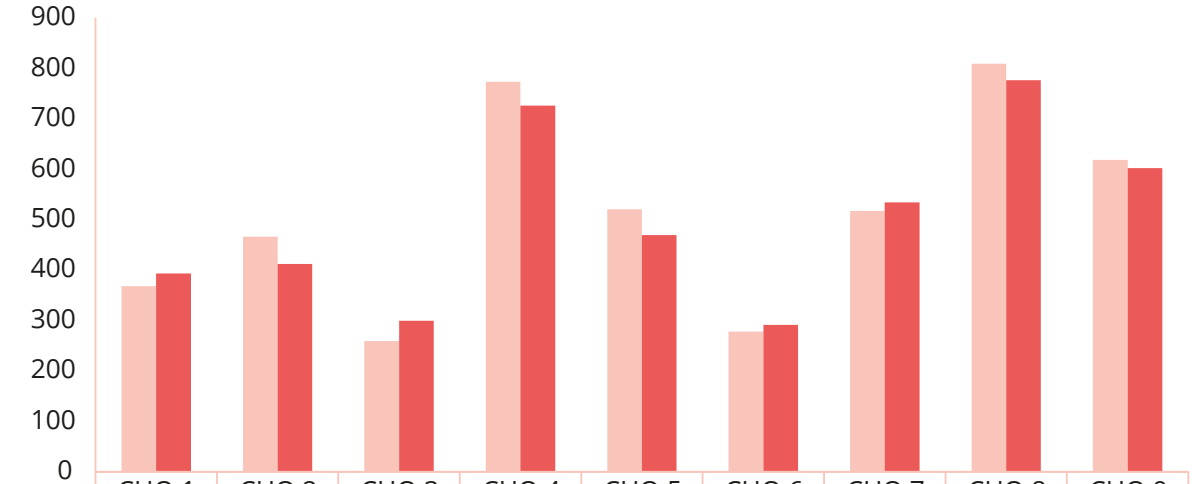
Adult Acute First Admissions

Fiirst admissions are admissions of persons who were not previously admitted to the receiving hospital or unit or to any other psychiatric inpatient facility.

At the end of 2019 the number of First admissions was 4,608, compared to 4,502 at the end of 2018. First admissions accounted for 38% of admissions in 2019 (37% in 2018).

	First time admissions					
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
CHO 1	333	352	373	406	393	368
CHO 2	557	584	527	484	412	466
CHO 3	290	324	311	299	299	259
CHO 4	691	724	715	702	726	773
CHO 5	487	509	516	460	469	520
CHO 6	335	357	293	238	291	278
CHO 7	519	542	510	476	534	517
CHO 8	518	586	727	702	776	809
CHO 9	539	545	499	612	602	618
National	4,269	4,523	4,471	4,379	4,502	4,608

Adult Acute First admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2019	368	466	259	773	520	278	517	809	618
2018	393	412	299	726	469	291	534	776	602

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 inpatient facility.

At the end of 2019 the number of re-admissions was 7,526, compared to 7,604 at the end of 2018. Re-admissions accounted for 62% of admissions in 2019 (63% in 2018).

	Re-admissions					
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
CHO 1	879	902	926	917	971	853
CHO 2	930	926	773	768	721	690
CHO 3	715	700	715	685	656	576
CHO 4	1,429	1,403	1,282	1,337	1,375	1,327
CHO 5	868	857	811	782	685	845
CHO 6	741	815	863	774	696	699
CHO 7	967	827	846	742	720	762
CHO 8	1,089	1,089	887	829	750	770
CHO 9	1,093	1,081	1,008	942	1,030	1,004
National	8,711	8,600	8,111	7,776	7,604	7,526

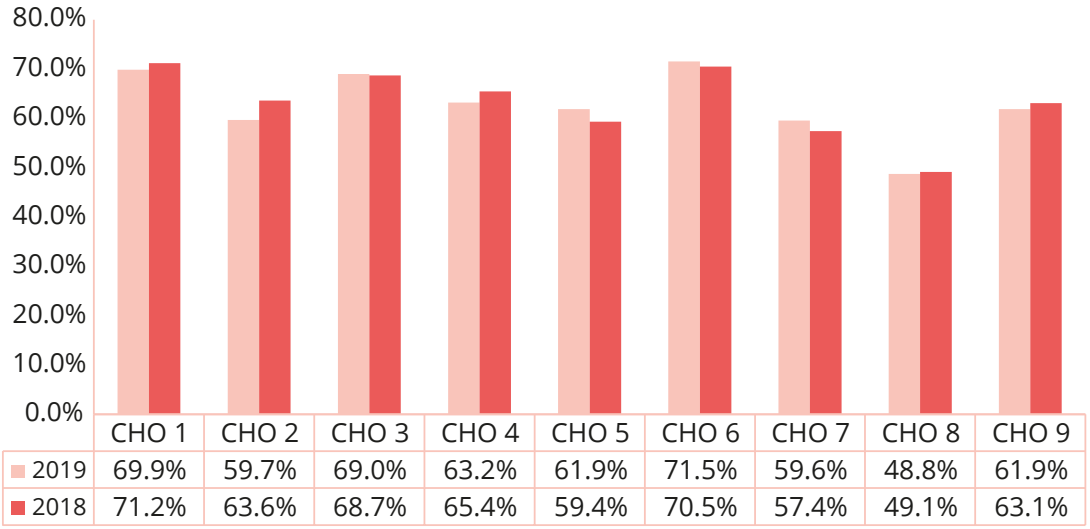
Adult Acute Re-Admissions by CHO

	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2019	853	690	576	1,327	845	699	762	770	1,004
2018	971	721	656	1,375	685	696	720	750	1,030

Percentage of Re-admissions

	2017		2018		2019	
CHO 1	917	69.3%	971	71.2%	853	69.9%
CHO 2	768	61.3%	721	63.6%	690	59.7%
CHO 3	685	69.6%	656	68.7%	576	69.0%
CHO 4	1,337	65.6%	1,375	65.4%	1,327	63.2%
CHO 5	782	63.0%	685	59.4%	845	61.9%
CHO 6	774	76.5%	696	70.5%	699	71.5%
CHO 7	742	60.9%	720	57.4%	762	59.6%
CHO 8	829	54.1%	750	49.1%	770	48.8%
CHO 9	942	60.6%	1,030	63.1%	1,004	61.9%
National	7,776	64.0%	7,604	62.8%	7,526	62.0%

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
2019	69.9%	59.7%	69.0%	63.2%	61.9%	71.5%	59.6%	48.8%	61.9%
2018	71.2%	63.6%	68.7%	65.4%	59.4%	70.5%	57.4%	49.1%	63.1%

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 stay 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 2019 the median length of stay was 11.3 days.

	Median Length of stay					
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
CHO 1	10.4	9.8	8.3	9.0	8.6	9.5
CHO 2	12.7	11.1	11.1	10.0	14.3	15.0
CHO 3	13.3	12.9	14.8	14.0	13.5	14.3
CHO 4	13.5	13.4	14.5	12.0	13.3	13.0
CHO 5	9.8	9.3	9.5	10.0	8.6	10.3
CHO 6	14.0	14.3	11.5	14.0	14.3	15.0
CHO 7	9.3	11.2	10.3	14.0	11.8	10.3
CHO 8	11.7	11.4	9.3	11.0	9.8	9.0
CHO 9	23.9	16.1	10.3	11.0	10.3	10.5
National	13.2	12.2	11.0	12.0	11.5	11.3

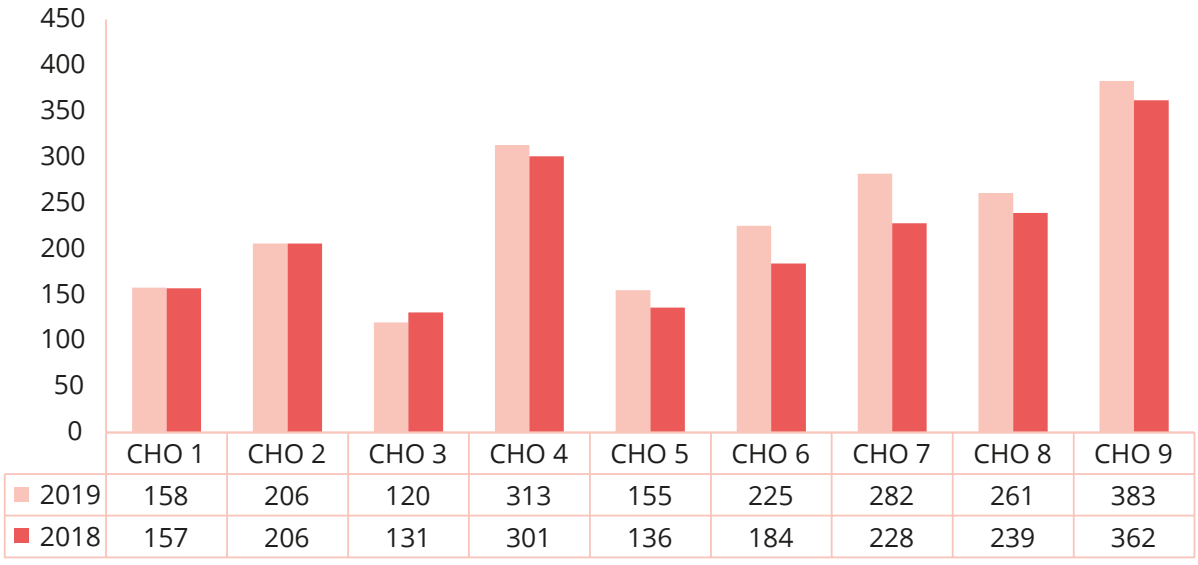
Involuntary Admissions to Adult Acute Inpatient Units

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 2019 the number of involuntary admissions was 2,103 (1,944 at the end of 2018).

Involuntary admissions accounted for 17% of both first and re-admissions to adult acute inpatient units in 2019.

	Involuntary admission					
	2014	**2015**	**2016**	**2017**	**2018**	**2019**
CHO 1	208	187	167	123	157	158
CHO 2	175	215	194	204	206	206
CHO 3	150	114	132	123	131	120
CHO 4	228	277	279	275	301	313
CHO 5	206	194	241	201	136	155
CHO 6	187	228	219	184	184	225
CHO 7	188	204	256	227	228	282
CHO 8	165	235	209	239	239	261
CHO 9	286	246	286	355	362	383
National	1,793	1,900	1,958	1,931	1,944	2,103

Involuntary admissions by CHO



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
2019	158	206	120	313	155	225	282	261	383
2018	157	206	131	301	136	184	228	239	362

Data Notes

The Health Research Board (HRB) provides Performance Indicator (PI) reports each quarter for 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 treatments, 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 inpatient services and do not necessarily represent the prevalence of mental illness.

Chapter 10

National Forensic
Mental Health Service

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

Definition of the specialty:

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 with special status 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 found not guilty by reason of insanity who are conditionally discharged. 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. In 2019 the hospital opened 10 additional beds, increasing to 102 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, Arbour Hill and Castlerea Prisons. In addition, it provides a highly specialised in-reach forensic child and adolescent mental health service to Oberstown Children Detention Centre where a consultant in forensic child and adolescent psychiatry has been appointed.

