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Projections of demand and bed capacity requirements for public psychiatric inpatient services in Ireland, 2023–2040: Based on the Hippocrates model

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Abbreviations and acronyms

CAMHS	Child and Adolescent Mental Health Services
CMH	Central Mental Hospital, Portrane
CMHT	Community mental health team
HRB	Health Research Board
HSE	Health Service Executive
IHA	Integrated Healthcare Area
MHC	Mental Health Commission
MHID	Mental Health Intellectual Disability unit
NPIRS	National Psychiatric In-Patient Reporting System
PICU	Psychiatric intensive care unit
POLL	Psychiatry of later life
VfC	A Vision for Change (2006)

Executive Summary

Introduction

This report provides projections of demand and bed capacity requirements for public psychiatric inpatient services in Ireland to 2040. Building on previous applications of the ESRI Hippocrates model, the analysis encompasses adult inpatient services (acute, continuing care, psychiatric intensive care units (PICU), forensic mental health – Central Mental Hospital (CMH), and mental health intellectual disability unit (MHID)) and Child and Adolescent Mental Health Service (CAMHS) inpatient units. The work was undertaken as part of the Department of Health/ESRI Research Programme in Healthcare Reform, under which the ESRI has developed the Hippocrates projection model.

Mental health policy in Ireland has increasingly emphasised the delivery of care in community settings where appropriate. However, inpatient services remain an essential component of the mental health system, providing specialist assessment, treatment and rehabilitation for individuals whose needs cannot be safely met elsewhere. Ensuring that sufficient inpatient capacity is available is therefore a key element of mental health service planning.

The objectives of this report are to:

- Provide 2023 activity profiles for public psychiatric inpatient services; and to
- Project demand and bed capacity requirements to 2040.

The projections are intended to inform future service planning and should be interpreted in the context of the assumptions underpinning the model. The analysis reflects the model of service delivery, data availability and quality, as well as the policy environment in the base year (2023). It is important that projections are reviewed as new or better data and evidence become available.

Methods

The report applies the Hippocrates healthcare demand projection model to project demand and bed capacity requirements for public psychiatric inpatient services to 2040. The analysis combines activity data from the Health Research Board's (HRB) National Psychiatric In-Patient Reporting System (NPIRS), information on bed availability from the HRB and Mental Health Commission, and ESRI population projections. Age- and sex-specific activity profiles for 2023 were developed and applied to projected population change over the period to 2040.

A range of projection scenarios were examined. Across all services, scenarios incorporate alternative assumptions regarding future population growth and ageing:

- Status quo scenario – applies the central population projection and no additional demand or capacity assumptions across all services.
- Low-pressure scenario – modelled for acute adult services and CAMHS services only. For acute adult services, this scenario assumes a 10 per cent reduction in inpatient bed days by 2040, reflecting shorter lengths of stay associated with the future enhancement in community-based services. For CAMHS services, the low-pressure scenario reflects a low fertility population projection. A low-pressure scenario is not modelled for continuing care, CMH, PICU or MHID services.
- High-pressure scenario – applies the high population projection across all services. For acute adult and CMH services it additionally assumes that bed occupancy rates gradually decline to 85 per cent by 2040, as maintaining lower occupancy rates requires additional bed capacity to meet the same level of demand and therefore increases pressure on health system resources.

The main demand metric is the number of bed days used in 2023 by service. Bed day projections are converted into bed capacity requirements using service-specific occupancy rates. For acute adult services, sensitivity analyses are undertaken to examine the impact of varying key assumptions regarding population change, inpatient length of stay and occupancy rates. In addition, projected bed requirements are compared with the recommendations of the HSE Specialist Group on Acute Bed Capacity report.

Overview of findings

Significant changes in psychiatric inpatient bed capacity requirements are projected between 2023 and 2040, although the scale of growth varies across service types. The largest increases of up to 37 per cent are projected for acute adult (11%–37%), continuing care (35%–37%) and CMH (15%–37%) services, while more modest increases of up to 17 and 26 per cent are projected for MHID (12%–17%) and PICU (23%–26%) services respectively. Reaching the HSE specialist group recommendation for acute adult beds would require even higher increases of between 50 and 55 per cent.

Population growth is projected to be the principal driver of increased demand for acute adult services, while population ageing is a particularly important contributor to projected growth in continuing care services. For acute adult and CMH services, projected requirements vary across scenarios owing to differing assumptions regarding future lengths of stay and occupancy rates.

For acute adult and continuing care services, which are modelled at the HSE Health Region level, projected growth in requirements vary across the regions. For acute adult services, the largest increases are generally projected in the eastern regions, reflecting stronger population growth, while lower growth is projected in the HSE Mid West and HSE West and North West. For continuing care services, regional projections are influenced by both population growth and differences in the age profile of service users, resulting in considerable variation in projected capacity requirements across regions.

For CAMHS inpatient services, no increase in bed requirements is projected, as the population aged 13–17 years is projected to fall by between 20.4 per cent under the low fertility population scenario to 13.5 per cent under the high migration population scenario. These projections are based on observed inpatient utilisation and population projections and do not model the potential effects of unmet demand elsewhere in the CAMHS system.

Discussion

The main finding of this report is that expansion of psychiatric inpatient capacity will be required between 2023 and 2040, although projected requirements vary by service type. For acute adult services, the lower end of the projected range is driven by assumptions regarding reductions in inpatient length of stay. Achieving such reductions would require expansion of community-based services to support earlier discharge and reduce avoidable admissions. While the continued rollout of National Clinical Programmes for mental health may contribute to this objective, these services are at varying stages of implementation and evidence on their impact remains limited to date.

