

A better future now

Saol níos fearr amárach  
an ráthaíocht inniu

Position statement on psychiatric services  
for children and adolescents in Ireland

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Irish College of Psychiatrists  
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In 2002 the Irish Division of the Royal College of Psychiatrists became the Irish College of Psychiatrists.

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# Preface

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The Faculty of Child and Adolescent Psychiatry of the Irish College of Psychiatrists commissioned a subgroup under the chairmanship of Dr Brendan Doody to provide this report to the Faculty on the current state of child and adolescent psychiatric services, estimate the service need and plan for future service development. This position statement was approved by the Faculty and the Executive Committee of the Irish College of Psychiatrists.

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The subgroup would like to take the opportunity to express its gratitude to other members of the Faculty of Child and Adolescent Psychiatry for their contributions and support in the preparation of this report.

## Executive summary

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- In this report the Faculty of Child and Adolescent Psychiatry of the Irish College of Psychiatrists sets out where psychiatric services for children and adolescents are now, estimates the need for services, and presents a model for future services. An action plan for implementation is also proposed.
- The funding of the mental health services in 2003 accounted for just 6.8% of the health budget, amounting to €622.8 million. Child and adolescent psychiatric services account for only 5–10% of spending on mental health services, while serving 22.68% of the population (around €53 per child under 16 years of age).
- The Faculty has made an estimate of the additional service resources and funding needed for:
  - specialist out-patient services
  - specialist adolescent services
  - specialist in-patient services
  - specialist day patient services
  - specialist hospital liaison services
  - specialist intellectual disability services
  - specialist forensic services
  - specialist alcohol and substance misuse services
  - suicide prevention and deliberate self-harm services, services for children with attention-deficit hyperactivity/hyperkinetic disorder, conduct disorder, autism spectrum disorder or an eating disorder, and services for looked-after children
  - service evaluation
  - academia and research.
- There are currently 55 whole-time equivalent (WTE) consultant child and adolescent psychiatry posts in the Republic of Ireland, a ratio of 1:16 150 of the population under 16 years of age. In Finland this ratio is 1:6000 (of the population aged 0–19 years).
- There are currently 40 specialist out-patient multidisciplinary teams (the recommended number is 59) serving local communities, the majority of which are significantly below the recommended multidisciplinary staffing complement.
- In-patient facilities for the assessment and treatment of children and adolescents under the age of 16 years are located in two centres which have a total of 20 beds (the recommended number is 156 beds).
- The in-patient facilities for the 16- to 17-year age group require an additional 80 beds.
- Adolescent services are poorly developed.

- Sub-specialty services have to date been developed to a very limited degree.
- A comprehensive service for young people up to the age of 18 years would require a total of 150 WTE consultant child and adolescent psychiatry posts.
- The recommended service level for young people up to the age of 18 years would require an extra annual expenditure of approximately €80 million and a capital investment of approximately €150 million.
- The Faculty requests that the Ministry of Health and Children undertakes further analysis and reports back to the Minister of Health with advice on the workforce development, funding plans and time frames necessary to support full implementation of the recommendations set out in this policy statement.

## Gearr-thuairisc

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Tá leagan amach déanta ag Dámh na Síciathracha do Leanaí is d'Ógánaigh de Choláiste Éireannach na Síciathraithe in a ráiteas polasaí faoi staid na seirbhísí síciathracha do leanaí is d'ógánaigh faoi láthair, faoi'n a meastachán do'n ghá atá ann do na seirbhísí agus faoi'n mbealach is fearr a leanúint le seirbhísí a chur ar fáil ins na blianta le teacht agus an dream 16/17 bl. d'aois a chur san áireamh.

### Leanaí sa Daonra

Sé daonra Phoblacht na h-Éireann ná 3.9m. Le sé bliana anuas (1996–2002) bhí méadú níos mó ar dhaonra na h-Éireann thar tír ar bith eile san Aondacht Eorpach, méadú 8% léirithe san daonáireamh 2002. Tá an chuid sin de'n daonra faoi 16 bliana d'aois níos mó na an chuid céanna in áit ar bith eile san Eoraip – mar atá léirithe thíos. Tá 25.86% den daonra faoi 18 mbl. d'aois.

**Tábla 1 Comparáid faoi chodanna den daonra**

<i>Tír</i>	<i>Iomlán</i>	<i>0–15 bl. d'aois</i>	<i>Céatadán</i>
Eire	3 917 000	888 310	22.68%
An Ríocht Aontaithe	58 800 000	11 900 000	20.24%
An Fhionlainn	5 206 000	991 635	19.04%

### Polasaí an Rialtais

Chuir an Roinn Sláinte agus Leanaí Grúpa Oibre ar bun i 2001 faoi sheirbhísí síciathracha do leanaí is d'ógánaigh le scrúdú a dhéanamh ar staid na seirbhísí sa tír agus moltaí a dhéanamh ar an mbealach forbartha is fearr dóibh. Tá Síciatraithe Leabh is Ógánach, Banaltraí, Síceolaí, Oibrí Sóisialta, Bainisteoirí ó na Seirbhísí Síciatracha do Leanaí is Ógánaigh agus oifigigh ó'n Roinn Sláinte is Leanaí ar an nGrúpa Oibre.

Rinne *An Chéad Tuarascáil de'n nGrúpa Oibre ar Sheirbhísí Síciathracha do Leanaí is d'Ógánaigh* (2001) moltaí áirithe i leith:

- Seirbhísí do leanaí is d'ógánaigh suas go 16 bl. d'aois (144 leabacha) in ospidéal.
- An cumadh ar fhóirne ilsmachtúla, bunaithe ins an bpobal, i leith seirbhísí síciathracha do leanaí is d'ógánaigh (13 baill de fhoireann chliniciúl).
- Líon na bhfóirne i gcóimheas an daonra (foireann amháin le haghaidh 66 000 den daonra).
- Aire dochtúra do leanaí agus d'ógánaigh ag fulainght le ADHD.



Rinne *An Dara Tuarascáil de'n nGrúpa Oibre ar Sheirbhísí Síciathracha do Leanaí agus d'Ógánaigh* (2003) moltaí áirithe i leith:

- Forbairt na seirbhísí le riachtanais ógánaigh 16–18 mbl. d'aois a shásamh.
- Síciathraithe Speisialta do Leanaí is d'Ógánaigh go raibh spéis faoi leith acu i easláinte intinne na nÓgánach timcheall 18 mbl. d'aois a liostáil.
- Fóirne ilsmachtúil d'ógánaigh a bhunú le seirbhísí forleathain a chur ar fáil agus go mbéadh síciathraithe do leanaí is d'ógánaigh i gceannas orthu.
- Aonaid a fhorbairt le seirbhísí speisialta a chur ar fáil d'ógánaigh in ospidéal.
- Bonn sonraí forleathan a bhunú le cuidiú le forbairt taighde.

Sa *Dara Tuarascáil de'n nGrúpa Oibre ar Sheirbhísí Síciathracha do Leanaí agus d'Ógánaigh* (2003) deirtear 'faoi láthair cuireann na Seirbhísí Síciathracha do leanaí is d'ógánaigh aire doctúra do leanaí suas go 16 bl. d'aois ach samhlaítear nach bhuil an socrú le haghaidh daoine fásta feiliúnach d'ógánaigh'.

Tá an clár sláinte leagtha síos ag an Straiteis Sláinte '*Mianach agus Cothrom*' (2001) le córas sláinte atá bunaithe ar dhearchadh nua a reachtáil ins na todhchaí; sé sin córas atá cothrom, bunaithe ar an bpobal, freagrach agus sásúil. Sé dearchadh na straitéise sláinte go bhfuil bearnaí ins na seirbhísí sláinte intinne atá ann faoi láthair do leanaí is d'ógánaigh. Tá moltaí ag an straitéis faoi fheabhsú a fhéadfaí a déanamh, iad seo leanas a chur sa chomhaireamh:

'Déanfar leathnú ar na seirbhísí mheabhairshláinte do leanaí is d'ógánaigh:

- Na moltaí san gCéad Tuarascáil den nGrúpa Athbhreithithe ar shíciatracht do leanaí is d'ógánaigh a chur i bhfeidhm.
- Seirbhísí mheabhairshláinte a fhorbairt le riachtanais leanaí idir 16 agus 18 mbl. a shásamh.'

Bhunaigh *an tAcht Mheabhairshláinte* (2001) an Coimisiún um Mheabhairshláinte 'le cur chun cinn spreagadh agus cothú a dhéanamh ar bhunú agus chothabhail ard chaighdeáin agus dea-chleachtais i soláthar seirbhísí mheabhairshláinte'.

Bunaíodh *an Grúpa Saineolach ar Mheabhairshláinte* in 2003 le creatlach náisiúnta nua a chur ar fáil do na seirbhísí mheabhairshláinte.

Bunaíodh an Feidhmeannach Shláinte ar 1 Eanáir 2005 le Seirbhísí Sláinte na hÉireann a laimhseáil. Tá a bhord féin aige agus tá sé freagrach don Aire i leith laimhseáil na seirbhísí sláinte.

Bunaíodh an Ombudsman do Leanaí faoi Acht na hOmbudsman do Leanaí 2002.

## **An Ciste do na Seirbhísí Mheabhairshláinte**

I 1997 caitheadh 11% den gCiste Shláinte iomlán ar sheirbhísí mheabhairshláinte. Idir 1997 agus 2001 tháinig méadú €3 bn ar an gcaiteachas ar Shláinte, sé sin méadú 90% sa tréimhse sin. Mar sin féin ní raibh an méadú ar seirbhísí mheabhairshláinte ach 15% agus faoi 2003 b'é 6.8% den bhuiséad sláinte é nó €622.8 m. Cé nach gcaithtear ach 5–10% den airgead ar sheirbhísí síciatracha do leanaí is d'ógánaigh san am gcéanna soláthraíonn sé seo seirbhísí do 22.68% den daonra (~€53 in aghaidh gach leinbh <16 bl. d'aois). Deirtear san *Tuarascáil*

Bliantúil den gCoimisiún um Mheabhairshláinte (2003); ‘Léiríonn an easpa maoinithe seo nach dtugtar tús áite do sholáthar ar seirbhísí mheabhairshláinte, nach bhfuil an pobal in iúl ar mhinicíocht na mheabhairshláinte, agus an dearcadh diúltach atá ann maidir le meabhairghalar agus an stiogma a ghabhann leis’. Bhí droch éifeacht ag an toirmeasc ar a thuile fóirne a liostáil ar na seirbhísí a bhí ann agus ar sheirbhísí nua a fhorbairt.

### **An méid Síciatraithe do Leanaí is d’Ógánaigh**

I 1997 bhí 30 Síciatraithe do Leanaí is d’Ógánaigh. I bPoblacht na hÉireann tá 55 postanna lán aimsire coibhéiseacha do Shíciatraithe Comhairleacha do Leanaí is d’Ógánaigh. Is fearr an uimhir seo a leiriú i gcóimheas leis an uimhir iomlán de Chomhairleoirí atá ann do leanaí is d’ógánaigh agus i gcomparáid leis na tíortha go bhfuil seirbhísí síciatracha maithe acu.

**Tábla 2 Síciatraithe do Leanaí is d’Ógánaigh i gcoimheas an daonra**

<i>Tír</i>	<i>Síciatraithe i gcoimheas an daonra (0–19 mbl.)</i>
An Fhionlainn	1 : 6 000
An tSualainn	1 : 7 000
An Fhrainc	1 : 7 500
	<i>Síciatraithe i gcoimheas an daonra (0 – 15 bl.)</i>
Éire	1 : 16 150

Tháinig méadú ó 6 go 21 ar na postanna do Phríomh Cláráitheoirí Síciatracha. Tí níos lú ná 5% de na postanna do shíciatraithe folamh faoi láthair.

### **Soláthar Seirbhísí Reatha**

*Fóirne Rannóga Speisialta d’Ógánaigh taobh amuigh de na hospidéal (<16 bl.)*

Tugann na Fóirne Rannóga Speisialta an chuid is mó den aire is leigheas do leanaí go bhfuil riachtanais mheabhairshláinte acu. Mhol *an Chéad Tuarascáil den nGrúpa Oibre ar Sheirbhísí Síciatracha do Leanaí agus d’Ógánaigh* (2001) gur cheart go mbéadh siad seo leanas mar baill de na fóirne ilsmachtúla:

- 1 Síciatraí Comhairleach
- 1 Príomh Cláráitheoir Síciatrach
- 1 Cláráitheoir Síciatrach
- 2 nó níos mó Príomh Oibríthe Sóisialta (go hidéalach le céim máistir i síciteiripe do leanaí nó teiripe clainne nó a coibhéiseach)
- 2 Síceolaí Cliniciúl
- 1 Teiripeach Ceirde

- 1 Teiripeach Teanga is Labhartha
- 1 Banaltra Pobail Síciatrach do Leanaí
- 1 Banaltra Síciatrach do Leanaí ag obair sa gclinic
- 1 Oibrí Cúram Leanaí/Teiripeach Súgradh
- 2 Riarthóir

Bearnaí 'sna Fóirne Rannóga Speisialta (0–16 bl.):

- 1 Ganntanas fóirne síciatracha faoi chúram Comhairléora do leanaí is d'ógánaigh (tá 40 ann, moltar 59 a bheith ann).
- 2 Na fóirne atá ann ag freastail ar an iomarcach den daonra.
- 3 Fóirne le ganntanas ball.
- 4 Ganntanas foireann oilte I bpostanna criticiúla.
- 5 Éileamh ar na fóirne de bharr ganntanas i seirbhísí eile (Sláinte, Oideachas, Seirbhísí Soisialta).
- 6 Iostas neamh – oiriúnach do roinnt fóirne.

### *Seirbhísí Speisialta 'sna hOspidéal*

De bharr ganntanas leabacha bíonn sé an-deachair leaba a chur ar fáil in am prainne. Is minic a chuirtear na leanaí sin i mbardaí péidiatracha nó i mbardaí do dhaoine fásta go bhfuil fadhbanna síciatracha acu agus amantaí cuirtear thar lear iad le haire dochtúra d'fháil. Rinneadh tagairt don fhadhb seo 'sna nuachtáin.

Tá dhá áit sa tír go bhfuil seirbhísí ann le leanaí agus ógánaigh (faoi 16 bl.) a mheasúnú agus aire dochtúra a thabhairt dóibh (20 leaba in iomlán).

- Baile Bhlainséir (aonad 8 leabacha) i dtuaisceart Átha Cliath.
- St Anne's (aonad 12 leabacha) I gcathair na Gaillimhe.

Tá an dá áit seo ag obair go lag de bharr easpa banaltraí. 'Sna 10 mbliana seo chaite dúnadh 3 aonaid (40 leabacha). Tá sé socraithe go mbeidh an t-Aonad d'Ógánaigh ag St John of Gods, Stigh Lorgan, Áth Cliath ar fáil go luath (32 leabacha in iomlán).

Moltar sa gCéad Tuarascáil den nGrúpa Oibre ar sheirbhísí síciatracha do leanaí is d'ógánaigh gur cheart 144 leabacha (ospidéal) a chur ar fáil do leanaí agus d'ógánaigh suas go 16 bl., le hocht n-aonaid nua do leanaí is d'ógánaigh (ceann amháin acu in áit ceann atá ann faoi láthair agus trí chinn nua sa Réigiún Oirthearach). Bhí sé beartaithe cúig aonaid a fhorbairt agus a bhuanú faoi'n bPlean Forbairtha Náisiúnta (2000–2006). Faoi láthair níl an chéim pleanála bainte amach ag ceann ar bith díobh.

### *Bearnaí 'sna Seirbhísí Speisialta 'sna h-Ospidéal*

- 1 Gan ach 2 aonad (Áth Cliath agus Gaillimh).
- 2 4 Aonaid nua faoi pleanáil fós (8 le cur ar fáil).

- 3 20 leaba ann faoi láthair (156 molta dóibh siúd faoi 16 bl.) (de bharr méadú sa daonra 1996–2002 12 sa mbreis ag teastáil).
- 4 Cead isteach mí-oiriúnach do bhardaí síciatracha do dhaoine fásta nó do bhardaí péidiatracha.
- 5 Gan aon aonad speisialta d'ógánaigh san ngrúpa níos sine.
- 6 Gá le 80 leaba le reachtanais na nógánach 16/17 a shásamh.

#### *Bearnaí i gCláracha na nOspidéal Laethiúl Speisialta*

- 1 Níl ach 3 cláracha ann faoi láthair.

#### *Bearnaí 'sna Seirbhísí Speisialta d'Ógánaigh*

- 1 Níl aon fhoireann ann do'n nGrúpa 14–17 mbl.

