AN ROINN SLÁINTE
Department of Health

Report of a Working Group on

Child and Adolescent Psychiatric Services in the Eastern Health Board Area

December 1989

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Introduction

Terms of Reference

1. In January 1988 the Minister for Health established a Working Group with the following terms of reference:

   (i) To carry out a review of the present provision of child and adolescent psychiatric services in the Eastern Health Board area which will include an examination of the capacity of the existing services in meeting the total needs of the area.

   (ii) To make recommendations regarding the future organisation of the service in the Eastern Health Board area which will ensure that child and adolescent psychiatric services are delivered in a co-ordinated and rational manner.

Membership

2. The following were appointed members of the Working Group:

Comhairle na n-Ospideal	*Eastern Health Board*	*Department of Health*
Mr D. Doherty	Dr M. Rahill	Mr F. Foley (Chairman)
Professor O.C. Ward	Dr B. O'Herlihy	Dr D. Walsh
Mr G. Martin	Mr M. Walsh	Mr A. Aylward Ms J. Groves (Secretary to the Group)

Number of meetings

3. The Working Group met on fourteen occasions. Visits were made to the Child and Family Services of the Eastern Health Board, Mater

Hospital and the St John of God Order together with visits to Our Lady's Hospital, Crumlin and the Children's Hospital, Temple Street. The Child and Adolescent Psychiatry Specialist Section of the Royal College of Psychiatrists Irish Division was also met. Submissions were received from a number of bodies and a list of these is given at Appendix I.

Acknowledgements

4. We would like to thank the various bodies with whom we had discussions for their generous co-operation and helpfulness, and we are indebted to Alan Aylward for his work in drafting the report, assisted by Joan Groves who arranged our various meetings and visits.

Summary of Recommendations

Chapter 2. Child Psychiatry — Future Organisation of Services.

The Eastern Health Board area should be divided into three catchment areas.

North Dublin City and County in which services would be provided by the Mater Hospital.

South West Dublin and Co Kildare served by the Eastern Health Board and *South East Dublin and Co Wicklow* served by the Order of St John of God.

In the short-term, the existing catchment area division should remain in place. However, immediate steps should be taken to reorganise the catchment areas in line with our recommendations and we see this as being one of the priorities for consideration by the co-ordinating committee referred to in paragraph 2.25 of this Report (2.8).

The Department of Health and Comhairle na n-Ospideal should, as a matter of urgency, examine the problem of the lack of a child and adolescent psychiatric service outside the Eastern Health Board area with a view to bringing about an improvement in this situation (2.12).

The North Dublin consultant team as well as providing community based child psychiatric services throughout the catchment area, would also be responsible for providing all consultant input to the Children's Hospital, Temple Street to cover both liaison psychiatry within the hospital and the Child Sexual Abuse Validation Unit (see recommendation at paragraph 4.5). The consultant team would also be responsible for appropriate child psychiatric input to Beaumont Hospital where a paediatric unit is to be developed. In addition, consultant cover should be provided for the Central Remedial Clinic, Clontarf. The structuring of consultant posts in the short-term should be the subject of discussion, in the first instance, between the authorities of the Mater and Temple Street Hospitals and the Eastern Health Board. New appointments should be structured and/or existing posts restructured in a manner which would allow a number of consultants to have

commitments to the Children's Hospital, Temple Street. All short-term arrangements should be formulated bearing in mind the longer term objective of a single catchment area service covering the whole of North Dublin (2.14).

Both the South-East and South-West Dublin consultant teams should be involved in providing the necessary child psychiatric input to meet the normal requirements of Our Lady's Hospital for Sick Children, Crumlin. In addition, consultant cover should be provided for the Cerebral Palsy Clinic, Sandymount by the South-East Dublin service. It is recommended that the South-West Dublin service should have a particular input to the Child Sexual Abuse Validation Unit (see recommendation at paragraph 4.5) and the consultant attached to that unit should have a formal relationship with the South-West Dublin service. In the longer term, the South-East Dublin service should have an input to the paediatric services planned for St Vincent's Hospital while the South-West Dublin service should have an input to the paediatric unit planned for the new Tallaght Hospital. In the latter respect, the existing relationship between the Eastern Health Board services and the National Children's Hospital, Harcourt Street which is to be incorporated into the new Tallaght Hospital, should be continued and developed on a more formal basis. The structuring of consultant posts in the short-term should be the subject of discussion, in the first instance, between the authorities of Our Lady's Hospital, Crumlin, the St John of God service and the Eastern Health Board. New appointments should be structured and/or existing posts restructured in a manner which would allow a number of consultants from both catchment areas to have commitments to Our Lady's Hospital for Sick Children, Crumlin. All arrangements in the short-term should be formulated bearing in mind the longer term objective of two separate catchment services both linked with the major children's hospital at Crumlin (2.15).

We recommend that the restructuring of consultant posts in the Eastern Health Board area be addressed by the co-ordinating committee referred to at paragraph 2.25. Proposals for the restructuring of consultant posts will of course require the approval of Comhairle na n-Ospideal (2.16).

We consider that the organisation of child and adolescent psychiatric services in the Eastern Health Board area should reflect the policy outlined in "Planning for the Future" and should be firmly based in the community. We believe that the links which already exist with the community care services should be further developed and that greater use should be made of health

centres for the holding of clinics by the child and adolescent psychiatric teams (2.17).

There is a need to develop hospital in-service training programmes for all staff which are geared towards the development of an appreciation of emotional problems in children. The consultant child and adolescent psychiatrist will have an important role to play in the training process though his/her involvement in individual cases should be confined to a small number of difficult problems requiring attention at consultant level (2.18).

Where Departments of Child and Adolescent Psychiatry are located in general hospitals which have no paediatric units, we recommend that these services should be relocated in areas closer to the community which they serve. Specifically, we recommend that the service located at St James's Hospital should be relocated in a more appropriate setting. If the Mater Hospital is to remain a solely adult hospital, we see little justification for a child psychiatric service remaining on that campus (2.19).

Given that the existing school psychological service is concentrated at post-primary level and on career guidance, we are of the view that a service for primary school children would represent a more effective use of available resources (2.20).

We recommend that, apart from referrals from other medical specialists, all cases should be referred to the child and adolescent psychiatric services by the primary care services i.e. general practitioners or other public health medical staff, including the school medical service. The child and adolescent psychiatric services should take the lead role in establishing close links with the primary care services which will involve the provision of advice to these services in the recognition of potential problem children (2.21).

We strongly recommend that a better school psychological service be established by the Department of Education and that links be established between it and the child and adolescent psychiatric services. In view of the impact that the lack of such a service is having on the workload of the child and adolescent psychiatric services, we consider that the Department of Health should pursue this matter with the Department of Education until it is resolved. We also recommend that periodic reviews be undertaken by each of the child and adolescent psychiatric services of their case mix to ensure that the most urgent service needs are being met (2.22).

We recommend that immediate steps be taken to establish a co-ordinating group comprising of the heads of each of the three child and adolescent psychiatric services together with representatives from the paediatric hospitals. This group should meet on a regular basis. The group should be chaired by the Chief Executive Officer, Eastern Health Board or his nominee as the Board has statutory responsibility for the provision of services in the area. We also recommend that the Clinical Directors of the three services should also meet on a regular basis to discuss clinical matters (2.25).

The Department of Health should examine existing anomalies in the method of funding child and adolescent psychiatric services in the Eastern Health Board area to see if a solution can be found (2.26).