Demographic change is projected to mitigate demand for CAMHS inpatient services over the projection period, reflecting the expected decline in the population aged 13–17 years. However, the extent to which this will translate into reduced demand for inpatient care is uncertain. The projections are based on observed patterns of inpatient service provision and utilisation in 2023 and therefore do not account for the potential impact of unmet demand for community CAMHS services on future inpatient service utilisation. Significant waiting lists for community CAMHS services, alongside workforce and service capacity constraints, may influence referral pathways and patterns of service utilisation across the CAMHS care pathway, including inpatient services. Consequently, while demographic change is likely to reduce pressure on CAMHS inpatient services, the scale of any reduction should be interpreted with caution.

The findings also highlight the importance of interpreting bed capacity and occupancy within the wider mental health system. Low occupancy rates for some services may mask pressures elsewhere, reflecting issues of service configuration, geographic distribution and operational constraints rather than surplus capacity. Future capacity planning should therefore consider not only overall bed numbers but also the distribution of capacity across services and levels of clinical need. As highlighted in Sharing the Vision and subsequent HSE recommendations, this includes ensuring appropriate provision for specific patient groups, such as older people and those requiring specialist services including perinatal mental health, eating disorder and dual diagnosis care. Failing to account for differences in clinical need risks creating mismatches between service requirements and available capacity, even where overall bed numbers appear adequate.

The analysis is constrained by limitations in the availability and linkage of patient-level data across inpatient and community settings and a lack of information on bed type. Planned implementation of the Community Care Record alongside a national electronic health record and unique patient identifier offers significant potential to address these limitations. Improved data quality and linkage will strengthen future applications of the Hippocrates model by supporting a better understanding of patient pathways, more robust projections, and more evidence-informed capacity planning. Alongside continued investment in infrastructure, expansion of the mental health workforce will be essential to ensure that additional capacity can be operated safely and effectively.

Chapter 1
Introduction and background

1.1 Overview

The ESRI Hippocrates model is a demand projection model that has been applied across a range of Irish health and social care services. For most services, current patterns of service utilisation are used as a starting point, with projections developed under a range of alternative scenarios. These scenarios primarily vary assumptions relating to population growth and ageing but may also incorporate, where data permit, assumptions regarding healthy ageing and policy change. Importantly, the model does not forecast future demand or capacity; rather, it provides a medium-term guide to future requirements based on a set of clearly defined assumptions regarding the evolution of key drivers of demand and capacity.

Demand and expenditure projections for public acute psychiatric inpatient services for adults were estimated using the Hippocrates model in Keegan et al. (2020). This report updates the demand analysis from a 2018 to a 2023 baseline and extends demand projections to 2040. Unlike the previous analysis, expenditure projections are not included. However, the scope of the analysis has been broadened to include all public hospitals and units and to project bed capacity requirements under a range of scenarios to 2040. Where appropriate, projections are additionally presented at the Health Service Executive (HSE) Health Region level.

1.2 Context and scope

The term mental health is described by the HSE as a spectrum that extends from enjoying positive mental health through to severe and disabling illness (HSE Mental Health Services, 2020). In recent decades, the organisation and delivery of mental health services in Ireland have undergone substantial reform, characterised by a shift away from an inpatient-centric model towards community-based care where appropriate.

This transition has been reinforced by the recent enactment of the Mental Health Act 2026, which provides the statutory framework for the regulation of mental health services and represents the most

significant reform since the Mental Health Act 2001. The Act is intended to replace the 2001 legislation on a phased basis. It establishes a rights-based and person-centred approach, including a presumption of capacity for adults, and provisions governing consent to treatment, in alignment with the Assisted Decision-Making (Capacity) Act 2015 and relevant human rights standards (Houses of the Oireachtas, 2026). Importantly, the 2026 Act expands the regulatory oversight role of the Mental Health Commission (MHC)[1] beyond inpatient 'approved centres' to include community mental health residences and services (MHC, 2026a).

This legislative shift reflects and reinforces longstanding policy objectives set out in A Vision for Change, Ireland's national mental health policy from 2006 to 2020, and subsequently in Sharing the Vision: A Mental Health Policy for Everyone, the current national mental health policy (Government of Ireland, 2006; Department of Health, 2020), as well as in international guidance from the World Health Organization (WHO, 2021). Collectively, they advocate for a person-centred rebalancing of mental health care away from residential and inpatient settings towards primary and community settings.

In Sharing the Vision, service delivery is usefully framed as a 'stepped care approach' which allows patients to access services across four tiers of care, depending on the complexity of their current circumstances. Tier 1 services are centred on social, peer, family and friends support alongside support from community and voluntary groups. Tier 2 services are centred on those provided by general practice and psychology services in HSE primary and community care. According to the HSE, over 90 per cent of mental health needs can be treated in the primary care setting (HSE Mental Health Services, 2020).

[1] Independent statutory body with the primary function of ensuring high standards of care and good practice in the delivery of mental health services, established under the Mental Health Act 2001.

For more complex cases, referrals are made to HSE specialist mental health services (Tier 3 and Tier 4), which accounted for €1,383 million (5.3%) of HSE net non-capital expenditure in 2024 (Department of Health, 2026a).[2] Tier 3 services are primarily coordinated and delivered through community mental health teams (CMHTs) at the Community Healthcare Area level within Integrated Healthcare Areas (IHAs) in the new HSE Integrated Service Delivery (ISD) model (HSE, 2025a). These multidisciplinary teams provide integrated care to patients, coordinating interventions including home-based supports, day hospitals, outpatient and inpatient services. Tier 4 services incorporate specialist inpatient or residential units for individuals requiring treatment or services that cannot be safely delivered in a community setting (MHC, 2020).

While Tier 4 services encompass a broader range of inpatient and residential services, the scope of this analysis is limited to public inpatient approved centres registered with the Mental Health Commission (MHC). An 'approved centre' was defined in the Mental Health Act 2001 as 'a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder'. All such centres must be registered with the MHC to operate and must comply with regulations under the Mental Health Act. In the new ISD model, operational accountability for inpatient care is at the IHA level (HSE, 2025a).