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. The construction of the new Central Mental Hospital on the Portrane site in North Dublin is continuing apace. The task of relocating to a new hospital is formidable but progressing well. It is expected to be completed and the service to transition in 2020. This new facility will increase the current bed capacity from 102 inpatient beds to 170.

The 170 beds include 10 specialist forensic mental health intellectual and developmental disability (FMHIDD) beds; 10 Forensic Child and Adolescent (FCAMHS) beds; a 30 bedded forensic intensive care and rehabilitation unit (F-ICRU), and additional bed capacity for women which will allow for the development of a care pathway for women. The transition programme is being actively developed so that modern, intensive services for the most severely mentally disordered patients will be delivered to international standards of quality and excellence.

Who is referred?

The National Forensic Mental Health Service provides 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 therapeutic programmes to reduce risk and to reduce the seriousness of risk. Highly specialised services are provided in the high risk environments of prisons and also in supervising 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, Arbour Hill and Castlerea 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 NFMHS 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 the Criminal Law (Insanity) Act, the Mental Health Act and sometimes Wardship; similarly 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, 2007-2019, as per Irish Prison Service Annual Report 2019.

Year	Total	Change from previous year - %	Persons	Change from previous year - %	Male	Female
2019	8.939	10.3	7,170	10.5	7,765	1,174
2018	8,071	- 13.1	6,490	-13.3	7,066	1,005
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 93 psychiatric in-reach team at Cloverhill.

Prison In-reach Service 2019

Prison	New Referrals	Patient Reviews	Transfer to other In-reach teams	Transfer from other In-reach teams	Total discharges
Arbour Hill	4	241	0	0	8
Cork	88	722	28	8	102
Clover Hill	315	1,416	81	6	218
Castlerea	88	274	23	6	42
Dochas	129	704	8	4	121
Midlands	107	677	28	6	85
Mountjoy	69	1,072	10	11	54
Portlaoise					
Shelton Abbey	1	12	0	1	1
Wheatfield Prison	60	467	20	42	59
Oberstown Children Detention Campus	26	88	0	0	25
Total	887	5,673	198	84	715

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 198 Mental Health Review Boards and 40 Mental Health Tribunals in 2019.

Admissions and Discharges 2007 to 2019

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL Admissions	41	50	61	56	52	57	74	52	45	30	27	23	28
TOTAL Discharges	33	41	52	55	62	61	76	52	47	30	26	18	21

Waiting List

The numbers admitted and discharged each year are falling while demand from the prison population and local approved centres is increasing. There has been a large increase in the number of patients found Not Guilty for Reason of Insanity (NGRI) (see table on next page). The waiting list for admission to the Central Mental Hospital is therefore an increasingly prolonged one. For 'legacy' reasons the NFMHS has 2 secure forensic beds per 100,000 population while most modern European states have in excess of 10 secure forensic beds per 100,000. Having opened 10 additional beds in 2019, any further increase in capacity is limited until the opening of the new hospital in Portrane in 2020.

NGRI Verdicts

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
NGRI	7	4	3	1	2	5	6	5	16	7	6	6	68

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	2018	2019
N	75	83	83	83	93	92	94	92	91	92	94	92	91	97	102
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)	6.8 (8.7)	6.9 (8.8)
Median (years)	5.0	3.5	2.3	2.1	2.6	3.3	4.4	4.8	4.9	3.1	3.7	3.5	3.8	4.1	4.4

Cross-sectional length of stay in bands.

Length of stay	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
N	93	92	94	92	91	92	94	92	91	97	102
<12 months	29	19	16	22	22	26	18	20	16	17	15
12 to 60 months	31	46	40	28	24	24	35	34	37	44	41
60 + months	38	31	38	42	45	42	41	38	38	36	46

Service Activity Levels of Forensic Rehabilitation and Recovery Teams

Patient Numbers 2019

	Start Jan 2014	End Dec 2014	2015	2016	2017	2018	2019
Inpatients on pre-discharge wards	24	23	24	24	23	23	25
Patients in supported community living	13	16	16	16	6	18	18
Patients in independent living	7	9	9	11	11	14	13
Patients living in other community services residences	3	2	4	6	17	5	7
TOTAL	46	50	53	57	57	60	63

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 doctors in training.

Community Consultation and Liaison Clinics 2019

	Referrals
Referrals received from HSE Community Mental Health Teams conducted in our outpatient clinic in Usher's Island and Approved Centres nationally	92
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	458
Prison in-reach team Cloverhill Prison Voluntary & Requested reports to District & Circuit Courts & High Court	204
Requests for psychiatric reports for inpatients.	12
Total	766

Teaching, Training, Research and Development

As a national tier three and tier four highly specialised service, the National Forensic Mental Health Service has an essential role in relation to teaching and training in all mental health disciplines including undergraduate and postgraduate medicine/psychiatry, nursing, clinical psychology, occupational therapy and mental health social work. There are close ties with Trinity College Dublin and with all relevant training schools and universities. This reflects an essential national role as the source of research and development, teaching and training in this area of specialist practice. Structured professional judgement tools for use by clinicians in forensic mental health practice (the DUNDRUM toolkit) are now in use in many countries, including translations into French and Dutch/Flemish. The National Forensic Mental Health Service aspires to university hospital status.

The Central Mental Hospital, through its affiliation with the Department of Psychiatry, School of Medicine, Trinity College Dublin, is recognised as one of the leading international centres for research and development in forensic psychiatry and forensic mental health.

https://academic.microsoft.com/search?q=central%20mental%2 hospital&qe=%40%40%40Composite(AA.AfN%3D%3D%27central%20mental%20hospital%27)&f=&orderBy=4&skip=0&take=10

Chapter 11

Other Specialty and Subspecialty Mental Health Services

Mental Health Intellectual Disability

People of all ages and with all levels of intellectual disabilities (ID) can be affected by mental health problems and it is recognised that people with an intellectual disability are actually more likely to develop mental health problems in comparison with the general population. If a person has an ID they are at least two to three times more likely to have a mental illness than the general population, with 4 in every 10 people with ID experiencing a mental illness in their lifetime (Cooper et al., 2007). Psychosis, bipolar disorder and neurodevelopmental conditions such as attention deficit hyperactivity disorder are all more common than in people without intellectual disability, and emotional disorders are at least as common.

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.

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 agencies are funded by the HSE through annually negotiated Service Level Agreements.

There have been 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 since 2013.

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 Community Healthcare Organisation (CHO). In addition, in late 2016 MHID was prioritised by Mental Health Services for a Service Improvement project and the "National MHID Service Development Programme" was developed.

This programme of work is supported through close partnership with the HSE's Social Care Service and relevant voluntary agencies and has a dedicated project manager. 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.

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 vs Actual Staffing (2019)

MHID Services	Vision for Change (2006)	No. of recommended teams	Teams in place	Rec. Staff	Staffing Levels in 2019
Adult MHID teams	1 : 150,000	31	17	310	98.2
CAMHS-ID	1 : 300,000	16	3	160	22.3
Total		47	20	470	120.5

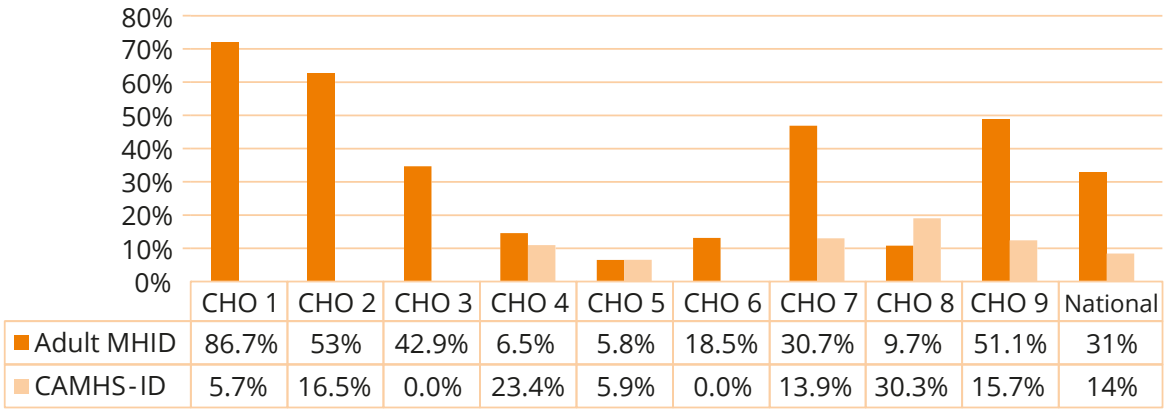
Based on the mapping exercise, there is a detailed understanding of actual staffing levels across both HSE and voluntary agencies and unfilled posts provided by the Programme for Government investment. The plan is to move towards full national coverage of both Adult and CAMHS ID services through further 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

The composition of each MHID team 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 stages in 2019. Staffing levels are computed in terms of whole time equivalents (WTEs). The total recorded staffing in MHID services in 2018 was 120.5.

In December 2019 there was a total of 98.2 staff in Adult MHID Teams nationally (87.9 Clinical). This represents 32% of the clinical staffing levels recommended in *A Vision for Change.* CAMHS-ID had a total of 22.3 staff nationally, 20.3 clinical. This represents 14% of the clinical staffing levels recommended in *A Vision for Change.*

Adult MHID and CAMHS-ID Teams Staffing vs VFC recommendations in 2019



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
Adult MHID	86.7%	53%	42.9%	6.5%	5.8%	18.5%	30.7%	9.7%	51.1%	31%
CAMHS-ID	5.7%	16.5%	0.0%	23.4%	5.9%	0.0%	13.9%	30.3%	15.7%	14%

Adult MHID and CAMHS-ID Teams Staffing and VFC recommendations per CHO in 2019

	Population Census 2016	Adult MHID Staffing 2019	% of VFC rec 2019	CAHMS-ID Staffing 2019	% of VFC rec
CHO 1	394,333	22.8	86.7%	1.0	5.7%
CHO 2	453,109	16	53%	2.5	16.5%
CHO 3	384,998	11	42.9%	0.0	0.0%
CHO 4	690,575	3	6.5%	5.5	23.4%
CHO 5	510,333	1.5	5.8%	1.0	5.9%
CHO 6	445,590	5.5	18.5%	0.0	0.0%
CHO 7	645,293	13.2	30.7%	3.0	13.92%
CHO 8*	616,229	4	9.7%	6.0	30.25%
CHO 9	621,405	21.2	51.1%	3.3	15.7%
National	4,761,865	98.2	31%	22.3	14%