#### *Bearnaí 'sna Seirbhísí Speisialta Péidiatracha*

- 1 Gan fóirne ceangail atá sáthach láidir ar fáil 'sna Príomh Ospidéal Péidiatracha.
- 2 Easpa Seisiún Síciatrach Comhairleach 'sna hAonaid Péidiatracha.
- 3 Easpa Seirbhísí Síciatracha Naíochta.

#### *Bearnaí 'sna Seirbhísí Speisialta dóibh siúd ar Neamhachmainn Intleachtacha*

- 1 Is beag dul chun chinn atá déanta ar fhoirne sa limistéar seo.

#### *Bearnaí 'sna Seirbhísí Speisialta Dlí – Eolaíocht Síciatracha d'Ógánaigh*

- 1 Níl seirbhís den gcineál seo ar fáil.

#### *Bearnaí 'sna Seirbhísí do mhí-úsáid Alcóil is Druga*

- 1 Níl ach dhá phost ann dóibh siúd. Níl an tseirbhís seo ar fáil taobh amuigh de Bhaile Átha Cliath.

#### *Tosaíochtaí le Seirbhís Síciatrach do Leanaí is d'Ógánaigh a fhorbairt*

Léiríonn an liosta thuas bealach soiléir do phleanáil stráitéiseach na seirbhíse. Mar sin féin ba cheart tús a thabhairt do na h-imeachtaí seo leanas sa ghearr théarma:

- 1 Méadaigh na fóirne ilsmachtúil 'sna Rannóga thaobh amuigh de na h-ospidéal ó 40 go 59.
- 2 Neartaigh na fóirne comh fada agus is gá.
- 3 Bunaigh Fóirne Síciatracha Speisialta d'Ógánaigh, moltar 39 díobh seo a bhunú (1 Fóireann in aghaidh 100 000 daonra).

- 4 Lean leis an 8 n-aonad síciathracha do leanaí is d'ógánaigh atá leagtha amach san gCéad Tuarascáil den nGrúpa Oibre do'n nGrúpa 0–16 bl. agus 156 (144 + 12) leabacha a chur ar fáil.
- 4a Cuir san áireamh san gcúrsa pleanála 80 leaba sa mbreis le riachtanais an ghrúpa 16–17 mbl. a shásamh.
- 5 Méadaigh na hOspidéal Laethiúla ó 3 to 12.
- 6 Déan forbairt ar na Seirbhísí Ceangail Speisialta 'sna hOspidéal.
- 7 Déan forbairt ar na Seirbhísí Speisialta Neamhachmainneacha Intleachtacha do Leanaí is d'Ógánaigh.
- 8 Bunaigh Seirbhísí Dlí-Eolaíochta Síciathracha.
- 9 Déan forbairt ar na Cláracha cóir leighis do Mhí-úsáid Alcóil is Druga.
- 10 Déan forbairt ar na Seirbhísí Aisfhéinspeiseacha.
- 11 Bunaigh Seirbhísí Speisialta dóibh siúd go bhfuil Iteachan ar Mhí-Eager acu.
- 12 Bain amach an cuspóir le seirbhísí do leanaí is d'ógánaigh a chur ar fáil leis an bhfoireann is gá a bhunú le freastail ar na reachtanais i leith Féinmharú a chosc, Féinghortú, ADHD, Iompar Mhí-órdaitheach agus Leanaí atá i gCúram.
- 13 Méadaigh na háiteanna sa bPríomh Scéim Speisialta Traenála i leith Síciatracht do Leanaí is d'Ógánaigh.
- 14 Bunaigh Bonn Sonraí Náisiúnta.
- 15 Leathnaigh amach ranna acadúla agus saothar taighde.

### *Impleachtaí Acmhainne*

- Le Seirbhís Forleathan a chur ar fáil (suas go 18 mbl. d'aois) tá gá le postanna Síciatrachta Comhairleacha lán aimsire do Leanaí is d'Ógánaigh cómhór le 150.
- Bhéadh costas €80 m ann le seirbhís mar sin a bhuanú (suas go 18 mbl. d'aois) agus bhéadh gá freisin le €150 m a chaitheamh ar fhuilleamh caipitil.
- Iarrann An Dámh ar an Roinn Sláinte is Leanaí anailís sa mbreis a dhéanamh agus tuarascáil a thabhairt don Aire le moltaí faoi fhorbairt forsaí oibre, pleananna faoin méid airgid a bhéadh le fáil, agus an t-am a thógfadh sé leis na polasaí ar fad a chur i gcrích.

# Introduction

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This position statement translates the principles and recommendations set out by a variety of bodies into a programme for the development of child and adolescent psychiatric services in the Republic of Ireland. It formulates a strategic plan to bring the service into the future.

Article 24 of the United Nations (1989) Convention on the Rights of the Child (ratified by Ireland in 1992) states that:

‘the State shall recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health ... [and] shall strive to ensure that no child is deprived of his or her right of access to such health care services.’

The World Health Organization (2003), in *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.’

The Health Strategy (*Quality and Fairness*) of the Department of Health and Children (2001*b*) sets the health agenda for organising the future health system around a new vision: the system will be equitable, people centred, accountable and quality driven. *Quality and Fairness* states that gaps exist in the provision of mental health services for children and adolescents. The Health Strategy outlines a number of initiatives to improve children’s health, including:

‘Mental health services for children and adolescents will be expanded:

- Implementation of the recommendations of the First Report of the Review Group on Child and Adolescent Psychiatry
- Development of mental health services to meet the needs of children aged between 16 and 18.’

*The Health of Our Children*, the second annual report of the Chief Medical Officer (Department of Health and Children, 2001*d*), states:

‘Approaches to the promotion and development of sound mental health for children, and the identification and treatment of psychological and psychiatric disorders, have been patchy, uncoordinated and under-resourced.

The absence of epidemiological information relating to children’s mental health on a national basis is a significant limitation in our current system.... A highly developed information system is required, in order to underpin approaches to quality assurance and evaluation of mental health prevention and treatment services, to monitor trends in incidence, and to identify risk factors and risk groups.’

The Department of Health and Children (2000), in its *National Children’s Strategy*, states that ‘Children will be supported to enjoy optimum physical, mental and emotional well-being’.

The Working Group on Child and Adolescent Psychiatric Services was established by the Department of Health and Children in June 2000 to examine the current state of child and adolescent psychiatric services in the country and to make recommendations on how they should be developed. Its members include child and adolescent psychiatrists, nurses, psychologists, social workers and managers of the child and adolescent psychiatric services, as well as officials of the Department of Health and Children.

The Working Group's first report (Department of Health and Children, 2001a) made specific recommendations with regard to:

- in-patient services for children and adolescents up to the age of 16 years
- the composition of multidisciplinary community-based child and adolescent psychiatry teams
- the ratio of teams to total population
- the treatment of children and adolescents suffering from attention-deficit hyperactivity disorder (ADHD).

Its second report (Department of Health and Children, 2003b) made specific recommendations with regard to:

- the development of services to meet the specific needs of 16- to 18-year-olds
- the recruitment of consultant child and adolescent psychiatrists with a special interest in the psychiatric disorders of later adolescence
- the establishment of adolescent multidisciplinary teams headed by a consultant child and adolescent psychiatrist, providing a range of services
- the development of specialist in-patient adolescent units
- the establishment of a comprehensive database to facilitate research and service development.

The Mental Health Act 2001 (Department of Health and Children, 2001c) set up the Mental Health Commission 'to promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of mental health services'.

The National Task Force on Medical Staffing (Department of Health and Children, 2003a) in its report recommended increasing the number of consultant child and adolescent psychiatrists recommended by the Working Group's first report by a factor of two. It will therefore be necessary to increase the number of specialist training places to meet this projected need.

*Minding Our Health – A Draft Strategy for Promoting Mental and Emotional Health in Northern Ireland* (Department of Health, Social Services and Public Safety, Northern Ireland, 2000) states that:

'Suicide may be seen as the extreme result of poor mental and emotional health and well-being. The traumatic impact of suicide on individuals, families, communities and society warrants a specific focus by those involved in promoting mental health and emotional well-being. It should also be emphasised in policies and practices developed and implemented across many sectors whether government, statutory, community, voluntary or private.'

## **Future trends and developments**

The population of the Republic of Ireland is likely to continue to grow, although possibly not at the rate observed between 1996 and 2002. Services will therefore need to be able to serve more people. The composition of the population is also changing. There is now much greater racial and cultural diversity in our population and this poses particular challenges to all health services.

Health information is now much more widely available (especially through the internet) and more widely discussed in the media. This leads to much greater levels of public expectation, which all services have to address. These expectations place particular demands on the child and adolescent psychiatric services, because of the great worry attached to any health issue related to children.

In spite of Ireland's improved economic performance, there is still poverty. Poverty and social disadvantage are associated with lower levels of mental and physical health, and increase the need for services addressing these problems. If the national policy of equity in health services is to be implemented, resources will have to be targeted at areas and populations of greatest need. The allocation and use of public funds have to be consistent with evidence-based practice and value for money. In this context it is important to make decisions on service developments in a strategic, well planned manner.



# 1 Need for child and adolescent psychiatric services

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## Understanding the needs of children – a developmental perspective

One of the four central principles of the Health Strategy (Department of Health and Children, 2001b) is equity, such that people (including children) are treated according to need and services are planned according to need. Planning on the basis of need is also necessary if we are to make the best use of scarce resources.

In recognition of the fact that children's lives do not occur in a vacuum, both policy (as set out in the Health Strategy) and best practice require a holistic approach to be taken to the needs of children and adolescents with mental health problems. Mental health problems in children that are more severe than their parents can deal with without professional help are not solely the concern of mental health services. The development and overall functioning of children and adolescents are the concern of a wide range of services and agencies, such as education, community care and paediatric medicine. Mental health services cannot respond to mental health needs in isolation.

Developmental psychiatry can be defined as the recognition, assessment, treatment and management of mental states and behaviours across the lifespan. It is not merely the study of the childhood years but of the continuities and discontinuities across the life cycle.

### *Early years (0–5 years) – 'Trust, autonomy and initiative'*

The importance of early experiences to mental health functioning in later life has been well documented, particularly in areas such as the attachment relationship with parents and carers. Interventions specifically targeting this age group can have preventive/protective value and have been shown to be successful (e.g. the Community Mothers Programme and programmes for the prevention of antisocial behaviour in childhood and adolescence).

There is variability between children in terms of the rate at which they develop across different aspects of functioning (e.g. one child may learn to walk more quickly but talk more slowly than another child). Where concerns arise regarding a possible delay or disturbance in development, it is not unusual for a number of services and professionals to be involved, as the precise nature of the difficulty may not be immediately evident. In addition to mental health services, other professionals likely to be involved include: general practitioners, public health nurses, speech and language therapists, clinical psychologists, educational psychologists, occupational therapists, paediatricians, specialist pre-school staff and representatives from the Department of Education and Science.

### *Primary-school-age children (6–11 years) – ‘Industry’*

The mental health needs of primary-school-age children must also be responded to in a manner that takes account of the key people in their lives. A model such as that outlined for the younger child is again recommended. In addition to the services identified above, the Community Care Social Work Service or the Family Support Worker Service may also be included.

### *Adolescents and young people (12–15 and 16–17 years, respectively) – ‘Identity, intimacy’*

The Adolescent Health Strategy (National Conjoint Child Health Committee, 2001) underlined the importance of developing adolescent-friendly services. A challenge is presented to mental health services to become more appealing to young people, through liaison with schools, youth clubs and so on. If mental health services are made available in such settings they will be more accessible to potential users; there will also be benefits in terms of de-stigmatising mental health issues and encouraging help seeking. A wide range of services is also required within the mental health services, such as day programmes, in order to make the service as accessible as possible to adolescents.

### **Implications of a developmental perspective**

A holistic approach to the child, as outlined above, has considerable implications for service delivery, as a significant amount of time will be spent liaising with other agencies and professionals involved with the child. The complexity of the child and family presentations requires ongoing, intensive, multidisciplinary assessment. The increasing awareness of disorders such as ADHD and of the importance of the early years has had a directly observable effect on services, with increasing numbers of children referred.

### **Benefits of a developmental perspective**

This holistic approach to the mental health problems of children has both short-term and long-term benefits. There is evidence that it offers the best outcomes for the child, which should be the top priority of services. Because the family are involved in the assessment and intervention, both as a unit and as siblings and parents, there are beneficial effects for all the family, and family functioning can improve. Children’s teachers will also be involved, and they will gain knowledge and experience that will help them deal with other children, creating a ‘multiplier effect’.

The beneficial effects can also encompass more than direct improvements in mental health. For example, when the behaviour of children with ADHD can be improved such that they are able to remain in school, their prospects for a fuller and more productive life are greatly enhanced. Children who leave school early

show lower levels of attainment in many areas of life. Further, a problem that is addressed in childhood will in many cases prevent a problem remaining into adulthood, when it may be more resistant to treatment. Thus, the long-term quality of life for the child is enhanced. An additional benefit is the likelihood of these children becoming better parents for their own children, therefore breaking the cycle of problems that often exists. In these ways, the child and adolescent psychiatric services can add immeasurable health and social gain to all those with whom they are in contact, ensuring ‘a better future now’ for our children.

### Children in the population

The proportion of the Irish population under the age of 16 years is one of the highest in Europe (Central Statistics Office, 2003), as shown in Table 1.1, which gives the figures for a representative sample of countries.

**Table 1.1 Comparison of population demographics (2002)**

<i>Country</i>	<i>Total population</i>	<i>Population aged 0–15 years</i>	<i>Percentage aged 0–15 years</i>
Republic of Ireland	3 917 000	888 310	22.68%
United Kingdom	58 800 000	11 900 000	20.24%
Finland	5 206 000	991 635	19.05%

Ireland’s population increase over the 6 years 1996–2002 far outstripped that in any other country in the European Union (EU), with the 2002 census showing an increase of 8%. (The population had increased by 291 249 from 1996; the population of the Republic is now 3 917 203.) The proportion of the population under 18 years is 25.86% (Table 1.2).

**Table 1.2 Irish 2002 census figures by age**

<i>Age (years)</i>	<i>Population</i>	<i>Percentage of total population</i>
0–3	222 349	
4–7	214 375	
8–11	217 926	
12–15	233 660	
0–15	888 310	22.68%
16–17	124 721	
0–17	1 013 031	25.86%
Total population (all ages)	3 917 203	

Source: Central Statistics Office (2003).

## **Prevention of child and adolescent psychiatric disorders**

The prevention of child and adolescent mental health disorders can be conceptualised as having three layers (Graham *et al*, 1999):

- 1 Primary prevention tries to stop a disorder occurring by removing the cause.
- 2 Secondary prevention tries to identify a disorder at onset and prevent its extension.
- 3 Tertiary prevention tries to limit disability from an established disorder.

Further details are given in Appendix 1.

In the realm of public health, nine areas have been identified which, if improved upon, should lead to increased mental well-being among children. These are:

- 1 poverty alleviation
- 2 increasing neighbourhood unity
- 3 good housing
- 4 increasing employment
- 5 good child protection from abuse and neglect
- 6 accident prevention
- 7 education
- 8 services to reduce marital disharmony
- 9 reducing alcohol consumption.

Specific primary prevention measures by health and other professionals can be conceptualised in terms of life stages. These subdivide into six intervention phases:

- 1 preparation for parenthood
- 2 antenatal care
- 3 birth and postnatal period
- 4 pre-school period
- 5 middle childhood
- 6 adolescence.

The quality of services provided during each of these six life stages by health and other professionals will impinge on mental health.

Secondary prevention tries to identify the presence of a disorder at onset and, by providing an appropriate therapeutic intervention, prevent it getting more serious. Tertiary intervention tries to limit the secondary disability that arises from the presence of an established disorder. At the levels of secondary and tertiary prevention, the provision of comprehensive, effective services working with families and other professionals who have contact with the child is all important.

## Children at risk of psychiatric disorder

Research has shown that there are increased rates of psychiatric disorder linked to the following factors.

### *Social factors*

- Children in urban areas usually have *twice* the rate of disorder of their rural peers.
- Children who live in environments characterised by unemployment, family discord, family violence, family break-up, social disadvantage (discrimination, isolation, homelessness, immigration) and traumatised circumstances have increased rates of disorder.
- Children who come to the notice of community care social services because of child care and protection concerns – and in particular because of confirmed physical, sexual or emotional abuse or neglect – have increased rates of disorder.
- Children in care (i.e. being cared for by a relative, or in foster care, children's homes or a secure unit) have significantly increased rates of disorder.
- Children of families who are experiencing discrimination a result of their cultural or ethnic background are more vulnerable to mental health problems. In Ireland this specifically includes the Travelling community and refugees.

### *Other conditions*

- Children with language and communication problems have *three* times the general population prevalence of psychiatric disorder.
- Children with specific developmental disorders (e.g. dyslexias and dyspraxias) have increased rates of disorder.
- Children with intellectual disability (i.e. an IQ less than 70) have *two to four* times the general population prevalence, with an increasing prevalence as the severity of the intellectual disability increases.

