

Child & Adolescent Mental Health Services

First Annual Report

2008

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Executive Summary

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

The development of comprehensive Child and Adolescent Mental Health Services (CAMHS) for young people up to the age of 18 years is described in the Department of Health and Children *A Vision for Change* (2006) policy document. CAMHS had been organised until then for young people up to the age of 16 years. Key to this is the development of 99 multidisciplinary CAMHS teams, of which 54 are in place, 49 community teams, 2 day hospital teams and 3 paediatric hospital liaison teams. Further recommendations are contained in the policy concerning inpatient services (a total of 100 beds), mental health intellectual disability teams (a total of 13), substance misuse, eating disorder and forensic services for young people.

Community child and adolescent mental health teams are the first line of specialist mental health services. In November 2008 a month long survey of children and young people seen by all community based CAMHS teams was carried out. This was the first fully comprehensive exercise to gather information on the age and gender of children and young people attending the service and the mental health problems they present. In addition to surveying waiting times for assessment, overall waiting lists and the level of development of CAMHS teams, it was possible to compare information on waiting lists and service development with a limited survey carried out in March 2007.

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

To achieve the goals set out in *Vision for Change* requires the allocation of significant additional resources to CAMHS. Systematic national and regional planning is necessary, working with local networks and structures, to provide the trained personnel and infrastructure. The total number of CAMHS teams increased substantially in the period 1996 to 2006. In 2008 the recruitment process began for 8 new child and adolescent community mental health teams together with the expansion of inpatient services. It has been estimated that increasing the age range of CAMHS from 16 to 18 years doubles the cost of providing the service.

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

This Annual Report provides the first comprehensive survey carried out on community CAMHS teams and includes preliminary data collected by The Health Research Board on the admission of young people under the age of 18 years to inpatient mental health facilities. As many measures in this report do not have historic comparators it provides a baseline foundation that will be built upon in subsequent years providing an indication of trends that cannot yet be drawn on the basis of this report. The next report will include day hospital, liaison and inpatient services. Subsequent reports will further extend the mapping of mental health services for young people.

For CAMHS team to work effectively, a range of disciplines, skills and perspectives are required, so that children and adolescents are offered a care and treatment package geared to their individual needs. Staffing of the 49 existing teams is 422.3 whole time equivalents, which is 66.2% of the recommended level for these teams. There is a significant variation in the distribution and disciplinary composition of the workforce across teams and regions.

All community CAMHS teams screen referrals received, those deemed to be urgent are seen as a priority, while those deemed to be routine are placed on a waiting list to be seen. A total of 767 new cases were seen in the month of November. 45.6% of new cases were seen within 4 weeks of referral, 67.4% within 13 weeks. 12% of new cases had waited between 13 and 26 weeks, 8.7% had waited between 26 and 52 weeks and 11.9% had waited more than 1 year to be seen.

A total of 3,117 children and adolescents were waiting to be seen at the end of November 2008. This represented a decrease of 492 (13.6%) from the total number waiting at the end of March 2007 (3,609). 18 (37%) of CAMHS community teams had a waiting list of < 25 cases, 2 (4%) had a waiting list of 25 to 49 cases, 20 (40%) had a waiting list of 50 to 99 cases, 5 (10%) had a waiting list of 100 to 149 cases and 4 (8%) had a awaiting list of > 150 cases.

In the course of the month a total of 6,687 cases were seen, 5,920 (89.9%) of these cases were returns and 767 (10.1%) were new cases. A total of 11,080 appointments were offered, 9,323 appointments were attended, with a resulting non attendance rate of 15.9%. Analysis of the data collected indicated that;

- Adolescents from the 15 years of age group are most likely to be attending community CAMHS, followed by children aged 10 to 14 years.
- Adolescents aged 16/17 years constitute 11.5% of the caseload reflecting the practice of keeping on open cases up to their 18th birthday.
- The hyperkinetic category (29.1%) was the most frequently assigned primary presentation followed by the emotional category which accounted for 26.3%.

- The hyperkinetic category peaked in the 4 to 9 years age group at 36.2% of cases in this age group, dropping to 15.6% of adolescents in the over 16 years of age category.
- The emotional category increased with age, accounting for 36.6% of the over 16 years' age group.
- Deliberate Self Harm, which increases with age, accounts for 13% of the primary presentations of the over 16 years' age group.
- Eating disorders increase with age, accounting for 6.2% of the primary presentations of the over 16 years' age group.
- Males represent the majority of primary presentations apart from Deliberate Self Harm (31.7%) and Eating Disorders/Problems (19.5%).
- 21.5% of cases were in treatment less than 13 weeks, 13.4% from 13 to 26 weeks, 16.8% of cases were in treatment from 26 to 52 weeks and 48.3% greater than 1 year.

In 2008 the capacity of the HSE child and adolescent inpatient units (Warrenstown, Dublin and St. Anne's, Galway) increased to a total of 16 beds, operating on a fulltime 7 day basis. In 2009 the opening of two new units at St. Vincent's Hospital, Fairview, Dublin and St. Stephen's Hospital, Cork increased this number to a total of 30 beds. Work is progressing on the 2 new 20 bed units at Merlin Park Hospital, Galway and Bessboro, Cork and both are due to open in 2010.

In 2008 there were 406 admissions of children and adolescents up to the age of 18 years to inpatient units. Females accounted for 58% of admissions. Forty-three per cent of all admissions were aged 17 years on admission, 28% were aged 16 years, and 29% were aged 15 years or younger. Of the 406 admissions, 263 (65%) were to adult inpatient units and 143 (35%) to child and adolescent units. Twenty-seven admissions of young people aged less than 16 years were to adult units.

The average length of stay was significantly longer in the child and adolescent units, at 49.7 days (median 41 days), than in adult units at 12.1 days (median 6 days). Twenty-nine per cent of admissions to adult units were discharged within two days of admission and 55% within one week. Seventy-three per cent of admissions to child and adolescent units were for periods longer than 4 weeks.

Depressive disorders accounted for 26% of all admissions. Eating disorders was the next largest diagnostic category at 17%, followed by neuroses at 15%, schizophrenia and delusional disorders at 9%, and behavioural and emotional disorders of childhood and adolescence at 5%. The diagnosis of mania accounted for 5% of admissions.

Section 1 - Introduction

1.1 Children in the Population

Ireland's population increase over the four years (2002 - 2006) far outstripped any other EU country, with the 2006 census showing an increase of 8 per cent. The population of the Republic is now 4,234,925. The proportion of the population under 18 yrs. is 24.46%.

Table 1.1 Census by age (2002 & 2006)

Age	Pop. 2002	Percentage	Pop. 2006	Percentage
0 - 15	888,310	22.68%	922,762	21.79%
16 - 17	124,721		113,267	
0 - 17	1,013,031	25.86%	1,036,029	24.46%
Total	3,917,203		4,234,925	

Table 1.2 Breakdown of 2006 census by age and HSE Region

HSE Region	Pop	%	0-17 yrs.	%
Dublin North East	926,315	21.85%	225,749	24.40%
Dublin Mid-Leinster	1,216,848	28.70%	292,461	24.04%
West	1,013,622	23.91%	251,943	24.90%
South	1,081,968	25.52%	267,849	24.80%
Total	4,238,753		1,038,002	24.49%

1.2 Prevalence of childhood psychiatric disorders

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

- 1 in 10 children and adolescents suffer from mental health disorders that are associated with "considerable distress and substantial interference with personal functions" such as family and social relationships, their capacity to cope with day-to-day stresses and life challenges, and their learning.^{1,5}
- The prevalence of mental health disorders in young people is increasing over time.²
- 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.³
- A range of efficacious psychosocial and pharmacological treatments exists for many mental health disorders in children and adolescents.^{4,6}
- 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).

1.3 Child and adolescent mental health services (CAMHS)

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

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

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

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

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

- A total of 7 multidisciplinary community mental health teams.
- 2 teams per 100,000 population (1/50,000).
- 1 additional team to provide a hospital liaison service per 300,000.
- 1 day hospital service per 300,000.
- Each multidisciplinary team, under the clinical direction of a consultant child psychiatrist, to have 11 clinical and 2 administrative staff.
- A total of 99 CAMHS teams (1,237 staff) providing community, hospital liaison and day hospital services nationally.

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

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

Table 1.3 Vision for Change recommendations

Child & Adolescent Mental Health Services	Recommended
Community Child & Adolescent Mental Health Teams	71
Adolescent Day Hospital Teams	14
Hospital Liaison Mental Health Teams	14
Eating Disorder Mental Health Team	1
Forensic Mental Health Teams	2
Substance Misuse Mental Health Teams	4
Intellectual Disability Mental Health Teams	13
Total	119

Specialist Inpatient Child and Adolescent Mental Health Services:

- 100 beds (to be reviewed in 2011).
- The building of 4 new 20 bed inpatient facilities.
- 10% of the bed complement to be provided as a secure / forensic facility.
- A 6/8 bed eating disorder unit in the new National Paediatric Hospital.

Table 1.4 Vision for Change recommendations

Inpatient Services	Recommended
General	90
Forensic / Secure	10
Eating Disorder	6/8
Total	108

1.5 Community child and adolescent mental health teams

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

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

- Assessment of emergency, urgent and routine referrals from primary care services.
- Treatment of the more severe and complex mental health problems.
- Outreach to identify severe or complex mental health need, especially where families are reluctant to engage with mental health services.
- Assessment of young people who require referral to inpatient, or day services.
- Training and consultation to other professionals and services.
- Participation in research, service evaluation and development.

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4. Carr, A. (2009) *What Works with Children, Adolescents and Adults? A Review of Research on the Effectiveness of Psychotherapy*. London: Routledge
5. Martin, M., Carr, A. & Burke, L., Carroll, L. & Byrne, S. (2006) *The Clonmel Project. Mental Health Service Needs of Children and Adolescents in the South East of Ireland: Final Report*.
6. National Institute for Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. (<http://www.nice.org.uk/>)

Section 2 – Community CAMHS Workforce

2.1 National survey of community CAMHS (2008)

In November 2008 a month long survey of all existing community based CAMHS teams was carried out. This was the first fully comprehensive exercise to gather data on CAMHS team completeness, waiting times for assessment, overall waiting lists, the age and gender of children and young people attending and their problem profile. This data collected was compared with results from a more limited survey which was carried out in March 2007.

2.2 Community child and adolescent mental health services (2008)

Table 2.1 Community child & adolescent mental health teams (2008)

HSE Region	Pop 0 to 17 yrs.	CAMHS Services	CAMHS Teams Number	Clinical Staff per Team	Clinical Staff In Post	Clinical Staff per 100k < 18yr
North East	225,749	2	10	2.5 – 14.0	85.22	37.75
Mid-Leinster	292,461	3	16	3.2 – 13.3	128.91	43.94
West	251,943	3	12	3.8 – 9.5	76.90	30.52
South	267,849	3	11	3.0 - 7.3	60.60	22.62
Total	1,038,002	11	49	Av. – 7.17	351.63	33.84
Pop < 18 yrs/ Team	21,184					

- In 2008 there were 351.63 clinical staff employed in 49 community CAMHS teams, with an average of 7.17 Clinical WTEs (whole time equivalents) per team, serving an average total catchment population of 86,505.
- This translates to a ratio of 1 clinical staff member, working in community based CAMHS teams, to 2,995 children aged 0 to 17 years.
- The recommended clinical staff complement for 49 community teams is 539; including administrative support staff this figure is 637.
- Staffing of the 49 existing teams is at 66.2% of the recommended level.
- There is a significant variation in the distribution of the workforce across the regions as expressed in the ratio of clinical staff per 100,000 population less than 18 years of age.
- The ratio was highest in Mid Leinster at 43.94 and lowest in the South at 22.62 clinical staff per 100,000 population 0 to 17 years.