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

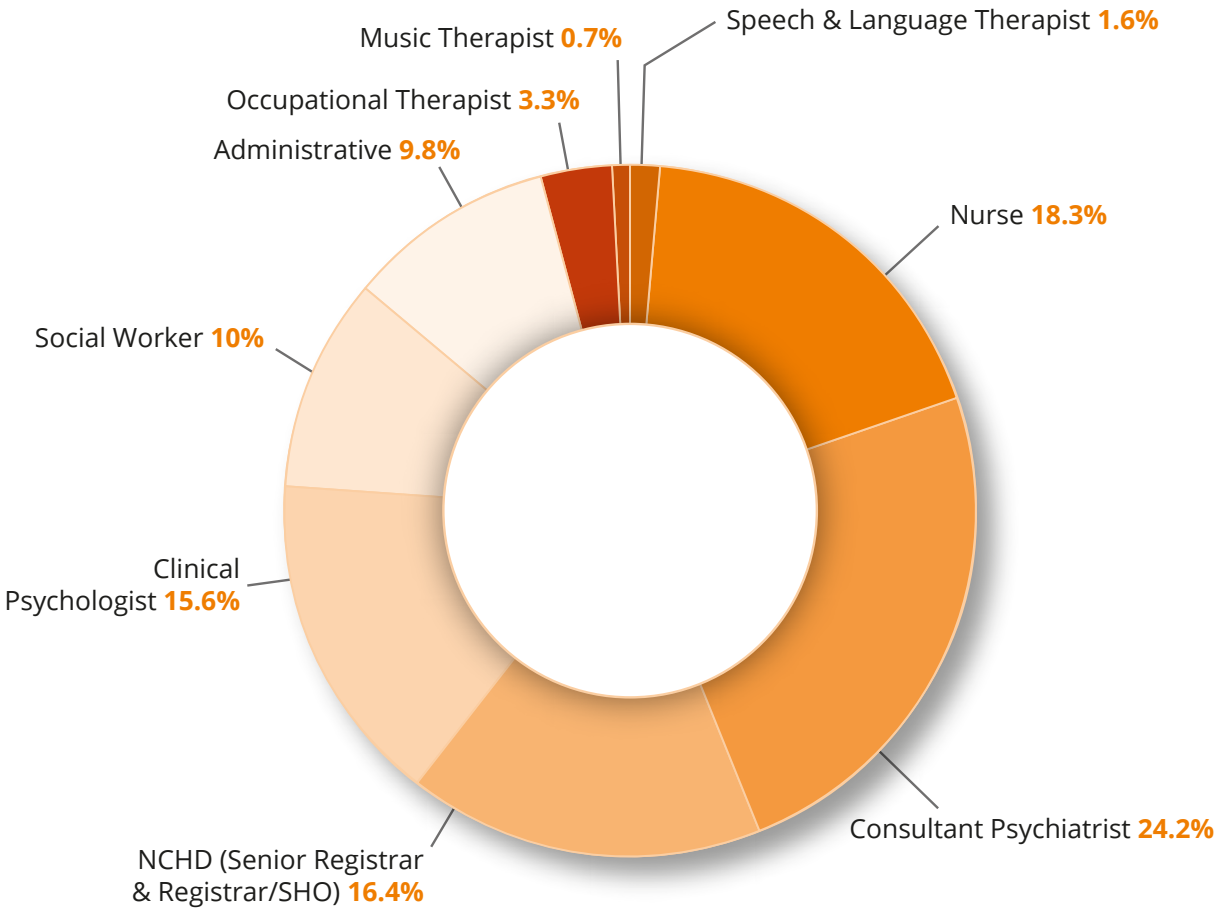
MHID Teams Staffing by discipline 2019

2019	Adult	CAMHS-ID
Consultant Psychiatrist	21.5	7.5
NCHD (Senior Registrar & Registrar/SHO)	16.9	2.8
Social Worker	9	3
Clinical Psychologist	14.3	4.4
Nurse	21	1
Occupational Therapist	4	0
Speech & Language Therapist	0.9	1
Music Therapist	0.8	0
Administrative Support Staff	9.8	2
Total	98.2	20.3

Workforce of Adult MHID and CAMHS-ID Teams by profession 2019

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

The largest professional group was psychiatry making up 40.6% of the workforce (consultant psychiatrists (24.2%), and doctors in training (16.4%).



Liaison Psychiatry or Psychological Medicine

Liaison psychiatry or Psychological Medicine is the sub-specialty which concerns itself with the mental health care of people with mental and physical health care needs, and those who are treated in the acute hospital setting. Liaison Psychiatry Services work in a collaborative way integrating the care for patients with mental and physical health problems across organisational boundaries (RCPsych 2020).

This usually involves care in 3 main settings: the Emergency Department (ED), medical/surgical inpatient wards, and outpatients for care of patients referred from medical/surgical outpatients or followed up from referrals on discharge.

There are 3 main patient groups:

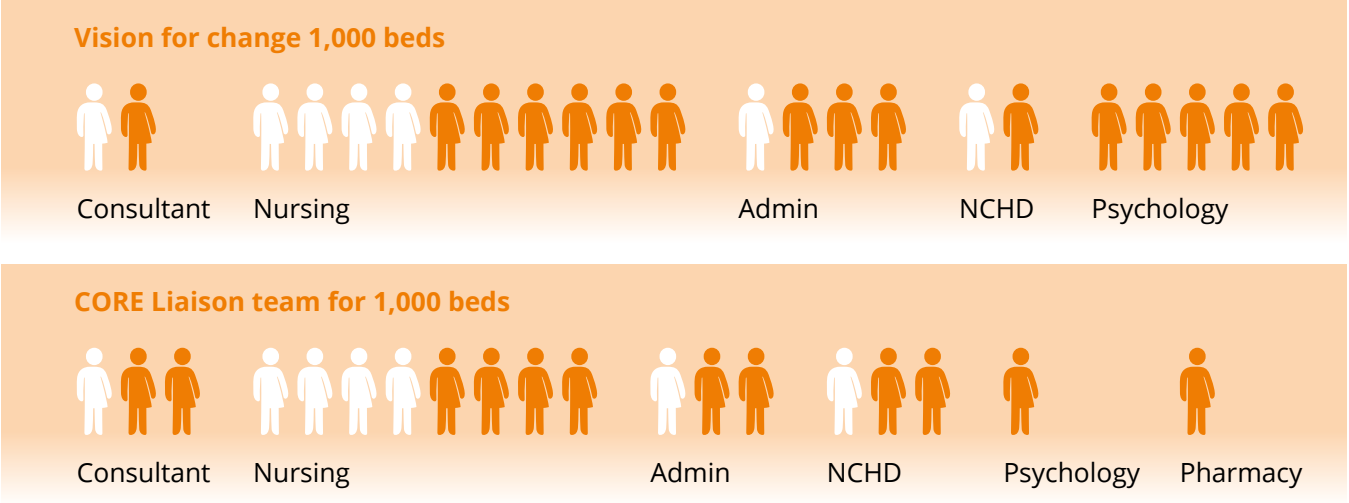
1. Those presenting with emergencies, including those admitted with self-harm and those seen in the ED;
2. Those with functional disorders, i.e. the physical manifestation of psychological problems including somatisation disorder, non-epileptic seizures, etc.;

3. Those with co-morbid mental and physical health problems, especially where the mental disorder impacts on physical health – e.g. where a person's depression means that they struggle to manage diabetes, placing them at greater risk of developing end-stage complications such as renal impairment, sight threatening retinopathies and stroke.

Liaison Psychiatry teams are multidisciplinary and led by one or more consultant liaison psychiatrist – a psychiatrist with a general adult CCST including a subspecialty endorsement in liaison psychiatry. The multi-disciplinary team should include specialist mental health nurses, clinical psychologists, addiction specialists, social workers, occupational therapists, administrators and pharmacists.

A Vision for Change clearly sets out the minimum staffing needs, similar to that recommended by the RCPsych for a "Core" or basic team, with greater staffing levels required for extended hours services and for services that provide outpatient treatments or specialist services (DoH, 2005; RCPsych, 2013). There is variability in the level of resourcing in Liaison Psychiatry services across Ireland and the UK (Parsonage et al, 2012).

An example of understaffing in Liaison Psychiatry services: Staffing of the Liaison Psychiatry Team at University Hospital Galway compared with (a) national and (b) UK minimum standard for 1000 beds.



Liaison psychiatry for every acute hospital: Inegrated mental and physical healthcare. College report from the Royal College of Psychiatrists (CR183).

Up to 5% of ED attendances have a primary mental health problem (RCPsych & BAAEM, 2004), and up to 30% have a mental health problem in addition to their other presenting complaints (AMRC, 2010). Psychiatric and psychological co-morbidities (e.g. depression) are common in patients with chronic physical disorders representing over 25% of medical inpatients. These co-morbidities are associated with poorer outcomes including higher mortality rates (Moussavi et al, 2007; Ismail et al, 2007) and unscheduled service use (Stein et al 2006; Unutzer et al, 2007). There is strong evidence that integrating mental and physical healthcare leads to better outcomes for patients (NICE, 2009; Katon et al, 2010; Coventry et al, 2015), but the complexities of real patients and segregation of mental and physical health services create difficulties in translating gold-standard research into real-life services (Ismail et al, 2019).

Psychiatric conditions presenting as medical symptoms can use up significant resources of services, both inpatient and outpatient, resulting in increased waiting lists and patient dissatisfaction (functional disorders account for up to 30% of medical outpatient referrals: Stone et al, 2009). This can be alleviated by having well-resourced and integrated liaison psychiatry services.

The RAID study in Birmingham demonstrated that for every £1 invested in a liaison psychiatry service, £4 were saved across bed days in acute medical (not psychiatric) settings. These savings arose from reduced admissions, reduced length of stay and avoidance of repeat admissions (Parsonage & Fossey 2011). In the UK these findings have been translated into service improvements.

In addition to providing direct clinical care to patients, liaison psychiatry services provide education and training to staff in the acute hospital: both *ad hoc* teaching and formal training sessions, bespoke sessions for departments or on topics, and hospital grand rounds, etc. This is effective in increasing all staff understanding of mental disorders and distress and improves the overall care experienced by patients with mental disorders and distress in the acute hospital setting.

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Specialist Perinatal Mental Health Service