Services can be broadly categorised as those providing general adult mental health services, Child and Adolescent Mental Health Services (CAMHS), forensic mental health services – Central Mental Hospital (CMH), and mental health intellectual disability (MHID) services (MHC, 2026b). For this report, general adult services are split, in line with available data, into acute beds, continuing care beds and psychiatric intensive care unit (PICU) beds.[3,4] Figure 1.1 presents the geographic distribution of the hospitals/units in the base year for the analysis, 2023.

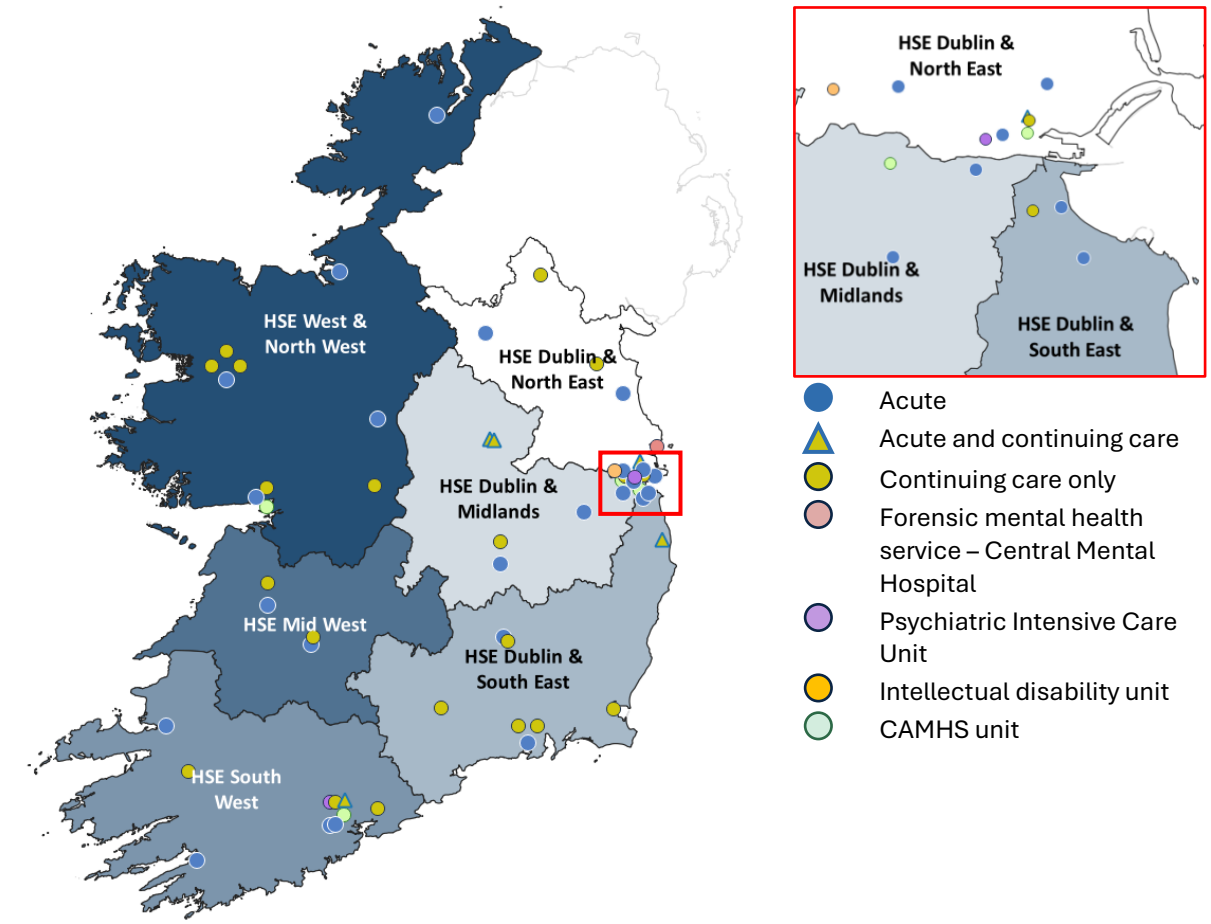
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2 Due to data limitations, expenditure attributable specifically to approved centres cannot be separately identified. Data submitted by the HSE to the CSO for the System of Health Accounts suggest that approximately 40 per cent of HSE specialist mental health services expenditure is attributable to inpatient centres, although this includes some expenditure on non-approved continuing care centres. Estimates were provided through personal communication with the HSE National Finance Division.

3 See Appendix A for a list of the hospitals/units included in the analysis.

4 A detailed description of the bed types under consideration in this analysis is provided in Chapter 2.

Figure 1.1 Public psychiatric inpatient approved units by HSE Health Region, 2023



Notes: Some hospitals/units have both acute and continuing care beds, they are marked separately on the map.
Overlapping points have been slightly offset to be visible.
See Appendix A for a list of the included hospitals/units.

Source: Author generated from health geographies mapping files available from https://www.geohive.ie/

In 2023, there were eight adult approved centres (715 registered beds) operated by independent (private) providers in Ireland, seven of which were in the broader Dublin area. There were also two private CAMHS units (26 registered beds), both of which are in Dublin.[5] In 2023, activity in private units accounted for approximately 28 per cent of bed days in adult approved centres (Daly et al., 2024). These units are beyond the scope of this analysis. It is acknowledged that some activity in independent units may be funded by the HSE (HSE, 2023). This may include HSE-funded private placements or the commissioning of units

[5] Bed numbers for private facilities obtained from MHC annual inspection reports 2023.

under Service Level Agreements. Data available for this report does not allow for an analysis of this activity.[6]

1.3 Objectives

The objectives of this report are to:

- Provide 2023 activity profiles for public psychiatric inpatient services; and to
- Project demand and bed capacity requirements to 2040.

1.4 Structure of the report

The remainder of the report is structured as follows:

- Chapter 2 provides an overview of policy pertaining to psychiatric inpatient services in Ireland and describes the categories of beds included in the analysis.
- Chapter 3 outlines the data and methods used in the report.
- Chapter 4 presents findings including baseline utilisation profiles for 2023, measured in episodes[7] and bed days, and bed capacity at national and HSE Health Region level where appropriate.
- Chapter 5 presents episode, bed day and bed capacity projections for all services and by HSE Health Region level where appropriate.