### *Stressors*

- Children who have been physically or sexually abused, or both, have an increased prevalence of psychiatric disorder, with rates probably *three* times higher than in the general population. The precise rate is influenced by the severity of the abuse and the family supports available following abuse.
- Children whose parents have a psychiatric illness, or an alcohol or drug misuse problem, show increased rates of disorder. This risk is related to the effect of the parents' difficulties on their ability to provide a safe and appropriate caring environment for their child.

### *Physical illness and disability*

- Children with a chronic illness have *twice* the general population prevalence of psychiatric disorder, while children with both a chronic illness and a physical disability have a prevalence *three* times that of the general population.
- Children with brain disorders, especially epilepsy and head injury, have *five* times the general population prevalence of psychiatric disorder.

### **Prevalence of childhood psychiatric disorders**

It is often the case that the data required to assess the need for services are not readily available. We are fortunate, however, to have reliable information on the prevalence of psychiatric disorders in childhood and reliable information on vulnerability factors in the population, based on international and Irish research findings.

The incidence and prevalence of mental and behavioural disorders in childhood (see Appendixes 2 and 3) increase with age. Overall, 20% of children have a disorder at any one time: 10% will have a mild disorder, 8% will have a moderate to severe disorder and 2% will have a disabling disorder. There is an equivalent amount of mental health disorder in the child as in the adult population. Among younger children boys have more disorders than girls but this evens out by middle to late adolescence.

Child and adolescent psychiatric disorders encompass a broad range, from psychosis, depression and eating disorders, through anxiety and attachment disorders, to autism and pervasive developmental disorders. Diagnosis of a childhood psychiatric disorder requires detailed assessment and observation, which build up a picture of problems and symptoms and the impairments which result.

A number of factors are considered in assessing the significance of a mental health problem or disorder (see Appendix 4): its severity, complexity and persistence; the risk of secondary handicap; the state of the child's development; and the presence or absence of protective factors, risk factors and stressful social factors.

### **Epidemiological data**

Table 1.3 shows the prevalence of various disorders estimated from a variety of studies. These rates are used to estimate prevalence in:

- the total population (3 917 203)
- the population served by a particular child and adolescent psychiatric service (e.g. Clare, Limerick, Tipperary North, 339 591)
- the catchment population of a specialist out-patient sector team (typically 66 000).

It must be stressed that the figures in Table 1.3 are based on rates of disorders expected from Irish and international epidemiological research. It should be noted that most of the figures relate to children aged up to 15 years. If the age range increases, say up to 18 years, greater numbers will be expected, especially in the categories of serious mental illness, such as schizophrenia.

**Table 1.3 Estimated prevalence of child psychiatric disorders in the population aged 0–15 years**

<i>Population</i>	<i>Prevalence of condition</i>	<i>Total for Ireland</i>	<i>Clare, Limerick, Tipperary North</i>	<i>Out-patient team</i>
Total population		3 917 203	339 591	66 000
Population aged 0–15 years		888 310	77 342	14 969*
<i>Groups with psychiatric disorder (population aged 0–15 years unless otherwise stated)</i>				
Overall prevalence (any psychiatric disorder)	20%	177 662	15 468	2 994
Moderate/severe disorder	8%	71 064	6 188	1 200
Disabling disorder	2%	17 766	1 547	300
<i>Psychoses and schizophrenia</i>				
Age 13	0.9 per 10 000	5.5	0.5	0.1
Age 18	17.6 per 10 000	98	8.5	1.7
<i>Mood disorder</i>				
Depression	2%	17 766	1 547	300
Deliberate self-harm (12–19 years)	1%	8 883	773	150
Obsessive–compulsive disorder	1%	8 883	773	150
Hyperkinetic disorder/ADHD	2%	17 776	1 547	300
Conduct disorder	5%	44 416	3 867	749
Anorexia nervosa (12–19 years)	0.5%	1 110	97	19
Emotional/anxiety disorders	5%	44 416	3 867	749
Recurrent abdominal pains	10%	88 831	7 734	1 497
Physical and psychiatric illness	1%	8 883	773	150
Autism spectrum disorder	60 per 10 000	5 330	464	90
Autism and learning disability	40 per 10 000	3 553	309	60
<i>Learning disability</i>				
IQ 50–70 (mild)	2.2%	19 543	1 703	330
IQ < 50 (moderate/severe)	0.3%	2 665	232	45
Specific learning disorder	8%	71 065	6 192	120

\*Based on the national average of 22.68% of the total population.

### Estimating need

As child and adolescent psychiatric services are specialist services, it is the 8% of children with moderate/severe and the 2% of children with disabling disorders who should be referred to them. As many disorders are often undetected in the

community, these numbers are not always evident at the level of specialist services.

Estimates of prevalence like those in Table 1.3 can be used to enable services to estimate the level of undetected disorder. For example, one would expect to see 1547 cases of ADHD/hyperkinetic disorder in an area with a population of 340 000. If the services in this area see 300 cases, there are approximately 1247 undetected cases in the community. While many of these may be milder than the referred cases, severe undetected disorder can have major consequences for the child, the family, the school and the community. Measures to improve detection of these disorders in the community could include educational initiatives for community-based professionals (e.g. family doctors, teachers and social workers). This type of initiative may bring about an increase in the number of cases being referred to child and adolescent psychiatric services, which could bring about even greater pressure on existing services, unless they are adequately resourced.



## 2 Where we are now – current service provision

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### Scope of service

The purpose of child and adolescent psychiatric services is to provide children and adolescents who have mental or behavioural disorders with appropriate levels of assessment, treatment and care so that they can attain and maintain a good state of mental health. The central principles of this service are that it is:

- child centred
- comprehensive
- integrated with other health services
- based as far as possible in the community
- organised in sectors close to the people being served.

Child and adolescent psychiatric services are specialist services, and thus deal mainly with children and families who have problems that require complex assessment and treatment. The services are primarily community based, with limited access to in-patient beds (these are located in Dublin and Galway).

### Population coverage

The child and adolescent psychiatric services have been organised in each former health board area. Some child and adolescent psychiatric services are provided by voluntary agencies.

### Which children can be helped

#### *Age issues*

The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2003b) states that ‘The Child and Adolescent Psychiatric Service currently provides treatment for children up to 16 years of age, however treatment in the adult setting is considered inappropriate for most under 18s’. The following age categories provide a useful outline of the type of services that are generally appropriate for children at different developmental stages:

- *0–5 years.* These children are seen by a member or members of the multidisciplinary team and are almost entirely dealt with on an out-patient basis, with direct and ongoing involvement of family. The need for in-patient treatment rarely arises.
- *6–11 years.* These children are seen by a member or members of the multidisciplinary team and are almost entirely dealt with on an out-patient

basis, with direct and ongoing involvement of family. The need for in-patient treatment does arise.

- *12–15 years.* These children are seen by a member or members of the multidisciplinary team and are almost entirely dealt with on an out-patient basis. The need for specialist day and in-patient treatment arises more often than it does with younger children.
- *16–17 years.* This group of adolescents is not currently within the remit of the child and adolescent psychiatric services. The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* makes recommendations for the development of services to meet the specific needs of this age group.

Existing adult psychiatric services are aware that they are poorly resourced to deal with older adolescents because of a different emphasis placed on a developmental perspective, which needs to centre on family, school and social interventions. Adult services do not have in-patient facilities that are appropriate for the admission of adolescents for various reasons, which include health and safety in addition to treatment issues. Adult out-patient clinics are generally not adolescent-friendly.

Existing child and adolescent psychiatric services are not equipped to deal with older young people because of the significant increase in major psychiatric illnesses that occur in this age group. Child and adolescent psychiatric services tend to provide out-patient services only, often with limited resources, and have restricted access to in-patient beds or day hospital facilities.

In addition, these services tend to find that younger adolescents (i.e. those aged 12–15 years) place a high demand on services. The frequent need for urgent responses to problems presented by this age group can lead services to deal disproportionately with adolescents at the expense of their work with younger children, thereby preventing useful early intervention, which has a secondary preventive value. Waiting lists for child psychiatric services are lengthened further as a result. This is particularly the case where the multidisciplinary team is under-resourced.

### *Condition issues*

Children and adolescents who have severe conduct disorder (who may or may not have a coexisting psychiatric disorder) pose difficulties for both child and adult psychiatric services. Their severe behavioural difficulties are often not amenable to conventional psychiatric treatment. Such children and adolescents are often inappropriately referred to psychiatric services. The most effective intervention for this group involves a multi-systemic approach, as outlined below (see pages 54–55).

### Social issues

The shortage of an appropriate range of child care services has increased the demand for psychiatric services. The implementation of national plans to develop high-support residential units for certain children will eventually alleviate this problem to some degree. In addition, a range of community care support services and support services to residential group homes are required. Shortage of these services tends to lead to an escalation of problems, thereby creating an extra demand for psychiatric services.

### The referral process

Figure 2.1 outlines the referral pathways to child and adolescent psychiatric services.

When a referral is made, the team discusses it in order to determine how best to respond. Appropriate cases may be allocated or put on the waiting list. Urgent and emergency referrals receive priority. Cases inappropriately referred are

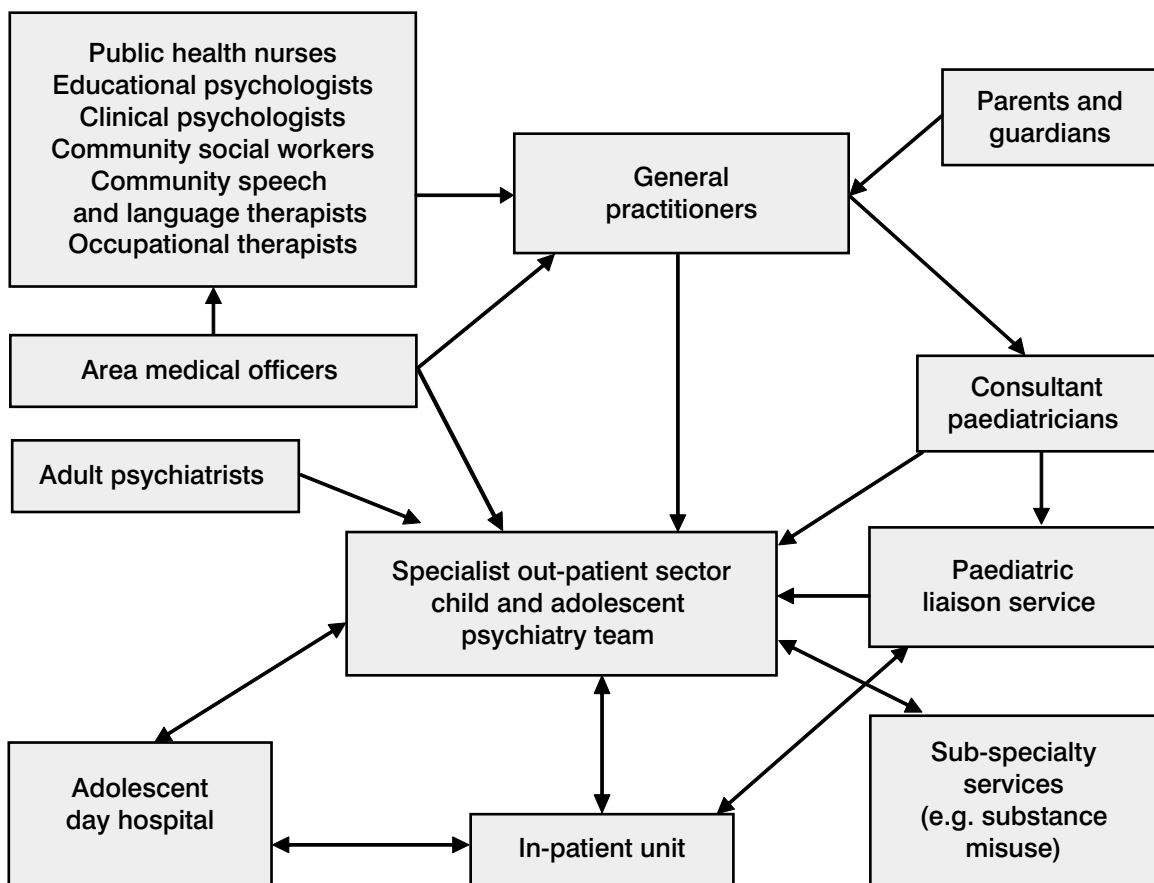


Figure 2.1 Referral pathways to child and adolescent psychiatric services.

discussed with the referrer and advice is given as to where a more appropriate referral may be made.

Once a case has been allocated, the referred child and the parents are usually invited to attend a number of appointments with one or more team members. The purpose of these consultations is to gain the best possible understanding of the difficulties for which the child has been referred. With parental permission, information may be obtained from other sources (e.g. teachers or public health nurses) to assist with this assessment process. Once the child has been fully assessed, a treatment plan is determined, with the involvement of the child, family and other services, as indicated (e.g. school, community care services).

On completion of treatment, the child may be discharged or, if necessary, transferred to another service.

### **Role and responsibilities of the consultant child and adolescent psychiatrist**

Child and adolescent psychiatry is a complex and rewarding specialty which applies a developmental understanding to medicine and psychiatry. This includes a knowledge and understanding of the impact of genetic factors and the environment, including family influences, on the development of individuals and the extent to which these factors influence their mental health.

Consultants in child and adolescent psychiatry are medical specialists skilled in the prevention, assessment and treatment of child and adolescent psychiatric disorders, as well as the promotion of emotional well-being in children and adolescents (Royal College of Psychiatrists, 1999a).

Child and adolescent psychiatry is a recognised specialty within the Irish College of Psychiatrists and is also a recognised medical specialty in the European Union of Medical Specialists (UEMS). Irish child and adolescent psychiatry has representation on the Central Committees of the UEMS and the European Society of Child and Adolescent Psychiatry (ESCAP).

### *Training*

Training will have typically involved:

- a medical degree (e.g. MB, BCh)
- psychiatric training culminating in membership through examination of the Royal College of Psychiatrists (i.e. MRCPsych) or equivalent
- a programme of specialist higher training in child and adolescent psychiatry leading to award of a Certificate of Completion of Specialist Training (CCST) – this will typically have involved a range of clinical experience as well as a formal academic programme and training in therapeutic, managerial, research, audit and teaching skills.

The main areas encompassed within the clinical training are: the full range of psychiatric disorders presenting in childhood and adolescence, from all aetiologies,

and including forensic, paediatric, liaison, neuropsychiatric, learning disability, in-patient and day patient experience.

Some consultants will have undergone further higher training in one or more psychological treatments. Some will have received additional training in a variety of related areas, such as substance misuse, paediatrics and research. Dual training, leading to the award of an additional CCST, is formally recognised in the psychiatry of learning disability, forensic psychiatry and psychotherapy.

### *Expertise*

Consultant child and adolescent psychiatrists will, by virtue of their training, have acquired a range of expertise, including in the following areas:

- 1 general medical knowledge and skills
- 2 postgraduate knowledge and skills relating to the causes, assessment, diagnosis and treatment of a wide range of psychiatric disorders, including severe mental illness
- 3 an understanding of the relevance of social, psychological and biological factors to the development and treatment of psychiatric disorders
- 4 specialist knowledge and skills relating to the causes, assessment, diagnosis and treatment of psychiatric disorders in children and adolescents including, in particular, severe mental illness, atypical childhood development and neuropsychiatric disorders
- 5 specialist knowledge of child development and family functioning
- 6 an understanding of the broad range of social interventions for psychiatric disorder, as well as the psychological and pharmacological treatments available, including their clinical indications and evidence base
- 7 specialist knowledge of and the skills to apply a variety of psychological and pharmacological treatments
- 8 the ability to contribute to the assessment and management of acute clinical crises and risk, for example in the context of severe mental illness, substance misuse, deliberate self-harm and seriously antisocial behaviour
- 9 application of the provisions of mental health legislation.

Consultant child and adolescent psychiatrists will also have acquired a wide range of expertise in related areas, including:

- 1 effective communication with children at all stages of development, their parents and carers, and other health and non-health professionals, including clinical correspondence and reports required for other purposes
- 2 working within a multidisciplinary child and adolescent psychiatry team, with other health professionals, and with professionals from other agencies
- 3 working within child protection legislation and systems
- 4 an awareness of when to seek advice from other health or non-health professionals

- 5 providing consultation and liaison to other health and non-health professionals.

Consultant child and adolescent psychiatrists will also have expertise in:

- 1 training and supervising junior doctors and other professionals in the multi-disciplinary team
- 2 teaching medical undergraduates
- 3 contributing to the teaching of professionals in other services
- 4 providing clinical and strategic leadership within child and adolescent psychiatric services
- 5 the critical evaluation of research findings and conducting research
- 6 the various aspects of clinical governance, including audit
- 7 maintaining up-to-date knowledge and skills through a system of continuing professional development.