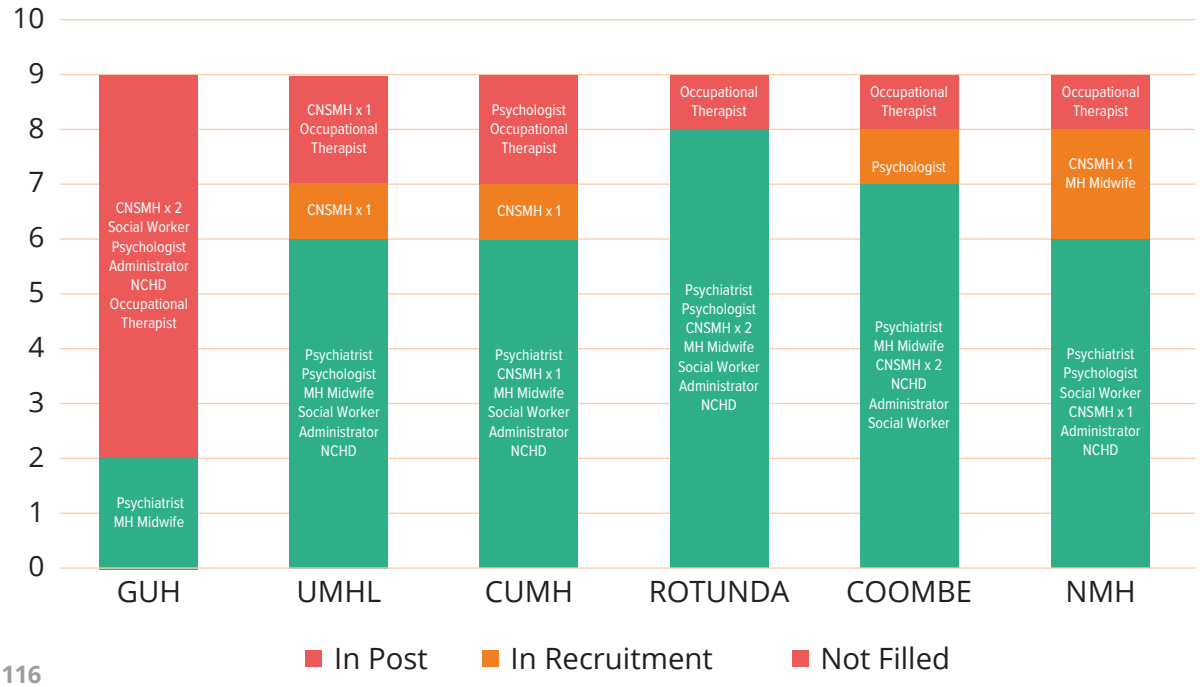
Background

As many as 1 in 5 women have mental health problems in pregnancy or after birth. Two years on from the launch of the Specialist Perinatal Mental Health Model of Care for Ireland, the Model supports the seven actions on mental health outlined in the HSE's National Maternity Strategy. Depression and anxiety are the most common mental health problems in pregnancy and affect about 10 to 15 out of every 100 pregnant women. Just like at other times in life, you can have many different types of mental illness and the severity can vary. Whilst the focus of this specialist service will be women with moderate to severe mental illness, it also ensures women with milder mental health problems are both identified and receive appropriate help from skilled staff within maternity services. This is done through the development of the role of the mental health midwife nationally and plays a central role in educating and training all involved in the delivery of services to women during the antenatal and postnatal periods. The specific circumstances of pregnancy, birth and early mother/infant bonding requires staff who are knowledgeable, skilled, sensitive and experienced. Specialist perinatal 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 specialist teams and mental health midwives work jointly to ensure all women attending the maternity service will have information on positive mental health. Standard questions on mental health as well as physical health are routinely asked of each woman attending both booking and review clinics.

SPMHS Staffing update 2019

During 2019 the focus of the National Programme for the implementation of Specialist Perinatal mental health services focused on the recruitment of multidisciplinary teams in the 6 hub sites, that is the three larger maternity hospitals in Dublin as well as the maternity units/hospitals in Cork University Maternity Hospital, University Maternity Hospital Limerick and Galway University Hospital. Bespoke panels were created for positions such as Senior Psychologists, Senior Mental Health Social Workers and CNSMH nursing staff. The recruitment of mental health midwives in both hub and the 13 spoke sites in Ireland also continued with a number of national recruitment campaigns. Staff were provided with specific induction and training including training from Dr. Liz McDonald, Hon Cons in Perinatal Psychiatry, Clinical Lead for Perinatal Workforce Development at the Royal College of Psychiatry in London.

Table 1: SPMHS multidisciplinary team staffing at March 2020

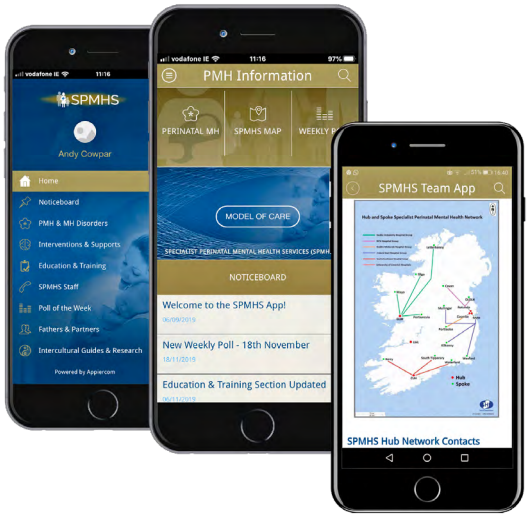


Specialist Perinatal MDT staff attending training at the University of Limerick, Dec. 2019

SPMHS Staffing update 2019

Supports available to staff

New staff recruited to work specifically in Specialist Perinatal Mental Health Services have been provided with a specific induction and specialist training. Other supports included the development and updating of the SPMHS App which is available to all frontline workers who may want to learn more about perinatal mental health. The National Programme also set up a National Oversight Implementation Group (NOIG) which is represented by a psychiatrist from each hub site as well as other multidisciplinary team members. The NOIG meet every two months and goals are developed and any challenges discussed with regard to roll out of new services. This also supports the roll out of equitable multidisciplinary team services nationally.



The Perinatal Mental Health Healthcare App for Staff

The Specialist Perinatal Healthcare App for healthcare staff was developed in 2019 and is designed to provide the latest information to assist frontline staff in their roles, providing information on how to access services for women seeking information, advice and support for mental health problems in pregnancy and the first year post-partum. The app has now been downloaded by almost 1,000 frontline healthcare staff who work in areas such as midwifery, public health nursing, psychology, CMHTs as well as GPs and practice nurses.

For staff it hosts all the latest education and training information on Perinatal Mental Health available in an easily accessible format. The app is regularly updated with new content, weekly MCQ questions and information on news and events related to perinatal mental health services.

Available at: Https://PMH.healthcarestaff.app

Patient Information Leaflets

During 2019 a project, developed from the NOIG meetings, was initiated to develop a range of patient information leaflets for Specialist Perinatal Mental Health Services. These, when finalised, will cover a wide range of topics including: perinatal mental health tips, mental health problems in pregnancy, health and supports available, information for women with existing mental health problems, postnatal depression information, Perinatal OCD, Lithium in pregnancy, Valproate in women and girls who could get pregnant, Postpartum Psychosis, as well as Information for carers. An editorial sub group has been established and it is hoped that the information leaflets will be available in early 2020. These will provide much needed advice to the public and support the awareness and importance of perinatal mental health for women and their families.

Feedback from our service users

The December 2019 issue of Health Matters featured the Specialist Perinatal Mental Health Service at the University Maternity Hospital Limerick.

It reported that two years after its launch, women across the country have spoken about the transformative effects the Specialist Perinatal Mental Health model of care has had on their pregnancies and beyond. The article also covered how the Specialist Perinatal Mental Health Service is constantly striving to develop and improve the service at University Maternity Hospital Limerick by holding an innovative workshop event where mums provided staff with vital feedback on their experiences to help inform future delivery of the service.

Rehabilitation and Recovery Mental Health Services

There is a cohort of our mental Health Service users and patients whose mental health challenges have escalated to an extent that they have severely impacted on their quality of life. This is due to the active nature of their symptomology and the impact of that on their social functioning and their subsequent ability to participate in their communities. 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 other significant challenges that affect their motivational and organisational skills to manage everyday activities. The effect of their mental health difficulties may impact on their ability to practice good self-care. In some cases the psychotic symptoms have not responded fully to medication or other treatments and co-existing mental health problems such as depression, anxiety, substance misuse , long-term physical issues and an increased risk to developing same may be present. Additionally some service users and patients may be on the autism spectrum.

However, 'recovery' is possible for all Service users and patients. As Anthony, W.A. (1993)[1] states: 'Recovery includes the development of new meaning and purpose in life as one grows beyond the

catastrophic effects of mental illness'. This Recovery can be achieved 'regardless of the severity or duration of those mental health challenges' (HSE 2018). Therefore rehabilitation and recovery mental health services should have the joint aims of minimising the symptoms of illness and promoting the person's social inclusion and recovery.

The cohort of service users and patients who experience severe psychosis and its resulting impact on their lives, can greatly benefit from an intensive care treatment and recovery intervention as provided by the 'Rehabilitation and Recovery Mental Health Services'. Rehabilitation and Recovery can be described as an area of practice that is "a whole systems approach to recovery from mental illness that maximises an 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" (Killaspy et al., 2005)[2].

The HSE National Mental Health Service 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.

Since 2014 the HSE has developed a number of additional processes and structures to support the delivery of services in a recovery oriented way.

Key achievements in 2018 in rehabilitation and recovery include:

- Publication of a National Framework for Recovery in Mental Health 2018 – 2020. This document sets out a framework and pathway to ensure the delivery of recovery focused treatment and services nationally.
- The development of a number of guidance documents to support the implementation of the 'National Framework for Recovery in Mental Health'.
- The continued recruitment of peer support workers onto mental health teams. Peer support workers provide direct supports to service users and act as advocates for service users on the mental health teams in which they are employed as well as providing a therapeutic benefit to the individual service users they are working with.
- The publication of a Peer Support Worker Impact Study and Toolkit to enhance the understanding and integration of peer support working into services.
- The publication of a quality assurance guidance document to ensure high quality and consistent delivery of recovery education across all services.
- The continued development of recovery education services including recovery Colleges across all CHOs with the recruitment of additional Peer educators.
- The enhancement of service user participation in their treatment, recovery and care planning through co-production with their mental health team.

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1 Anthony, W. A. (1993). Recovery from Mental Illness: The Guiding Vision of the Mental Health Service system of the 1990s. *Psychosocial Rehabilitation Journal,* 16(4), 11-23.

2 Killaspy, H. and Harden, C. and Holloway, F. and King, M. (2005) What do mental health rehabilitation services do and what are they for? A national survey in England. *Journal of Mental Health,* 14 (2). pp. 157-165.

Chapter 12

Service Improvement Function

Background

By 2016, the HSE's Mental Health Division established the Strategic Portfolio and Programme Management Office (SPPMO) in conjunction with the Centre for Effective Services. This collaborative initiative delivered a structured sustainable programme of change throughout mental health services within the broader context of the overall national healthcare reform programme.