Finally, Chapter 6 concludes with sensitivity analyses that explore variations in the main assumptions, followed by a summary and discussion of the report's findings.

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6 An exception is the inclusion of HSE-commissioned acute beds in St John of God University Hospital, Cluain Mhuire, as data for these beds are separately reported.

7 This is an aggregation of the following activity in 2023: completed episodes – discharges and deaths in 2023; active new episodes – patients admitted in 2023 who have not yet been discharged by 31 December 2023, and active long-stay episodes – patients admitted prior to 2023 that have not yet been discharged on 31 December 2023.

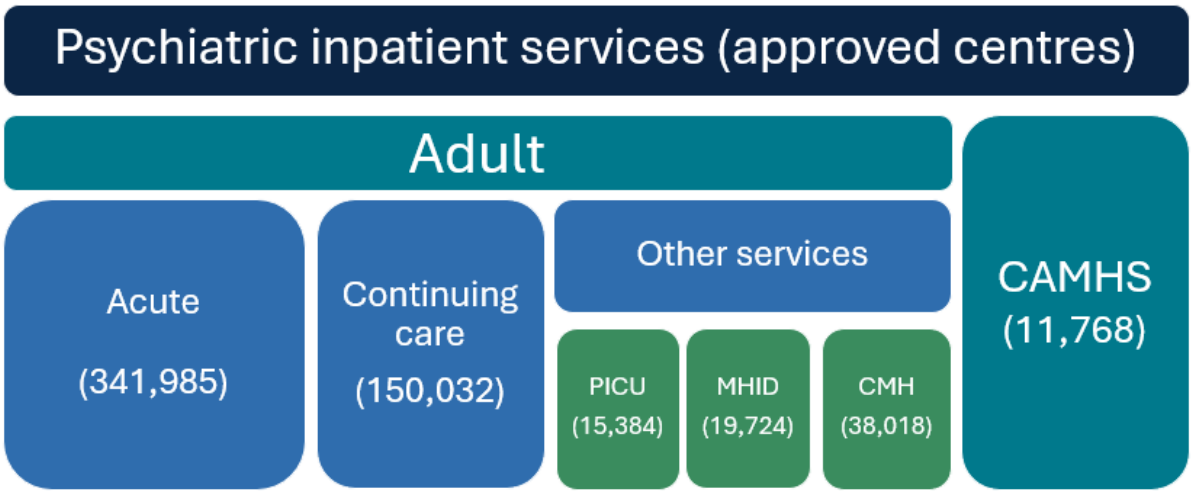
Chapter 2
Public psychiatric inpatient services in Ireland

2.1 Overview

This chapter provides an overview of the public psychiatric inpatient services included in the analysis. It describes the principal service categories, namely acute adult services, continuing care services, psychiatric intensive care units (PICUs), forensic mental health services – Central Mental Hospital (CMH), mental health intellectual disability (MHID) services, and Child and Adolescent Mental Health Services (CAMHS) inpatient units (Figure 2.1). For each service category, the chapter outlines the purpose of the service, broad patient diagnosis categories treated and, where relevant, policy recommendations relating to inpatient bed provision.

Psychiatric inpatient services comprise a range of specialist bed types and sub-units. However, the service categories presented here reflect the level of detail available in the current service utilisation data. While it is possible to broadly distinguish acute adult services from other adult services, the available data do not currently allow all specialist bed types to be identified separately, e.g. eating disorders, psychiatry of later life.

Figure 2.1 Public psychiatric inpatient services (approved centres) by type, 2023



Notes: Bed days in parentheses. Diagram is illustrative and not drawn to scale.
Sources: HRB National Psychiatric Inpatient Reporting System, see section 3.3 for data description.

2.2 Adult services

2.2.1 Acute services

In 2023, there were 29 public hospitals and units providing acute inpatient beds. These beds are typically co-located within general acute hospital sites. Patients admitted to these beds receive intensive support during periods of severe and acute mental illness. The bed complement includes general acute beds, beds for older adults, and a smaller number of specialist beds (HSE, 2023). A majority of patients in these units in 2023 (~60%) had a primary admission diagnosis in one of three broad categories: schizophrenia, schizotypal and delusional disorders, depressive disorders or bipolar disorders (Figure 2.2). There is a reasonably similar distribution of diagnoses across the regions.

Over the past two decades, there has been considerable debate across various policy and research documents as to the appropriate number of acute beds that should be available. In 2006, A Vision for Change (VfC) recommended that there should be 50 acute inpatient beds in each population catchment area of 300,000, with provision of beds across units cognisant of the location of existing services. This recommendation equated to 650 beds in 2006, significantly less than the ~900 acute beds available at the time (Government of Ireland, 2006, p.181).[8]

The Joint Committee on the Future of Mental Health Care (2018) stated that while the overall tenets of VfC were correct, the reduced number of acute beds recommended would only be practical if the level of primary and community care provision envisaged were operational. They recommended that the target number of acute beds be increased, at least in the short term, to 50 per 100,000 population. However, this recommendation includes CAMHS, CMH and private acute capacity, and is therefore not directly comparable with the VfC recommendations.

In 2018, the MHC carried out a census in 28 of the 29 public acute units. They found that, while the total number of acute adult beds (1,050) was higher than that recommended in VfC, these units had an overall occupancy rate of 89.3 per cent. The rate was found to vary across facilities, with only nine of the 28 units found to be operating within a stated safe occupancy level of less than 85 per cent on the

[8] Adjusting for population, the Vision for Change recommendation equates to 880 beds in 2023.

night the census was undertaken (MHC, 2020), suggesting that available capacity was insufficient. An 85 per cent occupancy rate threshold is frequently cited as an upper average threshold for the safe operation of inpatient psychiatric services (MHC, 2020; IMO, 2022; HSE, 2023).