The roles and responsibilities of a consultant child and adolescent psychiatrist are comparable to those of other hospital consultants. Mental health services are defined in the Mental Health Act 2001 as services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist. Consultant child and adolescent psychiatrists are employed under the same contract as other hospital consultants.

### **The number of consultant child and adolescent psychiatrists**

There are currently a total of 55 whole-time equivalent (WTE) consultant child and adolescent psychiatry posts in the Republic of Ireland. This number is best expressed as a ratio of the total number of consultants to the child and adolescent population, and compared internationally to countries with well developed psychiatric services for this population (Table 2.1).

**Table 2.1 International comparison of the ratio of the number of child and adolescent consultant psychiatrists to the child and adolescent population served**

<i>Country</i>	<i>Ratio</i>
<i>Population aged 0–19 years*</i>	
Finland	1 : 6 000
Sweden	1 : 7 000
France	1 : 7 500
Norway	1 : 8 700
<i>Population aged 0–15 years</i>	
Ireland	1 : 16 150

\*Source: Remschmidt & van Engeland (1999).

## **Undergraduate and postgraduate education**

In addition to providing mental health services for children and adolescents, child and adolescent psychiatric services also provide and facilitate training and further education for a range of professionals.

- Medical undergraduates:
  - Three chairs of child and adolescent psychiatry have been established in Trinity College Dublin and University College Dublin. It is imperative to establish chairs of child and adolescent psychiatry in each of the medical schools, in order to improve undergraduate education and promote the necessary postgraduate research.
- Medical postgraduates:
  - General training in psychiatry.
  - Higher specialist training.
- Nursing:
  - The establishment of postgraduate diploma and degree courses for nurses in child and adolescent psychiatry at Dublin City University has been a positive development.
- Other professions:
  - Placements are provided for trainees in clinical psychology, social work, speech and language therapy and occupational therapy.

## **Strengths of the child and adolescent psychiatric services**

The child and adolescent psychiatric services in place have many strengths, which can be built upon to provide a comprehensive, high-quality service for children with mental health problems:

- 1 A holistic approach is taken to the child.
- 2 The services are accessible to the public (but struggle to meet demand).
- 3 A good range of therapeutic interventions is available – including cognitive-behavioural therapy, pharmacotherapy, family therapy, psychodynamic therapies and parenting skills.
- 4 The service has skilled, dedicated staff.
- 5 There are 40 specialist out-patient sector teams, at varying stages of development.
- 6 In-patient services are available (to a limited degree).
- 7 Educational programmes are in place, providing training for many disciplines.

The gaps in the service are addressed in Section 3.

## **Clinical governance**

Clinical governance is of central importance in the development of specialist child and adolescent mental health services.

Richardson & Partridge (2003) have said that clinical governance is a way of integrating financial control, service performance and clinical quality into the management of health services. The objective is to provide clinical excellence to those served by the health services. This can be achieved by:

- moving the focus from finances and activity targets to quality
- safeguarding high standards of service delivery by creating an environment in which excellence in clinical care and awareness of current evidence will flourish
- continuously improving the quality of service delivered
- using failures and exemplars to increase the quality of care
- providing an organisational culture that encourages clear role definition within supportive teams and that discourages control by blaming.

Within child and adolescent psychiatry, the following are required for clinical governance:

- 1 good information technology systems designed to meet the needs of specialist child and adolescent psychiatric services
- 2 the involvement of all members of the team in an active process of continuing professional development
- 3 active multidisciplinary audit programmes
- 4 adequately resourced staff training
- 5 time set aside at intervals to allow the team to review service provision
- 6 feedback from service users
- 7 an environment that encourages innovation
- 8 an environment that values and supports staff
- 9 team working based on professional and individual role clarity, role confidence, role legitimacy, ownership of responsibility, commitment to children and families, collaborative agencies and colleagues, organisational clarity and communication skills
- 10 effective professional regulation
- 11 effective coordination
- 12 supportive and effective management.

## **Strategic issues for the future**

### *Medical staffing*

The *Report of the National Task Force on Medical Staffing* (Department of Health and Children, 2003a) recommended a restructuring of the health service by increasing the number of consultants and reducing the number of non-consultant hospital



doctors (NCHDs) in the system. This has implications both for the child and adolescent psychiatric service and for the recommendations contained in the reports of the Working Group on Child and Adolescent Psychiatric Services (Department of Health and Children, 2001a, 2003b):

- The recommended teams have a consultant:NCHD ratio of 1:2.
- The *Report of the National Task Force on Medical Staffing* recommends increasing the number of consultants in child and adolescent psychiatry by a factor of two (from 1 per 66 000 to 1 per 33 000) and reducing the number of NCHDs.
- The Task Force projects that, by 2013, the consultant:NCHD ratio will be 3.3:1 in psychiatry.
- Places in training schemes will have to be increased to meet this projected need for consultants in child and adolescent psychiatry.
- Junior doctors are eligible to apply for a higher training post after completing a period of basic training in a postgraduate training scheme and passing the membership examination of the Royal College of Psychiatrists (the Irish College of Psychiatrists being a constituent part of the Royal College of Psychiatrists).
- There are currently 20.5 places in the Higher Specialist Training Scheme in Child and Adolescent Psychiatry. Higher Specialist Training in Child and Adolescent Psychiatry is a three-year course. Therefore seven doctors are eligible to enter the Specialist Register each year. This is wholly inadequate to meet the needs of an expanding service.

#### *Other human resources issues*

The issues are similar to those experienced in other parts of the health service and include: recruitment, retention, selection, appropriate grading, facilitating continuing professional development and valuing staff.

- The difficulty in filling vacant clinical psychologist posts is exacerbated by the protracted length of time required to interview and offer posts to suitable applicants.
- Insufficient numbers of college places for training in disciplines such as clinical psychology, speech and language therapy and occupational therapy make it difficult to fill vacancies, particularly when services undergo expansion. This must be factored into the planning of future service developments.
- The most acute shortage of nursing staff occurs in the in-patient setting. Nurses with such specialised skills are a scarce resource.
- Ongoing resources must be made available to facilitate continuing professional development in order to maintain the quality of the service delivered.

### *The Health Service Executive*

The Health Service Executive was established on 1 January 2005 to take over the management of the Irish health services. The Executive has its own board and is accountable to the Minister for the executive management of the health service. The Health Service Executive is the first body to be charged with managing the health service as a single national entity. The Executive will be organised on the basis of three core divisions:

- the National Hospitals Office
- the Primary, Community and Continuing Care Directorate
- the National Shared Services Centre.

It is planned that child and adolescent psychiatric services will be managed within the Primary, Community and Continuing Care Directorate.

### *The Mental Health Commission and Inspectorate*

The Mental Health Commission is an independent body established under the Mental Health Act 2001 to promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of mental health services. The Act brings the entirety of mental health services for children and adolescents (i.e. those under the clinical direction of consultant psychiatrists) within the remit of the Commission and its Inspectorate of Mental Health Services. In its *Annual Report 2003*, the Mental Health Commission (2004) stated that 'services for children and adolescents are underdeveloped'. A priority of the Inspectorate in 2004 was to carry out an audit of these services and to consult with relevant experts and interested parties on the design of an appropriate inspection template.

### *Expert Group on Mental Health Policy*

The Expert Group on Mental Health Policy was established in 2003 to prepare a new national policy framework for mental health services, updating the 1984 policy document *Planning for the Future*. The terms of reference as agreed by the Group are:

- to prepare a comprehensive mental health policy framework for the next 10 years
- to recommend how services might be organised and delivered
- to indicate the potential cost of its recommendations.

The Expert Group plans specifically to examine psychiatric services for children and adolescents, and is expected to complete its work in 2005.

### *Ombudsman for Children*

The Ombudsman for Children was established under the Ombudsman for Children Act 2002. There are two primary functions of the Ombudsman outlined

in the Act: to promote the rights and welfare of children and young people under the age of 18; and to investigate complaints made against government services, schools and voluntary hospitals.

### *Funding of mental health services*

In 1997 spending on mental health services accounted for 11% of the total health budget. From 1997 to 2001, spending on health increased by €3 billion, which represented an increase of 90% in that period. However, by 2003 mental health services accounted for just 6.8% of the health budget, amounting to €622.8 million (€159 per person). Child and adolescent psychiatric services account for only 5–10% of spending on mental health services, while covering 22.68% of the population.

The Mental Health Commission (2004) has stated that:

‘This under funding is reflective of the low priority given to mental health services, the lack of public awareness of the prevalence of mental disorder and the generally negative and stigmatized attitudes toward mental illness generally.’

It argues that a minimum funding baseline should be established, as a percentage of total health spending, to ensure adequate resourcing. In England and Wales a figure of 12.5% has been adopted. A similar strategy should be adopted in Ireland to ensure the development of a comprehensive mental health service, which would ultimately reduce the costs to the Exchequer of disability related to mental illness.

### **3 Where we want to be – blueprint for service provision**

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#### **Service model for child and adolescent psychiatric services**

The child and adolescent psychiatric services provide assessment and treatment through area multidisciplinary teams, day hospital services, in-patient units, liaison services and consultation/forensic services. Section 1 outlined the complexity of meeting the mental health needs of children and adolescents in a holistic way, that is, taking into account the whole of their life and the other agencies they are involved with, such as the educational system. This complexity presents difficulties when trying to conceptualise a service model for this group of children, as so many different services and components can be involved.

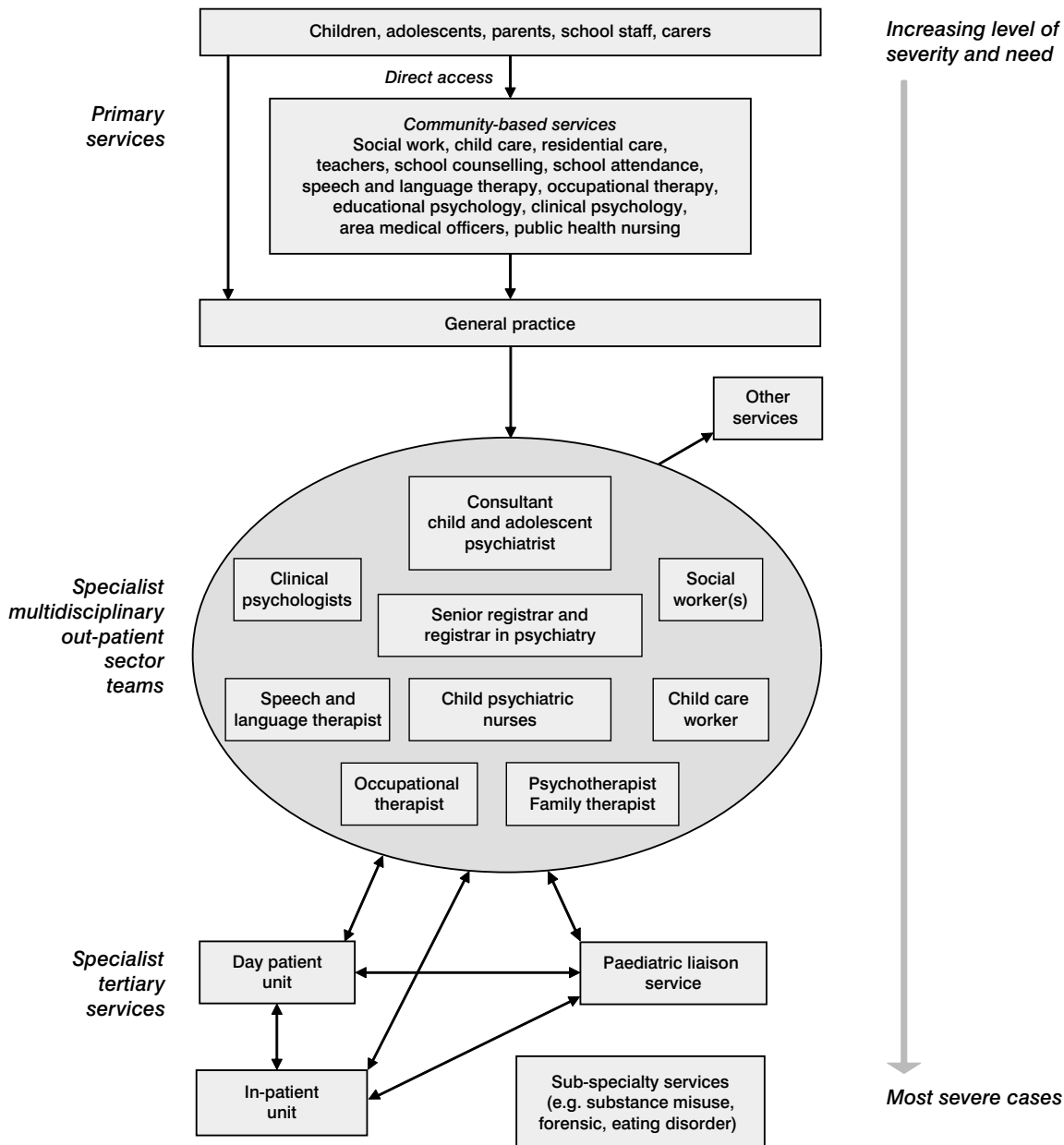
The network approach to mental health service delivery for children and adolescents with mental health problems is a model which includes a wide range of services, from highly specialised services (such as child psychiatry) through broadly focused health services (such as those provided by general practitioners) to services whose primary focus is not health (such as schools and other educational services). Figure 3.1 attempts to show the various elements of the service model and how they all ‘fit together’.

Figure 3.1 outlines what might be considered the essential components of the service model, or the minimum required for the provision of a comprehensive child and adolescent psychiatric service. They are as follows:

- 1 multidisciplinary out-patient sector teams
- 2 specialist adolescent services
- 3 in-patient units for children and adolescents
- 4 day hospital programmes
- 5 paediatric hospital liaison services
- 6 intellectual disability services
- 7 forensic services
- 8 alcohol and substance misuse services
- 9 services for disorders and conditions with specific needs.

The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2003b) recommends that all psychiatric services be managed under the umbrella of the one management structure, namely that of the mental health services, to facilitate appropriate cooperation and planning.

Consultant child and adolescent psychiatrists should have a key role in the management of services. Each child and adolescent psychiatric service should have a consultant child and adolescent psychiatrist holding the position of clinical director, with responsibility for overall service management and development, in partnership with clinical and administrative colleagues.



**Figure 3.1 Stakeholders in the children’s mental health network.**

*Primary or direct-contact services*

Figure 3.1 shows where individuals in the community have direct access to services. Staff in these general community services are not necessarily trained as specialists in mental health; however, because they are often the first point of contact for children and their families, or have ongoing contact with or responsibility for them, they are well placed:

- to identify mental health problems early in their development

- to offer general advice and intervention
- to refer children with more complex mental health needs.

### *Specialist child and adolescent psychiatry out-patient sector teams*

This is the first line of specialist service, under the clinical direction of consultant child and adolescent psychiatrists. The assessment and intervention provided by such teams are 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 multidisciplinary composition is therefore required, to incorporate the skills necessary for the clinical management of the varied and complex clinical problems presented.

The specialist team provides:

- assessment of emergency, urgent and routine referrals
- treatment of more severe and complex problems
- outreach to identify severe or complex mental health need, especially where families are reluctant to engage with mental health services
- assessment for referrals to specialist in-patient or day services
- training and consultation for other professionals
- participation in research and development.

When teams deal with the more severe, complex or persistent disorders, a number of professionals may work together to assess and manage such children and families.

Typical mental health difficulties of referred children are listed in Appendix 2. As the majority of multidisciplinary teams do not have the personnel resources recommended by the *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a), severe and urgent cases predominate, which restricts the scope for treatment and intervention. This in turn leads to significant unmet need, which is unacceptable and ultimately increases the resources required for intervention at a later stage.

### *Tertiary specialist services*

These services cater for a small group of children with complex needs, organised on a regional basis by professional teams of similar composition to the community multidisciplinary teams.

The services include:

- adolescent day hospitals
- child in-patient units
- adolescent in-patient units
- autism spectrum disorder services

- intellectual disability services
- alcohol and substance misuse services
- eating disorder services
- forensic services.

All services need adequate resourcing, as lack of resources in any one service creates excessive work for another and an inefficient use of that resource. For example, a day hospital can help maintain the adolescent in the community and in some cases will reduce the need for in-patient admission. A day hospital can also facilitate earlier discharge from the in-patient unit back into the community. However, there are currently limited day hospital programmes and this gap can put more pressure on the in-patient resource.

The main advantage of this model is that it makes the best use of resources. Resource input is related to complexity and severity of need, and appropriately filtered. Specific areas of deficit can be highlighted and appropriately addressed. It clarifies the distinction between primary community services and specialist child and adolescent psychiatry teams, thus avoiding duplication of services. It explains how better outcomes may be achieved by devoting resources to earlier interventions.