We have emphasised the importance of developing close liaison between the child and adolescent psychiatric services and the primary care services so that psychiatric problems in children and young people can be recognised at an early stage and appropriate treatment provided. "Planning for the Future" considered that the training of general practitioners and of public health nurses should have a greater emphasis on psychology to help them recognise a developing emotional problem. The provision of adequate training for primary care personnel can also help to avoid inappropriate referrals to the specialist child and adolescent psychiatric services and enable more cases to be dealt with at primary care level (2.27).

We support the development of the academic aspects of child and adolescent psychiatry and in this connection consideration might be given to converting one of the existing Chairs in Adult Psychiatry for this purpose. We would stress the need for the organisation and development of any such academic department to correspond with the framework of services as outlined in this Report (2.28).

We consider that the function of Warrenstown House/Court Hall as a regional crisis intervention service merits special consideration in relation to the allocation of resources within the overall child and adolescent psychiatric service. This factor will need to be borne in mind in the proposed discussions on the structuring of consultant posts (2.29).

We are satisfied that together with facilities recommended for young people in this Report, the existing residential units will be sufficient to meet the needs of the area (2.29).

Chapter 3. Services for Adolescents.

We recommend that for planning purposes the age range covered by this service should be 12 to 16 years. We would emphasise that the transfer of a young person from the child and adolescent service to the adult service is a matter for clinical judgement. Such transfers should be formalised in order to ensure continuity of care and to avoid patients becoming lost to the system (3.2).

We are glad to note that discussions have been held between the authorities of St Vincent's Hospital, Fairview and the Eastern Health Board regarding the establishment of a north-city community residential adolescent unit at St Josephs, Richmond Road and that it is the intention to provide such a unit there as soon as possible. We consider that it is inappropriate to have residential facilities for adolescents located in an adult psychiatric hospital. It is therefore recommended that the service currently provided in St John of God Hospital, Stillorgan should be relocated in a community residential adolescent unit for the south-city. This facility should be shared by the two south-city catchment area teams (3.4).

The Departments of Health and Education and the Eastern Health Board should explore the possibilities of providing additional residential facilities for young people with intractable conduct disorders with appropriate input from the child and adolescent psychiatric service (3.5).

The Eastern Health Board should continue its present policy of providing domestic scale facilities for adult autistics who cannot live in a home environment. Autistics with major disturbance should be accommodated in facilities for the mentally handicapped (3.5).

Chapter 4. Child Sexual Abuse.

We agree with the approach that the Child Sexual Abuse Validation (C.S.A.V.) Units should be headed by consultant child and adolescent psychiatrists on the basis that the specialist training of the consultant child and adolescent psychiatrist gives him/her an understanding of aspects of the development of children, including the psychological factors involved which govern the child's behaviour and thinking (4.3).

We consider that it is very important to have well trained teams who will develop a particular expertise in dealing with child sexual abuse cases. On the other hand it would be undesirable to have team members working full time on a long-term basis in this area due to the pressure of this type of

work and the need from the professional point of view to be involved in child psychiatric services outside the C.S.A.V. Unit (4.4).

We consider that child sexual abuse should be dealt with as part of the general child and adolescent psychiatric service and that the consultant manpower needs of the C.S.A.V. Units should be dealt with as part of the team approach and the overall structuring of consultant posts which we have recommended earlier in this Report. The responsibility for validation should rest with the units concerned with appropriate consultant input from the child and adolescent psychiatric services. Children requiring follow-up treatment should be referred to the appropriate service by the Validation Unit. We are accordingly recommending that the two temporary consultant posts assigned to the C.S.A.V. Units should be structured on the basis of permanent joint appointments between the hospitals concerned and the appropriate child and adolescent psychiatric service as set out in paragraphs 2.14 and 2.15 of this Report (4.5).

Chapter 1.

Current Provision of Services and Future Needs.

1.1 Three different services provide child and adolescent psychiatric services for the Eastern Health Board area with particular catchment areas assigned to each service. These are the Eastern Health Board service which covers Community Care Areas 5,6, part of Area 3 and Co Kildare; the Mater service which covers Areas 7 and 8 and the St John of God Service, which covers Community Care Areas 1,2,3, 4 and Co Wicklow (the Co Wicklow service is not yet fully established). An outline of the facilities provided by each of these services is given at Appendix II.

1.2 Our terms of reference presented us with the task of evaluating whether the present level and structure of child and adolescent psychiatric services within the Eastern Health Board area were appropriate for the delivery of a co-ordinated and effective service. We approached this task by concentrating on the organisational aspects of the service with a view to developing a broad strategic plan for the future delivery of a child and adolescent psychiatric service in the Eastern Health Board area. We did not attempt to undertake an in-depth evaluation of the role and function of a child and adolescent psychiatric service. We were also mindful of the recommendation contained in the Report of the Study Group on the Development of Psychiatric Services — "Planning for the Future" of the necessity "to review current services in the Eastern Health Board with the aim of achieving better co-ordination and rationalisation".

1.3 We examined the nature and level of the workload of each of the child and adolescent psychiatric services, including the services provided at the paediatric hospitals and the special Child Sexual Abuse Validation Units located at Our Lady's Hospital, Crumlin and the Children's Hospital, Temple Street.

We specifically looked at the following data which was supplied by each of the agencies:

— Staffing

— Number and location of clinics and number of attendances at clinics

— Catchment area covered by service

— Extent of case load and waiting list

— Breakdown of case load by community care area/county, by age and sex, by diagnosis and by source of referral

— Description as to how cases are dealt with

1.4 We were conscious of the fact that this information would give an indication of the workload of the child and adolescent psychiatrist and his/her team insofar as diagnosis and treatment is concerned but would not adequately reflect the role of the consultant in relation to consultation with other professionals and administrators, preventive work and research and development. However, as it would be very difficult to quantify many of these aspects of the consultant's workload, we are satisfied that the statistical information received, together with our discussions with the agencies involved and the Royal College of Psychiatrists, have given us sufficient insight into the range of activities carried out by the child and adolescent psychiatric services to enable us to put forward recommendations as to the future organisation of these services in the Eastern Health Board area.

1.5 Apart from the current provision of services we also had to consider service requirements in future years.

Population Trends

The Central Statistics Office Publication "Population and Labour Force Projections 1991—2021" contains a range of population projections up to the year 2021 based on a number of assumptions

relating to migration and fertility. Based on current trends in relation to changes in fertility rates and taking into account the levels of migration in recent years, the total population for this country in the year 2021 is projected at 3.347 million, a reduction of approximately 5% on the 1986 census figure. However, if we examine the population projections for the 0—19 age group using the same criteria, we find that the population in this age group is projected at 822,000, a reduction of 39% on the 1986 census figure. Also the number of people in the 0—19 age group as a proportion of the total population is projected to decrease from 38% (1986 Census) to approximately 24% by 2021. The projections outlined here are based on current trends in fertility and migration. Given the unpredictable nature of population trends and taking into account various likely permutations relating to fertility and migration rates, it is clear that there is likely to be a significant reduction in the 0-19 population over the next 30 years. This, of course, will have implications for the child and adolescent psychiatric services.

1.6 Prevalence of Child Psychiatric Disorders

Accurate epidemiological information is essential in order to assess the need for services. A number of studies carried out to determine levels of psychiatric problems among children have varied considerably in their findings. Investigations in the United Kingdom have suggested that between 5% and 18% of children have psychiatric disorder. A number of screening studies have been carried out in this country. While screening studies are not definitive, the results of these particular surveys indicate higher rates of behavioural deviance in this country than in the U.K. Not all affected children need psychiatric care, especially at consultant level, but available figures indicate that the need for child psychiatric services is substantial.

The following are the results which emerged from studies carried out in this country.