In 2020, Sharing the Vision (Department of Health, 2020) highlighted the recommendations in VfC and the Joint Committee report, but was not prescriptive on the number of beds that should be provided. Instead, it proposed establishing a committee to review inpatient capacity requirements (recommendation 46). The first report from that committee (Specialist Group on Acute Bed Capacity), based on a bed census undertaken in November 2021, indicated that bed occupancy rates for acute adult beds were over 85 per cent in three of the nine community healthcare organisations[9] and 77 per cent nationally. This appears to be an improvement on the figures reported by the MHC based on 2018 data, but arguably these figures are not comparable due to the COVID-19 context of the 2021 census. The specialist group recommended a phased approach to reaching 50 acute beds per 100,000 population (public and private), with an interim target of 25 acute beds (public) per 100,000 population (HSE, 2023).

2.2.2 Continuing care services

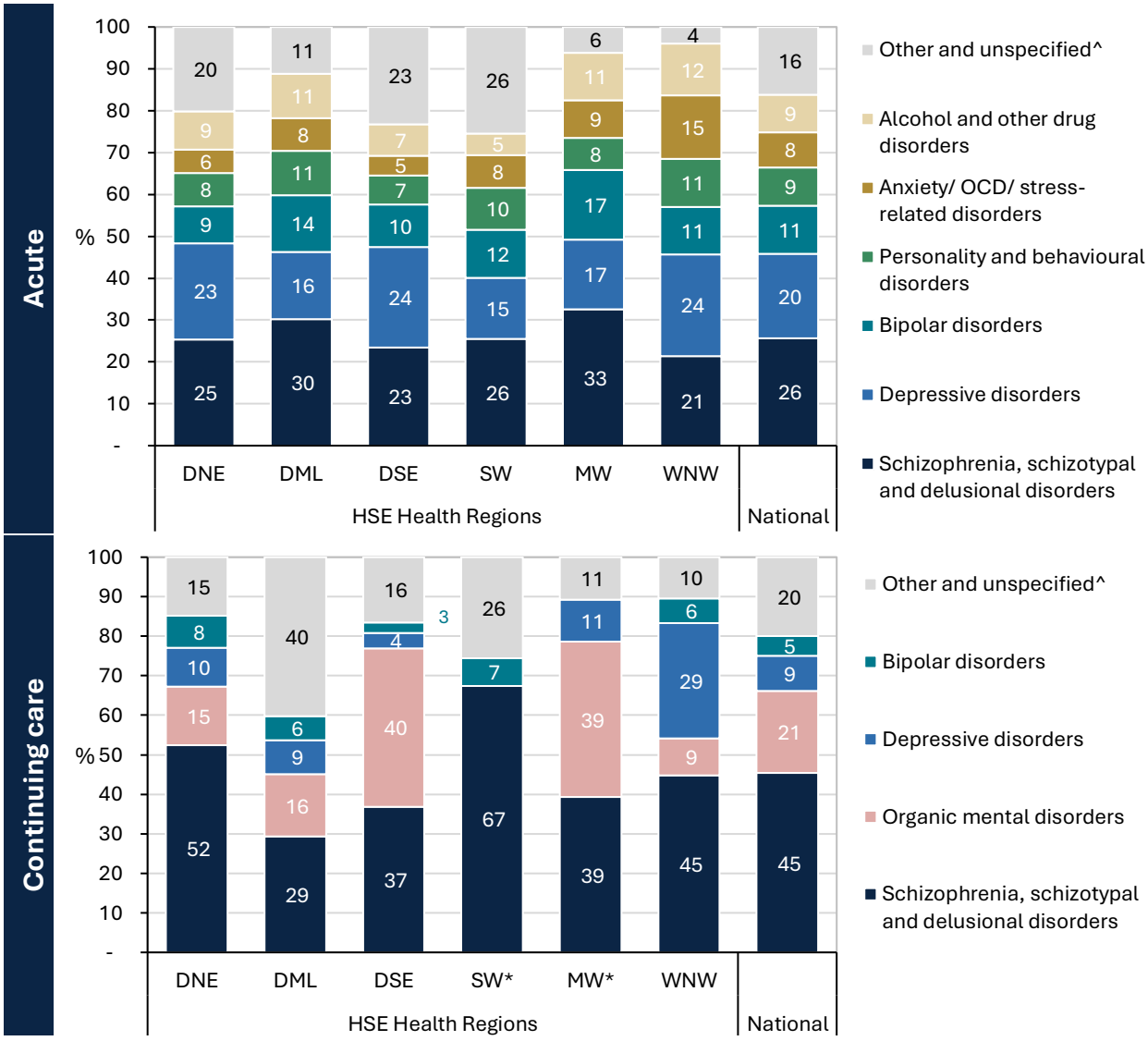
In 2023, there were 25 public approved centres providing continuing care beds (excluding PICU and St Joseph's Intellectual Disability unit).[10] Patients in these units typically have high levels of disability and long lengths of stay, with ongoing risks to their own health and safety or to others (HSE, 2023). The bed complement includes, but is not limited to, psychiatry of later life, high dependency rehabilitation, and rehabilitation psychiatry beds. Available service utilisation data for 2023 do not distinguish between the various bed types. In most regions, a majority of patients have a diagnosis of schizophrenia, schizotypal and delusional disorders or organic mental disorders (Figure 2.2). Regional differences in activity and diagnosis profiles should be interpreted in the context of local service configurations. Historical patterns of bed provision and variation in the balance between approved centre and community residential care may

[9] Community Healthcare Organisations were the former organisational structures through which non-acute services, including mental health, were delivered.

[10] In this analysis we consider PICUs and St Joseph's Intellectual disability unit separately.

contribute to differences in patient profiles across regions. There is no policy recommendation for the number of continuing care beds.