### **The elements of a child and adolescent psychiatric service**

The elements of a child and adolescent psychiatric service consist of specialist out-patient sector teams serving a defined population and a range of other, sub-specialist services, as set out in the previous section. Specialist multidisciplinary out-patient sector teams provide the bulk of the service. These elements are described in detail below.

#### *Specialist out-patient sector teams*

A specialist multidisciplinary out-patient child and adolescent psychiatric team provides a variety of skills, services and treatment options:

- knowledge of child development (normal and abnormal), of disorders (causes, natural course, prognosis), of treatment strategies (including prognosis), of resources in other services and of relevant legislation
- assessment and treatment interviews with parents, children, couples and whole families
- assessment of risk (e.g. of suicide)
- psychological assessment and interpretation of findings
- medical skills related to the assessment of complex cases, the development of complex treatment packages, mental illness, physical symptoms and illness, and medication
- psychotherapy, pharmacotherapy, family therapy, cognitive-behavioural therapy and activity-based therapies (play, art, occupational or drama).

Most of the assessment, treatment and care of children with mental health needs is provided by specialist multidisciplinary out-patient sector teams based in the community. At the pre-school level there can be assessment and treatment programmes run by a clinic nurse and a child care worker. The multidisciplinary team may also run a number of groups, such as social skills, anxiety management and parenting groups. Assessment and treatment of schoolchildren and adolescents often involve school visits, working and liaising with teachers and classroom assistants. There can also be home visits and home-based programmes and support. Clinical work involves individual and family assessments with single or many disciplines. Links with uni-professional groups working in the community are fostered.

The *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a) noted that ‘the internationally acknowledged best practice for the provision of child and adolescent psychiatric services is through the multidisciplinary team’. It recommended that the multidisciplinary team working in a community service should ideally comprise:

- one consultant psychiatrist
- two NCHDs – one senior registrar in psychiatry and one registrar in psychiatry
- two or more senior social workers (ideally with a masters in child psychotherapy or family therapy or equivalent)
- two clinical psychologists
- one occupational therapist
- one speech and language therapist
- one community child psychiatric nurse
- one clinic child psychiatric nurse
- one child care worker or play therapist
- two administrative support staff.

The multidisciplinary team should ideally comprise professionals with specialist training and expertise in different treatment modalities, such as family therapy, individual psychotherapy, play therapy and art therapy.

The *First Report of the Working Group on Child and Adolescent Psychiatric Services* recommended a 15-person team comprising the various professional groups required to provide a comprehensive, holistic service to children, following the principles and model outlined above. While it is important that these individuals are in place on every team, the crucial issue is the recognition of the skills and special training each professional brings to the team. While a team might have 10 people instead of 15, what is missing is much more than five people. What is missing are the special skills that those five people have. Thus, if a team has no psychologist, the ability of that team to do high-quality assessments is curtailed. This has consequences for other team members, who have to try to cover the gaps, but, more importantly, it has consequences for the quality of service that can be offered.



**Table 3.1 Multidisciplinary out-patient sector teams: recommended and actual staffing**

Non-consultant team members	Recommended number of staff <sup>1</sup>	Actual number of staff: <sup>2</sup> percentage of teams					
		0	< 1	1	2	3	4
Senior registrar	1	66.7	16.7	16.7			
Registrar/senior house officer	1	16.7	11.1	61.1	11.1		
Clinical psychologist	2	11.1	16.7	52.8	16.7	2.8	
Social worker	3	5.6	2.8	33.3	52.8	2.8	2.8
Psychotherapist }*		88.9	8.3	2.8			
Family therapist }		86.1	5.6	8.3			
Speech and language therapist	1	52.8	27.8	13.9	5.6		
Occupational therapist	1	58.3	30.6	8.3	2.8		
Nurse	2	40.0	5.7	28.6	14.3	2.9	8.6
Child care worker	1	61.1	2.8	22.2	8.3		5.6
Administrative support staff	2	13.9	13.9	38.9	27.8	5.6	

1. Recommended numbers are from the *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a).

2. Existing numbers of staff ascertained from a survey of consultant child and adolescent psychiatrists by Doody & Buckely (in preparation).

\* Flexibility in allocation as set out in the *First Report of the Working Group*.

The lack of crucial skills shown in Table 3.1 frustrates the team in their ability to complete and provide a comprehensive assessment and treatment plan. The important point is not that the team comprises 15 people *per se*, but that each team has the mix of skills and training that is required to provide a high-quality, holistic service to children with mental health problems and to enable services to attract new staff and retain existing staff.

In spite of staff shortages, services constantly strive to find creative and effective ways of responding to mental health needs. For example:

- many clinics run group programmes for children (and their parents) with similar difficulties
- early-intervention services use multidisciplinary diagnostic pre-school groups within clinics to provide intensive assessments for young children presenting with particularly complex difficulties.

The capacity of each team to deliver a comprehensive service will depend on the population it serves, the number of professionals on the team, the facilities and support available, and the level of development of other health and social services. The *First Report of the Working Group on Child and Adolescent Psychiatric Services* recommended that there be one specialist multidisciplinary out-patient sector team per 66 000 total population. A recent (2003) survey of consultant

**Table 3.2 Recommended<sup>1</sup> and actual number of out-patient sector teams**

<i>Health Service Executive area</i>	<i>Population</i>	<i>Recommended number</i>	<i>Actual number</i>
Eastern Region	1 401 441	21	16
Southern	580 356	9	6
South Eastern	423 616	6.5	3
Western	380 297	6	5
North Eastern	344 965	5	3
Mid-Western	339 591	5	3
North Western	221 574	3.5	2
Midlands	225 363	3.5	2
Total	3 917 203	59.5	40

1. Recommended numbers are from the *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a).

child and adolescent psychiatrists (Doody & Buckely, in preparation) found that all teams served populations in excess of this (see Table 3.2):

- 68% greater than 100 000
- 38% greater than 140 000.

#### *Gaps in this service*

- Shortage of teams.
- Existing teams serving too large a catchment population.
- Teams below recommended staffing complement.
- Shortage of trained staff in key disciplines.
- Inadequate accommodation for some teams.

#### *Specialist adolescent services*

The lack of dedicated adolescent psychiatric services is a serious deficit in the Irish mental health system, and is the subject of an action plan of the Health Strategy (Department of Health and Children, 2001b).

The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2003b) made specific recommendations with regard to mental health services for the 16- to 17-year age group. The Adolescent Health Strategy (National Conjoint Child Health Committee, 2001) underlined the importance of delivering adolescent-friendly services. There is a sharp rise in serious psychiatric disorder in later adolescence, particularly psychotic illnesses, including schizophrenia, with increased need for in-patient treatment. Mental health services for 16- and 17-year-olds are disproportionately expensive and may cost up to twice that for services provided to those younger than 16 years (Goodman, 1997).

There is currently no capacity in child and adolescent psychiatric services to provide for this group. In order to provide a comprehensive specialist adolescent service as envisaged in the report, a large amount of investment will be required.

**Table 3.3 Recommended number<sup>1</sup> of adolescent out-patient teams per health area**

<i>Health Service Executive area</i>	<i>Population</i>	<i>Recommended number</i>
Eastern Region	1 401 441	14
Southern	580 356	6
South Eastern	423 616	4
Western	380 297	4
North Eastern	344 965	4
Mid-Western	339 591	3
North Western	221 574	2
Midlands	225 363	2
Total	3 917 203	39

1. Recommended by the Irish College of Psychiatrists (2002).

This service should, over time, broaden its target age group to include 14- and 15-year-olds, as recommended by the Irish College of Psychiatrists (2002) in its position paper on the development of adolescent services. In that paper the College outlines the development of a specialist mental health service targeted at 14- to 17-year-olds and makes specific recommendations with regard to the resources required to provide a comprehensive service. The Irish College of Psychiatrists recommends that one adolescent multidisciplinary out-patient team be provided per 100 000 population (Table 3.3).

The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* recommends that a specialist adolescent service should have the following components:

- *Multidisciplinary out-patient teams.* These teams should be headed by a consultant adolescent psychiatrist and also consist of a senior registrar, a registrar, a psychologist, a social worker, psychiatric nurses, an occupational therapist, a speech and language therapist and child care workers.
- *Day hospital services.* These services should include a mix of occupational therapy, treatment programmes (e.g. group therapy) and social skills training, and have an educational focus. A day hospital service would cater for those who require more in-depth assessment and more comprehensive treatment than can be offered in the general out-patient setting, but who do not require in-patient treatment. These services could also provide patients with 'step-down' treatment and rehabilitation after an in-patient stay.
- *Assertive outreach services.* These would provide nursing and supportive services in the home, school and community.
- *In-patient services.* Acute (same-day) in-patient admission should be available to adolescents with major psychiatric disorders who require it.
- *Rehabilitation services.* There should be a rehabilitative approach to the care of teenagers who present with major psychiatric disorders. In some cases it is necessary to provide step-down services, such as hostels for the recovery and early rehabilitation phase of an adolescent's treatment.

- *Liaison to general hospitals.* Adolescents who overdose or otherwise harm themselves or who have acute psychiatric illness or psychosomatic problems often present to general hospitals as their first point of contact. All hospitals likely to encounter adolescents in these circumstances should have liaison adolescent psychiatric services.

It is important that broad flexibility exists in all the different services. While it is recommended that the 14- to 17-year age group is an appropriate target for service provision, there should be leeway for flexibility between child and adolescent and adult psychiatrists, whereby children or adolescents whose treatment would be more appropriately provided in a different setting could be facilitated.

Continuity of treatment across services should be made a priority for adolescents who need to transfer from adolescent to adult services. To facilitate this, an overlap between adolescent and adult services should be built into (i.e. be integral to) the operation of the new services. A structure with input from both adolescent and adult psychiatric teams should be established in each sector whereby transitions can be smoothly negotiated and planned, for example through dedicated time to meet regularly to discuss relevant cases.

Good practice would dictate that there should be forward planning and seamless transfer of these cases, in terms of both their psychosocial need and their needs in the area of physical treatments (e.g. medication). This highlights the need for multidisciplinary teams in both services. The numbers of cases needing transfer across services is likely to be significant, given the nature of psychiatric illnesses with onset in mid to late adolescence.

### *Specialist in-patient services*

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

- to provide accurate assessment of those with the most severe disorders
- to implement specific and audited treatment programmes
- to achieve the earliest possible discharge of the child back to the family and the general community.

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 and bulimia. Admission may also be required for clarification of diagnosis and appropriate treatment, or for the commencement and monitoring of medication. Occasionally admission is required where a mental health concern contributes to a family crisis.

In-patient facilities for the assessment and treatment of children and adolescents under the age of 16 years are located in two centres:

- Warrenstown In-patient Unit, situated in North Dublin, which has 8 beds
- St Anne's In-patient Unit, situated in Galway city, which has 12 beds.

**Table 3.4 Provision of in-patient beds in Ireland and Finland**

<i>Country</i>	<i>Total population</i>	<i>Population aged 0–15 years</i>	<i>Number of in-patient beds</i>
Ireland	3.9 million	888 310	20
Finland*	5.2 million	991 635	290 (0–19 years)

\*Source: Remschmidt & van Engeland (1999).

The serious lack of such beds (see Table 3.4) results in enormous difficulty accessing a bed in a crisis. Such children are frequently admitted to either:

- a paediatric hospital, where their mental health needs are often not well met as the environment can be unsuitable and the nursing and medical staff lack the specialist knowledge to treat such children and adolescents
- an adult psychiatric ward, which cannot provide an appropriate environment for the assessment and treatment of adolescents, and where the lack of specially trained staff to work with this age group further affects the quality of care available. At minimum adolescents admitted to adult psychiatric facilities should be treated in a separate area by appropriately trained staff.

The *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a) recommended the provision of a total of 144 in-patient beds, with the development of eight new child and adolescent psychiatric units (one unit replacing an existing one and three to be located in the Eastern Region). Five units were to be developed and funded under the National Development Plan (2000–06).

At present four of the proposed units are at the planning stage:

- Bessborough House, Cork
- Limerick Regional Hospital Complex
- Merlin Park Hospital Complex, Galway (replacing St Anne's Unit)
- St Vincent's Hospital, Fairview, Dublin.

Four further units were proposed at:

- AMNCH Hospital, Tallaght, Dublin
- Mater/Children's University Hospital, Temple St, Dublin
- Waterford Regional Hospital Complex
- Our Lady of Lourdes Hospital, Drogheda.

#### *Gaps in this service*

- There is an in-patient bed crisis. The *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a) recommended 144 in-patient beds for children and adolescents (0–15 years) based on the 1996 census. An extra 12 beds are required due to the population increasing by over 290 000 up to the 2002 census, giving a total

of 156 in-patient beds. Currently there are 20 functioning in-patient beds, located in Dublin and Galway.

- The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2003b) recommended the development of specialist in-patient services for the 16- to 17-year age group. To meet this need requires the provision of an extra 80 in-patient beds.

### *Specialist day hospital services*

The lack of adolescent day hospital facilities is a major gap in existing services. Currently there are only two adolescent day hospital programmes in the country. Many adolescents would benefit from access to a service that provides intensive assessment and treatment programmes (individual, family and group). This would help maintain the adolescent in the community and in some cases would reduce the need for in-patient admission. It can also provide a very important step-down service following in-patient treatment. This transition can otherwise be somewhat abrupt and is dealt with by having a graduated discharge from the in-patient unit, which creates further demand on an already scarce resource. The availability of a day patient service can thus facilitate earlier discharge from the in-patient unit.

### *Gaps in this service*

- No adolescent day hospital programmes are available outside Dublin and Galway.

### *Specialist paediatric liaison service*

A liaison service is a partnership between child and adolescent mental health professionals and paediatric hospital services that provides integrated medical and psychological care for children (see Appendix 5). The psychosocial impact of childhood illness, especially when it is chronic, on the child, parents and siblings is considerable. The level of psychiatric disorder in chronically ill children is higher than that in well children. Specific psychiatric disorders are also associated with particular illnesses. These disorders are most effectively treated in a liaison service.

The three central functions of a liaison service are: clinical care, staff consultation and teaching. These can be provided only when a comprehensive team is in place.

In addition to dealing with children with physical illness, emergency cases such as self-harm are also dealt with. It is the aim of services to reduce deliberate self-harm and suicide. The practical response to this is to give absolute priority to any child who has engaged in self-harm, as there is an increased risk of suicide. These children are given clinic appointments at the earliest opportunity or, if they present at an accident and emergency (A&E) department, they should

be assessed as a matter of policy. This should consist of a period of observation, which facilitates the assessment of the child or adolescent, and involvement of the family, so that management and crisis intervention can be planned and initiated.

Infant psychiatry deals with the diagnosis, treatment and prevention of maladaptive psychological functioning in the very young. Children's attachment relationship with their parents is of great developmental importance; the quality of these attachments is predictive of their subsequent emotional well-being.

#### *Gaps in this service*

- Liaison psychiatry teams exist only in major paediatric hospitals. These teams are at varying stages of development and require appropriate resourcing. Not all paediatric units nationwide have a specialist paediatric liaison service.
- There is no infant psychiatry service.
- This report recommends 1 WTE consultant child and adolescent liaison psychiatrist per 250 000 population.

#### *Specialist intellectual disability services*

Intellectual disability is defined as an IQ of less than 70. It affects about 2.5% of the general population. When one adds the requirement that, in addition to intellectual disability, there is impairment in the individual's ability to function socially, such that he or she is in need of special care and attention, this reduces to about 1%. Service provision for this group is governed by the philosophy of 'integration', with the provision of appropriate educational and community supports and medical services. The role of child and adolescent psychiatric services is in the assessment and treatment of those children who have coexisting psychiatric problems.

One-third of all children with intellectual disability have psychiatric disorders, which is two to four times the rate among children with an IQ in the normal range. The range of psychiatric disorders is broadly similar, but the combination with intellectual disability can be particularly stressful for the child and family. Interventions need to take into account the individual's level of functioning and must be tailored appropriately.

The service responsibility for children with mild intellectual disability (i.e. an IQ of 50–69) is shared between consultants in child and adolescent psychiatry and consultants in intellectual disability in an *ad hoc* manner. Neither service is adequately resourced to provide services appropriate to the identified need. Although a proportion of this group (those with high levels of adaptive functioning) will be looked after by the specialist out-patient sector team, children with a low level of adaptive functioning should in general be referred to specialist intellectual disability services for assessment and treatment.

The Irish College of Psychiatrists recommends the development of specialist intellectual disability multidisciplinary teams under the clinical direction of a

consultant psychiatrist who has the appropriate training in both child and adolescent psychiatry and intellectual disability to meet the mental health needs of children and adolescents with intellectual disability and mental health problems. Detailed recommendations with regard to development of this service are contained in *Proposed Model for the Delivery of a Mental Health Service to People with Intellectual Disability* (Irish College of Psychiatrists, 2004).