Table 2.2 Staffing - Vision for Change recommendations (2008)

Vision for Change (2006)	Rec.	No. Of Teams	Teams In place	Rec. Staff	Total Staff in Place
Child & Adolescent CMHTs	1 : 50,000	85	49	1,105	422.3
Adolescent Day Hospitals		(14)	2		N/R*
Hospital Liaison MHTs	1 : 300,000	14	3	182	N/R*
Total	1 : 42,857	99	54	1,287	

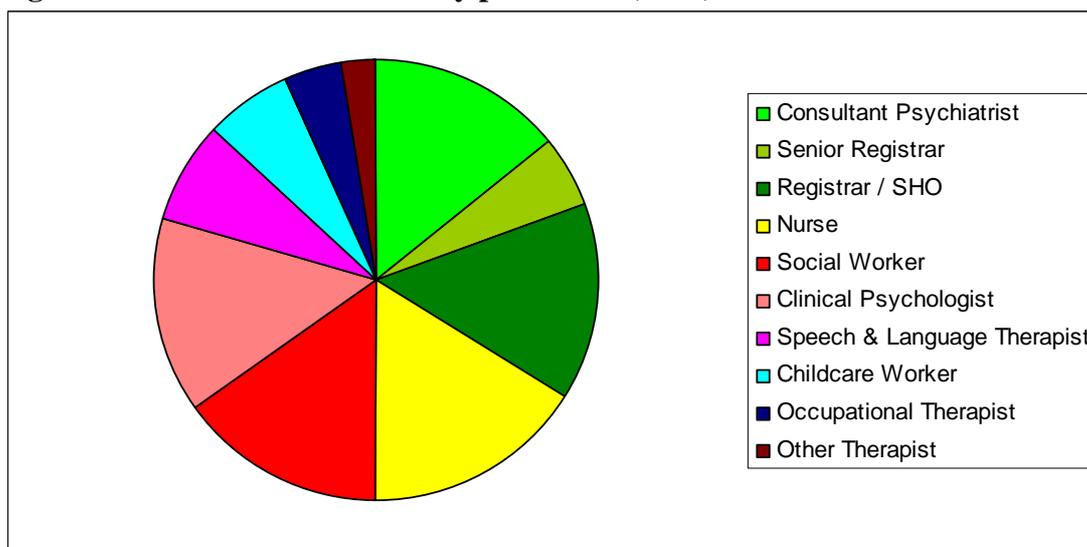
*Not recorded in this survey

- The total number of community, adolescent day hospital and hospital liaison teams recommended in *A Vision for Change* policy is 99.
- In addition to the 49 community teams, there are currently 2 adolescent day hospital programmes in Dublin, located at St. Vincent's Hospital, Fairview and at St. John of God Lucena, Rathgar.

- Each of the 3 Dublin paediatric hospitals has a dedicated child psychiatry liaison team.
- 54 of the recommended number of 99 teams are in place.

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

Fig 2.1 Total clinical workforce by profession (2008)



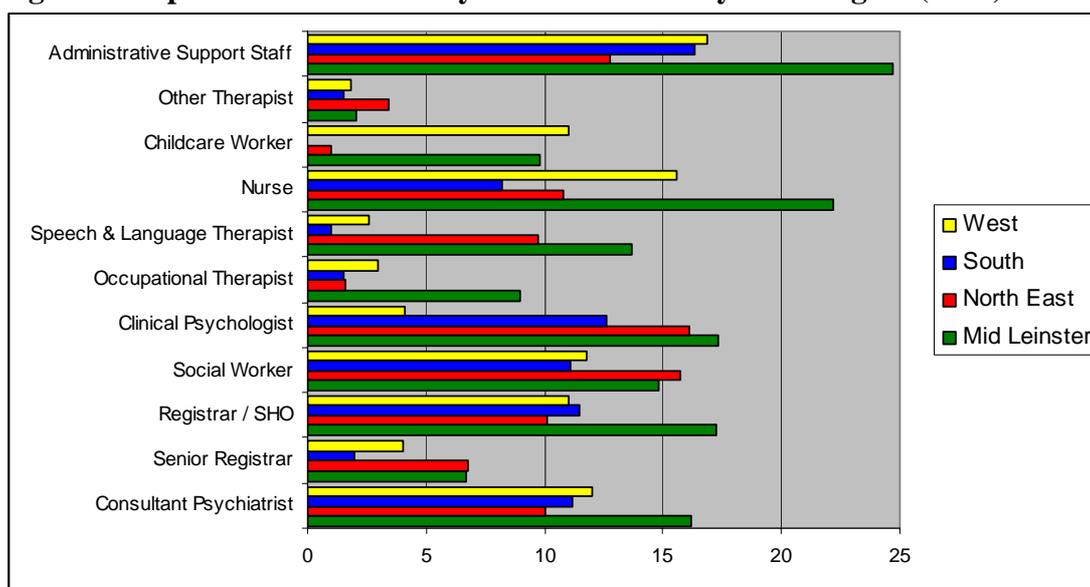
- The largest professional group was doctors making up 33.8% of the workforce (consultant child & adolescent psychiatrists 14% and junior doctors in training 19.8%).
- The other main professional groups were nurses (16.2%), social work (15.2%), clinical psychologists (14.3%), speech and language therapists (7.7%), childcare workers (6.2%), occupational therapists (4.3%), and other therapists (2.5%).

Table2.3: Composition of community teams by professional discipline (WTE).

Recommended Composition (WTE) Vision for Change (2006)	No.	Composition of CAMHS Teams by Discipline (WTE)									
		0	>0	0.5	>0.5	1	>1	1.5	>1.5	2	>2
Consultant Psychiatrist	1	0	1	4	4	32	2	4	1	1	0
NCHD	1	2	2	2	1	21	3	1	2	9	6
Social Worker	2	6	0	4	4	16	3	6	5	2	3
Clinical Psychologist	2	10	0	5	4	13	4	1	2	7	3
Occupational Therapist	1	30	1	8	0	9	0	0	0	1	0
Speech & Lang. Therapist	1	23	1	6	3	8	1	2	2	3	0
Nurse	2	10	1	1	7	10	3	1	3	8	5
Childcare Worker	1	30	0	2	2	9	0	4	0	0	2
Other Therapist		38	2	4	1	1	1	1	1	0	0
Administrative Staff	2	0	0	1	3	22	1	5	2	11	4
Total Staff CAMHS Team	13										

- The recommended 13 member multidisciplinary team comprises of 11 clinical and 2 administrative support staff.
- Table 2.3 shows how each team compares with the recommended staffing complement.
- There is wide variation in the size and professional composition of teams.
- 30 teams have no occupational therapy input, 23 teams have no speech and language therapy input, 10 teams have no clinical psychology input, and 30 teams have no childcare worker input.

Fig 2.2 Composition of community CAMHS teams by HSE Region (2008)



- The numbers of each professional grouping employed across the regions also shows significant variation.

2.3 Workforce trends from 2007 to 2008.

Using data from the survey carried out in March 2007 it is possible to compare current staffing and identify changes. Total staffing of community teams has increased from 407.99 to 422.33, an increase of 14.34 (3.5%).

Table 2.4: Community Teams Staffing Breakdown 2008

Community Teams (2008)	Mid Lein.	Nth. East	South	West	Total
Consultant Psychiatrist	16.15	10.02	11.2	12	49.37
Senior Registrar	6.7	6.8	2	4	19.5
Registrar / SHO	17.25	10.1	11.5	11	49.85
Social Worker	14.8	15.7	11.1	11.8	53.4
Clinical Psychologist	17.3	16.1	12.6	4.1	50.1
Occupational Therapist	9	1.6	1.5	3	15.1
Speech & Language Therapist	13.67	9.7	1	2.6	26.97
Nurse	22.18	10.8	8.2	15.6	56.78
Childcare Worker	9.8	1	0	11	21.8
Other Therapist	2.06	3.4	1.5	1.8	8.76
Administrative Support Staff	24.7	12.8	16.3	16.9	70.7
Total	153.61	98.02	76.9	93.8	422.33

Section 3 – Caseload of Community CAMHS

3.1. Numbers and lengths of time on waiting lists

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

Community CAMHS teams reported a total of 3,117 children and adolescents waiting to be seen at the end of November 2008.

- 1,057 (33.9%) were waiting less than 13 weeks
- 495 (15.9%) 13 to 26 weeks
- 668 (21.4%) 26 to 52 weeks
- 897 (28.8%) more than 52 weeks.

This represented a decrease of 492 (13.6%) from the total number waiting at the end of March 2007.

Table 3.1 Number of children waiting to be seen by time (weeks)

Waiting Time (Weeks)	0 to 4	4 to 13	13 to 26	26 to 52	> 52	Total
Number	458	599	495	668	897	3,117
Percentage (2008)	14.7%	19.2%	15.9%	21.4%	28.8%	100%
Percentage (2007)	13.3%	17.0%	17.7%	22.2%	29.8%	100%
Total (2007)						3,609

Decreases in the numbers waiting occurred in Dublin Mid Leinster (-421), the South (-103) and the North East (-27). There was a small increase in the West (+59).

Table 3.2 Change in waiting lists by HSE Region

Region	Waiting List 2008	Waiting List 2007	Change
Dublin Mid Leinster	651	1072	-421
Dublin North East	634	661	-27
South	997	1100	-103
West	835	776	+59
Total	3117	3609	-492 (13.6%)

There was variation in the numbers waiting by community team, with the majority of teams (40) having a total number waiting of less than 100.

Table 3.3 Waiting lists in each HSE Region

Total Number Waiting List (2008)	No. of Teams	Mid Leinster	North East	South	West
0 -49	20	10	3	3	4
50 - 99	20	5	6	3	6
100 - 149	5			4	1
150 - 199	2	1		1	
200 - 249	2		1		1
Total	49	16	10	11	12

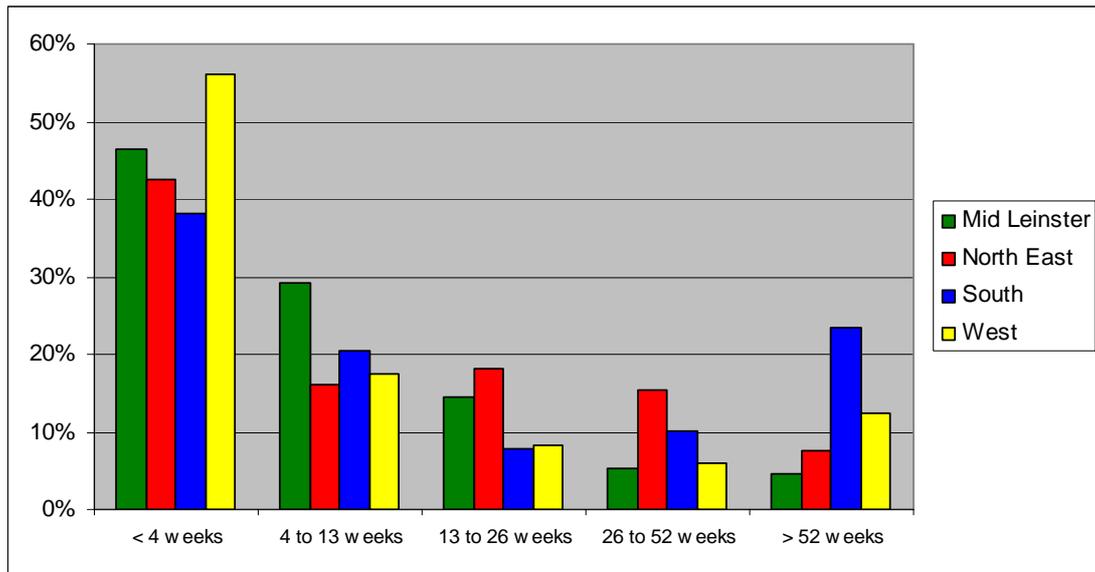
- 18 (37%) of CAMHS teams had a waiting list of < 25 cases.
- 2 (4%) of CAMHS teams had a waiting list of 25 to 49 cases.
- 20 (40%) of CAMHS teams had a waiting list of 50 to 99 cases.
- 5 (10%) of CAMHS teams had a waiting list of 100 to 149 cases.
- 4 (8%) of CAMHS teams had awaiting list of > 150 cases.

3.2 Waiting times for new cases seen

In the month of November 2008 a total number of 767 new cases were seen by community CAMHS teams. The waiting time to be seen was recorded for each case.

- 45.6% of new cases were seen within 4 weeks of referral
- 67.4% within 13 weeks
- 12% of new cases had waited between 13 and 26 weeks
- 8.7% had waited between 26 and 52 weeks
- 11.9% had waited more than 1 year.