Figure 2.2 Primary admission diagnosis profile – acute and continuing care services, 2023



Notes: ^ Incorporates the NPIRS category 'other and unspecified' (acute – 83%, continuing care – 57%) and categories with small numbers of patients (acute – 17%, continuing care – 43%).
* Where cells are <5 these categories have been combined into the 'other and unspecified' category.

Source: HRB NPIRS, 2023, personal communication from HRB, 11 June 2026.

2.2.3 Other adult services

Psychiatric intensive care unit

There are currently two PICUs in Ireland providing specialist intensive mental health care and treatment for adult patients with a mental disorder that cannot be managed safely in an open adult admission unit (MHC, 2024a; b). A majority of patients in these units in 2023

(~83%) had a primary admission diagnosis in one of two broad categories: schizophrenia, schizotypal and delusional disorders or bipolar disorders.[11] There is no policy recommendation for the appropriate number of units or beds for this service. In Sharing the Vision (recommendation 47) it was recommended that 'sufficient' PICUs to meet identified need should be developed (HSE and Department of Health, 2025).

Forensic mental health services – Central Mental Hospital

There is one forensic inpatient facility in Ireland, the Central Mental Hospital (CMH) in Portrane. It forms part of the National Forensic Mental Health Services and provides both medium- and high-security units. In addition, it includes specialist beds for individuals with intellectual and developmental disabilities, as well as recovery and rehabilitation services. Residents are admitted under the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006 (MHC, 2024c). In 2023, 86 per cent of patients treated in this hospital had a primary admission diagnosis of schizophrenia, schizotypal and delusional disorders or bipolar disorders.[12] There is no policy recommendation for the appropriate number of beds for this service.

Mental health intellectual disability unit

St Joseph's Intellectual Disability Service is a specialist unit which provides care for adults with an intellectual disability and a mental health diagnosis (MHC, 2024d). In 2023, almost all patients had a diagnosis of intellectual disability.[13] There are other units that provide this type of care, but it is not currently possible to disaggregate the service utilisation data by bed type. There is no policy recommendation for the appropriate number of beds for this service, although it was recommended in Sharing the Vision (recommendation 50) that a national network of Mental Health and Intellectual Disability teams and acute treatment beds be developed (HSE and Department of Health, 2025).

[11] HRB NPIRS, 2023, personal communication from HRB, 11 June 2026.
[12] HRB NPIRS, 2023, personal communication from HRB, 11 June 2026.
[13] HRB NPIRS, 2023, personal communication from HRB, 11 June 2026.

2.3 CAMHS services

In 2023, there were four public units for children and adolescents requiring inpatient care in Ireland. HRB published data for 2023 for all CAMHS units (including two private units) show depressive disorders, anxiety or fear-related disorders/OCD/stress-related disorders, and eating disorders accounted for almost 70 per cent of admissions (Table 5.3 – Daly et al. (2024)). While in 2006, VfC recommended 100 CAMHS beds across five units (Section 8.3 – Government of Ireland, 2006), subsequent policy is not prescriptive regarding bed numbers.

2.4 Summary

This chapter outlined the organisation of public psychiatric inpatient services in Ireland, including acute adult, continuing care, CMH, PICU, MHID and CAMHS inpatient services. The chapter places these services within the broader policy shift towards community-based mental healthcare set out in Sharing the Vision, while highlighting that inpatient care remains an essential component of the mental health system for people whose needs cannot be met safely in community settings. Although recent recommendations regarding the appropriate level of inpatient provision are available for acute services (HSE, 2023), equivalent recommendations do not currently exist for the other service categories examined in this report.

Chapter 3

Hippocrates methods and data

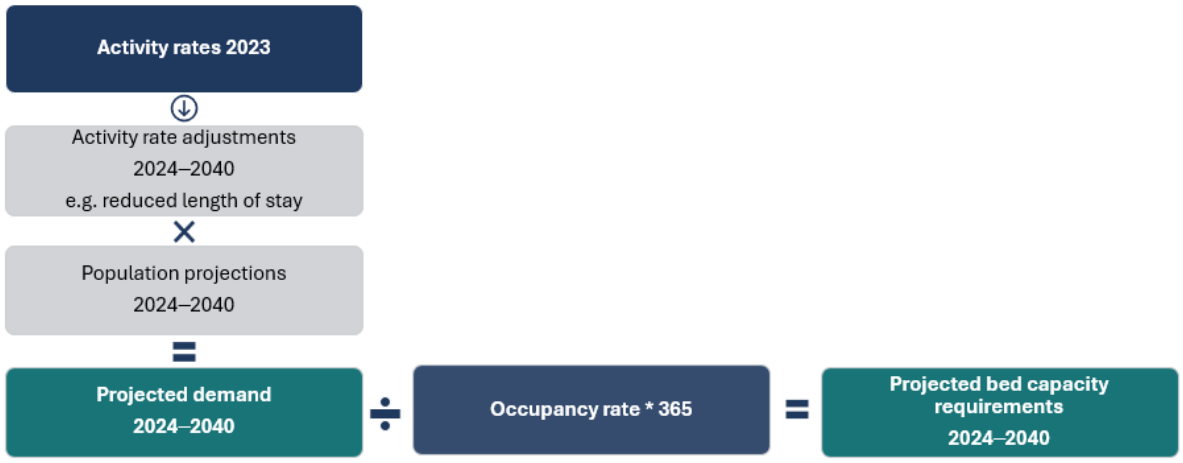
3.1 Introduction

This chapter describes the Hippocrates projection methodology and the data employed in the analysis (see also Brick et al., 2020; Keegan et al., 2020). First, it provides an overview of the Hippocrates model and the development of 2023 activity rate profiles. These profiles quantify rates of service use by age and sex and form the basis for projecting future demand under alternative assumptions. It then outlines the key projection assumptions, including population growth and ageing, length of stay (LOS) and occupancy rate reductions. Finally, the projection scenarios used in this report are presented.