A screening study carried out on pre-school children rated 33% of boys and 3% of girls as behaviourally deviant. In the same study 50% of the mothers of these children were rated as depressed and 40% as anxious on a screening questionnaire.[1]

In a study of 10-11 year old girls, 5% of social class 1 and 2 were rated as behaviourally deviant and 32.7% of social class 4 and 5 were rated as behaviourally deviant.[2] In another study 37% of boys were rated as behaviourally deviant in an urban area as compared to 18% of boys in a rural town. 33% of girls in an urban area were rated as behaviourally deviant as compared with 6% of girls in a rural town.[3] A study of behavioural deviance in Ireland and Malaysia found that levels of behavioural deviance in children were the same in the two cultures. The rates of anxiety and depressive symptoms in mothers were significantly higher in the Irish sample.[4] The total population of 10 and 11 year old boys in an urban primary school in a working class area was studied using interview methods. The prevalence of child psychiatric disorder was found to be 18.6%. This survey probably represents the most accurate finding as it was done using standard psychiatric techniques.[5]

In an epidemiological study of behavioural deviance, hyperactivity and physical abnormalities in a primary school population, 39.5% behavioural deviance was found on teachers' questionnaires. 21.2% hyperactivity was found on the activity rating scale. A prevalence of cross laterality of 46% and soft neurological signs of 30% was found.[6] A study of the prevalence of sleep related disorders and bed wetting of children of mothers attending a public health clinic found that 26.7% of boys and 32.2% of girls had a sleep disorder. 25% of four year old boys and 20% of 6 year old boys had bed wetting. For girls the figures were 50% for 4 year olds and 14% for those over 6 years.[7] A survey was carried out which looked at all children with possible diagnosis of autism in the Eastern Health Board and came up with a rate of 4 per 10,000 which is the standard figure.[8] Finally, a study was commissioned by the Mid-Western Health Board to ascertain the prevalence of problems among school going children in relation to psychological adjustment, intellectual functioning and educational achievement. This survey covered a broad range of pupils, in city, town and rural schools. It showed a psychological maladjustment rate of 14% (corrected). Prevalence of conduct and emotional problems was only slightly greater among males than females but there were distinct differences between the prevalence of conduct disorders and of emotional problems. In rural schools 5 times more children were identified as having conduct

problems as against emotional problems. In a city school in a disadvantaged area the ratio was 2:1.[9]

1.7 In summary therefore while general population surveys on the prevalence of child psychiatric disorders have never been undertaken in this country, the various screening studies so far indicate higher rates of disorder in children from disadvantaged areas and higher rates in urban areas. In addition, the view that with the greater proportion of children in our population at present, the number of children with emotional problems relative to the total population is greater in Ireland than in the U.K. seems to be borne out in these studies.

1.8 The impact which the factors outlined in this chapter will have on the workload of the child and adolescent psychiatric services is difficult to predict. While it appears that there will be a significant reduction in the numbers of children and young people in this country in future years, this may be offset to a certain degree by the increasing complexity of problems presenting in large urban areas particularly where there is social deprivation.

Workload and Organisational Problems

1.9 "Planning for the Future" referred to the severe social and environmental problems within the Eastern Health Board area which have given rise to a large number of highly vulnerable families where children are at considerable risk of emotional maladjustment. It is clear from our examination of the activities of the child and adolescent psychiatric services that these services are being asked to deal with a range of problems in the family which can be directly linked to social, economic and environmental factors and that a number of these services have a considerable workload to deal with. We were primarily concerned with the organisational aspects of the service and we have come to the conclusion that organisational problems exist within the services provided in the Eastern Health Board area which are adversely affecting their capacity to meet real needs. We have accordingly made a number of recommendations which we consider will help to overcome many of these problems.

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Chapter 2.

Child Psychiatry — Future Organisation of Services.

Responsibility for Services

2.1 One of the major difficulties in providing a co-ordinated and comprehensive child and adolescent psychiatric service within the Eastern Health Board area arises from the manner in which responsibilities for the provision of services are distributed between the agencies involved. For example two of the child and adolescent psychiatric services have an input into Our Lady's Hospital, Crumlin and Temple Street Hospital, with one service having an input into both while the third service has no input into either hospital.

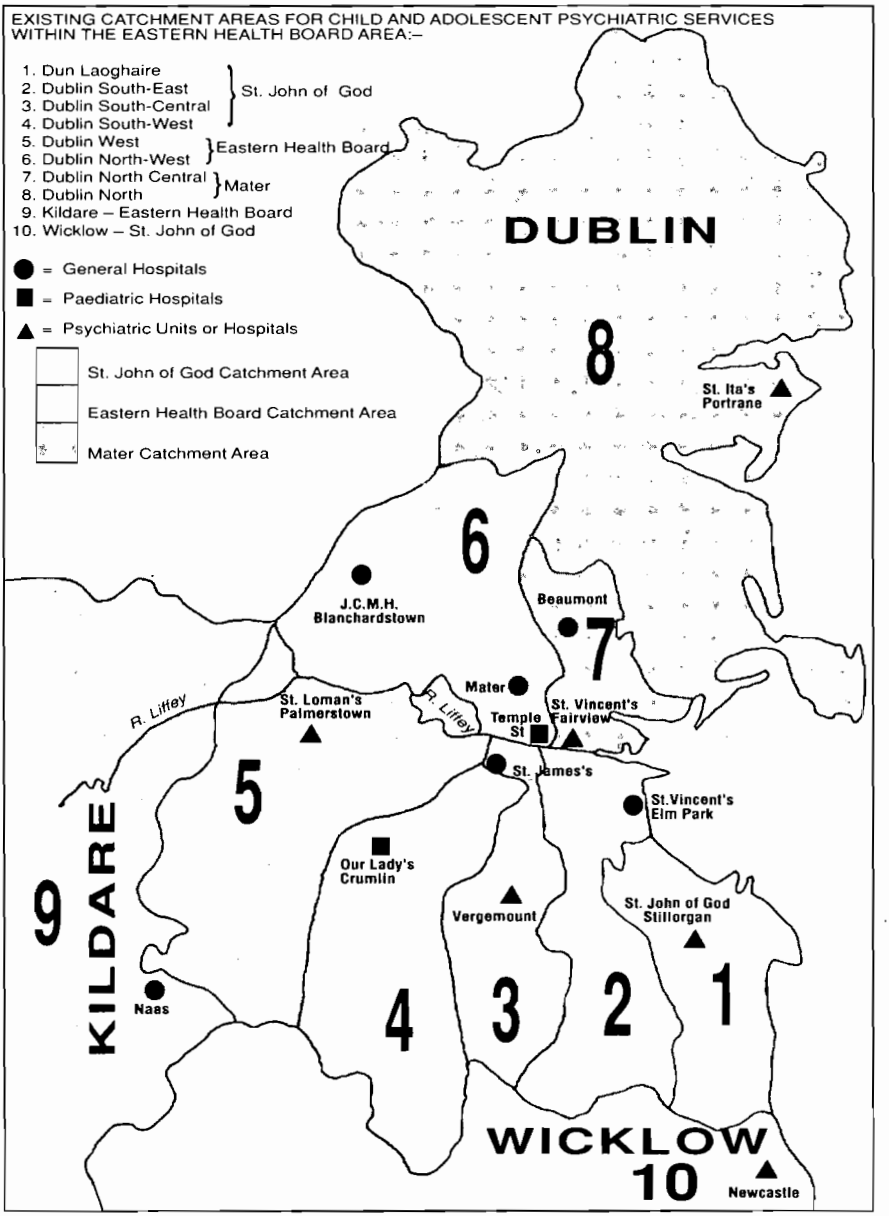
2.2 As stated earlier, we have concentrated on the organisational aspects of the service and we are making recommendations regarding the re-organisation of the service under a number of headings and these are contained in the following paragraphs.