#### *Gaps in this service*

- Specialist intellectual disability teams have been developed in only a very limited manner.

#### *Specialist forensic services*

Forensic psychiatry refers to the interface between the courts and mental health services. Forensic psychiatry services can have a role with children in relation to:

- the juvenile justice system
- child abuse proceedings
- child custody, access and placement.

*The juvenile justice system.* There is at present no forensic service in Ireland for children (those under the age of 18 years) who come before the courts. Children and adolescents who present with criminal behaviour are sometimes referred to generic child and adolescent psychiatrists or adult psychiatrists, neither of whom have sufficient expertise in the area. The provision of a specialist adolescent forensic psychiatric service requires urgent attention. A consultant child and adolescent forensic psychiatrist is dually trained in child and adolescent psychiatry and forensic psychiatry.

A forensic psychiatric service for children and adolescents would have the following components:

- two multidisciplinary teams, led by consultant child and adolescent psychiatrists with special expertise in forensic psychiatry, providing consultation to all secure detention facilities for adolescents and liaising with the juvenile court system
- one outreach forensic psychiatric team for children and adolescents, in which the young people are seen directly by members of the specialist team, which would share responsibility with the local service
- a national secure adolescent psychiatric unit of 10–14 beds, to provide specialist forensic assessment and treatment, for children and adolescents who are psychiatrically ill and in need of treatment in a secure setting (it is recommended that 10% of the total number of beds for a population should be secure).



*Child abuse services.* There are two independent assessment and validation teams dealing specifically with child sexual abuse. These teams are located in Dublin and serve the Eastern Region:

- 1 St Clare's Unit, Children's University Hospital, Temple St
- 2 St Louise's Unit, Our Lady's Hospital for Sick Children, Crumlin.

*Child custody, access and placement.* Service needs in this area are not dealt with in this report.

### *Specialist alcohol and substance misuse services*

Over 1900 children under the age of 18 years sought addiction treatment in Dublin during the 1990s (Smyth & O'Brien, 2004). They accounted for 20% of all new attendances, according to data from the Health Research Board. Although the main drug of misuse fluctuated dramatically over the decade, heroin accounted for 43% of all presentations by children. The majority of children who misuse drugs and alcohol do not access treatment.

The European School Survey Project on Alcohol and Drugs (ESPAD; Hibell *et al*, 2000) found that one in three 16-year-old Irish schoolchildren had smoked cannabis and one in seven was a current cannabis smoker. The national Survey of Lifestyles, Attitudes and Nutrition (SLAN) found that rates of cannabis and alcohol misuse among teenagers were similar across all socio-economic groups (Department of Health and Children, 2003c). A survey of agencies working with teenagers has indicated that the threshold for entry into addiction treatment is viewed as too high and the geographical spread of treatment services makes treatment difficult to access (Vitale & Smyth, 2004). Research indicates that the treatment of adolescents with addiction problems results in improvement for both the adolescent and the family, while delivering cost savings to wider society (Gossop *et al*, 2003).

International research on adolescent addiction has identified parameters for best practice in this area. Surveys have been conducted of the views of service users, service providers and service referrers in Ireland (Department of Health and Children, 2004). This body of knowledge concludes that adolescent addiction services should:

- be child centred
- be family oriented
- be locally delivered, in a building separate from adult addiction services
- offer a range of evidence-based medical, psychological and social interventions
- actively collaborate with other agencies (e.g. education, probation, mental health)
- deliver after-care in conjunction with partner agencies
- deal with alcohol problems as well as drug problems.

The Health Advisory Service (2001) has proposed a four-tiered model of service delivery for the treatment of adolescent addiction (see Table 3.5). The Working Party on Treatment of Under 18 Year Olds has endorsed this model for use in Ireland (Department of Health and Children, 2004). This model, using the above criteria, can be adapted for both urban and rural settings. As one goes up the tiers, from 1 to 4, services increase in their capacity to work with adolescents with more complex addiction problems. As the adolescent recovers, he or she can move back down the tiers.

The element of this model that is currently lacking in Ireland is tier 3 – the multidisciplinary team. The tier 3 multidisciplinary team has a vital role in supporting preventive and therapeutic interventions delivered at tiers 1 and 2. Research on evidence-based therapeutic interventions in this field indicates that the tier 3 team will require competencies in:

- the psychiatric assessment of addiction and comorbid mental disorder
- the assessment of adolescent developmental issues
- the assessment of coexisting physical illness
- the medical treatment of addiction (e.g. substitution treatment where appropriate)
- family therapy
- individual therapies, such as cognitive-behavioural therapy and motivational enhancement therapy
- group therapy
- the assessment and management of child protection issues.

Although individual team members may have competencies and specialist skills in more than one area, no professional will have all of the above competencies. Nonetheless, the team will be capable of meeting the needs of all but the most severe adolescent addiction problems. Such teams could include child and adolescent psychiatrists, clinical psychologists, child mental health or other nurses, social workers, child care workers, family therapists and counsellors. Ideally, some members of the tier 3 multidisciplinary team will also work part time in tier 2 services (e.g. an adolescent mental health nurse working half-time with the specialist adolescent psychiatric service and half-time with the tier 3 team). Such 'split' posts will bring a two-way flow of both skills and communication. This will facilitate good inter-agency working and reduce the possibility of duplication of interventions by services.

- It is recommended that a consultant child and adolescent psychiatrist trained in this area is the lead clinician on such teams.
- For a population 350 000 it is estimated that one tier 3 multidisciplinary team will be required, depending on level of need.
- This team should include 0.6 WTE consultant child and adolescent psychiatrists and five WTE clinical staff members with a mix of the above competencies. The team will also require 1.5–2 WTE administrative support staff.

**Table 3.5 Four-tier model of adolescent addiction treatment**

	<i>Specialist skills*</i>	<i>Type of adolescents accessing service</i>	<i>Type of intervention for addiction difficulties</i>	<i>Intervention delivered by</i>	<i>Examples of service providers at this tier*</i>	<i>Intensity and duration</i>
Tier 1	Specialist skills in <i>neither</i> adolescent mental health <i>nor</i> addiction	Considering, or commencing, experimentation with drugs or alcohol	Basic advice Onward referral	An individual	Teacher, general practitioner, probation officer, youth worker, A&E staff, primary care nurse, community social worker	Low intensity and ongoing
Tier 2	Specialist skills in <i>either</i> adolescent mental health <i>or</i> addiction, but <i>not both</i>	Misusing drugs or alcohol and encountering some problems with same	Basic counselling Brief interventions Harm reduction advice	An individual	Child and adolescent psychiatric service, addiction service, teen counselling, Garda/JLO (juvenile liaison officer), local (or regional) drug task force projects, home-school liaison officer, Youth Reach (community training scheme), educational psychologist	Low intensity and medium duration
Tier 3	Specialist skills in <i>both</i> adolescent mental health <i>and</i> addiction	Substantial problems secondary to drug or alcohol misuse Drug or alcohol dependence	Specialist addiction counselling Family therapy Group addiction therapy Substitution treatment	A multi-disciplinary team	The specialist adolescent addiction service	High intensity and short to medium duration (1–6 months)
Tier 4	Specialist skills in <i>both</i> adolescent mental health <i>and</i> addiction	Drug or alcohol dependence with severe associated problems	Specialist addiction counselling Family therapy Group addiction therapy Substitution treatment	A multi-disciplinary team	Specialist in-patient or day hospital adolescent addiction services	Very high intensity and short duration (2–6 weeks)

\* Tiering here refers only to a position within the specific context of adolescent addiction assessment and treatment: services at tiers 1 and 2 may have very specialist expertise in other areas, such as child mental health, crime reduction, child welfare, etc.

Configuring a service in this manner will deliver a number of specific actions contained in the National Drug Strategy (Department of Tourism, Sport and Recreation, 2001, including actions 51, 59 and 60).

#### *Gaps in this service*

- There are only two consultant child and adolescent psychiatrist posts specialising in this field, both based in Dublin.
- There is a lack of specialist multidisciplinary teams in this area.

### **Disorders with specific needs**

#### *Suicide prevention and deliberate self-harm*

Youth suicide is a major global public health issue. Suicide consistently ranks as one of the leading causes of death for adolescents between 15 and 19 years of age. Suicide accounts for 30% of deaths in the 15- to 24-year age group (Carr, 2002). There has been an increase in suicide mortality and morbidity over most of the 20th century among white adolescents in the USA and Europe (Diekstra, 1996; Guo & Harstall, 2002):

- In the last 30 years, suicide rates have increased by more than 10% on average among the member states of the Organisation for Economic Co-operation and Development (OECD), which include western Europe, the USA, Australia, Mexico and Japan (OECD, 2002).
- Every 40 seconds a person commits suicide somewhere in the world. Every three seconds a person attempts to die. Suicide is among the top three causes of death among young people aged 15–35 years (World Health Organization, 2000).

Suicide and deliberate self-harm are closely related phenomena but they differ in important ways. Suicide is a relatively rare event in childhood but increases in adolescence, particularly among adolescent males, and afterwards reaches a peak in the early to mid-twenties. In the USA, about 1 in 10 000 15- to 19-year-olds commit suicide each year. Deliberate self-harm is extremely common, increasing in prevalence through adolescence to reach a peak in late adolescence or early adulthood.

Suicidal ideation occurs throughout childhood and adolescence, and is very common in the 15- to 17-year age group (14% of boys and 25% of girls at this age report such ideation). Research from around the world has consistently indicated that suicide and suicide attempts in young people are complex behaviours with multiple causes (Beautrais, 1998). Studies of youthful suicidal behaviour consistently report that many young people who die by suicide or who make serious suicide attempts have a recognisable mental or behavioural disorder at the time of their attempt, such as depression, anxiety, conduct disorder or substance misuse.

In Ireland suicide is the second leading cause of violent death in the 15- to 24-year age group, after traffic accidents (National Suicide Review Group, 2000). The average annual number of suicides occurring in the five-year period 1996–2000 was 468. Suicide begins to rise in the late teens and peaks in the 20- to 29-year age range, particularly in males (National Suicide Review Group, 2002). Suicide accounts for 1% of all deaths in Ireland and Northern Ireland (National Suicide Review Group, 2001).

Deliberate self-harm is the greatest predictor of eventual suicide (Welch, 2001). Over 40% of completed suicides are preceded by a previous attempt (Walker & Townsend, 1998). Women and younger people have higher rates of deliberate self-harm, and younger women have the highest rates (Gunnell, 1994; Welch, 2001; Carr, 2002). Figures compiled by the National Parasuicide (Deliberate Self-harm) Registry indicate that, at a national level, there were 8304 hospital presentations due to deliberate self-harm, by 6705 individuals (National Suicide Review Group, 2002).

A study in south-west Ireland (Corcoran *et al*, 2004) found that the Irish rate of deliberate self-harm was higher than that in 8 of 11 centres in a 1995 study by the World Health Organization. The rate peaked in the 20- to 24-year range and rates were significantly higher in women, particularly those aged under 20 years.

Suicide is nearly always associated with pre-existing mental or behavioural disorder; it makes sense to orientate prevention to identifying and effectively treating young people with disorders that place them at risk of suicide. Accessible mental health services are therefore of vital importance.

#### *Gaps in this service*

- Comprehensive, fully staffed, specialist out-patient child and adolescent sector teams are required.

#### *Attention-deficit hyperactivity disorder/hyperkinetic disorder*

The estimated prevalence of this disorder (detailed in Appendix 6) is somewhere between 1% and 5% of school-age children (i.e. those aged 5–15 years). It would be reasonable to assume that the lower prevalence figures refer to the more severe cases, that is, those requiring referral to a specialist child and adolescent psychiatric service. A figure of 2% amounts to about 18 000 children nationally. Currently, only a small proportion of school-age children with ADHD are referred to a specialist child and adolescent psychiatric service for assessment and treatment. With increasing recognition of this condition in the community, the number of children referred will increase substantially, and this will have serious resource implications.

Children with ADHD place considerable demands on child and adolescent psychiatric services. ADHD is a clinical diagnosis; there is no diagnostic test available to confirm it. Assessment, therefore, means considering whether there are alternative causes for inattentive, impulsive, restless behaviour as well as

making a full appraisal of the child in order to detect associated (comorbid) conditions or problems. Considerable care and expertise are essential in assessing children's emotional disorders and comorbid problems in order to ensure a correct diagnosis. The management or treatment of ADHD requires input from the child, the parents and the school; therefore, the clinician has a strong co-ordinating role. ADHD has an extended course and so requires long-term input from the child and adolescent psychiatry team. Ongoing review of the treatment programme and medication is also required.

The *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a, p. 5) reported on the appropriate development of services for children with ADHD. The Working Group concluded:

'The enhancement and expansion of the overall Child and Adolescent Psychiatric Service throughout the country would represent the most effective means of providing the required services for this group.'

Multidisciplinary teams best provide the type of assessment and treatment required by children with ADHD. The Working Group also recommended that multidisciplinary teams develop formal liaison arrangements with the educational system, particularly the National Educational Psychological Service (NEPS), as well as other areas of the community health service, such as community care.

#### *Gaps in this service*

- Comprehensive, fully staffed, specialist out-patient child and adolescent psychiatry sector teams are required.

#### *Strategic issue*

The effective working of the child and adolescent psychiatric service can be adversely affected by gaps in other services. For example, the lack of educational psychologists and resource teachers can impede the implementation of a school-based treatment programme for children with ADHD. The child and adolescent psychiatric service needs to support other services in their own development and needs to be aware of these gaps and how they might affect service delivery in mental health.

#### *Conduct disorder*

Conduct disorder is a term used to denote a syndrome of core symptoms characterised by a *persistent failure to control behaviour appropriately within socially defined rules*. It is a common problem, often persistent, has a heavy cost for society, and yet in its severest form has proved to be often untreatable. Child and adolescent psychiatric services therefore have a limited role in the treatment of severe conduct disorder. Parent management training has been shown to be effective, as have educational initiatives focusing on early support and detection of learning difficulties. The subset of children with a conduct disorder and with comorbid

mental health difficulties (such as ADHD or depression) do require referral to child and adolescent psychiatric services.

Child and adolescent psychiatric services can be pressured to provide answers for this group. This expectation is unrealistic in the population with severe conduct disorder who do not have a psychiatric illness or disorder. The problems they present generally require a multi-systemic approach, with intervention at social, community and educational levels at early developmental stages. The scientific evidence is that there are no specific *psychiatric* treatments that make any significant impact in this group.

Multi-systemic therapy was developed in America and there is scientific evidence confirming its effectiveness in the treatment of conduct problems in adolescence. It is an intensive programme delivered in the home and local environment; professionals carry a very small case-load (2–4 cases) and are available 24 hours a day, 7 days a week. A key element is the high level of supervision available to the case-workers and monitoring of progress. There are pilot projects currently being set up in Ireland and the Irish College is supportive of this development and the further extension of the programme.

There needs to be a coordinated approach from social services, education and voluntary agencies to meet the needs of this group of children.

### *Autism spectrum disorder*

The number of diagnosed cases of autism spectrum disorder (which is detailed in Appendix 7) has shown a significant increase worldwide. Better diagnostic practices and recognition of the spectrum of the disorder are contributory factors. The estimated prevalence of this disorder is 60 in every 10 000 children (Fombonne, 1999). It is estimated that there are approximately 5330 children and adolescents (under the age of 16 years) nationally with autism spectrum disorder. It is a complex, lifelong condition which manifests in different ways. Consequently the current concept of autism is broad, recognising that it can manifest as profoundly severe difficulties or more subtle problems of understanding and impaired social functioning. It may coexist with intellectual disability or other disorders of development and can occur with other physical or psychological disorders. It is estimated that 40–60% of those diagnosed with autism spectrum disorder have intellectual disability.

The increasing recognition of this condition has resulted in increased referrals to child and adolescent psychiatric services. The assessment process requires multidisciplinary input, which should include psychiatry, nursing (for pre-school groups), psychology, social work, speech and language therapy, and occupational therapy. Early diagnosis and intervention are important in maximising the behavioural and educational outcome of children with autism spectrum disorder. Families require support in coming to terms with the diagnosis and in minimising the adverse emotional impact of the condition on the child and other family members. It is important that there is close liaison with all other agencies involved, including education.

Specialist autism services, as recommended in planning documents (e.g. Eastern Regional Health Authority, 2002), should work jointly with other agencies to assess the needs of individuals diagnosed with autism spectrum disorder and develop planned packages of care to be delivered within the individual's local community.

A key focus needs to be on minimising the delay between initial concerns, a diagnosis being made and the provision of appropriate interventions and support.

#### *Gaps in this service*

- Specialist autism services have developed in an uneven manner.
- Specialist out-patient sector teams do not have resources to carry out initial assessments or to offer appropriate long-term interventions.