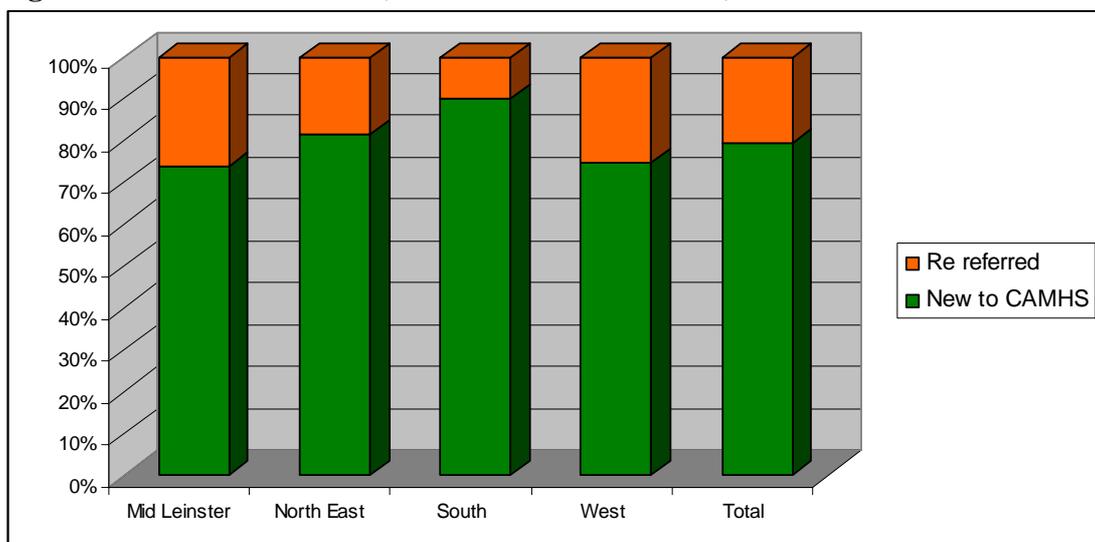
Fig 3.1: New cases seen length of wait to 1st appointment



3.3 Profile of new cases (new vs. re referred cases)

Of the new cases seen a proportion will have previously attended the service and been discharged. The proportion of re referred cases varied from 10.1% in the South to 26.2% in the Mid Leinster region, with a national average of 20.5%.

Fig 3.2 Profile of new cases (new vs. re referred cases)



3.4 Source of referral

As a secondary specialist service children and young people are referred to community CAMHS teams from a number of sources. 76.6% of referrals were received from general practitioners and child health services. Educational services were the next largest source of referral with 9.4%, primary care services 5.6% (community psychology, speech and language therapy, occupational therapy) and social services (community social work) accounting for 3.2% of referrals. Self referral accounted for 2.7% and other sources 2.4%.

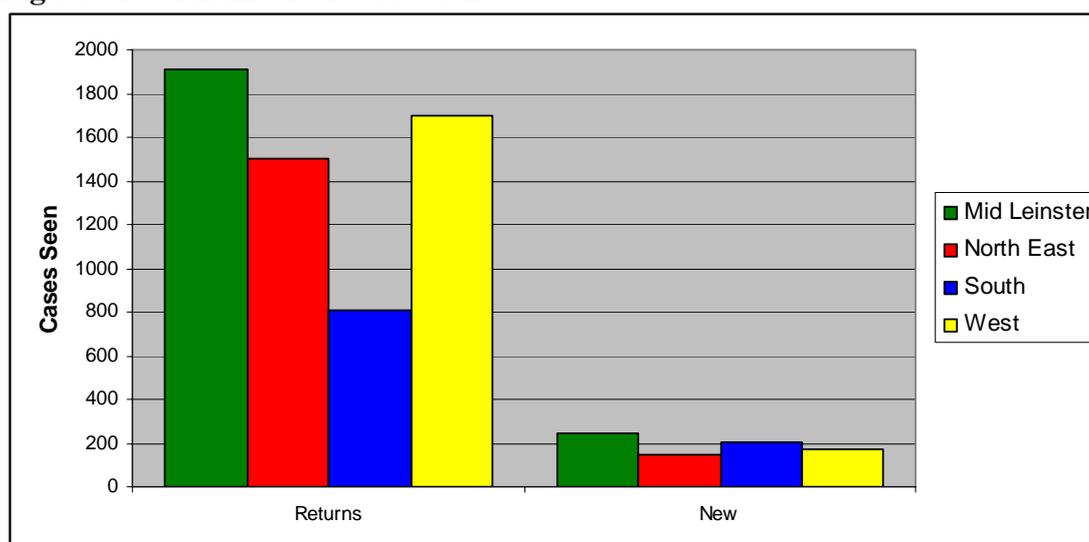
Table 3.4 Source of referral to community CAMHS teams

Source of Referral	Mid Leinster	North East	South	West	% Total
General Practitioner	61.69%	57.45%	68.27%	69.23%	64.3%
Child Health Services	11.11%	12.77%	19.71%	4.74%	12.3%
Education	14.56%	17.73%	2.41%	2.96%	9.4%
Primary Care Services	4.60%	4.26%	3.37%	11.24%	5.6%
Social Services	3.06%	5.67%	0.48%	4.73%	3.2%
Self referral	4.98%	1.41%	1.92%	1.18%	2.7%
Learning Disability Services	0%	0%	1.92%	2.37%	1.0%
Adult Mental Health	0%	0%	1.92%	1.18%	0.8%
Medico legal	0%	0%	0%	2.37%	0.5%
Voluntary Agencies	0%	0.71%	0%	0%	0.1%
Youth Justice	0%	0%	0%	0%	0.0%
Total	100%	100%	100%	100%	100%

3.5 Number of cases seen in the month

During the period of measurement a total of 6,687 cases were seen by the 49 teams. 5,920 (89.9%) of these cases were returns and 767 (10.1%) were new cases.

Fig 3.3: Total number of cases seen



3.6 Number of appointments offered and non-attendance rates

During the period of measurement a total of 11,080 appointments were offered. A total of 9,323 appointments were attended, with a resulting non attendance rate of 15.9%. The non-attendance rate was highest in the North East at 20.1% and lowest in Mid Leinster at 12.1%.

Fig 3.4 Number of appointments attended and not attended by HSE Region

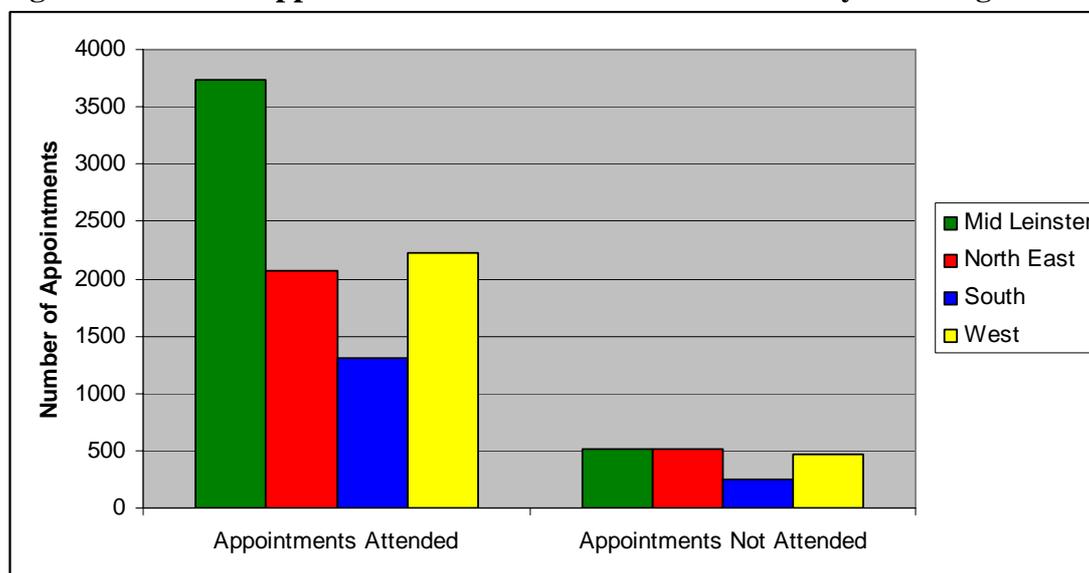


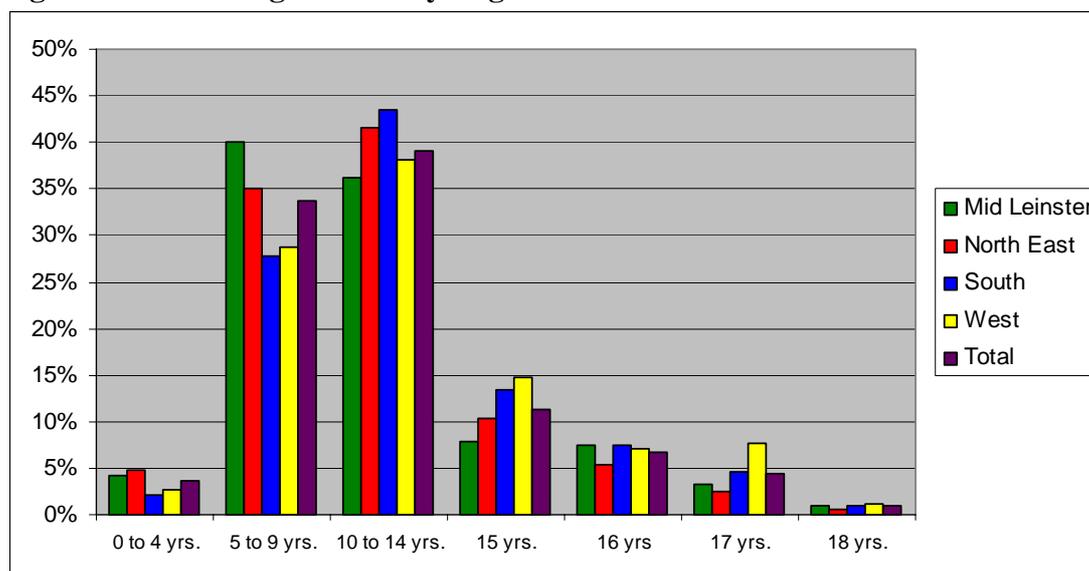
Table 3.6 Attendance for appointments

Appointments	Mid Leinster	North East	South	West	Total
Attended	3728	2067	1301	2227	9323
Not Attended	514	519	252	472	1757
Total Number	4242	2586	1553	2699	11080
DNA Rate %	12.1%	20.1%	16.2%	17.5%	15.9%

3.7 Age profile of young people attending the service

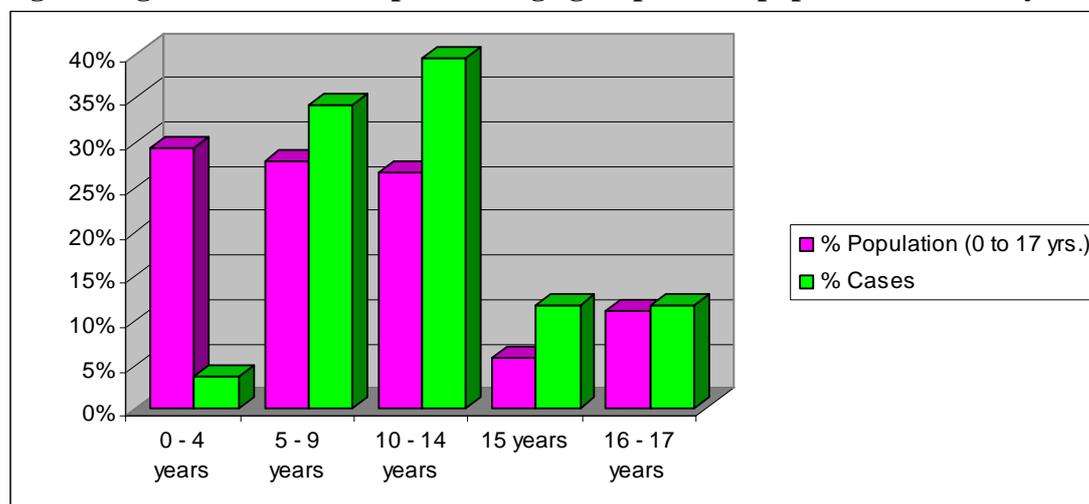
Both the Mid Leinster and North East Regions had a younger age profile of children attending than the South or the West reflecting the longer presence of services in these regions. 12.2% of the cases seen were aged 16 yrs. or older.