Catchment areas

2.3 Child and adolescent psychiatric services are provided in the Eastern Health Board area broadly speaking on a catchment area basis as follows:

Service	Catchment Area	Population	No. of Consultant Child and Adolescent Psychiatrists
St John of God Service	Community Care Areas 1, 2, 3, 4 and 10 (service not developed in Area 10)	542,563	6
Eastern Health Board Service	Community Care Areas 3 (part of), 5, 6 and 9	380,639	5
Mater Service	Community Care Areas 7 and 8	309,036	4
	Total	1,232,238	15

These catchment areas are outlined in the following map:



Future Development of Services

2.4 While these catchment areas are clear in theory, in practice there is an amount of overlapping of services and a lack of clear definition of which service is responsible for a particular geographical area. Such a situation can only hinder the development of a co-ordinated approach to the delivery of child and family services. If a service is provided for a region based on a division into different catchment areas, it can only be effective if each agency is prepared to provide a comprehensive service for its particular area.

We accept that there will be instances where one agency may require access to a facility which is available in the catchment area of another agency and it is important that there are agreed liaison arrangements to deal with such matters. We will be discussing co-ordination and liaison arrangements later in the Report.

2.5 In our deliberations regarding the division of the catchment areas, our primary concern was to ensure that our recommendations would facilitate the provision of a child and adolescent psychiatric service which is fully integrated with the primary care services, paediatric service and adult psychiatric services. In this connection, we looked at the division of the Eastern Health Board region into community care areas and the future plans for the development of paediatric and adult psychiatric services. While the child and adolescent psychiatric services should continue to be firmly based in the community, close links will need to be established with the paediatric and adult psychiatric services so that the needs of these services for each others specialist input can be met. In the future, general paediatric and adult acute psychiatric services in the Eastern Health Board area will, for the most part, be attached to general hospitals. With regard to paediatric services, Crumlin and Temple Street Hospitals will of course continue to discharge their specialist paediatric role, in structured association with the general hospitals. Our recommendations are formed to fit in with such a structure.

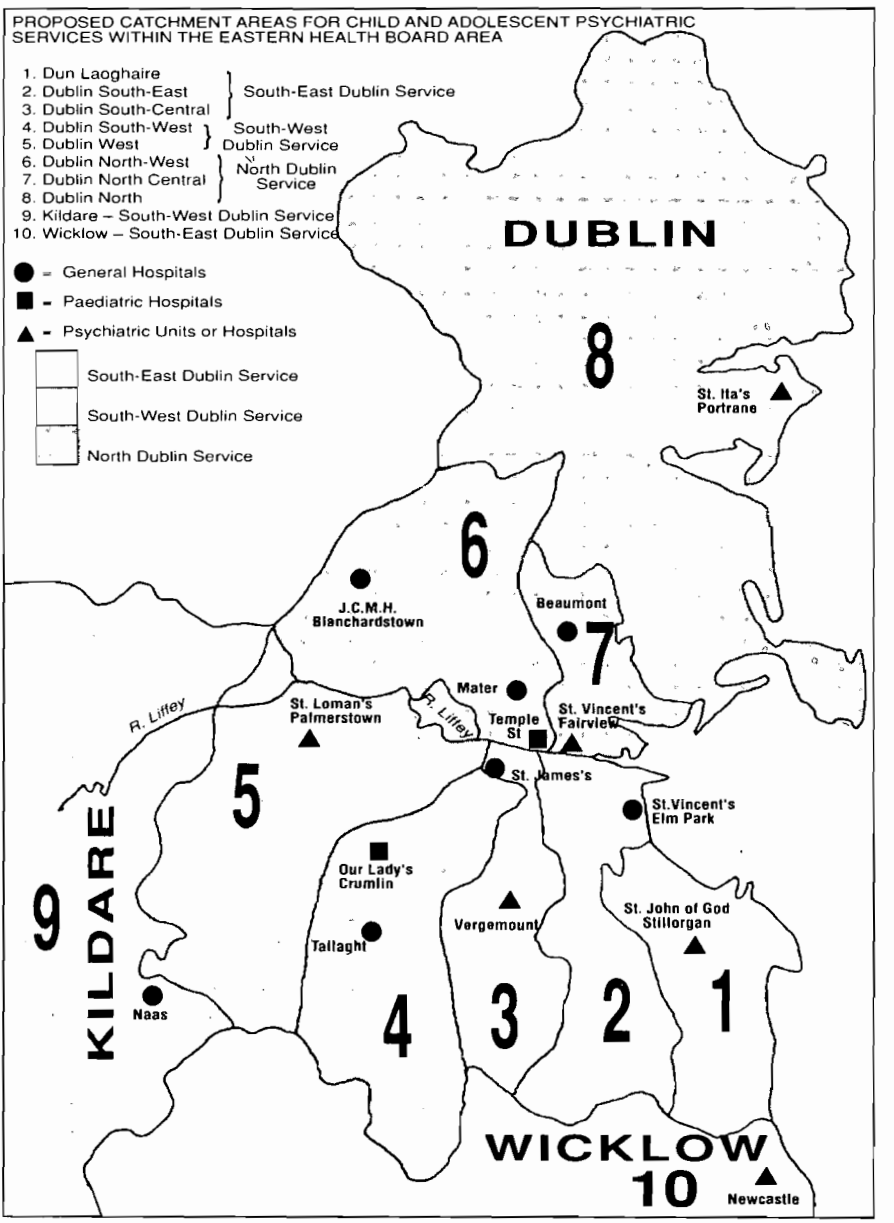
2.6 We have considered, from the long-term viewpoint, the question of the optimum catchment area size and distribution of workload in child and adolescent psychiatry as between the different catchment area teams. Bearing in mind the latter consideration, it seems reasonable that, irrespective of how many catchment areas there might be, they should be more or less equal in the size of the

population they serve and in the number of consultants whose activity they would encompass. At catchment area level, the number of consultants should be sufficient to facilitate good cross-cover between them to cope with inevitable absences (e.g. holidays, sickness, study leave, etc.) and also to enable a reasonable degree of special interests (e.g. sexual abuse, adolescent problems, etc.) to emerge in the future. Due regard must also be had to the agencies which are currently providing the services, their investment over the years in building up the services and their aspirations for the future. Finally, as indicated in the previous paragraph, the catchment areas in order to ensure integration should be co-terminus with the community care areas, the adult psychiatric catchment areas, and the general hospital catchments. It is also necessary to ensure that each child and adolescent psychiatric team should have an involvement in one of the two specialised children's hospitals where their in-put will be necessary to provide, inter alia, for liaison psychiatry and for child sexual abuse validation activities.

2.7 *Bearing in mind all of the considerations outlined in paragraphs 2.5 and 2.6 we recommend the following division of catchment areas within the Eastern Health Board region as shown in the following table:*

Service	*Catchment Area (Community Care Area)*	*Population*	*Paediatric Facility*	*Adult Psychiatry*
South-East Dublin Service	1, 2, 3 and 10	418,782	St Vincent's, Elm Park and Crumlin	St James's St John of God, Stillorgan, St. Vincent's, Elm Park, Vergemount, Clonskeagh Newcastle C.C. Areas 1, 2, 3 and 10
South-West Dublin Service	4, 5 and 9	368,292	Tallaght and Crumlin	Tallaght Naas St Loman's C.C. Areas 4, 5 and 9
North Dublin Service	6, 7 and 8	445,164	Mater/Temple Street Beaumont	Mater/ St Vincent's Fairview J.C.M.H. Blanchardstown St Ita's Beaumont C.C. Areas 6, 7 and 8

The following map illustrates the proposed changes:



2.8 The net effect of the recommended changes is that the Eastern Health Board area would be divided into three catchment areas: *North Dublin City and County* in which services would be provided by the Mater Hospital.