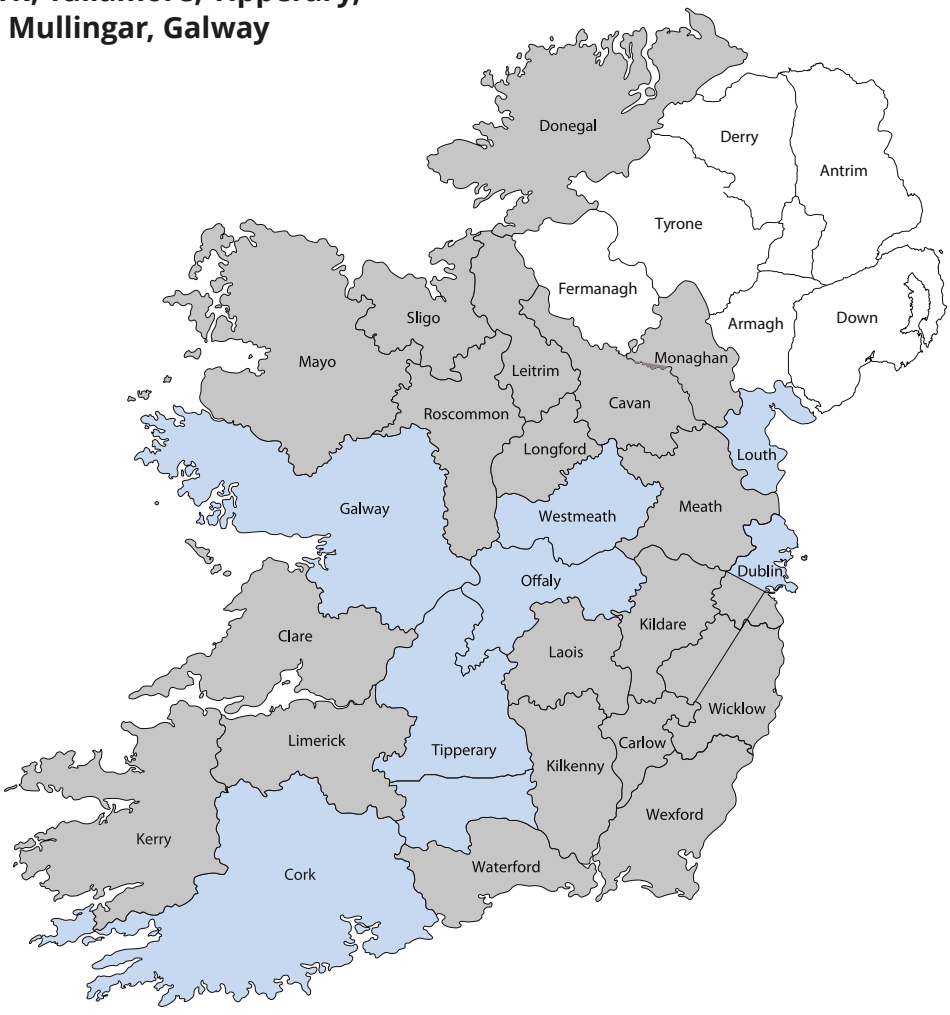
In line with wider HSE organisational changes, the SPPMO transformed into the Community Healthcare Operations Improvement and Change (CHOIC) Office in 2019. The aim of CHOIC is to support and enable a structured, integrated and sustainable programme of change across Community Operations in collaboration with local services, staff, service users and family members.

The current portfolio primarily consists of improvement projects specific to mental health services. However, the CHOIC Team is also supporting a number of initiatives across other service areas, including older people services, disability services and primary care, and soon further projects will be added to the CHOIC portfolio.

The CHOIC Team consists of a Team Lead, Service Improvement Leads, Project Managers, Programme Managers, Data Specialist and Support Staff. The team members have local/national reach and knowledge due to their diverse backgrounds and dispersed locations across the country.

The CHOIC team members are currently based at the following locations across Ireland:

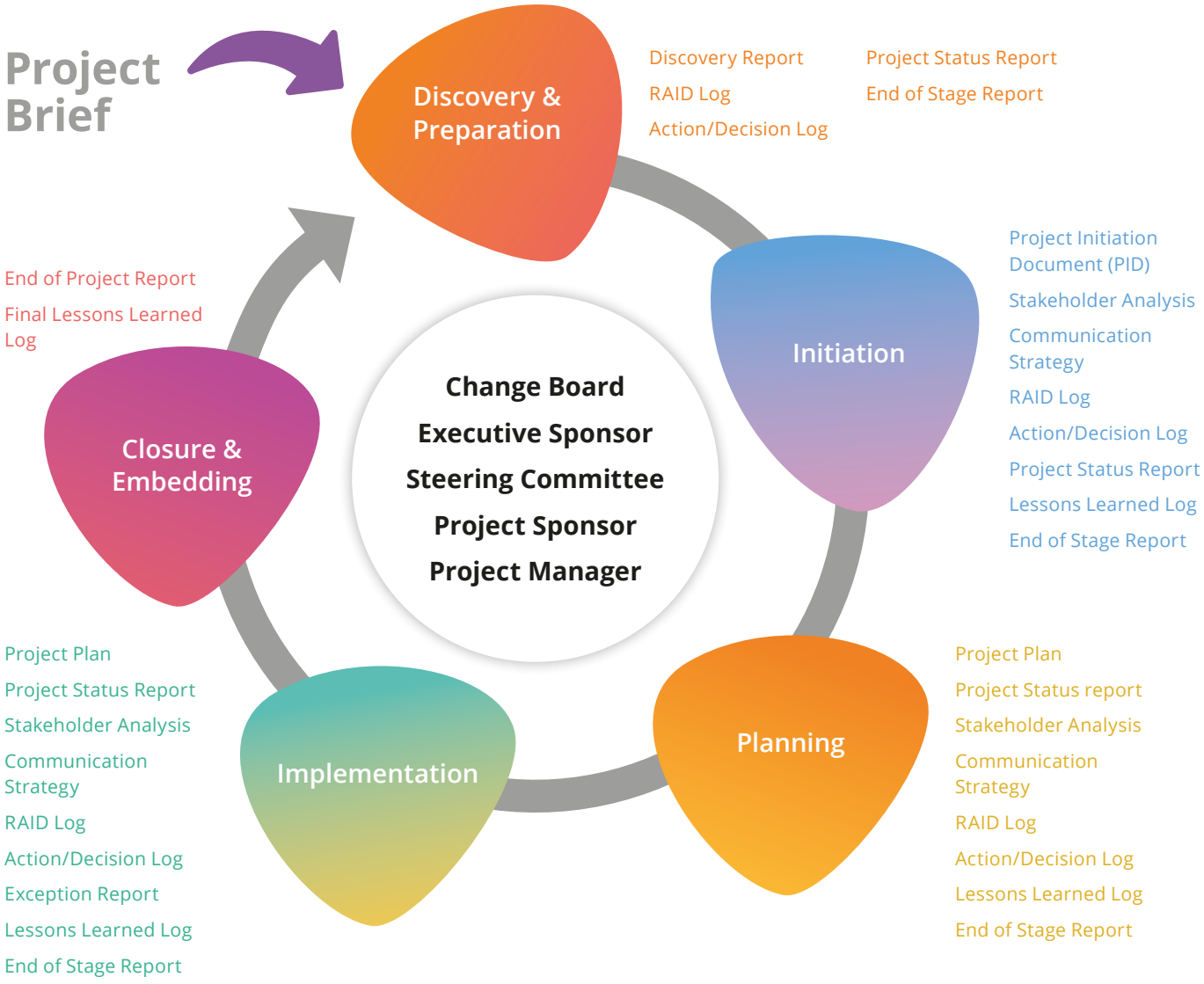
Dublin, Cork, Tullamore, Tipperary, Drogheda, Mullingar, Galway



Methodology

The CHOIC methodology is developed specific to the context of health and social care and informed by Prince2, PMBOK, MPMM and Implementation Science. It is aligned with the principles underpinning the Health Services Change Guide, Framework for Improving Quality and the National Framework for Developing Policies, Procedures, Protocols and Guidelines. These were all published post the establishment of the methodology but are considered as the methodology is updated.

As illustrated below, the methodology is structured around five project stages: Discovery and Preparation; Initiation; Planning; Implementation; and Closure and Embedding.

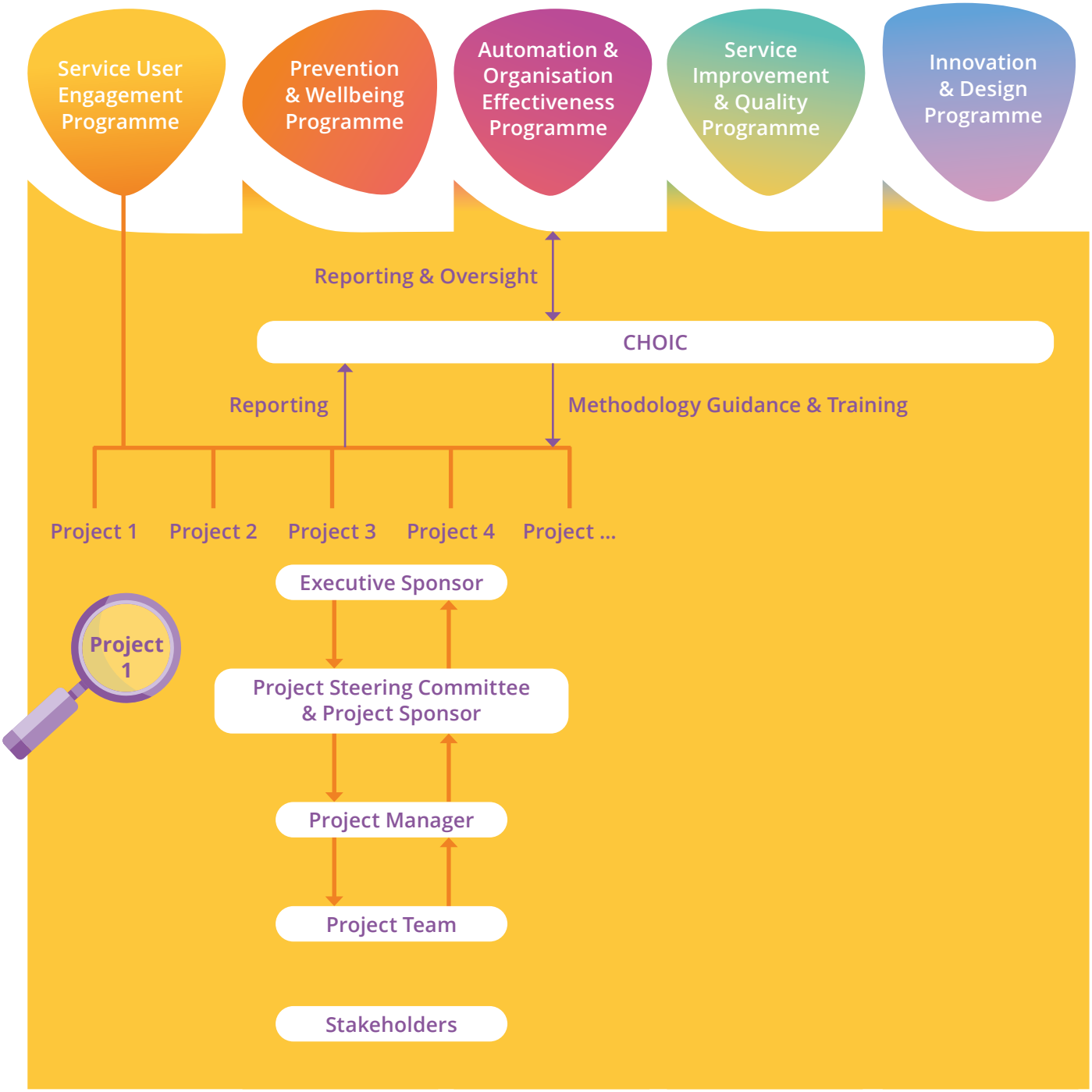


Governance Structure

The Mental Health portfolio consists of five programmes of work in line with the strategic objectives set out by the Mental Health Service Area. These include Service User Engagement, Prevention & Wellbeing, Automation & Organisation Effectiveness, Service Improvement & Quality and Innovation & Design.

The CHOIC Mental Health Change Board provides governance and oversight for all projects entering and progressing through the portfolio of approved projects. The Change Board consists of members of the Community Operations Management Team, Clinical Group Lead, Quality and Service User Safety Lead, Heads of Service – Mental Health, CHO Chief Officer nominee, Director of National Office for Suicide Prevention, Strategic Transformation office (STO) and the Office of Chief Information Officer.