Fig 3.6: Caseload Age Profile by Region



Adolescents from the 15 year old age group are most likely to be attending the community CAMHS teams, followed by children aged 10 to 14 years. Adolescents aged 16/17 years of age constitute 11.5% of the caseload although the majority of teams do not accept new referrals of adolescents over the age of 15 years and reflects the practice of teams keep a proportion of cases open after the young person reaches their 16th birthday.

Fig 3.7: Age of caseload compared to age groups in the population (0 to 17 yrs.)



3.8 Ethnic background

- 91.3% of children and adolescents attending were from a white Irish ethnic background. The proportion in the population 0-19 years is 88.4%.
- 3.6% were from a white any other white ethnic background, highest in Mid Leinster region at 6.2%. The proportion in the population 0-19 years is 4.1%.
- The white Irish Traveller community accounted for 2.0% of cases, highest in the West Region at 4.1%. The proportion in the population 0-19 years is 1%.
- Children from a Black ethnic background accounted for a total of 1.8% of all children attending. The proportion in the population 0-19 years is 1.7%.
- Children from an Asian ethnic background accounted for a total of 0.6% of all children attending. The proportion in the population 0-19 years is 1%.

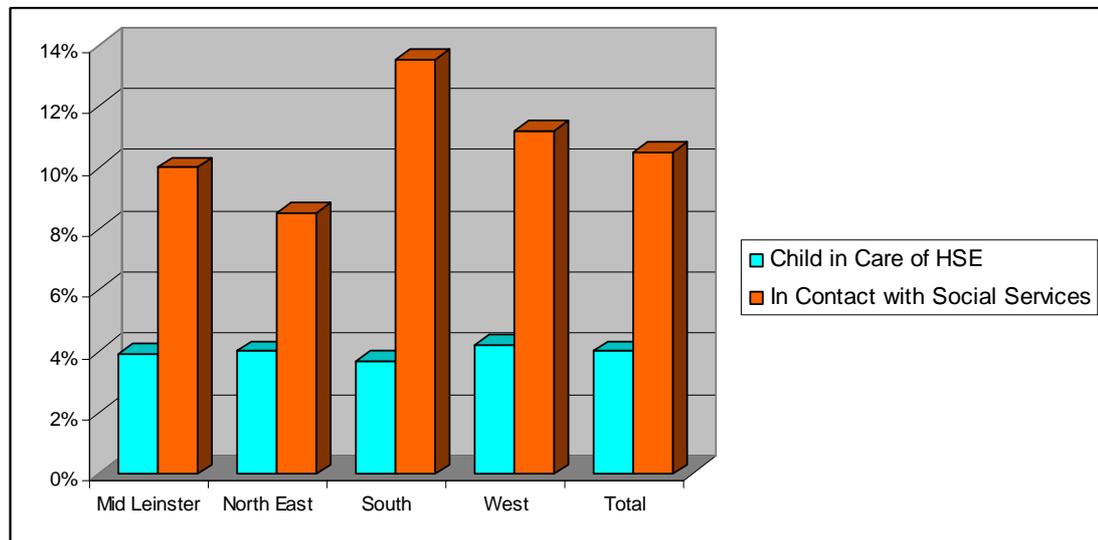
Table 3.7 Ethnic Background

Ethnic Background	Mid Leinster	North East	South	West	Total	Census (0-19 yrs.) 2006
White: Irish	88.4%	94.1%	93.0%	91.2%	91.3%	88.4%
White: Irish Traveller	1.2%	0.6%	2.4%	4.1%	2.0%	1.0%
White: Roma	0.2%	0.2%	0.1%	0.2%	0.2%	Not recorded
White: Any other White background	6.2%	2.1%	2.7%	2.3%	3.6%	4.1%
Black / Black Irish: African	1.6%	1.9%	0.6%	1.2%	1.5%	1.6%
Black / Black Irish: Any other Black background	0.7%	0.1%	0.2%	0.1%	0.3%	0.1%
Asian / Asian Irish: Chinese	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%
Asian / Asian Irish: Any other Asian background	0.8%	0.5%	0.6%	0.3%	0.5%	0.8%
Other	0.8%	0.4%	0.3%	0.5%	0.5%	1.3%
Not Stated						2.4%

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

4% of children and adolescents attending community CAMHS teams were in the care of the HSE. This figure was consistent across the four regions. The percentage of children in contact with social services ranged from 8.5% to 13.5%, the overall figure being 10.5%.

Table 3.8: Children in the care of the HSE or in contact with social services



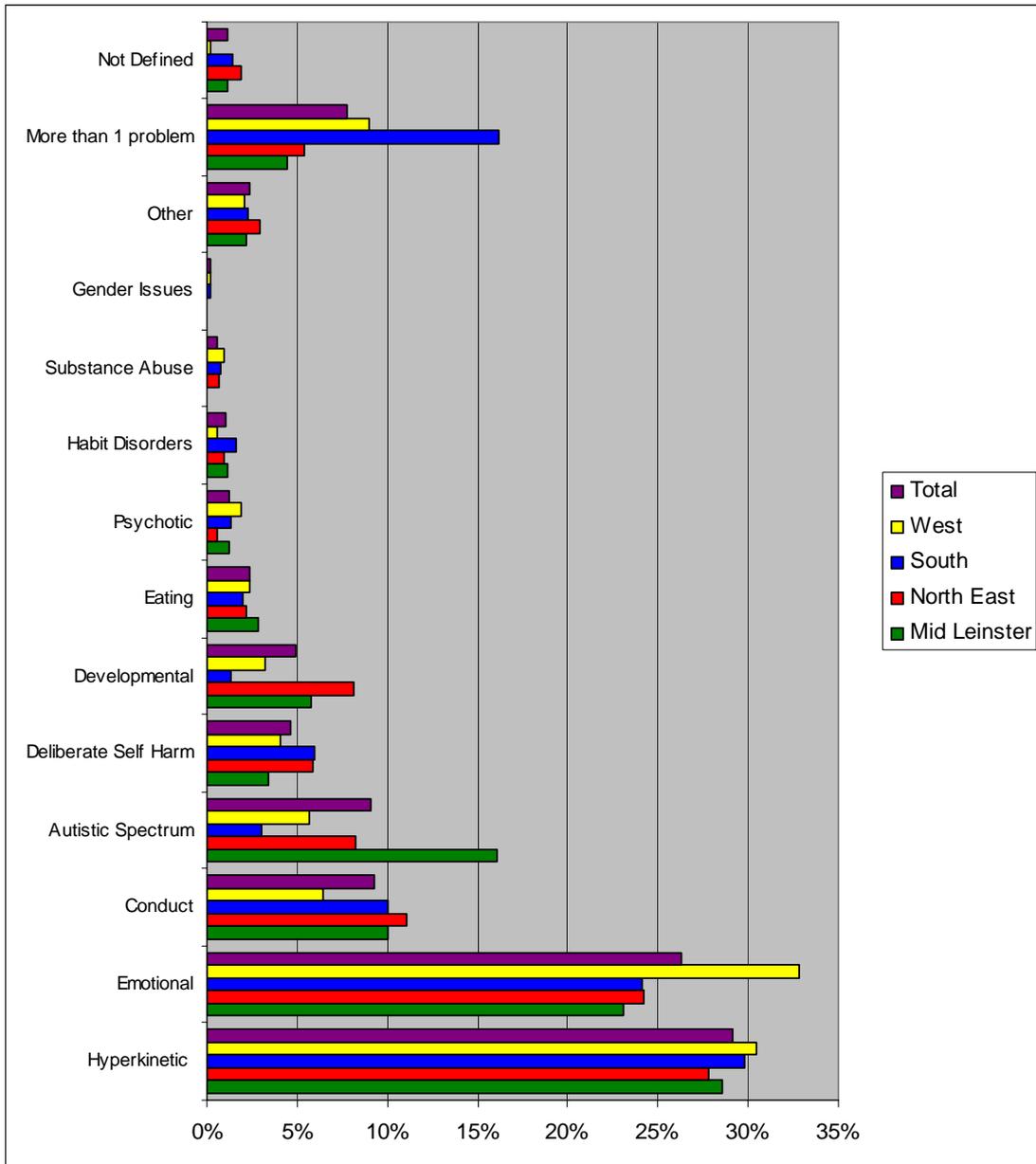
3.10 Primary presentation

The primary presentations of 6,629 cases were recorded by gender and age. For the purpose of the audit only one disorder / problem was entered for each case.

- **Hyperkinetic disorders/problems** included ADHD and other attentional disorders, 1,925 (29.1%) cases.
- **Emotional disorders/problems** included anxiety, depression, phobias, somatic complaints, obsessional compulsive disorder, post traumatic stress disorder, 1,734 (26.3%) cases.
- **Conduct disorders/problems** included oppositional defiant behaviour, aggression, anti social behaviour, stealing, and fire-setting, 617 (9.3%) cases.
- **Eating disorders/problems** included pre-school eating problems, anorexia nervosa, and bulimia nervosa, 159 (2.4%) cases.
- **Psychotic disorders/problems** included schizophrenia, manic depressive disorder, or drug-induced psychosis, 81 (1.2%) cases.
- **Deliberate self harm** included lacerations, drug/medication and alcohol overdose, 328 (4.6%) cases.
- **Substance abuse** referred to drug and alcohol misuse, 37 (0.6%) cases.
- **Habit disorders/problems** included tics, sleeping problems, and soiling, 64 (1%) cases.
- **Autistic Spectrum Disorders/problems** referred to presentations consistent with autistic spectrum disorder, 608 (9.1%) cases.
- **Developmental disorders/problems** referred to delay in acquiring certain skills such as speech, and social abilities, 325 (4.9%) cases.
- **Gender Role / Identity disorder/problems** referred to gender role or identity problems or disorder, 10 (0.2%) cases.

- **Not possible to define** was only to be used if it was impossible to define the prominent disorder, 71 (1.1%) cases.
- **Other** was to be used when the primary presentation was not included in the list, 156 (2.4%) cases.
- **More than 1 disorder/problem** was only to be used if there was more than one prominent disorder, to the extent that it is not possible to identify ‘one primary presenting disorder / problem’, 514 (7.8%) cases.