South West Dublin and County Kildare served by the Eastern Health Board and *South East Dublin and County Wicklow* served by the Order of St John of God.

This recommendation would result in a continuation of three catchment areas but with responsibility for Community Care Area 6 (population 136,000) transferring from the Eastern Health Board to the Mater service. In addition, responsibility for Community Care Area 4 (population 150,000) would transfer from the St John of God service to the Eastern Health Board service and the St John of God service would take on responsibility for developing a service in Community Care Area 10 (Co Wicklow — population 95,000). We recognise that these proposed changes may give rise to certain difficulties particularly for the St John of God and the Eastern Health Board child and adolescent psychiatric services insofar as these agencies have commitments and have invested considerable resources into Community Care Areas 4 and 6 respectively. *We are recommending therefore that in the short-term the existing catchment area division should remain in place. However, immediate steps should be taken to reorganise the catchment areas in line with our recommendations and we see this as being one of the priorities for consideration by the co-ordinating committee referred to in Paragraph 2.25 of this Report.*

Consultant Staffing in the Eastern Health Board Area

2.9 Child and adolescent psychiatric services in the Eastern Health Board area are provided by three teams of consultant child and adolescent psychiatrists with each team headed by a Clinical Director. The individual consultant heads a multidisciplinary team which usually comprises of psychologists and social workers. In the Eastern Health Board region, services are provided in Child Guidance Clinics, Departments of Child and Adolescent Psychiatry attached to general and paediatric hospitals, Child and Family Centres and Residential

Treatment Units. A consultation and assessment service is provided to children's homes and to centres for the assessment and rehabilitation of young people with problems of delinquency.

2.10 As the multidisciplinary team is headed by the child and adolescent psychiatrist, we have concentrated on examining the number and structure of child and adolescent psychiatrist posts in the Eastern Health Board area. The regulation of the number and type of consultant posts is, of course, the statutory responsibility of Comhairle na n-Ospideal which will make the final decisions on consultant manpower for the specialty. The number of approved consultant child psychiatrist posts in the E.H.B. area is 15 or 2 consultants per 164,000 total population. In addition there are two temporary posts attached to the Child Sexual Abuse Validation Units at Our Lady's Hospital, Crumlin and Temple Street Hospital which gives a ratio of 2 consultants per 145,000 total population which includes regional and supra-regional activities presently in the Eastern Health Board area.

2.11 The Royal College of Psychiatrists' recommendations on consultant staffing propose a ratio of 2 consultant child and adolescent psychiatrists for a population of 200,000 with the staffing of regional and supra-regional units being additional to this. The Irish Division of the Royal College of Psychiatrists has suggested that this ratio may be inadequate because of the different population structure in this country from that of the U.K. with a high proportion of young people, large numbers of vulnerable families in urban areas and an inadequate school psychological service.

2.12 In tackling this question, we also had to have regard to the considerable imbalance between the number of consultant posts in the Eastern Health Board area and in other health board areas. For example, there are currently fifteen approved posts of consultant child and adolescent psychiatrist in the Eastern Health Board area while there are three such posts in the rest of the country.

While our terms of reference precluded us from dealing with the situation outside the Eastern Health Board area, nevertheless, we had to consider those areas which are currently depending on agencies within the Eastern Health Board area for a child and

adolescent psychiatric service. We have examined the statistics received from each of the agencies within the Eastern Health Board area and it is clear that in general the quantum of service provided by these agencies for cases from outside the Eastern Health Board area is quite small. Given the level of demand for services within the Eastern Health Board where specialist child and adolescent psychiatric services are in place, there is obviously a need for such a service for a large proportion of the population outside the Dublin area which is not being met. This is a source of grave concern to us and *we recommend that the Department of Health and Comhairle na n-Ospideal should, as a matter of urgency, examine the problem with a view to bringing about an improvement in this situation.*

2.13 We advocate the concept that, within each of the three catchment areas in the E.H.B. area, the consultants involved should function as a team sharing, in a collective manner, responsibility for providing child psychiatric services at consultant level to the community and the hospitals (both children's and general hospitals with paediatric units) within the catchment area. It would be a matter for the members of the consultant team to organise themselves to discharge these responsibilities and to support one another in maintaining services on a continuous basis throughout the catchment area. Because of different hospital management authorities being involved, it may be necessary for some, though not necessarily all, posts to be formally structured with the approval of Comhairle na n-Ospideal to include a hospital commitment agreed with the hospital authorities concerned but these should be backed up by the consultant team to ensure continuity of services during absences.

North Dublin

2.14 The long-term recommendations (see paragraph 2.8) envisage North Dublin being designated as a single catchment area. *The consultant team as well as providing community based child psychiatric services throughout the catchment area, would also be responsible for providing all consultant input to the Children's Hospital, Temple Street to cover both liaison psychiatry within the hospital and the C.S.A.V. unit (see paragraph 4.5 in Chapter 4). The consultant team would also be responsible for appropriate child psychiatric input to Beaumont Hospital where a paediatric unit is to be developed. In addition, consultant cover*

should be provided for the Central Remedial Clinic, Clontarf. The structuring of consultant posts in the short-term should be the subject of discussion, in the first instance, between the authorities of the Mater and Temple St Hospitals and the Eastern Health Board. New appointments should be structured and/or existing posts restructured in a manner which would allow a number of consultants to have commitments to the Children's Hospital, Temple Street. All short-term arrangements should be formulated bearing in mind the longer term objective of a single catchment area service covering the whole of North Dublin.

South Dublin, Kildare and Wicklow

2.15 The long term objective is to develop two separate catchment area services with the Eastern Health Board service catering for South-West Dublin and Co Kildare and the St John of God service catering for South-East Dublin and Co Wicklow. Since there is only one large Children's Hospital — Our Lady's Hospital for Sick Children, Crumlin — *both services should be involved in providing the necessary child psychiatric input to meet the normal requirements of the Hospital. In addition, consultant cover should be provided for the Cerebral Palsy Clinic, Sandymount, by the South-East Dublin service. It is recommended that the South-West Dublin service should have a particular input to the C.S.A.V. Unit (see paragraph 4.5 in Chapter 4) and the consultant attached to that unit should have a formal relationship with the South-West Dublin service. In the longer term, the South-East Dublin Service should have an input to the paediatric services planned for St Vincent's Hospital while the South-West Dublin service should have an input to the paediatric unit planned for the new Tallaght Hospital. In the latter respect, the existing relationship between the E.H.B. services and the National Children's Hospital, Harcourt St which is to be incorporated into the new Tallaght Hospital, should be continued and developed on a more formal basis. The structuring of consultant posts in the short-term should be the subject of discussion, in the first instance, between the authorities of Our Lady's Hospital, Crumlin, the St John of God service and the Eastern Health Board. New appointments should be structured and/or existing posts restructured in a manner which would allow a number of consultants from both catchment areas to have commitments to Our Lady's Hospital for Sick Children, Crumlin. All arrangements in the short-term should be formulated bearing in mind*

the longer term objective of two separate catchment services both linked with the major children's hospital at Crumlin.

2.16 *We recommend that the restructuring of consultant posts in the Eastern Health Board area be addressed by the co-ordinating committee referred to in paragraph 2.25. As stated earlier, proposals for the restructuring of consultant posts will require the approval of Comhairle na n-Ospideal.*

Location of Services

2.17 "Planning for the Future" states that "children are best understood in their everyday environment of home and school, and assessment and treatment should be carried out in these settings. The practice of child psychiatry, therefore, is based in the family and community, and admission to residential settings is rarely necessary".