CHOIC MH Change Board



CHOIC Mental Health Portfolio (as of 31st December 2019)

Mental Health Service Improvement Projects

Project Name
National Mental Health e-Rostering Project
MHD ICT - Infrastructure Improvement Project
Standardised process for Service Users Journey within General Adult Community Mental Health Teams
Developing Digital Mental Health supports in Ireland
Implementation of Team Coordinators for Community Mental Health Teams
Develop a Stepped Model of Mental Health Care for the Homeless Population in Dublin (CHO 6,7,9)
Integration of Peer support working into Multi-disciplinary teams
Design of a revised Care and Recovery planning process
Mental Health Intellectual Disability (MHID)
Standard availability Talking Therapies in Mental Health Services
Formalisation of Service User, Family Member and Carer Engagement Recognition and Reward Procedures
Development of an Independent Advocacy service in CAMHS
Suicide and Self-Harm Awareness, Assessment and Response Project
Introduction of Early Warning Score in Approved Centres

Completed MH Service Improvement Projects in 2019

	Completed Projects in 2019
Artefact Reference	**Project Name**
1	Develop a model of care for people with Severe and Enduring Mental Health Illnesses and Challenging Behaviours
2	Developing Digital Mental Health Supports in Ireland - YourMentalHealth.ie website - YourMentalHealth Information Line
3	Connecting for Life actions 4.3.1 and 4.3.2 Enhanced Bereavement
4	Physical Health Needs of Mental Health Service Users
5	HSE Best Practice Guidance for Suicide Prevention Services
6	Future of Mental Health Stigma Reduction Campaign
7	Review of CAMHS SOP (COG)
8	Implementation of the HSE Best Practice Guidance for Mental Health Services
9	Implementation of the roles and structures to support mental health engagement through local and area fora development and Area Leads posts
10	Implementation of the National Recovery Framework in Mental Health (2018-2020)

Note: Please refer to Appendix A for a full list of completed MH Service Improvement Projects.

1. Develop a model of care for people with Severe and Enduring Mental Health Illnesses and Challenging Behaviours

Overall Aim:

To develop a recovery focused rehabilitation model of care for service users with severe and enduring mental health illness and complex needs

Process

- The development of a Model of Care (MOC) for People with Severe and Enduring Mental Illness and Complex Needs by an expert group (including service user representation) that clearly describes the rehabilitation care pathway
- The commissioning of two National Specialised Rehabilitation Units (SRUs)
- The establishment of a SRU referral process
- The establishment of a National SRU Referral Committee
- A referral process that ensures SRU placements are prioritised for people with the greatest clinical need

Outputs

- A Model of Care for People with Severe and Enduring Mental Illness and Complex Needs
- Two national SRUs commissioned that provide placements for people with severe and enduring mental illness throughout the country
- Guidelines for the management of National SRU Placements which includes SRU referral and transition process
- Standardised SRU Referral Form
- A National SRU waiting list
- Waiting list decision matrix
- Key performance indicators (KPIs) which captures key activity metrics as the service user progresses from point of referral to discharge from the SRU placement

Outcomes

- A recovery focused model of care that described a recovery pathway for service users with severe and enduring mental health illness and complex needs
- Availability of national SRUs placements for service users with severe and enduring mental health illness and complex needs
- Increased capacity of Acute In -Patient Units to respond to service user needs
- Improved outcomes for service users with severe and enduring mental health illness and complex needs
- Momentum to continue to develop mental health rehabilitation and recovery services throughout the country

2. Developing Digital Mental Health Supports in Ireland

Overall Aim:

- Develop new/develop upon existing online presence for hosting of validated mental health and wellbeing information, HSE mental health services directory information, and with an integrated personalised information and services signposting tool.
- Establish a single dedicated point of telephone contact for HSE mental health services information and relevant helplines in the State in collaboration with the National Ambulance Service.

Process

YourMentalHealth.ie:

- Sub Group including HSE Mental Health, HSE Digital, National Office of Suicide Prevention, UCD PhD Researcher.
- Theoretical framework development.
- Global review of integrated smart search signposting tools.
- Content production process Hackathon.

YourMentalHealth Information Line:

- Sub Group including HSE Mental Health, HSE Live, Samaritans, National Office of Suicide Prevention, Aware.
- Global review of telephone services and options.
- Engagement with National Ambulance Service.
- Launch of YourMentalHealth Information Line – Nov 2019.

Outputs

YourMentalHealth.ie:

- Redevelopment of YourMentalHealth.ie including validated mental health and support information.
- Implementation of biopsychosocial model based theoretical framework.
- Creation of integrated smart search functionality to allow user to obtain personalised content on online information, online supports, telephone supports, and mental health services.

YourMentalHealth Information Line:

- Single Contact Telephone Information and Signposting Service.
- Integrated Mental Health Services Directory including all funded partner organisation support services nationally.
- Available 24/7, 365 days per year.

Outcomes

YourMentalHealth.ie:

- Validated information provision.
- Availability of tailored and localised service & support information finding.
- Improved Search Engine Optimisation - Organic Search up 93% on 2018.
- 1.4m visits in the last 12 months – up 30+% on 2018.

YourMentalHealth Information Line:

- Single Contact Telephone Information and Signposting Service.
- Integrated Mental Health Services Directory including all funded partner organisation support services nationally.
- Available 24/7, 365 days per year.
- Call takers fully trained in safeTALK protocols.

3. Connecting for Life actions 4.3.1 and 4.3.2 Enhanced Bereavement

Overall Aim:

This project refers to Connecting for Life action items:

4.3.1. Deliver enhanced bereavement support services to families and communities affected by suicide of those people known to mental health services.

4.3.2 Commission and Evaluate Bereavement Support Services

The Improving suicide bereavement supports in Ireland report produced by the project sets out 10 core action areas that encompass 21 actions that the Steering Committee and Working Group identified as essential for the improvement of suicide bereavement supports. The report also identifies the ownership of the actions that will allow for the improvement and sustainability of services in this area. HSE Mental Health Operations and the National Office for Suicide Prevention have collaborated on the publication and have agreed on the appointment of a national coordinator to work on the implementation of the actions set out in the report.

Process

- The project established a cross sector Working Group, which included a service user representative. The group supported cross sector and collaborative working
- A mapping was carried out of the existing HSE funded and non HSE funded bereavement support services; this work was supported by the Resource Officers for Suicide Prevention (ROSPs)
- A review of existing suicide bereavement service provider evaluation data was carried out
- A Literature review "Suicide Bereavement Supports – A Literature Review" was conducted and published
- Ten core action areas were identified and Sub-Working Groups were established to make recommendations and identify key action areas
- To help inform the "HSE MHS Communication Guide following Suspected Suicides in Services", examples of current practices were obtained from 3 Community Healthcare Organisations (CHOs)
- All of the above informed the report "Improving suicide bereavement supports in Ireland (2020)". This report sets out 10 core action areas that encompass 21 actions that the Working Group identified as essential for the improvement of suicide bereavement supports

Outputs

- A MS Excel 'mapping' of the existing HSE funded and non HSE funded bereavement support services per CHO/County, including a review of information sources that are currently available. (This will inform any future service requirements)
- A review of two existing service providers' evaluation data (Pieta House and the Family Centre, Mayo)
- "Suicide Bereavement Supports – A Literature Review" was published. A review of literature and approaches to suicide bereavement support including grey literature and relevant international practice and policy in this area which included a review of existing Irish reviews and reports on suicide bereavement support
- The "HSE MHS Communication Guide following Suspected Suicides in Services" was developed. The purpose of this guide is to assist HSE Mental Health Services in supporting families with an appropriate and consistent response and to ensure signposting to bereavement supports
- The "Improving suicide bereavement supports in Ireland" report produced by the project sets out 10 core action areas that encompass 21 actions that the Steering Committee and Working Group identified as essential for the improvement of suicide bereavement supports.

Outcomes

- National coordination requirements of suicide bereavement supports and the 10 Core areas for improvement are identified
- A national coordination point is assigned, to have dedicated responsibility for the coordination of suicide support actions outlined in the report
- There is consistency in the response to families affected by the suspected suicide of someone known to mental health services. (HSE MHS Communication Guide following Suspected Suicides in Services)
- HSE Mental Health Staff are aware of the HSE Employee Assistance Programme (EAP).

4. Physical Health Needs of Mental Health Service Users

Overall Aim:

It is widely recognised that physical health disparities exist across the spectrum of mental illness. People with a serious mental illness have a life expectancy 10-20 years shorter than the general population; are times more likely to die from a respiratory disease; and almost three times as likely to die of a cardiovascular disease. A new Physical Health Assessment process was developed with practitioner and service user involvement using a Plan Do Study Act (PDSA) approach and iterations were made to the form based on the views of the practitioners on the ground. The Health and Wellbeing Making Every Contact Count (MECC) assessment was also incorporated into the assessment form. An audit was carried out before and after the introduction of the form based on Mental Health Commission criteria for general health. Following a period of five months there was an overall compliance rate of 71%, up from 34%; one site was at 81.4% .There was 100% compliance with ECGs, an 83% compliance for family history, and 86% compliance for checking on National Cancer Screening attendance. One service user in one site was picked up with early diabetes which will have significant benefits to them. With improvement in physical health assessment mental health services can now develop initiatives to address and prevent chronic physical health issues.

Process

- Developed Physical health assessment in conjunction with all disciplines working in mental health and service users
- Three pilot sites tested physical health assessment form and using a Plan Do Study Act (PDSA) approach, ensured the form was practical and effective for all end users
- Incorporated the MECC recording tool to avoid duplication of recording of lifestyle assessment
- Developed, with the working group, care pathways on tobacco cessation, physical activity, national cancer screening, alcohol and diet and nutrition to assist staff on brief interventions with service users.
- Held a launch of the Physical Health Assessment From, Care pathways and Physical Activity Guidelines
- Communicated and gave workshop on the Physical Health Assessment Form and Care Pathways nationally

Outputs

- Guidelines on an Escalation Policy of the Deterioration of the Mental Health Service User
- Standardised Physical Health Assessment Form
- Referral lifestyle pathways based on assessment for Tobacco, Alcohol, Physical Activity and National Screening Programme
- Document on initiatives to Meet the Physical Health Needs of Mental Health Service Users
- Report on Clinical Site Visits to Acute Approved Centres (AAC)
- Evaluation report from pre and post audits of Physical Health in pilot sites
- Report on Training and Development Needs of Mental Health Nursing Personnel

Outcomes

Acute Services are able to assess the Physical Health of service users in a standardised way that meets with the Judgment Support Framework Regulation 19.

- Service providers can follow a care pathway for National Screening services, tobacco cessation, alcohol misuse and physical activity
- Physical health assessment including lifestyle assessment has increased from 30% compliance with Regulation 19 to 90% in one site
- There have been improvements in the detection of risk factors for chronic disease
- Physical health assessment and monitoring integrated into the mental health services in pilot sites

5. HSE Best Practice Guidance for Suicide Prevention Services

Overall Aim:

The development and implementation of standards for suicide prevention governing service quality was an objective outlined in Connecting for Life, Ireland's National Strategy to reduce suicide 2015-2020. Goal (5) of the strategy aims to ensure safe and high quality services for people vulnerable to suicide, and action 5.1.1 specifies the need to "develop quality standards for suicide prevention services provided by statutory and non-statutory organisations, and implement through an appropriate structure."