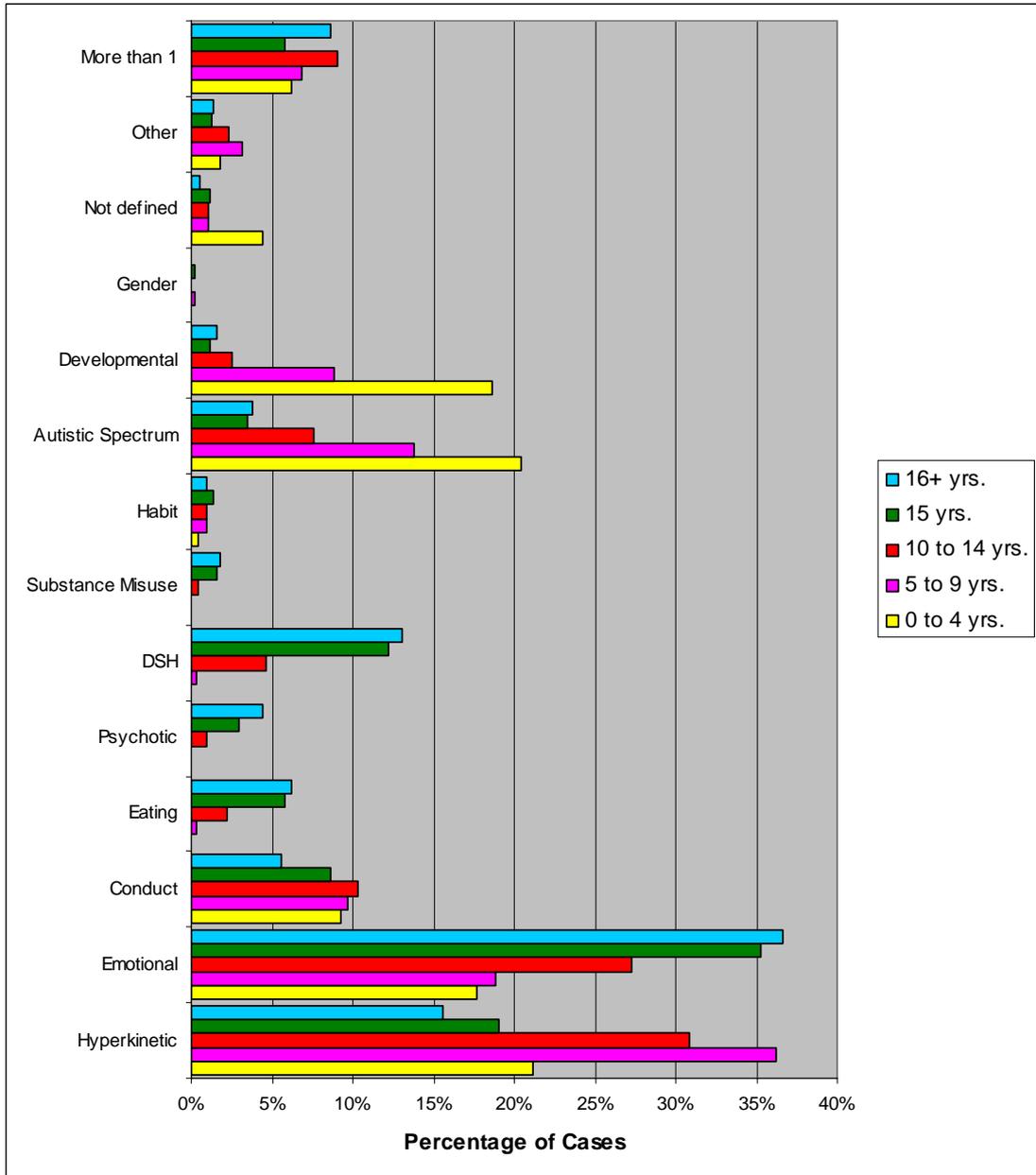
Fig 3.9: Primary presentation by HSE Region



- The hyperkinetic category (29.1%) was the most frequently assigned primary presentation overall and in each of the regions except the West where the emotional category was most frequently assigned (32.8%).
- The emotional and hyperkinetic categories accounted for 55.4% of primary presentations.

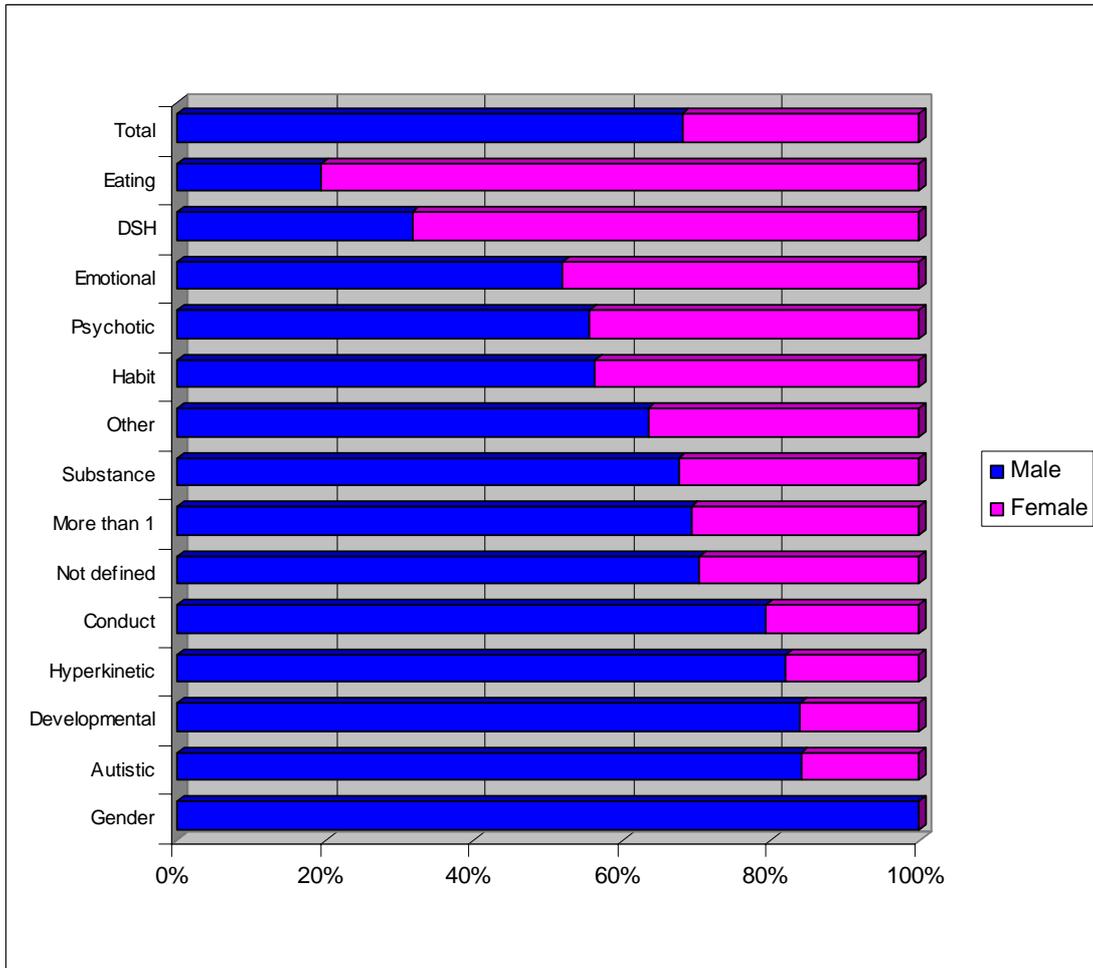
- The autistic spectrum and developmental categories were more frequently assigned in Mid Leinster and the North East reflecting the younger age profile of the cases in those regions.

Fig 3.10 Primary presentation by age group



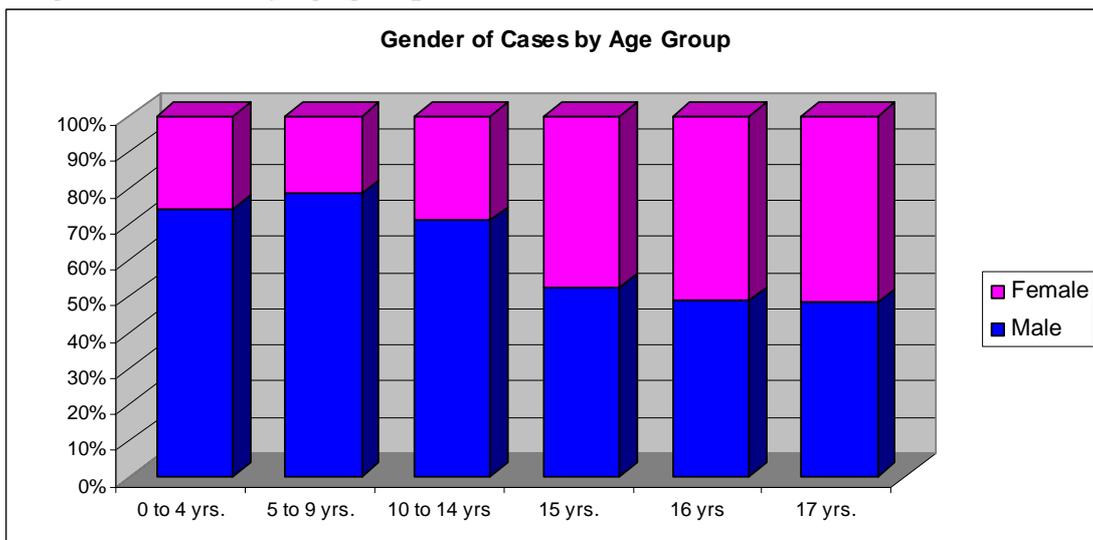
- The hyperkinetic category peaks in the 4 to 9 years age group at 36.2% of cases in this age group and falls back to 15.6% of the over 16 years group.
- The emotional category increases with age, peaking at 36.6% of the over 16 years' age group.
- The autistic spectrum and developmental categories are most frequently assigned to the 0 to 4 and 5 to 9 years age groups.
- Deliberate Self Harm, which increases with age, accounts for 13% of the primary presentations of the over 16 years' group.
- Eating disorders increase with age, accounting for 6.2% of the primary presentations of the over 16 years' age group.

Fig 3.11 Primary presentation by gender



- Males represent the majority of primary presentation apart from Deliberate Self Harm (31.7%) and Eating Disorders/Problems (19.5%).

Fig 3.12 Gender by age group

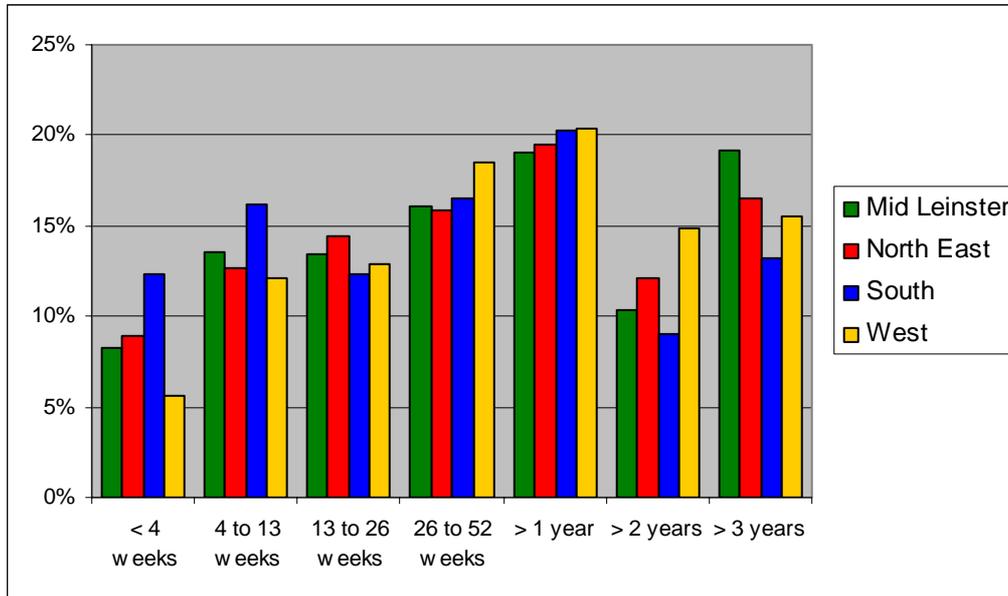


- Males are in the majority in each age group up to 16 years of age.

3.11 Duration of treatment

This is measured from the date the case was first seen by any member(s) of the CAMHS team to their appointment in the month of November.

Fig 3.13: Duration of Treatment



- 21.5% of cases were in treatment less than 13 weeks.
- 13.4% of cases were in treatment from 13 to 26 weeks.
- 16.8% of cases were in treatment from 26 to 52 weeks.
- 19.7% of cases were in treatment greater than 1 year.
- 11.9% of cases were in treatment greater than 2 years.
- 16.7% of cases were in treatment greater than 3 years.

Almost half (48.3%) of all cases had been seen over a period greater than 1 year.

Section 4 – Service Characteristics

4.1 Services for young people aged 16 and 17 years

A *Vision for Change* (2006), Department of Health and Children, recommended that child and adolescent mental health services take over responsibility in providing mental health service for young people up to the age of 18 years. As outlined earlier in the report additional resources will have to be put in place such that the recommended level of service, as set out in the policy, can be delivered.

During the measurement period 12.2% of the young people attending the service were aged 16 years or older. CAMHS teams were asked as to their current arrangements with regard to this age group of young people who previously were the responsibility of Adult Mental Health Services in most areas of the country. From 2006 the practice of teams keeping on existing cases beyond their 16th birthday was extended, without the provision of additional resources.