We consider that the organisation of child and adolescent psychiatric services in the Eastern Health Board area should reflect this policy and should be firmly based in the community. We believe that the links which already exist with the community care services should be further developed and that greater use should be made of health centres for the holding of clinics by the child and adolescent psychiatric teams.

2.18 We are aware of the need to increase the level of psychiatric services provided to the paediatric hospitals in Dublin. These hospitals have indicated their serious concern about the level of service provision particularly in the areas of liaison psychiatry and psychiatric services for children and adolescents with long-term physical illness. The Central Remedial Clinic and the Cerebral Palsy Clinic also require a psychiatric input to cater for children and adolescents with physical handicaps who are treated at these clinics. Apart from the provision of adequate consultant child and adolescent psychiatric input to these services which we have recommended earlier in this Report, *there is a need to develop hospital in-service training programmes for all staff which are geared towards the development of an appreciation of emotional problems in children. The consultant child and adolescent psychiatrist will have an important role to play in the training process though his/her involvement in individual cases should be confined to a*

small number of difficult problems requiring attention at consultant level.

2.19 We have referred earlier to the need for an integrated approach to the delivery of child and adolescent psychiatric services. This involves the child and adolescent psychiatric service developing close links with the primary care services, adult psychiatric services (for both service provision and training), paediatric services, mental handicap services and the school psychological services. We are convinced that such an integrated approach is the only way in which a comprehensive and effective service can be provided for children who are most in need of services. We have therefore examined the requirements of particular services such as the paediatric hospitals in this light. In addition to the needs of the paediatric hospitals, we fully accept that the child and adolescent psychiatrist requires ready access to medical diagnostic facilities and consultation with paediatric and other specialist colleagues. "Planning for the Future" stresses the importance of the child and adolescent psychiatric teams developing close links with paediatric departments. These requirements can be achieved through association with a paediatric hospital or a general hospital with a paediatric unit.

Two of the existing services in the Eastern Health Board area have Departments of Child and Adolescent Psychiatry located in general hospitals which have no paediatric units. *We recommend that these services should be relocated in areas closer to the community which they serve.* People most in need of services are frequently not in a position to travel distances to Child and Adolescent Psychiatric Clinics and we would cite the success of a Child and Family Centre which is located in the Ballymun Shopping Centre to support our recommendation here. *Specifically, we recommend that the service situated at St James's Hospital should be relocated in a more appropriate setting. If the Mater Hospital is to remain a solely adult hospital, we see little justification for a child psychiatric service remaining on that campus.*

Methods of Referral

2.20 The manner in which cases are referred to the child and adolescent psychiatric services has an important bearing on the workload of

these services and their capacity to meet service requirements. If the child and adolescent psychiatric teams are to operate a secondary or tertiary referral service, adequate screening and intervention at primary care level must exist. It is clear that there is a wide variation in the method of referral to child and adolescent psychiatric clinics. For example, in one service a large proportion of referrals come directly from schools without any medical involvement at primary level. While the argument has been made that wider referral by parents or school authorities presents better prospects for preventing problems developing in children through early intervention, we feel that the operation of a child and adolescent psychiatric service in this manner does not represent the best use of a highly skilled specialist resource. It seems to us that an open ended referral system to secondary care can lead to a distortion of the case mix and workload within a service and inhibit its effectiveness in dealing with children and young people who are most in need of help. In offering this opinion, we are conscious of the fact that the child and adolescent psychiatric services are being asked to operate in a situation where there is an inadequate school psychological service. Such a service could in many instances intervene at an early stage in cases of learning difficulties thereby preventing the onset of subsequent emotional problems requiring the input of the child and adolescent psychiatric team. The existing school psychological service is concentrated at post-primary level and on career guidance. *We are of the view that a service for primary school children would represent a more effective use of available resources.*

2.21 If the specialist skills of the child and adolescent psychiatric team are to be used to the maximum benefit, there will have to be a rationalisation of the methods of referral to the service. *We recommend that, apart from referrals from other medical specialists, all cases should be referred by the primary care services i.e. general practitioners or other public health medical staff including the school medical service.* We recognise that the community care services have many demands placed on them and that they may require additional resources to carry out this function. *The child and adolescent psychiatric services should take the lead role in establishing close links with the primary care services which will involve the provision of advice to these services in the recognition of potential problem children.*

2.22 According to information supplied to us by one of the agencies providing child and adolescent psychiatric services in the E.H.B. area, 36% of cases dealt with by its service were referrals from schools. *We strongly recommend that a better school psychological service be established by the Department of Education and that links be established between it and the child and adolescent psychiatric services. In view of the impact that the lack of such a service is having on the workload of the child and adolescent psychiatric services, we consider that the Department of Health should pursue this matter with the Department of Education until it is resolved. We also recommend that periodic reviews be undertaken by each of the child and adolescent services of their case mix to ensure that the most urgent service needs are being met.*

Co-ordination and liaison

2.23 One of the principal shortcomings which we found in the current provision of child and adolescent psychiatric services was the lack of a co-ordinated approach to the delivery of a comprehensive service. This situation has manifested itself in the structure of consultant posts, designation of catchment areas, linkages with paediatric hospitals, arrangements for the transfer of cases between services, etc.

2.24 We have already referred to the importance of establishing close links between child and adolescent psychiatric services and the primary care services, paediatric and adult psychiatric services, mental handicap services and the school psychological services. However, of equal importance is the establishment of effective liaison arrangements between the three child and adolescent psychiatric services in the Eastern Health Board area. We fully agree with the recommendation in "Planning for the Future" that formal arrangements be made, involving representatives from the existing services, both health board and voluntary, to develop a co-ordinated policy for the delivery of child and adolescent psychiatric services throughout the E.H.B. area and to monitor its implementation.

2.25 *We recommend that immediate steps be taken to establish a co-ordinating group. This group should comprise of the heads of each of the three services together with representatives from the paediatric*

hospitals and should meet on a regular basis. The Group should be chaired by the Chief Executive Officer, Eastern Health Board or his nominee as the Board has statutory responsibility for the provision of services in the area. We also recommend that the Clinical Directors of the three services should also meet on a regular basis to discuss clinical matters.

2.26 We have also been made aware of anomalies in the method of funding the child and adolescent psychiatric service within the E.H.B. area. The child and adolescent psychiatric services of the Eastern Health Board, the Mater service and the Cluain Mhuire catchment of the St John of God service is funded through the Eastern Health Board while the Orwell Road catchment of the St John of God service is funded directly by the Department of Health. We consider that such a parallel system of funding is inequitable and is an obstacle in the way of developing better co-ordination. *We recommend that the Department of Health should examine those anomalies to see if a solution can be found.*

Training and Research

2.27 *We have emphasised the importance of developing close liaison between the child and adolescent psychiatric services and the primary care services so that psychiatric problems in children and young people can be recognised at an early stage and appropriate treatment provided. "Planning for the Future" considered that the training of general practitioners and of public health nurses should have a greater emphasis on psychology to help them recognise a developing emotional problem. The provision of adequate training for primary care personnel can also help to avoid inappropriate referrals to the specialist child and adolescent psychiatric services and enable more cases to be dealt with at primary care level.*

2.28 In undertaking the examination of the organisation of services in the Eastern Health Board, we were struck by the lack of epidemiological and clinical research in child and adolescent psychiatry. Research of this kind is required to plan future treatment programmes. *Both "Planning for the Future" and the Royal College of Psychiatrists support the development of the academic aspects of child and adolescent psychiatry and we also support this view. Consideration might be given*

to converting one of the existing Chairs in Adult Psychiatry for this purpose. In any event, the funding of such a development is a matter for the medical schools. We would stress the need for the organisation and development of any such academic department to correspond with the framework of services as outlined in this Report.