Process

- Established a Project Advisory Group to provide subject matter expertise and inform the development of the Guidance documentation, the self-assessment framework and the associated training programme.
- The Best Practice Guidance (BPG) was refined based on the learning and feedback collated from the engagement events and the testing of the draft BPG.
- The BPG is aligned with the overall framework of the BPG for Mental Health Services (MHS) and considerable input and collaboration with Non-Governmental Organisations (NGOs) working in the area of suicide prevention.
- The training programme developed by the MHS was adapted for use to provide a 2 day self-assessment training programme.
- Five NGOs agreed to be learning sites and test the draft BPG. They participated in a 2 day training programme, tested the draft BPG over 6 weeks and participated in a 'Capture the Learning' Event.
- The GAIT (Guidance Assessment Improvement Tool) in use by MHS has been adapted for use by the NGOs to enable self-audit.
- Charity Regulator Code (launched Nov 2018) is referenced in the BPG. NGOs will be required to be compliant with same by 2020.
- Document review completed by HSE legal.

Outputs

- Produced the Best Practice Guidance Document for Suicide Prevention Services
- Engagement events organised with NGOs to "capture the Learning"
- 2 Day self-assessment training programme developed and delivered
- The GAIT (Guidance Assessment Improvement Tool) in use by MHS has been adapted for use by the NGOs.

Outcomes

- The Best Practice Guidance for Suicide Prevention Services (BPGSP) is completed, printed and available to partner NGOs in PDF format. In the longer term it is intended that the BPG will be available to, and have the capacity to be adapted for use by organisations operating in the area of suicide prevention beyond those that are currently funded by the HSE.
- The GAIT (online guidance assessment improvement tool) was adapted and is accessible for use by Suicide prevention NGOs during the implementation phase
- A collaborative approach between HSE and NGOs supported the development of the BPG, a shared understanding as to the rationale for the project, a common language with which to support a collaborative approach to a quality improvement agenda
- NGOs have demonstrated their commitment to best practice and to the delivery of high-quality services by engaging and supporting the development of the BPGSP

6. Future of Mental Health Stigma Reduction Campaign

Overall Aim:

There are many HSE funded and non-funded mental health stigma activities taking place in the NGO Sector. Most notable among them is SeeChange, "Ireland's national programme working to change minds about mental health problems in Ireland", which is a partnership of over 90. The majority of SeeChanges' funding is provided by the HSE -(SeeChange is funded by HSE to coordinate the Green Ribbon Campaign as well as SeeChange in the workplace, Please Talk and the Headline media monitoring service)

Process

- External evaluation of SeeChange programmes
- A Request for Proposal (RFP) was issued to contract an independent researcher(

Outputs

- The evaluation report delivered a comprehensive set of recommendations.
- 20 "Programme wide" recommendations on, for example, strategy, focus, governance, funding, evaluation and staffing.
- 17 additional "Programme specific" recommendations on the 4 main strands of SeeChange's work
- Recommendations included considerations on how Irish stigma campaigns could be strengthened and better integrated and provided some international comparisons
- Evaluation informed the consolidation of agreed activities with SeeChange for the 2019 Service Level agreement and thereon. These developments have improved the service level agreements with the current provider and will continue to do so in the future
- Funding for 2 strands were discontinued in 2019 – they were demonstrated to be outside the scope of stigma reduction work
- In 2019 funding was committed for the 2 remaining strands of their stigma-reduction work.
- SeeChange have responded to, and committed to, addressing remaining recommendations and have incorporated them into their 2019 plans

Outcomes

- A better understanding has been achieved to inform future commissioning and/or integration of this work
- There will be ongoing monitoring of the recommendations of the report with the Service Provider
- For potential new providers, a clearer rationale for mental health stigma reduction work is now in place
- HSE are better informed on the range of stigma reduction activities which have the strongest potential for impact and with international comparisons in mind
- Sharing of the information has helped to inform other related projects underway – e.g. Mental Health Communications Working Group, Connecting for Life Interim Strategy Group

7. Review of CAMHS SOP (COG)

Overall Aim:

The HSE published the CAMHS Standard Operating Procedure (SOP) in 2015. Following an extensive review and consultation with a wide range of stakeholders the 2019 document has taken on board much of this feedback and has been renamed the CAMHS Operational Guideline. The full document can be found online at https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/operational-guideline/

Process

- Gap Analysis carried out in all CHOs to establish adherence to the SOP and implementation of same.
- Consultation exercise held with a wide variety of stakeholders including staff, unions, service users and families on the benefits/challenges of existing document.
- CAMHS SOP Review Project/Advisory Group set up to review the document and incorporate feedback where applicable.
- Feedback on final document received from HSE Legal team and Mental Health Commission.
- Published the document online and also generated a limited print run.
- Held engagement sessions with the 9 CHOs to promote the revised document and templates, and incorporate a Q&A session.
- Circulated final products to each Head of Service Mental Health following the engagement session for wider dissemination.
- Worked with BlueWave Technology to develop an online self-assessment tool

Outputs

- Gap analysis Report of SOP implementation (Internal document)
- Analysis Report of Submissions following consultation exercise (Internal document)
- CAMHS Operational Guideline
- Sample templates of commonly used clinical forms for use by CAMHS teams and referrers
- PowerPoint presentation for use by Heads of Service as part of dissemination of the document including useful links.
- Service User and family information leaflet
- Online CAMHS Self-Assessment Improvement Tool to monitor compliance

Outcomes

- All CHOs have received the updated CAMHS Operational Guideline
- Clear Guideline and templates to enable implementation locally
- Consistent, standardised, transparent and responsive Guideline according to best practice.
- Clear processes for referral, assessment, treatment and discharge.
- PPPG Compliant.
- Self-Assessment Tool to measure effectiveness of implementation

8. Implementation of the HSE Best Practice Guidance for Mental Health Services

Overall Aim:

There are a number of initiatives required to support the smooth roll out of the Best Practice Guidance. The role of the Coordinators in each CHO is vital for the BPG implementation; they have a leading role in linking with trainers, agreeing the CHO plan with the head of service, coordinating with the Quality Champions on the planned roll out, linking with QSUS and monitoring progress. Training and information sessions: the project delivered seven, five-day "train the trainer" programmes, line manager training and information sessions. The trainers then delivered a one-day programme to the self assessment teams. The Guidance Assessment and Improvement Tool (GAIT) was developed as an online framework/tool, for all MH services to self assess against the BPG, to capture the good practice and where improvements could be made. The GAIT includes all current legislation and has the capacity to allow future amendments to be made easily.

Process

- Engaged with each CHO Area Management Mental Health Team and staff.
- Project plan produced for implementation following SPPMO methodologies.
- Engaged the services of Bluewave and HSE IT to support us with the development of GAIT.
- Trained Champions for five days; line manager training; and the one day programme was developed.
- Engaged with Coordinators from across the MHS.
- Established the governance arrangements for the project.
- Identified the communication needs.

Outputs

- Provided information sessions to Mental Health Management Teams & staff in each CHO area and the National Forensic Service
- Project Initiation Document and status reports produced for the Mental Health Change Board. Plans received from CHOs.
- Provided IT tool - (GAIT)
- Delivered 7 five-day Champions courses, line managers training and 60 teams have attended the one day programme developed. 2 x Refresher days
- Quarterly face to face meetings with Coordinators.
- Developed a suite of indicators, provide monthly update for the engagement calls.
- Developed a suite of communication tools for stakeholders, these include PowerPoint presentations, widget, yammer groups, website, Guide to Inspection.

Outcomes

- Improved compliance from 2016 to 2017.
- The BPG includes the Approved Centre Regulations, Codes of practice, Rules and international best practices.
- The GAIT has kept the process on track and captures all the work done. It was enhanced to include reporting of risks, regulations.
- 110 Quality champions were trained. Course evaluations showed the champions confidence and ability levels increased in order to deliver the BPG training locally.
- The meetings between the BPG Coordinators are seen as a positive opportunity to share learning and support each other.
- Performance indicators used to monitor the programme.

9. Implementation of the roles and structures to support mental health engagement through local and area fora development and Area Leads posts

Overall Aim:

In August 2014, the National Management Team established a Reference Group (whose membership included service users, families and carers) to make recommendations on the structures and mechanism for Service User, Family Member and Carer Engagement. The primary task of the reference group was to propose mechanisms for promoting widespread and regular consultation with service users, family members and carers in relation to HSE Mental Health services at local and national level such as would influence decision making in respect of the planning and development of services.

The project specifically focused on the implementation of these recommendations in particular the roles and structures to support mental health engagement through local and area fora development, Area Leads posts and make this operational at a local and national level.

Process

- Building on the roles defined as part of the work of the Reference Group, recruited Area Leads with Lived Experience in all CHO areas and carried out orientation and induction programme.
- Established the local forum structures to support engagement with Service Users, Family Members and Carers (SUFC).
- Documentation and rollout of Process and Operations of fora:
  - Communication mechanism
  - Management Teams Engagement
  - Data collection, analysis and sharing with identified stakeholders
  - Team Analysis and sharing of issues and actions
- Establishment of 35 local forums and inaugural Area Forums in 4 CHOs.

Outputs

- Guidelines to support good governance at fora finalised following HR and legal advice
- Leaflets containing information on local forums.
- Family Carer and Supporter Guide.
- Process for Management of Data raised at forums:
  - Logging and categorisation of data
  - Process for raising and managing through local and area management teams
  - Analysis of data at national level through MHE Office
  - Feedback to local forums

Outcomes

- In all areas of the country, SUFC are empowered through having the opportunity to contribute their experience.
- SUFC are influencing service improvement through partnering with local service providers
- Where Area Forums are established, Voluntary Organisations are availing of the opportunity to work in partnership with Service Providers and SUFC on addressing issues which have been raised through local forums.
- Because of the practice of sharing and learning at team level, there is a focus on continuous improvement and sharing good practices between CHOs.

10. Implementation of the National Recovery Framework in Mental Health (2018-2020)

Overall Aim:

The development in 2017 of the National Framework for Recovery in Mental Health 2018 – 2020 set out an understanding of Recovery and a Recovery-Orientated service, the core values and principles that underpin it and the actions and measures that support services in becoming more recovery focused.

The aim of the "Implementation of the National Framework for Recovery Project" that commenced in 2018 was to assist in a standardised approach to the implementation plans in the Community Healthcare Organisations (CHOs) and implement a single national monitoring and evaluation plan for the framework.