Table 4.1 Arrangements for young people aged 16 and 17 years

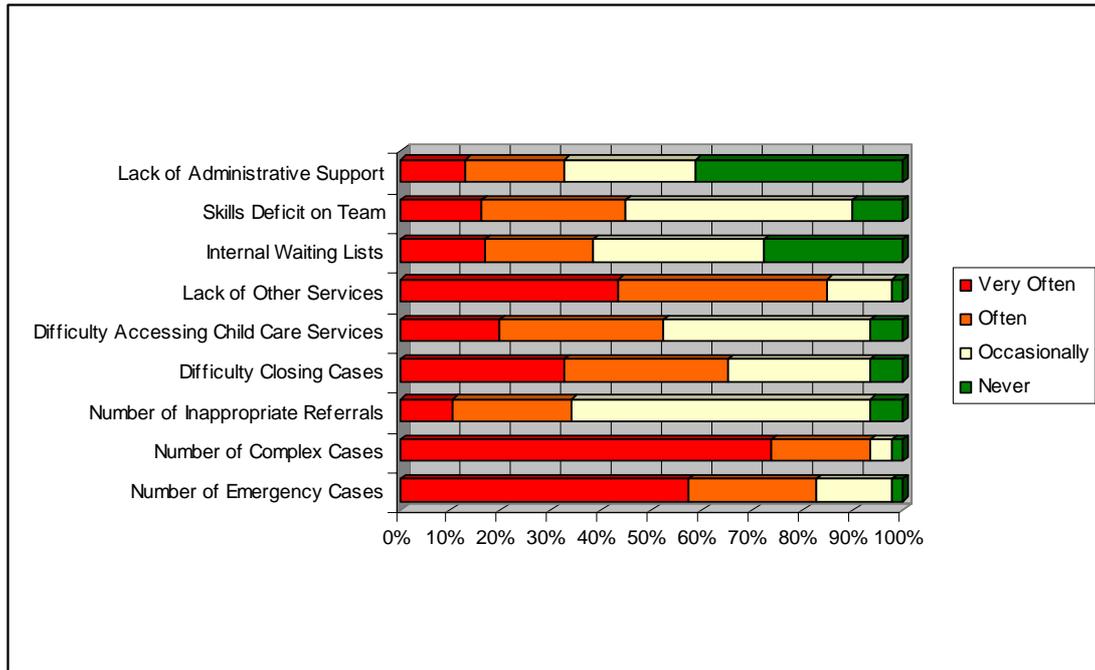
Operational Criteria of CAMHS teams	No.
Continue to see existing open cases beyond their 16 th birthday as appropriate Consider re referral of previously known cases after their 16 th birthday Do not see new cases aged 16 / 17 years	33
Continue to see existing open cases beyond their 16 th birthday as appropriate Consider re referral of cases of known cases after their 16 th birthday Consider new referrals of young people over 16 years on a case by case basis	10
Accept referral of all young people up to and including 16 years.	1
Accept referral of all young people up to and including 17 years	5
Total	49

- From the above information the proportion of the caseload seen over the age of 15 years can be explained.
- Child and adolescent mental health services currently provide a significant level of service to this age group.
- Some young people are transferred to adult mental health services after their 16th birthday due the nature of their illness and care / treatment needs.
- As the older age group present with more acute mental health difficulties access to services by younger children with less acute presentations may be affected.
- The provision of additional teams is planned to facilitate over time the transfer of responsibility for mental health services for this age group to Child and Adolescent Services as set out in *The Report of the Inpatient Capacity Forum* HSE (2006).

4.2 Capacity of CAMHS teams to respond to demand

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

Fig 4.1 Factors which impact on a team’s capacity to respond to demand



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

Section 5 –Service Infrastructure

5.1 Accommodation of CAMHS teams

Community CAMHS teams are currently sited in a range of different locations. The capacity of a CAMHS team to deliver a service, expand and develop can be adversely affected by the size and suitability of the accommodation available to it and this must be taken account of in future development plans.

Table 5.1 Location of community CAMHS teams

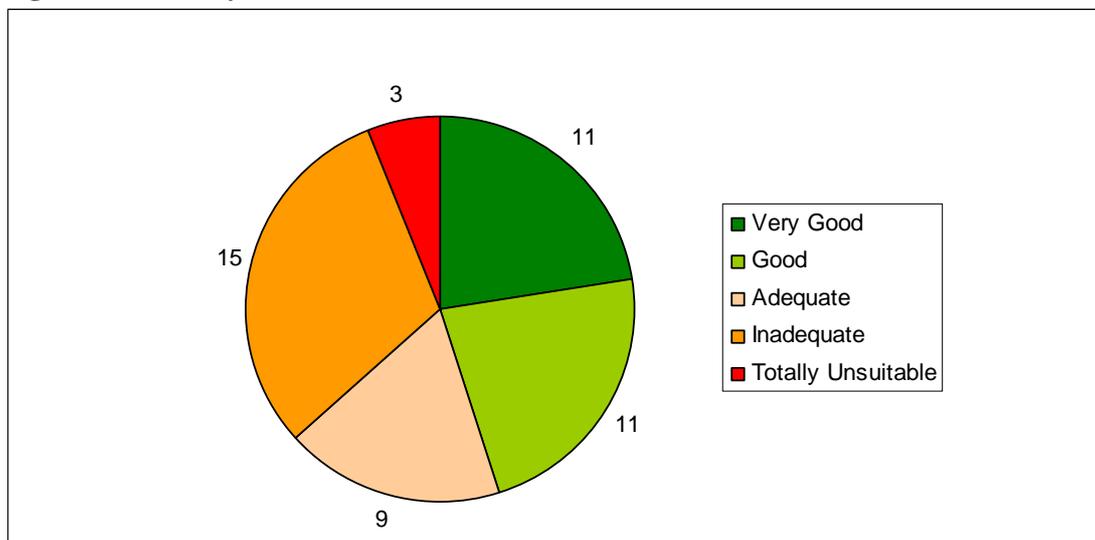
Location of Team	Number
Hospital Site	4
HSE Building located in the community – Sole Occupant	8
HSE Building located in the community – Shared	7
Rented Premises – Located in the Community	15
Premises owned by Service located in the community (Voluntary Provider)	11
HSE Building & Rented Premises (Located in the Community)	4
Total	49

- 19 teams have a dedicated building.
- 15 teams share the building with other services.
- 19 teams utilise rented accommodation.

5.2 Suitability of accommodation

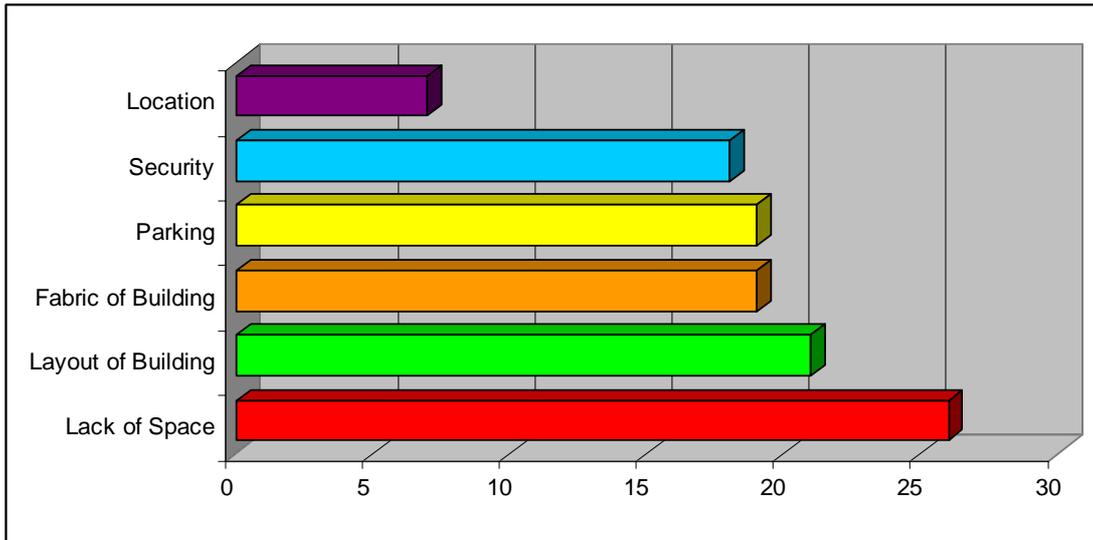
Each team rated the suitability of their accommodation in order to provide a service.

Fig 5.0 Suitability of accommodation (49 Teams)



- 31 teams rated their premises as adequate, good or very good.
- 18 teams rated their premises as inadequate or totally unsuitable.

Fig 5.1: Difficulties encountered with premises



- Lack of space was the most commonly cited difficulty with accommodation.

Section 6 – Inpatient Child and Adolescent Mental Health Services

6.1 Inpatient Services Child and Adolescent Mental Health Services.

The aim of admission to a child and adolescent in-patient unit is to:

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

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

As the Adult Mental Health Services were responsible for the care of the 16/17 year age group, the majority of admissions of young people under the age of 18 years were to Adult facilities. Due to the limited availability of inpatient facilities for young people under the age of 16 years, a number of this age group were admitted to Adult facilities also (See Table 6.1).

The HSE has made the provision of additional child and adolescent inpatient units a priority, such that in the future all young people under the age of 18 years will be admitted to age appropriate facilities, as recommended in *A Vision for Change* (2006).

6.2 Development of inpatient services in 2008.

In 2008 the capacity of Warrenstown and St. Anne's units increased to a total of 16 beds operating on a fulltime 7 day basis.

Table 6.1: Inpatient Services (2008):

Child & Adolescent In-Patient Units	Capacity 2007	Capacity 2008
St. Anne's Inpatient Unit, Galway	6	10
Warrenstown Inpatient Unit, Dublin	6	6
Total	12	16

- **St. Anne's Inpatient Unit** increased its capacity from 6 to 10 beds. A consultant psychiatrist was recruited to the unit as part of the ongoing development plan that will see the unit moving to a new purpose built 20-bed facility at Merlin Park Hospital in 2011.
- **The Warrenstown Inpatient Unit** moved 5 to 7-day functioning in 2008 thus increasing the ability of the unit to provide inpatient assessment and treatment to children and young people with a wider range of more acute presentations that require the young person to be admitted on a full time basis.

6.3 Inpatient admissions in 2008

There were 406 admissions of children and adolescents in 2008. Of this total 263 (65%) admissions were to adult inpatient units and 143 (35%) to child and adolescent units. The child and adolescent units include St. Anne's Children's Centre, Galway; Warrenstown Child and Adolescent Inpatient Unit, Dublin; and Ginesa Unit, St. John of God Hospital, Dublin, which is a private facility. The 406 admissions in 2008 compared with a total of 364 in 2007 and 398 in 2006.