Residential Facilities

2.29 The existing residential units at Orwell Road, Warrenstown House, Court Hall, Mulhuddart and St Paul's Beaumont provide services for children from outside the Eastern Health Board area in addition to a catchment area service within the region. A crisis intervention service is also provided at Warrenstown House/Court Hall for particularly difficult cases which are referred by the other agencies within the Eastern Health Board and by other health boards. *We consider that the function of Warrenstown House/Court Hall merits special consideration in relation to the allocation of resources within the overall child and adolescent psychiatric service and this factor will need to be borne in mind in the proposed discussions on the structuring of consultant posts.*

We have examined the residential requirements for children and adolescents within the Eastern Health Board area *and we are satisfied that together with facilities recommended for young people in Chapter 3, the existing residential units will be sufficient to meet the needs of the area.*

Chapter 3.

Services for Adolescents.

3.1 In the Eastern Health Board area adolescent services are based at Cluain Mhuire, Blackrock and at St Vincent's Hospital, Fairview. The service at Cluain Mhuire consists of a day hospital and rehabilitation programme and an in-patient service in the St John of God Hospital, Stillorgan. A day hospital service is available at St Vincent's Hospital, Fairview.

3.2 The traditional age structure dealt with by the adolescent psychiatric service has been from the onset of puberty up to 16 years of age. In these few areas where specific adolescent services exist, the concept of psychological adolescence rather than chronological age applies. In practice there is a flexibility in the system insofar as a particular young person might be dealt with by the children's service, the adolescent service or by the adult psychiatric service or a combination of these, depending on the age of the young person and the condition involved. While recognising that flexibility exists in relation to the age structure covered by the adolescent psychiatric services, we considered that it would be essential for planning purposes to establish "cut-off" ages in adolescent psychiatry and *we recommend that for planning purposes the age range covered by this service should be 12 — 16 years. We would emphasise that the transfer of a young person from the child and adolescent service to the adult service is a matter for clinical judgement. Such transfers should be formalised in order to ensure continuity of care and to avoid patients becoming lost to the system.*

3.3 Adolescent psychiatric services have traditionally come under the umbrella of the child psychiatric service although there are close links between the adolescent and adult services. From our discussions with the Royal College of Psychiatrists and the agencies involved the point has been made that adolescents have unique service needs which cannot be fully met by either the child or adult services. Many

adolescents are reluctant to seek help and tend to be sensitive about attending a psychiatrist on an individual basis. The differences between psychiatric resources and facilities for adolescents and those for younger children need to be recognised in the planning and organisation of services.

In looking at adolescent psychiatric services in the Eastern Health Board area, we were conscious of the particular difficulties faced by this age group in coping with the pressures of life particularly in large urban areas and of the increase in disturbed behaviour among this group.

There are a number of deficits in the provision of services for adolescents in the Eastern Health Board area which need to be addressed.

Acute Psychotic Disorders in Young People aged 14-16 years

3.4 Each of the agencies has indicated to us the need for the provision of services to deal with acute psychotic disorders in young people. The Royal College of Psychiatrists has indicated that young people who may have a psychotic depressive illness or an acute schizophrenic illness frequently need a short period of in-patient treatment for their own protection and in order to start them on appropriate medication. Following in-patient treatment they will continue to need out-patient follow up. The College has referred to the difficulty in finding an in-patient facility willing to take such young people. The children's units frequently do not have the security of accommodation and level of staffing that such psychotic young people require for their treatment, and the adult psychiatric in-patient services are extremely reluctant to take young people under the age of 16 years as they believe an acute admission ward of a psychiatric hospital is not the appropriate setting to treat such young people.

The adolescent psychiatric service attached to Cluain Mhuire Child and Family Centre, Blackrock provides an out-patient service with access to a small number of beds in St John of God Hospital, Stillorgan for psychotic adolescents residing within its catchment area. Outside of the Cluain Mhuire catchment area there is no service with access to in-patient beds. The College has recommended that

the provision of such a service should be strongly considered and that it might be located in St Vincent's Psychiatric Hospital in Fairview where such adolescents could then attend St Joseph's adolescent day programme based in the grounds of St Vincent's Hospital, Fairview, when their condition permits.

We are glad to note that discussions have been held between the authorities of St Vincent's Hospital, Fairview and the Eastern Health Board regarding the establishment of a north-city community residential adolescent unit at St Joseph's, Richmond Road and that it is the intention to provide such a unit there as soon as possible. We consider that it is inappropriate to have residential facilities for adolescents located in an adult psychiatric hospital. We therefore recommend that the service currently provided in St John of God Hospital, Stillorgan should be relocated in a community residential adolescent unit for the south-city. This facility should be shared by the two south-city catchment area teams.

Deficits Requiring Child and Adolescent Psychiatric Support

3.5 The following service deficits which we have identified as requiring attention are not the sole responsibility of the child and adolescent psychiatric services. These services will, however, require allied support from the child and adolescent psychiatric services.

Intractable Conduct Disorders

Young people are being referred in increasing numbers to short-term residential assessment centres. These are frequently from very disturbed family backgrounds where their behaviour cannot be handled in a normal school environment or in some cases within the families. The longer term placement of these cases is limited for boys and non existent for girls. *We recommend that the Departments of Health and Education and the Eastern Health Board should explore the possibilities of providing additional residential facilities for these young people with appropriate input from the child and adolescent psychiatric service.*

Autistic/Mental Handicap

Services for autistic children are available in the Eastern Health Board area but more residential outlets are required for older teenage autistic/mental handicap children as they reach adulthood. *We*

recommend that the Eastern Health Board should continue its present policy of providing domestic scale facilities for adult autistics who cannot live in a home environment. Autistics with major disturbance should be accommodated in facilities for the mentally handicapped.

Chapter 4.

Child Sexual Abuse.

4.1 Child sexual abuse is a significant element in the workload of the child and adolescent psychiatric services although it is not yet recognised as a sub-specialty by the Joint Committee on Higher Psychiatric Training. Two specialised Child Sexual Abuse Validation (C.S.A.V.) Units have been established in Crumlin and Temple Street Hospitals respectively. These Units are dealing with about 500-600 cases on an annual basis. Each Unit has a consultant child and adolescent psychiatrist in clinical charge and there are also other consultants involved. Two temporary consultant child and adolescent psychiatrists, seconded from the Eastern Health Board, occupy these posts at present. These two consultant posts are of a temporary nature and are funded by the Department of Health.

4.2 A multi-disciplinary approach is essential due to the complex nature of cases of child sexual abuse. The Community Care Services have a major function in this area and there is close liaison between the C.S.A.V. Units and these services. Regular meetings are held with the Directors of Community Care and Medical Officers of Health and with the Garda Siochana. A considerable amount of staff time is taken up with court attendances and it appears that litigation is becoming a major issue in this area.

4.3 Child sexual abuse is a very difficult area which requires considerable expertise and understanding of families and children. The Working Group which was established by the Minister for Health to consider the type of services required to deal with the problem of child sexual abuse in the Eastern Health Board area, recommended the establishment of specialised validation units and that such units should be headed by consultant child and adolescent psychiatrists. *We would agree with this approach on the basis that the specialist training of the child and adolescent psychiatrist gives him/her an understanding of aspects of the development of children, including the*

psychological factors involved which govern the child's behaviour and thinking.