Process

- A framework baseline data collection template was developed by the Advancing Recovery Ireland (ARI) team.
- The process of completing the template was agreed with the recovery coordinators, Service Reform Fund (SRF) leads and Heads of Service Mental Health (HOSMH.)
- Baseline data was collected and uploaded onto the FLUXX system in May 2018. The aim was to gather current data in relation to each measure and action within the framework
- Just Economics, an external group with research and monitoring expertise, were recruited to carry out an evaluability assessment of the National Framework for Recovery. The aim of the work was to inform the development of a monitoring and recovery plan for the life of the framework including an evaluability assessment
- The project team worked with each CHO on their implementation plans
- Based on the experience of implementing the current framework, recommendations were made for the next iteration of the framework
- The continued engagement with the CHOs regarding the implementation of the Framework, and future recommendations, will now be progressed by Mental Health Engagement and Recovery as part of their operational work plan

Outputs

- A recovery orientation baseline/monitoring template
- Development of documents such as the guidance documents on Family Recovery, Recovery Education, Co-production in Practice, College of Psychiatry Position Paper on Recovery
- The monitoring and evaluation (M&E) strategy
- The M&E implementation plan for national actions
- A communication strategy
  - Face to face meetings with front line staff, service users, family members and NGO groups
  - Development of a media campaign around understanding recovery
- Utilising the lived experience of service users that are attending services
- Recommendations for the next framework

Outcomes

- National and CHO structures, plans, governance process are in place for the implementation, monitoring and evaluation of the Framework
- The evaluation process will inform the next iteration of the framework
- Recovery practice and the monitoring of recovery practice is business as usual within services
- Recovery practice is evident to all stakeholders and can be identified within the services (service users,family members, providers and external services and community)
- Mechanisms are in place to ensure all staff are aware of their recovery competencies in line with the framework
- The framework recovery principles will underpin the current and future design, delivery and evaluation of the mental health services.

Appendix
List of all completed MH Service Improvement projects

All Completed Projects – 2017 to 2019
Optional Appraisal Project- Approved Acute Centre admission data reporting
Standardised Management of first re-referred appointment DNAs in the community Mental Health setting
National Directory of Mental Health Services
Mental Health Services Workforce Plan Programme Phase 1 – Assessing the Supply and Future Demand
Development of HSE Best practice Guidance for Mental Health Services
Training Plan to enable the implementation of the HSE Best Practice Guidance for Mental Health Services
Development of a National Recovery Framework for Mental Health Services
Improving the Accessibility of Emergency Mental Health Services in Ireland
National Peer Support Worker Implementation
Developing Weekend Community Mental Health Services in Ireland
Implementation of the HSE Best Practice Guidance for Mental Health Services
Mental Health Engagement - Research & Evaluation
Implementation of the roles and structures to support mental health engagement through local and area fora development and Area Leads posts
Training and capacity building required to support roles and engagement structures
Alignment of CHO Connecting For Life Action Plans
HSE Best Practice Guidance for Suicide Prevention Services
Future of Mental Health Stigma Reduction Campaign
Develop a model of care for people with Severe and Enduring Mental Health Illnesses and Challenging Behaviours
Implementation of the National Recovery Framework in Mental Health 2018-2020
Review of the CAMHS SOP (COG)
Deliver enhanced bereavement support services to families and communities affected by suicide of those people known to mental health services
Physical Health Needs Mental Health Service Users

Chapter 13

Conclusion

As can be seen from the foregoing, Mental Health Services have continued the journey of transformation from primarily hospital focused 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).

In June 2020 Government approved the publication of the National Mental Health policy, 'Sharing the Vision – a Mental Health Policy for Everyone' for the period 2020-2030.

'Sharing the Vision' is the successor to *'A Vision for Change'* that was launched in 2006. It carries forward those elements of the original policy that still have relevance in light of expert opinion. It incorporates new recommendations as appropriate to enhance national policy, while simultaneously aligning with the ten-year vision for reform and transformation of Ireland's health and social care services encapsulated in the Sláintecare report.

Sharing the Vision focuses on developing a broad based, whole system mental health policy for the whole of the population. A large-scale consultation process informed the recommendations in this policy, and directly engaged a wide range of stakeholders, including people with personal experience, family members, community and voluntary sector groups and staff.

As stated earlier in this report Mental Health Services and mental health staff nationwide 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, Clinical Programmes and other specialist mental health services has been provided.

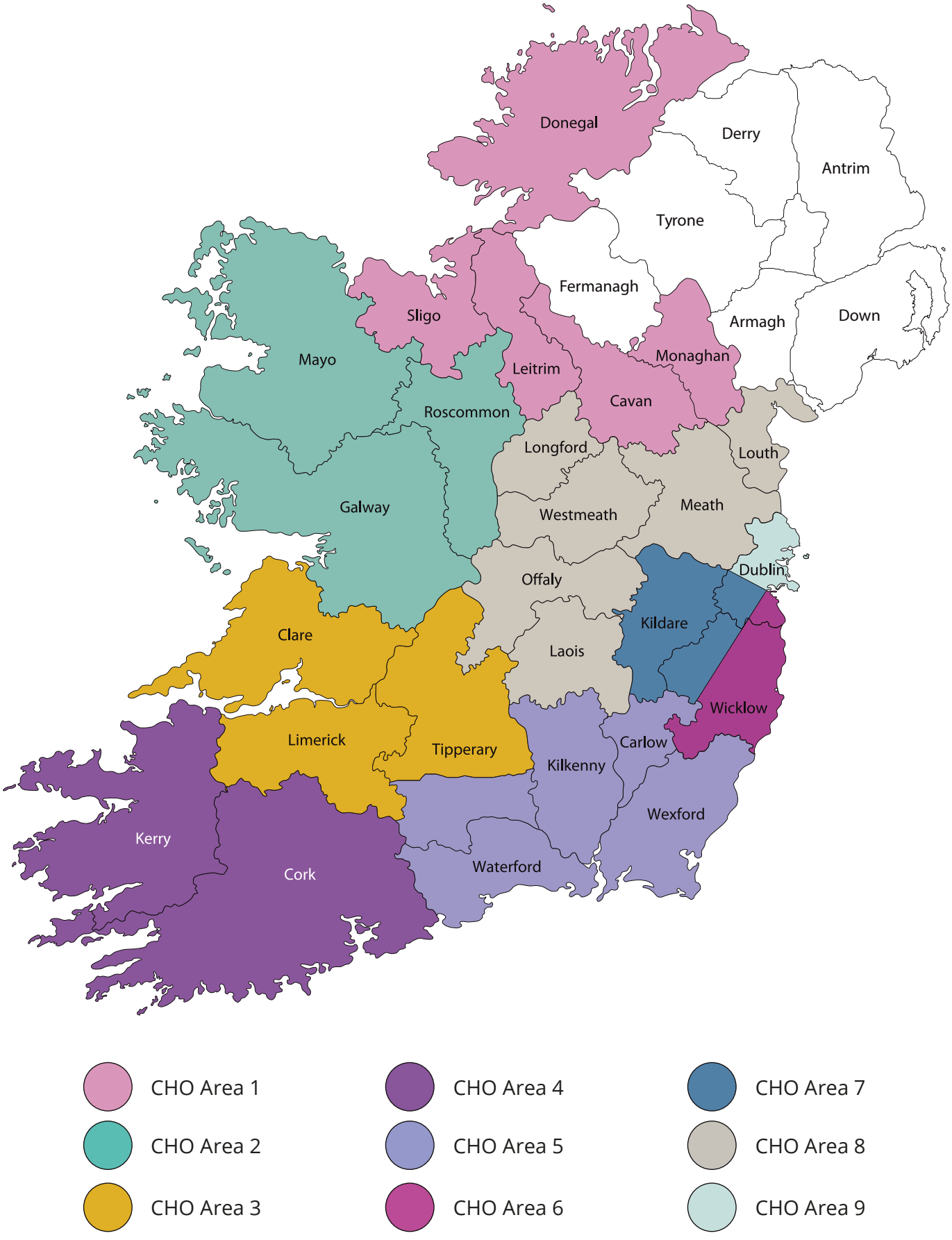
In reporting on activity in 2019, Mental Health Services are cognisant and supportive of the planned changes in the wider health service. Mental Health Services are fully committed to the implementation of the Slaintecare report and to the delivery of integrated services.

Significant work has been undertaken in Mental Health Services in 2019 to plan for the changes required. 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. Mental Health Services 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.

It is the intention of 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 on-going work in developing and improving Mental Health services nationally.

Appendix 1

Community Healthcare Organisations (CHOs)



Community mental health service populations by CHO

	CAMHS		GAMHT		POLL	
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 Later Life (POLL) services covers the 13.4% who are over the age of 65 with the remaining 61.6% of the population covered by the General Adult Mental Health Teams (GAMHT).

'Sharing the Vision – a Mental Health Policy for Everyone' publication can be found on the Government website.

https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/

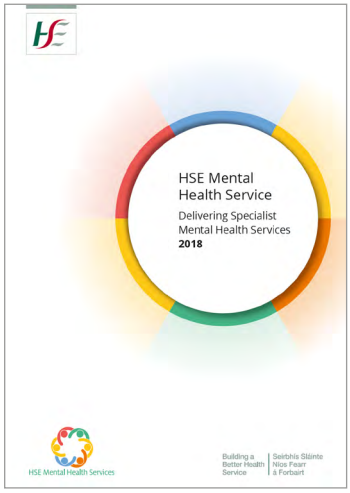
Other publications which provide information on Mental Health can also be found on the HSE website.

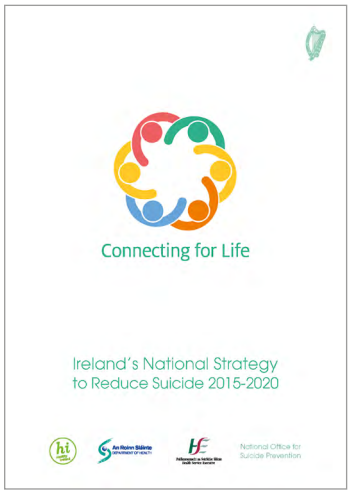
http://www.hse.ie/eng/services/publications/

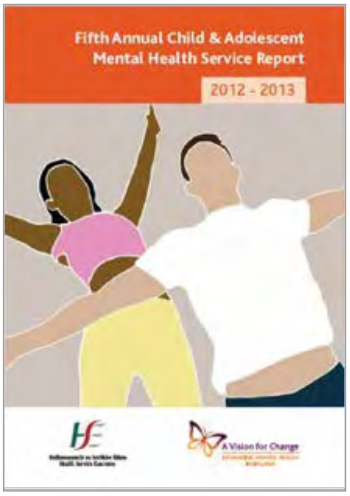
https://www.hse.ie/eng/about/who/cspd/ncps/mental-health/

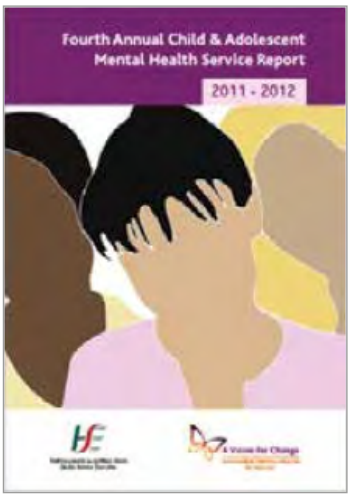
Mental Health Performance Reports can be found at

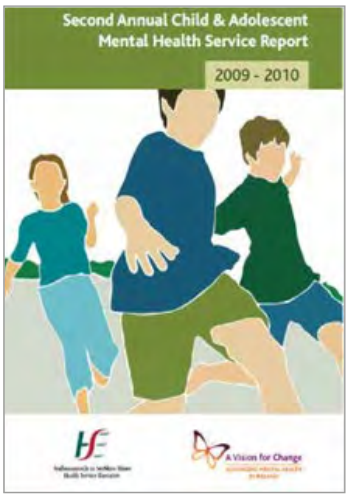
http://www.hse.ie/eng/services/publications/performancereports/











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

HSE Mental Health Services