3.2 Hippocrates overview

Figure 3.1 presents a diagrammatic representation of steps involved in applying the Hippocrates model to project demand and bed capacity. The first step in developing projections in Hippocrates is to develop 2023 age- and sex-specific activity rate profiles (regionally where appropriate) for services under consideration. Rates are then adjusted, where possible, based on the outlined assumptions and then multiplied by population projections to provide estimates of demand requirements in a projection year. Finally, bed capacity requirements are calculated by dividing the estimated aggregate bed days by 365 times the assumed occupancy rate. The following sections discuss each step in more detail.

Figure 3.1 Hippocrates model | diagrammatic representation of bed capacity projections 2023–2040



Source: Authors' representation of the Hippocrates model.

3.3 Development of activity rate profiles for 2023

Activity rates are calculated by dividing activity volumes by corresponding populations in the base year. The calculations are undertaken at the most disaggregated level possible given the underlying data available, preferably single year of age and sex.[14] The data and methods used to calculate the baseline activity rates vary by service and are discussed below.

Data: All centres registered with the MHC must provide data on admissions and discharges to the National Psychiatric Inpatient Reporting System (NPIRS) which is managed by the Health Research Board (HRB).[15,16] The data collected includes demographic details, socio-economic data and diagnosis on admission and discharge (Daly et al., 2024).

For this analysis the HRB provided information on episodes and associated bed days in 2023.[17] This is an aggregation of activity related to completed episodes (discharges and deaths in 2023); active new episodes (patients admitted in 2023 who have not yet been discharged

[14] As discussed in Wren et al. (2017), age aggregation has the consequence of understating the projections particularly where demand is concentrated in older ages.

[15] Unlike public acute hospitals, there are currently no waiting-list data available for acute adult inpatient psychiatric services, see Brick et al. (2020). However, a field is currently under development for NPIRS which will capture the length of time a patient is waiting from referral to admission. It will only be collected on admission.

[16] Data do not include patients who were sent abroad for treatment. Data relating to the HSE Treatment Abroad Scheme show that there were nine such patients in 2023 and this cost €12m (HSE, 2026a).

[17] For two acute units in 2023, significantly fewer bed days were recorded due to bed closures. Therefore, we use 2022 bed days for these units.

by 31 December 2023) and active long-stay episodes (patients admitted prior to 2023 that have not yet been discharged on 31 December 2023). It should be noted that only bed days accumulated in 2023 are included regardless of when the patient was admitted. Data were provided by five-year age group and sex at hospital/unit level.[18]

For acute and continuing care units, hospital level data are aggregated to HSE Health Region level.[19] For PICU, CMH, MHID and CAMHS services analysis is undertaken at national level only. The analysis covers activity in public units, it does not cover activity in private units even if that activity may be publicly funded/commissioned, as this cannot currently be identified in the data.[20]

Methods: Age- and sex-specific baseline utilisation rates are calculated by taking the number of episodes and bed days used in 2023 and dividing by corresponding ESRI population data in 2023. For acute and continuing care services, regional utilisation rates were calculated using the HSE Health Region population in 2023 as the denominator, without adjustment for service catchment areas. For PICU, CMH, MHID and CAMHS services the national population in 2023 is the denominator, reflecting the supra-regional nature of these services.

3.4 Projection assumptions

(1) Population growth and ageing

ESRI national and HSE Health Region population for 2023 and projections to 2040 are used in the analysis. Four population projection scenarios are considered in our analysis. The data and methods used to develop these updated ESRI projections, based on the CSO Census of Population 2022, are described in detail in Bergin and Egan (2024) and Bergin et al. (2026). Summarised in Table 3.1, the central scenario is based on assumptions around the three key drivers of population change: mortality, migration and fertility. The only difference between the central, low migration and high migration scenarios is in the migration assumption, which assumes lower and higher migration in the low/high migration scenarios respectively. The

[18] Except for CAMHS which was provided by single year of age at national level.
[19] HSE Health Region refers to the area of hospitalisation and not area of residence of the patient.
[20] HSE-commissioned acute beds in St John of God University Hospital, Cluain Mhuire, are included in the analysis as this data is separately reported.

low fertility scenario models a lower fertility rate compared to the central scenario.[21]

Table 3.1 Summary of main assumptions for population scenarios

		Assumptions		
		Mortality	Migration	Fertility
Scenarios	Central	Life expectancy at birth for males (females) is expected to increase from 81.1 (84.6) in 2022 to 84.2 (87.1) for males (females) in 2040.	Net immigration to average +35,000 p.a. to 2030 (higher at +45,000 in the first two years) and +20,000 p.a. thereafter.	Total fertility rate is unchanged at 1.65 over the period.
	Low migration	No change from central scenario.	Net immigration to average +25,000 p.a. to 2030 (higher at +35,000 in the first two years) and +10,000 p.a. thereafter.	No change from central scenario.
	High migration	No change from central scenario.	Net immigration to average +45,000 p.a. to 2030 (higher at +55,000 in the first two years) and +30,000 p.a. thereafter.	No change from central scenario.
	Low fertility	No change from central scenario.	No change from central scenario.	Total fertility rate reduces to 1.4 by 2031 and remains constant thereafter

Note: p.a. = per annum.
Source: Bergin and Egan (2024) and additional low fertility scenario provided by the authors.

Table 3.2 presents the population by HSE Health Region in 2023 and by scenario in 2040. The national population is projected to grow by between 11.6 and 19.3 per cent by 2040. In the central scenario, the highest growth is projected for HSE Dublin and Midlands (DML) at 18.3 per cent and the lowest in HSE West and North West (WNW) at 12.1 per cent.

[21] A central population scenario with a low fertility assumption in which the fertility rate reduces to 1.4 by 2031 and remains constant thereafter rather than the constant 1.65 modelled in the other scenarios.