4.4 Given the complexities involved in validating cases of child sexual abuse and dealing with the litigation which may arise, *we consider that it is very important to have well trained teams who will develop a particular expertise in dealing with child sexual abuse cases. On the other hand it would be undesirable to have team members working full time on a long-term basis in this area due to the pressure of this type of work and the need from the professional point of view to be involved in child psychiatric services outside the C.S.A.V. Unit.*

4.5 *We consider that child sexual abuse should be dealt with as part of the general child and adolescent psychiatric service and that the consultant manpower needs of the C.S.A.V. Units should be dealt with as part of the team approach and the overall structuring of consultant posts which we have recommended earlier in this Report. The responsibility for validation should rest with the Units concerned with appropriate consultant input from the child and adolescent psychiatric services. Children requiring follow-up treatment should be referred to the appropriate service by the Validation Unit. We are accordingly recommending that the two temporary posts assigned to the C.S.A.V. Units should be structured on the basis of permanent joint appointments between the hospitals concerned and the appropriate child and adolescent psychiatric service as set out in paragraphs 2.14 and 2.15 of this Report. Following on from this, it should be possible for the paediatric hospitals and the child and adolescent psychiatric services to agree on a structuring arrangement which will provide appropriate consultant cover for these Units bearing in mind the particular service needs involved.*

Signed:

F. Foley (Chairman)

A. Aylward

D. Doherty

G. Martin

Dr B. O'Herlihy

Dr M. Rahill

Dr D. Walsh

M. Walsh

Professor O. C. Ward

J. Groves (Secretary)

APPENDICES

APPENDIX I

Written Submissions.

Written submissions were received from the following:-

(i) Royal College of Psychiatrists Irish Division — Child and Adolescent Psychiatry Specialist Section.

(ii) Eastern Health Board Child and Family Psychiatric Service.

(iii) Mater Hospital Child and Family Service.

(iv) St John of God Child and Adolescent Psychiatric Service.

(v) Children's Hospital, Temple Street.

(vi) Our Lady's Hospital for Sick Children, Crumlin.

(vii) South-Eastern Health Board.

(viii) North-Eastern Health Board.

(ix) Submission from Social Workers in Psychiatry on behalf of the Irish Association of Social Workers.

APPENDIX II

Child and Adolescent Psychiatric Services in the Eastern Health Board Area.

Mater

Areas 7 & 8

1. *Community Care Areas* — *Population*

7	121,230
8	187,806
TOTAL	309,036

2. *Areas*

North County Dublin
Beaumont/Artane
Coolock
Ballymun

3. *Staffing*

Mater Hospital

Psychiatrists —	4
Psychologists —	1 Principal
	2 Seniors
	3 Basic Grade
Social Workers —	1 Senior
	2 Basic Grade
Speech Therapists —	1 Principal
	1 Senior
	1 Basic Grade

Others —	1 Psychiatric Nurse 1 School Principal 2 Remedial Teachers 2 Secretaries
Temple Street	
Psychiatrists —	2 Consultants from the Mater Service and 1 Consultant from Cluain Mhuire provide sessional services.
*Psychologists	4
*Social Workers	5
*Speech Therapists	2
*Audiometrician	1

4. *Clinics*

Mater Hospital

Mater
Ballymun

Temple Street

St Francis' Clinic

5. *Schools*

Mater
St Paul's, Beaumont

6. *Residential*

St Paul's — 21 places

7. *Special Services*

C.S.A.V. Unit, Temple Street
St Joseph's Adolescent Unit, St Vincent's, Fairview

* Part of staff complement of Temple Street.

8. *Consultancy Services*

Provided to Children's and Young Persons' Homes

9. *Liaison to Hospitals*

Temple Street
Mater

St John of God

Areas 1, 2, 3, 4 and 10 (limited service)

1. *Community Care Areas* — *Population*

1	123,089
2	118,228
3 (part of)	57,923
4	148,781
10	94,542
TOTAL	542,563

2. *Areas*

Blackrock/Dun Laoghaire
Ballybrack
Crumlin
Stillorgan/Foxrock
Rathgar
Tallaght
Wicklow

3. *Staffing*
Orwell Road
Psychiatrists — 4 (1 post shared by 2 Consultants)

Registrars —	4
Psychologists —	1 Senior
	1 Basic Grade
	3 Trainees
Social Workers	1 Senior
	7 Basic Grade
Speech Therapists —	1 Senior
	2 Basic Grade
Occupational Therapists —	1
Child Care Workers and Others —	33

Cluain Mhuire — Children's Service

Psychiatrists —	1 + 1 Temp. Sessional Post
Registrars —	1 Senior (1/2 time)
	1 Trainee (6/12 Rotation)
	2 Sessional (9 Sessions)
Psychologists —	1 Senior
	1 Trainee
Social Workers —	1 Senior
	2 Basic Grade
Speech Therapists —	1
Occupational Therapists —	2 Play Therapists
	1 Sessional Play Therapist

Cluain Mhuire Adolescent Service

Psychiatrists —	1
Registrars —	1 Senior (1/2 time)
	1 Basic Grade
Psychologists —	1 Senior
	1 Trainee
Social Workers —	2

Crumlin

Psychiatrists —	Sessional service provided by one Consultant from Orwell Road

	Registrars —	1 Senior from Orwell Road (Sessional)
	*Psychologists —	3
	*Social Workers —	7
4.	*Clinics*	
	St John of God, Orwell Road	
	Orwell Road Tallaght Crumlin Hospital Wexford	
	Cluain Mhuire Children's Service	
	Cluain Mhuire Wyattville House, Ballybrack Benincasa School, Blackrock	
	Cluain Mhuire Adolescent Service	
	Cluain Mhuire Our Lady's Hospital, Crumlin National and catchment area service for South Dublin	
5.	*Schools*	
	St Peter's Special School, Orwell Road Benincasa School, Blackrock	
6.	*Residential*	
	Orwell Road — 12 places Young Person's Unit, St John of God, Stillorgan — 18 places	
7.	*Special Services*	
	C.S.A.V. Unit, Our Lady's Hospital, Crumlin Day Care Programmes at Centenary House, Dun Laoghaire & Burton Hall, Foxrock (Adolescent Service)	

* Part of staff complement of Crumlin

8. *Consultancy Service*

   Provided to Children's Homes and Schools

9. *Liaison to Hospitals*

   Our Lady's Hospital, Crumlin

Eastern Health Board
Areas 3 (part of), 5, 6 and 9

1. *Community Care Areas*

	Population
3 (part of)	25,000
5	103,264
6	136,128
9	116,247
TOTAL	380,639

2. *Areas*

Clondalkin/Ballyfermot
Mulhuddart/Blanchardstown
Castleknock
Finglas/Cabra
Kildare

3. *Staffing*

Eastern Health Board

Psychiatrists —	5 (2 Consultants seconded to C.S.A.V. Units)
Registrars —	1 Senior
	10 Basic Grade
Psychologists —	4 (1 post vacant)
Social Workers —	5
Speech Therapists —	3
Nursing staff and Others —	1 C.N.O.
	2 A.C.N.O 's
	54 Nurses
	15 Non-Nursing
	15 Domestics

4. *Clinics*

Ballyfermot
Castleknock
St James's
N.C.H. Harcourt Street

5. *Schools*

Ballyowen Meadows
Phoenix Park
Warrenstown House
St Loman's Children's Unit

6. *Residential*

St Loman's —	31 places
Warrenstown House —	14 places
Court Hall, Mulhuddart	12 places
Hostel at Drumheath, Mulhuddart —	5 places

7. *Consultancy Services*

Provided to St Michael's Assessment Centre, Finglas,
St Laurence's School, Finglas,
Trinity House and various hostels and Children's Homes

8. *Liaison to Hospitals*

Harcourt Street