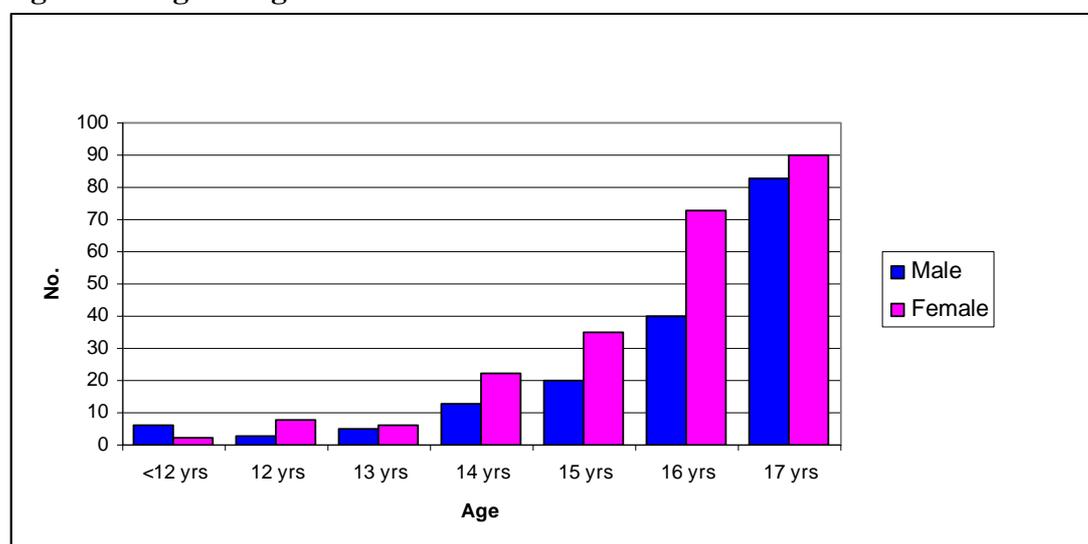
Table 6.2 Place of admissions by age

Year	Admissions	Age (Yrs)	< 12	12	13	14	15	16	17	Total	%
2006	Adult Units		0	0	0	2	21	78	152	253	64%
2006	Child & Adolescent Units		9	7	16	31	49	20	13	145	36%
2007	Adult Units		0	1	2	8	3	70	134	218	60%
2007	Child & Adolescent Units		8	14	15	28	42	23	16	146	40%
2008	Adult Units		0	3	0	7	17	82	154	263	65%
2008	Child & Adolescent Units		8	8	11	28	38	31	19	143	35%

6.4 Age and gender of admissions

Females accounted for 58% of admissions. Forty-three per cent of all admissions were aged 17 years on admission, 28% were aged 16 years, 13% were aged 15 years, 9% were aged 14 years, 3% were aged 13 years, 3% were aged 12 years and 2% were aged less than 12 years.

Figure 6.1 Age and gender of admissions:



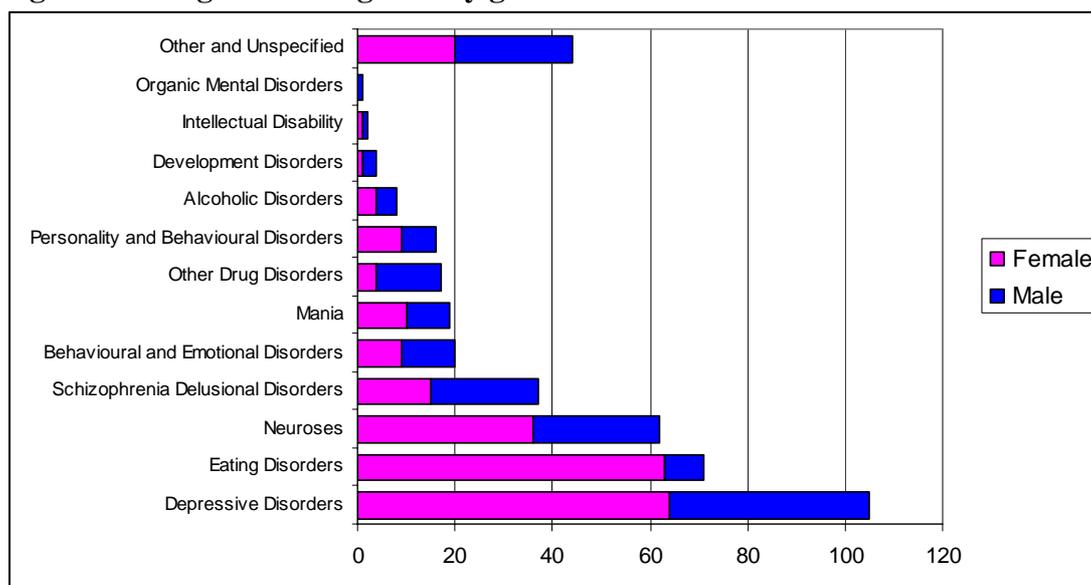
Of the 143 admissions to the child and adolescent inpatient units 13% were aged 17 years on admission, 22% were aged 16 years, 27% were aged 15 years, 19% were aged 14 years, 7% were aged 13 years, 6% were aged 12 years and 6% were aged less than 12 years.

Of the 263 admissions to adult inpatient units 27 (10%) were less than 16 years of age on admission. Of this number 17 were aged 15 years on admission, 7 were aged 14 years and 3 were aged 12 years.

6.4 Diagnostic categories

Depressive disorders accounted for 26% of all admissions (See Figure 6.2). Eating disorders was the next largest diagnostic category at 17%, followed by neuroses at 15%, schizophrenia and delusional disorders at 9%, and behavioural and emotional disorders of childhood and adolescence at 5%. The diagnosis of mania accounted for 5% of admissions.

Figure 6.2 Diagnostic categories by gender:



Females accounted for 61% of all admissions with depressive disorder, 89% of all admissions with eating disorder, and 58% of all admissions with neuroses. Males accounted for 59% of all admissions with schizophrenia and delusional disorders, and 55% of all admissions with behavioural and emotional disorders of childhood.

6.5 Duration of Admission

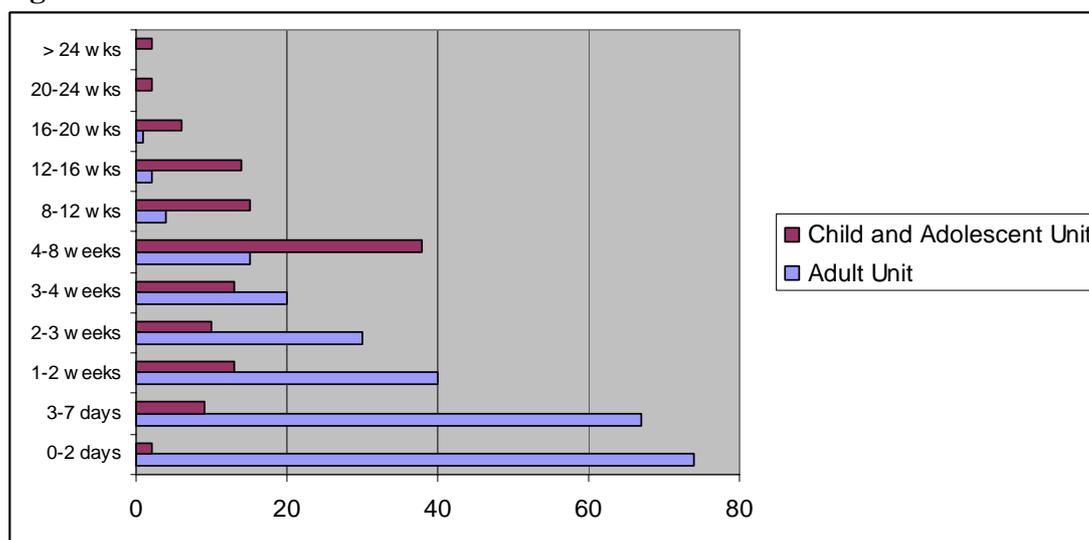
The average length of stay (for those admitted and discharged in 2008) was 24.5 days (median length of stay 13 days). The average length of stay was significantly longer in the child and adolescent units, at 49.7 days (median 41 days), than in adult units, at 12.1 days (median 6 days). Forty-one per cent of children and adolescents admitted in 2008 were discharged within one week of admission.

Fifty-five per cent of young people admitted to adult units were discharged within one week of admission, 29% were discharged within two days of admission. Sixteen per cent were discharged within one to two weeks of admission, and a further 28% within two to four weeks of admission. Eight per cent were discharged within four to twelve weeks of admission and a further 1% was discharged after admissions of greater than twelve weeks.

Nine per cent of young people admitted to child and adolescent units were discharged within one week, 10% were discharged within one to two weeks of admission, 18 %

were discharged within two to four weeks, 51% were discharged within four to twelve weeks and a further 22% was discharged after admissions of greater than twelve weeks duration.

Figure 6.3 Duration of admission



6.4 Development of Inpatient Services 2009

In 2009 work continued on the development and planning of inpatient services to meet the recommended inpatient service provision as set out in *A Vision for Change* (2006).

- **St. Vincent's Hospital, Fairview, Dublin** completed the first phase of its development of inpatient facilities, with the opening of a 6 bed adolescent unit. A consultant psychiatrist, nursing staff and other members of the multidisciplinary team were recruited. The new unit began operation in March.
- **St. Stephen's Hospital, Cork**, an interim 8 bed adolescent unit was opened on the site pending the completion of purpose built 20-bed unit at Bessboro. A consultant psychiatrist, nursing staff and other members of the multidisciplinary team have been recruited. The new unit begins operation in October.
- **Merlin Park Inpatient Unit (20 bed), Galway**, which will replace St Anne's unit, is in the process of construction. As part of development of the service a consultant psychiatrist and a dietician were recruited to the team.
- **Bessboro Inpatient Unit (20 bed), Cork**, which will replace the interim unit at St Stephen's hospital, is in the process of construction.
- **Warrenstown Inpatient Unit** is in the process of finalising plans to upgrade and extend its inpatient capacity from 6 to 9 beds. A consultant psychiatrist and 5 multidisciplinary staff are being recruited to the team.
- **AMNCH Hospital, Tallaght**, has been identified as the location for the development of inpatient services in the Dublin Mid Leinster Region. The planning for services on this site is to commence in 2009.

The opening of the units at St. Vincent's and St. Stephen's hospitals in 2009 increased the number of HSE child and adolescent inpatient beds from 16 to 30.

Section 7 – Child and Adolescent Mental Health Service Developments 2008 / 2009

7.1 Developments 2008 - Community Mental Health Teams

In June 2008 the recruitment process began for the position of consultant child and adolescent psychiatrists for 8 new community CAMHS teams. The interviews took place in November 2008 and the appointees have been taking up their positions in the course of 2009, with other members of the multidisciplinary teams, a total of 56, to follow.

Table 7.1 New Community Mental Health Teams

Community Mental Health Teams	HSE Region
Swords, North Co. Dublin	North East
Meath	North East
Cavan / Monaghan	North East
Limerick	West
Carlow / Kilkenny	South
Wexford	South
Laois / Offaly	Dublin Mid Leinster
Clondalkin / Lucan	Dublin Mid Leinster

Together with the appointment of a consultant psychiatrist to a new adolescent day hospital team in South West Dublin, this will potentially increase the number of community / day hospital / paediatric liaison teams to a total of 63.

Four consultant child and adolescent psychiatrists were appointed to positions that had become vacant in the last number of years and had been filled in a locum capacity in the intervening period. In a number of these positions it had not been possible to employ a locum continuously, due to the shortage of suitably qualified psychiatrists, which had in turn an effect on waiting times for these services.

7.2 Developments 2008 – Inpatient services

In June 2008 the recruitment process began for 3 consultant child and adolescent psychiatrists to St. Anne's, St. Stephen's Hospital, and St. Vincent's Hospital inpatient units. The interviews took place in November 2008 and the appointees have taken up their positions in the course of 2009, together with other members of the multidisciplinary teams recruited to each of the units.

7.3 Planned Developments 2009 - Community mental health teams

A further 6 community child and adolescent mental health teams are to be established, with the additional allocation of 30 therapy posts. In order to progress the development of community services in line with service need across the country 2 new teams have been allocated to each of the West, South and North East HSE regions.

7.4 Planned Developments 2009 – Inpatient services

A consultant psychiatrist and 5 therapist posts are to be recruited to the Warrenstown Inpatient Unit.

Section 8 – Developing and Supporting Child and Adolescent Mental Health Services

8.1 Monitoring progress and evaluating outcomes

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

This group will, in consultation with child and adolescent mental health service providers and other stakeholders, undertake the following:

- develop a minimum dataset for CAMHS that will be reported by each team on a monthly basis
- set of quality standards, and clarifying of care pathways
- develop a suite of key performance indicators that take into account resource allocation, case mix, demographic and other factors
- implement routine outcome measurement across services
- foster service user involvement in the planning and evaluation of services
- develop a communication strategy to foster sharing of best practice and service innovation
- address manpower planning and training needs
- extend service mapping in 2009 to include liaison, day hospital, inpatient and mental health intellectual disability services

The Second Annual Report on Child and Adolescent Mental Health Services will be published in the second quarter of 2010.

Appendix I – Initiatives and Developments

The Londubh Project is a community-based preventative project targeting children aged between 4-12 years attending two local National Schools who are identified as being at-risk of early school leaving. The project developed in 1998 from a governmental task force seeking to improve inter-agency working. The Londubh project aims to provide a holistic service to children giving them a secure and nurturing environment in which their social, emotional, physical, psychological as well as educational needs can be addressed to help them develop to their full potential.