#### *Eating disorders*

The need to develop services for children and adolescents with eating disorders was identified in the Health Strategy (Department of Health and Children, 2001*b*). Eating disorders (which are detailed in Appendix 8) pose a considerable threat to the health and well-being of adolescents and adults in the Western world. When compared with other major psychiatric disorders, eating disorders have the highest mortality rate, as a result of both their medical complications and completed suicides. The prevalence rates in adolescent girls aged 12–19 years may have increased over recent years; current estimates are 0.5–1% for anorexia nervosa, 2% for bulimia nervosa and 4–5% for partial presentations of these syndromes (Bryant-Waugh & Lask, 1995). The peak age of onset is during adolescence and the disorder is often chronic, with significant associated morbidity and mortality.

The diagnosis and management of eating disorders present an ongoing challenge to clinicians. The frequent onset in childhood and the often secretive nature of the condition highlights the need for early detection and intervention. The current level of service provision struggles to provide an adequate response to the needs of this group, who are often admitted to medical wards owing to medical complications arising from malnourishment.

#### *Gaps in this service*

- There is no specialist eating disorder service.

#### *Strategic issue*

The Child and Adolescent Faculty of the Irish College of Psychiatrists recommends the development of a specialised national eating disorder service, with regional elements, to combat the significant morbidity and mortality associated with these conditions. Using the 'hub and spoke' model, such a service would comprise in-patient facilities, out-patient services and outreach teams to support out-patient child and adolescent psychiatric services, delivered in a manner best meeting the needs of the individual child/adolescent and family.



### *Looked-after children*

The term 'looked-after children' refers to the population of children and young people in the care of the community social services. In October 2003, the Social Services Inspectorate found there were 610 children in residential care and a fostering audit undertaken in January 2004 found there were 4080 children in foster care. We know that children in care are likely to have experienced significantly more risk factors for mental health problems. The failure to identify and acknowledge significant mental health problems in a child may lead to serious difficulties in the care placement.

Focusing on mental health issues is important because, with the support of the social worker, young person and the carers, interventions can be made which make a difference, and which reduce disturbed and disturbing behaviour, improve relationships and make the care situation more manageable. These interventions are made at a number of levels. It is possible to support the child by means of consultation, offering strategies for management, so that the carers and professionals work together consistently to alleviate difficulties. Foster carers and residential staff may also be offered support. Therapeutic interventions may be offered to the young person individually, or together with his or her carers. It is crucial to the success of the work that the roles of all the key people in a young person's life are understood and that they are involved in the process (Richardson & Joughin, 2002).

For specialist out-patient teams with limited resources, it can be difficult to meet the needs of this group, as the work involved is complex, challenging and time consuming.

For some disturbed and distressed looked-after children, secure accommodation may be required. A network of special-care and high-support units is being developed nationally by community care social services. The children in these units would benefit from access to child and adolescent psychiatric services.

The Social Services Inspectorate (2004) identified the 'Mental health of young people in care' as an issue requiring particular attention.

### **Other functions of the child and adolescent psychiatric service**

As well as providing the range of patient services described above, the staff of multidisciplinary teams are also required to fulfil other functions, such as training and education, evaluation and research. There is an increasing requirement on services to provide these additional functions, either as part of ongoing professional development (e.g. research and education) or as part of the new vision for the health services (e.g. emphasis on evaluation and quality).

### *Service evaluation*

The development of a quality culture throughout the health system can ensure the provision of homogeneous, high-quality, integrated healthcare at local, regional

and national level (Department of Health and Children, 2001b). While the provision of direct patient services is the central function of any health service, there is increasing emphasis on service performance and clinical quality. The *Second Annual Report of the Chief Medical Officer* (Department of Health and Children, 2001d) and the *Second Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2003b) recommended the establishment of a comprehensive database to facilitate research and service development.

The availability of information systems and information technology (IT) support in general would greatly facilitate the development of a research and audit culture within child and adolescent psychiatric services.

#### *Gaps in this service*

- There is no national database.
- There is an absence of computerised systems to facilitate patient management.
- There are limited resources (e.g. staff and IT support) to facilitate research.

#### *Academic and research issues*

The recently formed university medical school departments of child and adolescent psychiatry will further propel much-needed research in this field. There is a very wide range of research topics, such as in-depth study of child and adolescent psychopathology, the impact of family functioning and the forms of trans-generational transmission, assessing the effectiveness of therapies, or studying the links between mental illness and genetics. By engaging in this research we learn more about Irish children and adolescents, are able to assess the impact of social and cultural change, and are able to evaluate the therapeutic interventions we offer, such that our practice gains a strong evidence base. By obtaining this information we are better able to inform health policy and target intervention programmes effectively.

Research should not be the sole preserve of academic departments, but should be fostered and encouraged at all levels of the service. Incorporating research sessions into consultant contracts and making the necessary funding available on an ongoing basis can best achieve this goal.

#### *Gaps in this service*

- Only two of the five medical schools have academic child and adolescent psychiatry departments.
- Each medical school should have an academic child and adolescent psychiatry department (1 WTE academic/teaching position per medical school).
- Existing departments need to be expanded.
- Research sessions should be included in consultant contracts.
- Adequate funding of research is needed, through a dedicated budget.

## 4 How we get there

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### **Building on strengths**

'Getting there' will best be done by building on the service that already exists and by recognising the strengths of that service:

- A rudimentary service is already in place, with 40 specialist multi-disciplinary out-patient sector teams. (This, however, represents just 66% of the total out-patient complement required for the national population and these services are at varying stages of development.)
- A holistic approach is taken to the child.
- There is at least limited access to in-patient child and adolescent psychiatric facilities.
- The service has highly skilled, dedicated staff.
- A good range of therapeutic interventions is available, including cognitive-behavioural therapy, pharmacotherapy, family therapy, psychodynamic therapies and parenting programmes.
- The service is accessible to the public (but is limited in its capacity to respond, owing to scarcity of resources).
- There are training programmes in place for many disciplines.

### **Gaps in the service**

There are, however, gaps in the current service. The gaps between the actual and recommended numbers of consultant child and adolescent psychiatrists are shown in Table 4.1. Section 3 described the essential components of a comprehensive child and adolescent psychiatric service and enumerated the gaps that exist. These are summarised below in the order in which they appeared in Section 3.

#### *Gaps in specialist out-patient sector teams*

- Shortage of teams led by a consultant child and adolescent psychiatrist.
- Existing teams serving too large a catchment population.
- Teams below recommended complement.
- Shortage of trained staff in key disciplines.
- Demand due to deficiencies in other services (health, education, social services).
- Inadequate accommodation for some teams.

#### *Gaps in specialist adolescent services*

- No existing teams for the 14- to 17-year age group.

**Table 4.1 The gaps between the actual and recommended numbers of consultant child and adolescent psychiatrist WTE posts, by area of specialty, February 2005 (vacant posts in parentheses)**

Health Service Executive area	Population	Number of consultants serving population aged:		In- patient <sup>1</sup>	Substance misuse <sup>2</sup>	Liaison and infant <sup>3</sup>	Academic <sup>4</sup>	Forensic	Child abuse	Autism	Intellectual disability
		0–15 years (1 per 66 000)	16–17 years (1 per 100 000)								
<i>Actual numbers of posts: 55 plus 6.6 in intellectual disability</i>											
Eastern Region	1 401 441	16.3 (1)	2	0.7	2 (1)	4.6	0.7		1.5	1.75	1
Southern	580 356	5.9									1.1
South Eastern	423 616	3 (1)									2
Western	380 297	4		0.5							0.5
North Eastern	344 965	2.8				0.2					
Mid-Western	339 591	4 (1)									1
North Western	221 574	2									
Midlands	225 363	2									1
<b>Total</b>	<b>3 917 203</b>	<b>41 (3)</b>	<b>2</b>	<b>1.2</b>	<b>2 (1)</b>	<b>4.8</b>	<b>0.7</b>	<b>0</b>	<b>1.5</b>	<b>1.75</b>	<b>6.6</b>
<i>Recommended numbers of posts: 150 total (1 per 26 000 total population)</i>											
Eastern Region	1 401 441	21	14	7	2.5	7	3	2	1.5		
Southern	580 356	9	6	3	1.2	2	1				
South Eastern	423 616	6.5	4	2	0.8	2					
Western	380 297	6	4	2	0.6	1	1				
North Eastern	344 965	5	4	2	0.6	1					
Mid-Western	339 591	5	3	2	0.5	1					
North Western	221 574	3.5	2	1	0.4	1					
Midlands	225 363	3.5	2	1	0.4	1					
<b>Total</b>	<b>3 917 203</b>	<b>59.5</b>	<b>39</b>	<b>20<sup>1</sup></b>	<b>7<sup>2</sup></b>	<b>16<sup>3</sup></b>	<b>5<sup>4</sup></b>	<b>2</b>	<b>1.5</b>		

1. Based on 244 in-patient beds and 1 WTE per 12 beds (Royal College of Psychiatrists, 1999b).

2. Based on 0.6 WTE per 350 000 population.

3. Based on 1 WTE per 250 000 population.

4. Based on 1 WTE per medical school.

#### *Gaps in specialist in-patient services*

- Only two units, located in Dublin and Galway.
- Four new units still at the planning stage (a total of eight units proposed).
- Existing capacity 20 beds (recommended 156 (144 + 12) for those aged < 16 years).
- Inappropriate admissions to adult psychiatric or paediatric wards.
- No specialist units for the older adolescent group.
- Extra 80 beds required for those aged 16–17 years.

#### *Gaps in specialist day hospital programmes*

- Only three adolescent day hospital programmes nationally.

#### *Gaps in specialist paediatric/general hospital liaison services*

- Liaison psychiatry teams exist only in major paediatric hospitals. These teams are at varying stages of development and require appropriate resourcing. Not all paediatric units nationwide have a specialist paediatric liaison service.
- There is no infant psychiatry service.
- This report recommends 1 WTE consultant child and adolescent liaison psychiatrist per 250 000 population.

#### *Gaps in specialist intellectual disability service*

- Specialist intellectual disability teams have been developed in a very limited manner.

#### *Gaps in specialist forensic adolescent services*

- No specialist adolescent forensic service.

#### *Gaps in specialist alcohol and substance misuse services*

- Only two child and adolescent psychiatrist posts in substance misuse.
- No such service available outside the Dublin area.

#### *Gaps in specialist services for children at risk of suicide and the treatment of deliberate self-harm*

- Inadequate development of comprehensive, fully staffed, child and adolescent multidisciplinary teams.

#### *Gaps in specialist services for children with ADHD*

- Inadequate development of comprehensive, fully staffed, child and adolescent multidisciplinary teams.

*Gaps in specialist services for children with conduct disorder*

- Inadequate development of comprehensive, fully staffed, child and adolescent multidisciplinary teams.

*Gaps in specialist services for children with autism spectrum disorders*

- Inadequate development of specialist autism spectrum disorder services.

*Gaps in specialist services for children with eating disorders*

- No specialist eating disorder service.

*Gaps in specialist services for looked-after children*

- Inadequate development of comprehensive, fully staffed, child and adolescent multidisciplinary teams.

*Gaps in service evaluation and audit*

- No national database.
- Absence of computerised systems to facilitate patient management.
- Limited resources to facilitate research (e.g. staff and IT support).

*Gaps in academic departments and research*

- Only two of the five medical schools have academic child and adolescent psychiatry departments.
- Each medical school should have an academic child and adolescent psychiatry department (1 WTE academic/teaching position per medical school).
- Existing departments need to be expanded.
- Research sessions should be included in consultant contracts.
- Adequate funding of research is needed, through a dedicated budget.

**Priorities in the development of the child and adolescent psychiatric service**

The above list provides a clear direction for the strategic planning of the service. However, in order to proceed in the short term, a number of developments can be prioritised:

- 1 Increase the number of multidisciplinary out-patient sector teams from 40 up to the recommended complement of 59.
- 2 Bring established teams up to the recommended staffing complement.
- 3 Establish sufficient specialist adolescent out-patient psychiatry teams to bring the total number to the recommended 39 to meet the needs of this age group.

- 4 Proceed with the eight proposed in-patient facilities for the 0- to 15-year age group, to provide a total of 156 (144 + 12) beds, as set out in the *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a).
- 4a Incorporate the need for a further 80 beds to meet the in-patient needs of the 16- to 17-year age group in the planning process.
- 5 Expand the limited day hospital programmes available from 2 to 12.
- 6 Develop specialist hospital liaison services.
- 7 Develop specialist child and adolescent intellectual disability services.
- 8 Establish specialist forensic services.
- 9 Develop existing substance misuse treatment programmes.
- 10 Develop autism spectrum disorder services.
- 11 Establish specialist eating disorder services.
- 12 Achieve the target of comprehensive, fully staffed, child and adolescent services for the specific needs of suicide prevention, deliberate self-harm, ADHD/hyperkinetic disorder, conduct disorder and looked-after children.
- 13 Increase the number of places on the Higher Specialist Training Scheme in child and adolescent psychiatry.
- 14 Establish a national database.
- 15 Expand academic departments and research.

### **Action plans to address the priorities**

*Increase the number of specialist out-patient sector teams from 40 up to the recommended complement of 59*

Filling this gap will meet not only the requirement for multidisciplinary teams for the catchment area but will also help address the gap identified in providing a comprehensive range of services, that is, a fully staffed multidisciplinary team available per 66 000 population. The action plan to achieve this is:

- Prioritise the training and recruitment of an extra 19 consultant child and adolescent psychiatrists and other members of the multidisciplinary team.
- Revenue cost approximately €19 000 000 (€1 million per team).
- Capital cost approximately €12 350 000 (€0.65 million per team).

*Bring the established specialist out-patient sector teams up to recommended staffing complement*

Addressing this need will improve the capability of a team to provide a comprehensive range of services but does not wholly address the serious lack of capacity in the service. The action plan to achieve this is:

- Fill existing vacancies as an absolute priority. Where there is a lack of suitably trained personnel to fill such posts, there may be a need to review the number of training places available in each of the constituent disciplines,

including clinical psychology, speech and language therapy, nursing and occupational therapy.

- Provide funding to bring existing teams up to the recommended complement. This will depend on the status of each team, and newly established teams have frequently struggled in this regard. The *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a) estimated:  
Revenue cost approximately €7 600 000.
- Capital investment. Where accommodation is inadequate or inappropriate, additional capital investment will be required. The *First Report of the Working Group on Child and Adolescent Psychiatric Services* estimated:  
Capital cost to improve existing accommodation €7 600 000.

*Establish specialist adolescent psychiatry teams (the total number recommended to meet the needs of this group being 39)*

The *Second Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2003b) states that the needs of this age group are best met by the development of specialist services. The current situation whereby services for the 16- to 17-year age group are provided by adult mental health services is not appropriate or satisfactory. However, this group by the nature of the psychiatric problems they present (typically depression, deliberate self-harm or psychotic illness) and their preference for age-appropriate and user-friendly services require the development of adolescent multidisciplinary out-patient teams catering for the 14- to 17-year age group and serving a population unit of 100 000. The action plan to achieve this is:

- Funding for the recruitment of 39 consultant child and adolescent psychiatrists with a special interest in the adolescent age group and the other members of the multidisciplinary team as recommended in Working Group's second report.
- Revenue cost approximately €31 200 000 (€0.8 million per team).
- Capital cost approximately €25 350 000 (€0.65 million per team).

*Proceed with the eight planned in-patient facilities, as set out in the first report of the Working Group, for the 0- to 15-year age group, to provide the extra capacity to achieve a total of 156 in-patient beds*

*Incorporate an extra 80 beds for the 16- to 17-year age group, which requires the development of a further three in-patient facilities*

The Working Group's first report set out the resource implications of developing in-patient services. The cost of developing an in-patient unit will partly depend on whether an existing building is converted or a green-field site is developed.



Ideally, adolescent units should be developed as part of a regional hospital campus with adult psychiatric in-patient facilities on site, which provides medical support and allows transfer of a patient who requires a more secure treatment setting. Children's units catering for a younger age may be sited away from an acute hospital campus.

- Capital cost: funding the capital investment in order to provide 11 in-patient units, approximately €84 700 000 (€7.7 million per unit).
- Revenue cost: the annual staffing costs for these units, approximately €20 900 000 (€1.9 million per team).

*The establishment of adolescent day hospital programmes in each health area*

- Capital investment in suitable facilities. Capital cost will depend on local circumstances; such a facility may be part of an in-patient complex, for example.
- Recruitment of necessary staff. Revenue cost approximately €700 000 per team.

*Develop child and adolescent psychiatry liaison services at major children's hospitals, and establish liaison sessions to paediatric units*

- Recruit extra staff as required.
- Introduce child and adolescent psychiatry sessions to all paediatric units.
- Capital cost: small.
- Revenue cost: to be estimated.

*Develop specialist intellectual disability services*

- As outlined by the Irish College of Psychiatrists (2004).
- Capital and revenue costs to be estimated.

*Develop specialist adolescent forensic psychiatric services*

There is no forensic service in Ireland for children (those under the age of 18 years). The components of this service should include:

- Two adolescent multidisciplinary teams, each led by a consultant adolescent psychiatrist with special expertise in forensic psychiatry.
- One team providing consultation and assessments nationally.
- One team in a secure treatment facility providing 8–10 beds, with the necessary specialist staffing.
- Capital cost of secure treatment facility €7.7 million.
- Revenue cost approximately €2 million (for in-patient and consultation teams).

*Develop alcohol and substance misuse services*

- A further six consultant child and adolescent psychiatry posts in this area.
- Each supported by multidisciplinary teams.
- Capital cost to be estimated.
- Revenue cost approximately €2.1 million (€350 000 per team).

*Establish eating disorder services*

- Specialist out-patient team providing a regional service.
- One of the in-patient facilities to specialise in the treatment of eating disorders.
- Revenue cost approximately €0.8 million.

*Develop specialist autism spectrum disorder services*

- Capital and revenue costs to be estimated.

*Increase the number of places on the Higher Specialist Training Scheme in child and adolescent psychiatry*

- Increase the number of places from 20.5 to 32. This will allow an increase from 64 to 90 trained child and adolescent psychiatrists over the period 2003 to 2013.
- Revenue cost to be estimated.

*Service evaluation.*

- Establish a national database for child and adolescent psychiatric services.
- Investment in IT systems and staff training.
- Capital cost of IT system and network approximately €5 million.
- Revenue cost of IT support and training approximately €0.5 million.

*Expand academic departments and research*

- The creation of academic child and adolescent psychiatry departments in all the university medical schools (currently only two out of five schools have one).
- The expansion of existing departments.
- The inclusion of research sessions in consultant contracts.
- The adequate funding of research, through a dedicated budget.

# Appendix 1. Prevention of child and adolescent mental health disorders

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The prevention of child and adolescent mental health disorders can be conceptualised as having three different layers:

- 1 primary prevention tries to stop a disorder occurring by removing the cause
- 2 secondary prevention tries to identify a disorder at onset and prevent its extension
- 3 tertiary prevention tries to limit disability from an established disorder.

If prevention programmes are to have any hope of success, they need to be based on knowledge of predisposing, precipitating and perpetuating influences on psychosocial disorders. Prevention and treatment need to be distinguished from each other. Treatment focuses on individuals who are referred with an identified problem and the aim is remedial; treatment is an attempt to restore the status quo. Prevention focuses on unreferred groups or populations who are at risk; the aim is protective and tries to enhance competence.

## Primary prevention

In the realm of public policy, nine areas can be identified in which improvement should lead to increased mental well-being among children. These are:

- 1 poverty alleviation
- 2 increasing neighbourhood unity
- 3 good housing
- 4 increasing employment
- 5 good child protection from abuse and neglect
- 6 accident prevention
- 7 education
- 8 services for marital and family disharmony
- 9 reducing alcohol consumption.

Specific primary prevention measures by health and other professionals can be conceptualised in terms of life stages. These subdivide into six intervention phases:

- 1 parenthood preparation
- 2 antenatal care

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This appendix is based on Graham *et al* (1999).

- 3 birth and the neonatal period
- 4 pre-school period
- 5 middle childhood
- 6 adolescence.

The quality of services provided during each of these six life stages by health and other professionals will impinge on mental health.

### **Secondary and tertiary prevention**

Six principles can be identified within child health services to underpin the secondary and tertiary prevention of disorder. These are as follows:

- 1 The physical and mental health needs of a child are inseparable and every child must be seen in the context of the family.
- 2 It must be acknowledged that no one person or professional grouping has all the knowledge or skills.
- 3 It must be acknowledged that good communication between all professionals is essential.
- 4 Consultation to other professionals in place of individually seeing a child and family can be useful. There is value in psychosocial ward rounds in paediatrics, consultations to community care social workers, consultations to teachers in schools, consultations to residential homes, consultations to general practitioners, public health nurses, speech therapists, and so on.
- 5 The involvement of parents in decision making is essential.
- 6 Voluntary support groups should be encouraged.

### **Conclusion**

As can be seen, prevention extends and permeates through many professions and different interventions, sometimes in an unapparent way. Understanding of prevention theory can help to link disparate interventions and services to a common goal. Public health policy should have the ability to draw the various strands together (both health and care issues) such that there is awareness of when prevention can occur.

## **Appendix 2. Child and adolescent psychiatry presentations and disorders**

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Child and adolescent psychiatry presentations and disorders encompass the following:

- anorexia/bulimia
- anxiety disorders
- attachment disorders
- attention-deficit hyperactivity disorder
- autism spectrum disorders, including Asperger's syndrome
- conduct disorders
- depression
- encopresis (soiling)
- enuresis (wetting)
- feeding disorders
- gender identity difficulties
- major psychotic illness (schizophrenia, mania)
- obsessive-compulsive disorders
- oppositional defiant disorder
- personality disorder
- post-traumatic stress disorder
- psychiatric aspects of physical illness
- psychiatric sequelae of child abuse (physical, sexual, emotional, neglect)
- psychoactive substance or alcohol misuse
- psychosomatic disorders
- school refusal
- selective mutism
- sleep disorders
- stress reactions
- suicide attempts and intentional self-harm
- tics (including Gilles de la Tourette's syndrome).

## **Appendix 3. Definitions of problem, symptom, disorder and impairment**

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### **Mental health problem/symptom**

A mental health problem or symptom is a disturbance of function in one of the following areas:

- relationships
- mood
- behaviour
- development.

This must be of sufficient severity to require professional intervention.

### **Psychiatric disorder**

This can be defined as the presence of a severe and persistent mental health problem or symptom (e.g. selective mutism) or the co-occurrence of more than one problem that satisfies the criteria for a disorder according to ICD-10 (World Health Organization, 1996) or DSM-IV (American Psychiatric Association, 1994). Disorders encompass abnormalities of behaviour, emotions or social relationships that are sufficiently marked or prolonged to cause suffering or hardship to the child or distress or disturbance in the family or community.

### **Impairment**

This refers to a reduction or deterioration in the capacity to perform a valued role. It is a measure of the extent to which symptoms interfere with full functioning in the social, emotional, educational or vocational domain and determines the need for therapeutic intervention.

## **Appendix 4. Factors considered in assessing the significance of a mental disorder or problem**

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- **Severity:** the level of distress or concern it is causing to the child, family or agency and hence the amount of care the child may require.
- **Complexity:** the number of incapacitating features present and the presence and persistence of another disorder or complex family or social situation.
- **Persistence:** the length of time the problem has been present or is likely to last.
- **Risk of secondary handicap** (e.g. the possibility of specific learning difficulties contributing to the development of a conduct disorder).
- **State of the child's development:** whether the problem is considered 'normal' for the child's age and stage of development.
- **Presence or absence of protective factors** (e.g. good-quality early attachment relationships).
- **Presence or absence of risk factors** (e.g. marital disharmony).
- **Presence or absence of stressful social factors** (e.g. family under stress from social or economic disadvantage).

## Appendix 5. Liaison child and adolescent psychiatry

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A liaison service concerns itself with the following:

- Emergencies (e.g. deliberate self-harm, psychosis, anorexia nervosa, delirium and reactions to trauma or abuse).
- Differential diagnosis of physical symptoms that have a psychological origin (e.g. recurrent pain, conversion disorder, failure to thrive, Munchausen's syndrome by proxy).
- Collaborative care of children with stress-sensitive illness (e.g. diabetes mellitus, asthma, rheumatoid arthritis).
- Diagnosis and care of children with psychiatric symptoms following a somatic illness (e.g. post-illness depression, post-viral fatigue syndrome).
- Chronic illness. The increased risk to the full spectrum of psychiatric morbidity is recognised. In addition, specific problems arise (e.g. non-compliance with treatment).
- Reactions to major paediatric treatment techniques (e.g. bone marrow transplantation, repeated surgical intervention).
- Reaction to paediatric illness (e.g. the variable impact on the child and family).

Responding to emergencies will always be a priority, but it must not be at the expense of developing the other components of the service outlined above. More complex presentations may require the involvement of a number of disciplines in their assessment and treatment.

### Adolescents

Adolescents present to both paediatric and general hospitals in mental health crises. An adolescent in-patient unit in a general hospital setting and with adult psychiatric services on the same campus is the most appropriate model to meet the needs of acutely unwell adolescents presenting in crisis.

### Components of a liaison service

- Clinical
  - Emergency service
  - Weekly psycho-social ward round
  - Consultation on individual cases or groups
  - Joint work with paediatricians or others
  - Direct referrals
  - Groups with children and/or parents
  - Staff support/consultation



- Teaching
  - Medical under-graduates
  - Medical graduates
  - Other professionals
- Research

## **Appendix 6. Attention-deficit hyperactivity disorder (ADHD)**

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Recommendations on the assessment and treatment of ADHD are set out in the *First Report of the Working Group on Child and Adolescent Psychiatric Services* (Department of Health and Children, 2001a).

- The estimated prevalence of this disorder is somewhere between 1% and 5% of school-age children (i.e. children aged 5–15 years).
- Currently only a small proportion of school-age children with ADHD are referred to a specialist child and adolescent psychiatric service for assessment and treatment.
- With increasing recognition of this condition in the community, the number of children referred will rise substantially, and this will have serious resource implications for the child and adolescent psychiatric services.
- It would be reasonable to assume that the lower prevalence figures refer to the more severe cases, that is, those necessitating referral to child and adolescent psychiatric services.

### **Assessment procedure**

ADHD is a clinical diagnosis – that is, there is no diagnostic test available to confirm it. Assessment, therefore, means considering whether there are alternative causes of inattentive, impulsive, restless behaviour, as well as a full appraisal of the child in order to detect associated (comorbid) conditions or problems. Considerable care and expertise are essential in assessing children's emotional disorders and comorbid problems in order to ensure a correct diagnosis is made.

This detailed assessment is required to establish a diagnosis and rule out underlying conditions which may mimic ADHD and to establish the presence or absence of other (i.e. comorbid) conditions. Recognition of comorbid conditions and difficulties enables the child to be treated in a more holistic fashion. ADHD is in itself associated with the development of conduct disorder. At least one-third of children with ADHD will have a diagnosis of conduct disorder by current criteria, although this figure may be higher in older children. The comorbid rates of emotional disorders are also raised, increasingly so by age.

### **Treatment/management plan**

The management and evaluation of the treatments used for ADHD require input and cooperation from the patient, the parents and the school, making the clinician's role as a coordinator or case manager vital to the treatment. ADHD has an

extended course and so requires monitoring to evaluate the effectiveness of current treatment and the emergence of new problems.

### **Review**

Once diagnosis of ADHD has been established and a treatment plan initiated, it is vital to maintain long-term supportive contact with the patient, family and school to ensure compliance with the treatment and to address problems at new developmental stages or in response to family or environment changes. This will require regular review.

### **Pharmacotherapy**

The decision to medicate is based on the presence of a diagnosis of ADHD and persistent target symptoms that are sufficiently severe to cause pervasive functional impairment (i.e. at school, at home and with peers). A large number of research studies and many years' experience with large numbers of patients attest to the effectiveness of stimulant medications. Children who are receiving medication require regular, careful monitoring of both response and possible onset of side-effects (which can usually be improved by altering the dosage of medication). An annual review of the child's need for pharmacotherapy is recommended. This involves withdrawal of the medication for a number of weeks in order to establish whether the need for pharmacotherapy exists any longer. Children at the severe end of the spectrum (0.5–1% of the school-age population) may need to continue medication for an extended number of years.

### **Recommended action – resource provision**

- At present, only a small proportion of children and adolescents with ADHD are referred to child and adolescent psychiatric services for assessment and treatment.
- With increasing awareness of this problem, which affects 1–5% of school-age children in the community, referrals will undoubtedly increase dramatically.
- Taking into account the process of assessment and management of ADHD, this is a need that can be adequately addressed only when the existing child and adolescent psychiatric service is resourced to the level recommended by the Working Group on Child and Adolescent Psychiatric Services (Department of Health and Children, 2001a).

## Appendix 7. Autism spectrum disorder

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The number of cases of autism spectrum disorder being diagnosed has increased significantly worldwide. Better diagnostic practices and recognition of the spectrum of the disorder (especially higher-functioning children on the autism spectrum) have contributed to this increase.

- The estimated prevalence of this order is estimated at over 60 in every 10 000 children (16.8 with autism per 10 000 children and 44.5 with other autism spectrum disorders, including Asperger's syndrome). It is four times more prevalent in boys than in girls (Fombonne, 1999).
- The increasing recognition of this condition has resulted in increased service demands on the child and adolescent psychiatric services.
- A large proportion of children and adolescents on the autism spectrum are referred to specialist child and adolescent psychiatric services for assessment and treatment.
- Autism spectrum disorders may coexist with intellectual disability or other developmental disorders such as language disorders and ADHD.
- Early diagnosis and intervention are important in maximising educational and behavioural outcomes.

### Assessment procedure

Autism spectrum disorders refer to a wide diversity of neurodevelopmental disorders, which can be associated with an intellectual disability. There is considerable variation in the degrees of severity with which these disorders manifest. Differentiation from other conditions is of considerable importance because the various conditions require different treatments and have different outcomes.

This group of disorders is characterised by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped and repetitive repertoire of interests and activities. These qualitative abnormalities are a pervasive feature of the individual's functioning in all situations, although they may vary in degree.

### Treatment/management plan

Autism spectrum disorders cause lifelong disability. A range of treatment approaches is recommended, with various educational methods, speech and language programmes and behavioural therapies.

The challenge is to provide appropriate interventions in an equitable and timely manner. Autism is a multi-faceted problem; the needs of each child and the prognosis depend on the level of disability, as well as the child's IQ and

language skills. Medication may be indicated. Research has indicated that the best outcomes are realised when families receive the necessary support. A range of support services is required. This may be in the form of respite for families or social skills intervention packages, particularly for people with Asperger's syndrome (a milder form of the disorder, in which intelligence is usually in the normal range). Appropriate educational placement is critical and is based on individual needs. This range of services includes special schools, special classes in mainstream schools and full integration with support.

A partnership between professionals on multidisciplinary clinical teams, educators and parents underpins this model, in which the emphasis is on training in autism-specific approaches.

### **Review**

Once a diagnosis of autism spectrum disorder has been made, the management plan should ideally incorporate referral to a specialist autism service and an appropriate educational placement, based on individual need. Children with high-functioning autism and Asperger's syndrome who are attending mainstream classes may access specialist autism services, as the need arises. These children are at risk of being bullied in school and developing depression in adolescence.

### **Pharmacology**

Medications are sometimes indicated for the treatment of associated conditions, such as ADHD. Children who are receiving medication require careful monitoring. Parents and siblings are likely to need counselling and advice. It is also important to forestall the development of anxiety and low self-esteem by providing multidisciplinary team support.

## Appendix 8. Eating disorders

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Eating disorders are complex medical and psychiatric disorders associated with significant morbidity and mortality. Two main subgroups are identified:

- anorexia nervosa, which is characterised by severe calorie restriction
- bulimia nervosa, where binge eating alternates with behaviours such as vomiting, laxative use or dieting and exercise, designed to counteract the additional calories consumed.

They have a peak age of onset in adolescence and often run a chronic course. This is occurring at a time that is also marked by significant and important developmental tasks, in physical, social and cognitive spheres. The presence of a chronic illness at this point has a significant impact on many domains of a child's development.

The mortality rate from eating disorders is higher than that from any other psychiatric disorder. Estimates vary with the methodology of the studies but are estimated to be around 5% (Steinhausen, 2002). Apart from a high mortality rate, morbidity includes problems with reproduction, osteoporosis, continuing low body mass, and major psychiatric comorbidity, particularly depression. More than half the adolescents presenting will also meet the criteria for a depressive disorder, and a similar number for an anxiety disorder.

Epidemiological studies over the last 20 years appear to suggest an increase in the incidence and prevalence of eating disorders.

### Treatment principles

- The treatment of anorexic patients must be based on a comprehensive and detailed assessment of their mental and physical status.
- A decision is then made as to whether treatment in an in-patient or out-patient setting is more appropriate.
- The increase in clinical cases has affected admission rates not only to psychiatric units but also to paediatric medical wards.
- It is clear that a severely emaciated patient will require intensive medical treatment; it can be extremely difficult to provide the necessary psychotherapeutic milieu in such an environment.
- In-patient treatment in a specialist unit offers the attraction of a wealth of accumulated experience in treating these disorders; however, patients with eating disorders can be effectively treated in a unit that treats a range of psychiatric disorders.
- Working with the parents is an integral part of any intervention programme.
- Out-patient programmes are increasingly considered as a treatment option; these involve specialist teams, who may work jointly with community teams.

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