An interagency monitoring group comprised of staff from the local community Social Work, CAMHS, Gardai and Education meeting monthly with the two project workers in the school to process new referrals, discuss ongoing cases and their management, as well as explore the continued development of the work of the project. In 2008 the Londubh project was the overall winner in the country of a prize awarded by the Children's Acts Advisory Board.

- Solution Focused Therapy was employed as a means of reducing the waiting list.
- An audit of non-attendance at initial assessment was carried out by the team.
- A specialist ADHD monitoring Clinic was set up.
- Parent psycho-education evening meetings - ADHD, Anger Management. Art Psychotherapy.
- Speech & language therapists prepared a group on how to work on meta cognitive strategies for children with ADHD, initiated research looking at Theory of Mind skills in 8 year olds with specific language impairment, ADHD and ASD.
- Liaising with Adult Mental Health Services looking at the impact on children whose parents are experiencing mental health problems and how children could be helped and those in need of intervention identified.

*

The team have participated in the development of an Advanced Nurse Practitioner post. The team have also focussed on developing protocols in the following areas:

- Induction of new staff joining the team.
- Designing a new referral form for the services.
- Developing a multidisciplinary rota to respond to emergencies.

*

An initiative to reduce the waiting list for the service, using Brief Solution Focussed Therapy, was initiated. An ADHD review clinic was established run jointly by nursing and medical staff members. The introduction of a number of audit systems facilitated: improved communication with referral agents and feedback from children and families attending the ADHD clinic.

- A parent group for supporting emotional/social communication and development in children was set up. This group was facilitated by Principal Speech and Language Therapist, who has recently completed PHD on Theory of Mind, and the Clinical Nurse Specialist on the team who has undergone training in Marte Meo Group work.

- A group for children to promote socialisation and communication using play therapy and Marte Meo methods was set up. The staff members facilitating the group had recently completed professional training in these therapeutic modalities.
- A psychotherapy group for adolescent girls attending the service was introduced.
- Co-facilitation of a community parenting group using the Incredible Years Programme with Youth Services in the area.
- The Senior Psychologist on the team was involved in Garda and Social Work training at the Garda Training College Templemore.

*

A Consultation Clinic was initiated to respond to referrals from Community Care services. A Crisis Intervention Parenting Group was set up for parents of adolescents attending the service and a Dinosaur Group for children (this is linked to Incredible Years Parenting Programme).

*

Clinical resources were made available to the team temporarily (occupational therapy and speech and language therapy) to facilitate the reduction of internal waitlists.

*

Clinicians Training events in which team members participated in: Adolescent Psychosis Intervening Early, Attachment Theory in a Clinical Setting, Cognitive Behavioural Therapy for Anxiety Disorders, Depression and Psychosis, Circle of Security Attachment Training, an Eating Disorders Workshop, Hanen communication training “It Takes Two to Talk”, Introductory Motivational Interviewing Workshop, Manchester Child Attachment Story Task training workshop, Risk Assessment within a Legal Framework, Self-Directed Parent Management Training, and SIPS Training.

Courses for teachers: Managing ADHD in the Classroom, Mental Health Issues in the Classroom, Anxiety & Depression in School Children and The A-Z Mental Health in the Classroom.

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An Incredible Years parent training programme (1992) version was run for parents of children with externalising behaviours (with a wide range of diagnoses) between age 3 and 12 years of age. This took place over 12 weeks between February and April. The revised Incredible Years parent training programme 2008 is currently being run for parents of children aged 3 to 6 years for 18 weeks. Children aged 6 to 8 years and 8 to 12 years have been referred to separate Incredible Years parent training programmes being run concurrently in other clinics for these age groups. This is part of a co-ordinated approach to the provision of parent training within the service.

Quarterly psycho-educational evening seminars for parents of primary school aged children with Autistic Spectrum Disorder (ASD), and Asperger's Syndrome were provided and will continue in 2009.

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We endeavour to deliver interventions in a cost effective, efficient way e.g. through the delivery of group based interventions such as the Incredible Years Parent Management Training, Dina Dinosaur School, Triple P Parent Management Training, Adolescent Group and Social Skills Groups. In addition we, as capacity allows, see children on the waiting list on a regular basis in order to reduce waiting times. We operate an active screening of referrals in order to minimise people being

inappropriately waitlisted for our service. Unfortunately this year we have experienced a huge number of referrals of children with eating disorders (14 in the last year) which compromises the capacity of the team to see other cases.

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Adolescent therapeutic groups were provided with parallel groups for parents, together with social skills/coping groups for younger children with mental health disorders.

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An audit of all referrals received by the clinic from January to December 2006 (inclusive) was carried out. A screening checklist for children with ADHD was developed by the Speech and Language Therapist. The Incredible Years Parenting Programme was run jointly with Parenting Skills Unit and the Dina programme with Psychologists working with Community Care Services. The Hanen programme was run jointly by the Social Work and Speech & Language Therapy on the team for first time in the service. An information afternoon, which included a team presentation, was provided for local Primary School Principals.

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Initiatives were made by the team to reduce the waiting list. The ADHD clinic was further developed and parenting groups for parents of children with ADHD. Training in Risk Assessment and Brief Solution Focused Therapy was undertaken by members of the team in addition to team in service training. A member of the team is undertaking a Masters in Cognitive Behavioural Therapy. Cognitive Analytic Therapy is now available from a trained team member. Socialisation/Communication Therapeutic groups have been provided.

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This service continues to provide an Early Development and Autism Assessment service, which was further developed by an increase in Consultant Psychiatrist sessions from March 2008 to November 2008, in a locum capacity, which was used to provide additional assessments.

An occupational therapy service was developed, in addition to the provision of a Visual Art Psychotherapy service, a Family Therapy service, Parents Plus parenting programme, and a group based Cognitive Behaviour Therapy service for adolescents (the Working Things Out Programme).

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The team introduced a waiting list initiative to address waiting times and numbers on the waiting list. This resulted in a 100% increase in numbers of routine and preschool team assessment cases opened from the waiting list, with an increase of 50% in the total number of cases opened in 12 months compared to the previous 12 months. There was also a reduction in longest waiting time by 25%.

The team was enhanced by the addition of Occupational Therapy as a discipline. A manager post was established across the sector teams in 2007 and this team was allocated a 0.5 WTE Senior Occupational Therapist in June 2008. Whilst this resource is extremely valuable it is insufficient to meet demand currently. A number of groups have been run by the team throughout the year, including two parent training groups (Parents Plus Early Years Programme) for parents of young children and a Social Skills Group for children.

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A Service Development Group was established to examine efficiency, quality, throughput etc. of service provided. Improved liaison with Child Protection Services

was achieved. A new client database was implemented. A number of Occupational Therapy sessions were allocated to the team in last year.

Adolescent and Parent groups were provided by the team, including 2 Parents Plus Middle Years Programmes (PPP), a 'Working Things Out' CBT based Adolescent Group and 2 Social Skills Groups (SSG) were run.

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The "waiting list initiative" was continued to keep the waiting list down. The day programme provided by the team was increased from 1 to 2 days per week. A community psychiatric nursing service was developed at basic level and funding of an external Ireland worker for our service maintained.

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A wait list initiative was introduced and a shared care model for children and young people attending the service with ADHD developed. The provision of Family Therapy was increased. The DAWBA (assessment instrument) was piloted by the team. A Consumer Satisfaction Survey is underway, and Crosslinx continued. In service training provided and staff morale issues addressed.

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A number of wait list initiatives introduced, internal team audits and clarification of referral and management pathways together with enhanced inter-agency liaison. A dedicated ADHD clinic established.

The recruitment took place of 1.2 WTE Consultant Child & Adolescent Psychiatrists and granted for an additional CAMHS team.

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A clinical nurse specialist was recruited to the team facilitating an increased focus on community treatment in the form of home and school visits. This policy fits in extremely well with the national devolution of patient treatment from hospital to community primary health care teams.

The provision of placements throughout the year for psychiatric nursing students has been very successful and recently (December 2008) received a ringing endorsement from An Bord Altranais. The team is actively engaged in clinical audit. 2 audits of young people presenting with self harm were completed. Communication with community care social work colleagues has improved with frequent meetings taking place between the services. Improved working relationship achieved with adult mental health service.

A member of the team participated in a national group set up to examine the role of CAMHS in relation to the Disability Act and prepared a care pathway for publication.

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A Basic Grade psychologist was recruited to the team. The practice of one team member assessing new patients followed by consultant review was initiated as an alternative when appropriate to routine multidisciplinary assessment at the first appointment. A rapid outreach behavioural / family intervention was introduced for first episodes of Deliberate Self Harm.

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Currently we are developing an Information Leaflet for circulation to families on referral whereby we invite service users to give feedback and suggestions regarding our services. If a service user is unhappy about any aspect of the service we

encourage them to discuss the matter with us. The HSE Comments and Complaints Policy leaflet is also available in our waiting room. We are also developing a circular to be sent to all referrers to the service informing them of referral pathways.

We are facilitating service users by bringing the service to satellite clinics, where accommodation is accessible. Groups provided by the team included Social Skills Group for adolescents and a 10 week “FRIENDS Group” for adolescents with anxiety/depression.

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A parenting course lasting 8 weeks was provided twice through the year. A group programme for children with anxiety/depression was run over a 10 week period (The FRIENDS Group). Art therapy was made available to the team by a student under clinical supervision.

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An ADHD information pack was developed for Parents and a handout for teachers on managing ADHD in the classroom. The team also developed a Sleep Hygiene leaflet for children and adolescents.

A waiting list initiative was introduced, a formal Care Plan developed for all open cases and a biannual clinical audit system. A consultation service commenced for referrers to the team and an Emergency and Risk assessment protocol introduced. A Parents Plus adolescent parenting group was provided. An internal CPD programme is in situ.

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The CAMHS team facilitated a group in summer 2008 for adolescents with a diagnosis of Attention Deficit Hyperactivity Disorder attending the service. The team also facilitated a 6-week pilot group for children aged 8 -12 years with a diagnosis of ADHD in autumn 2008. Both groups are currently the subject of evaluation and their focus was to help children and young people to better understand the meaning of diagnosis of ADHD and the impact on their lives in a peer group setting.

The Nurse on the CAMHS team has successfully completed an MSc in Cognitive Behaviour Therapy from UCD and two members of the team are now able to provide Cognitive Behavioural Therapy intervention to clients where clinically appropriate. The CAMHS team have actively participated in the ‘Jigsaw’ Planning Group for the area. Waiting Lists were validated in January 2008.

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The CAMHS Service developed information leaflets for families and General practitioners. Staff on the team undertook training in Suicide Risk Management (DICES Training). A joint CAMHS / Community Psychology initiative in working together was undertaken. A policy was prepared by staff on response of the team to critical incidents. A waiting list initiative was undertaken by the team for children referred with ADHD. Groups were run for parents on anxiety management.

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The team maintained a “no waiting list policy”. Regular satellite clinics were established in a number of towns in the catchment area. The team participated in Athru (multidisciplinary, multi-agency team for adolescent perpetrators of sexual abuse). The team participated in a multi-centre therapeutic trial.

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A senior dietician joined the CAMHS team. The team continues to operate satellite clinics on a 2 day per week basis in a Health Centre in a rural town. An additional therapy room was secured and refurbishment of administration offices completed.

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A senior dietician joined the CAMHS team. Monthly satellite clinics and consultation service were set up in 2008. The appointment of a Speech & Language Therapist to the team facilitated Parent Programmes such as Hanen More Than Words. The team provided a range of groups for parents and children. A new satellite clinic was established to facilitate access.

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A Family Therapy Clinic was commenced and approval granted to secure a base in key location approved but not yet in place.

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The team commenced a review of our waiting list in line with recent guidance from the National Working Group.

A team member completed training in Cognitive Behaviour Therapy, another team member is participating in training in Sand Play Psychotherapy.

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A number of initiatives were undertaken to reduce the waiting list maximise clinical effectiveness, including resource reallocation and time management strategies to increase efficiency within the team.

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An Away Day gave the team an opportunity to review the service we provide and consider ways to develop the service.