Table 3.2 Population by projection scenarios and HSE Health Regions, 2023–2040

Lower growth — Higher growth

	2023	2040				Growth 2023–2040			
		Central	Low	High	Low fertility	Central	Low	High	Low fertility
	'000	'000	'000	'000	'000	%	%	%	%
HSE Dublin and North East (DNE)	1,217	1,429	1,375	1,483	1,397	17.4	13.0	21.8	14.8
HSE Dublin and Midlands (DML)	1,105	1,307	1,261	1,353	1,278	18.3	14.1	22.5	15.6
HSE Dublin and South East (DSE)	997	1,143	1,110	1,176	1,119	14.7	11.4	18.0	12.3
HSE South West (SW)	760	874	847	901	855	15.0	11.4	18.5	12.5
HSE Mid West (MW)	424	479	464	495	468	13.1	9.5	16.7	10.5
HSE West and North West (WNW)	780	874	848	901	855	12.1	8.7	15.5	9.7
National	**5,282**	**6,097**	**5,892**	**6,302**	**5,965**	**15.4**	**11.6**	**19.3**	**12.9**

Note: It should be noted that the aggregation of regional population projections will not perfectly align with the national-level projections, but the differences are minor.

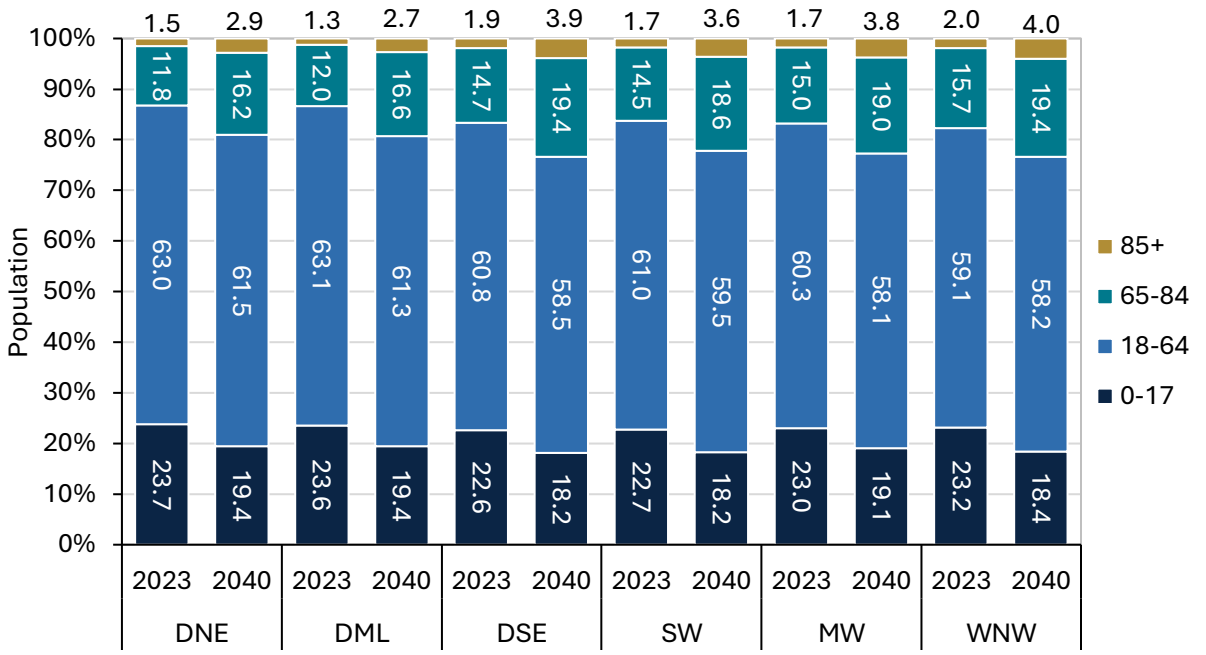
Source: Generated by the authors from additional tables provided by Bergin and Egan (2024).

Of note is the change in the structure of the population over the projection period. Figure 3.2 presents the proportion of the population in each broad age group by HSE Health Region in 2023 and 2040 (central). In all regions, the proportion (and absolute number) of the population in the CAMHS cohort (0–17 years) is projected to decrease by between 3.9 (MW) and 4.8 (WNW) percentage points. Importantly, for CAMHS inpatient services, most service users are aged 13–17 years. This narrower age cohort is projected to experience a substantially greater population decline over the period, ranging from 20.4 per cent under the low fertility scenario to 13.5 per cent under the high migration scenario.[22]

At the other end of the age distribution, the proportion of the population aged 65 and older is projected to increase by between 5.7 (WNW) and 6.7 (DSE) percentage points over the period in the central scenario. The proportion aged 85 and older is expected to more than double in all regions.

[22] See Appendix B for single year of age and sex national population pyramids for 2023 and 2040 (central).

Figure 3.2 Age-specific population distribution by HSE Health Region, 2023 and 2040 (central)



Source: Generated by the authors from additional tables provided by Bergin and Egan (2024).

Model assumptions: Given the relatively high levels of migration to Ireland in recent years, with net migration numbers exceeding those included in the population projections, the central and high migration population scenarios are likely the most relevant to current projections (Connolly et al., 2025). In the main analysis, the central and high migration population scenarios are applied for all services, with the low fertility scenario also applied for CAMHS services. The low migration scenario is included in the sensitivity analysis in section 6.2.

(2) Reduction in acute adult inpatient length of stay

Data: Bed days used in 2023 provided by the HRB.

Method: Achieving a consistent time trend for acute adult bed days is challenging because, until relatively recently, some services with co-located acute and non-acute beds did not distinguish between bed types in their activity returns, resulting in combined reporting of acute and non-acute activity. As with other health services, utilisation of inpatient psychiatric services reduced in the COVID-19 period. Focusing on general hospital units in the NPIRS annual reports, we observe some volatility in the numbers, with reductions in 2020, increases in 2021 and reductions again in 2022. This makes trends difficult to interpret. We currently model a 10 per cent reduction in the

inpatient length of stay to reflect faster discharge, rather than fewer admissions, from acute adult services with the establishment of appropriate step-down services in the community. A similar assumption is applied in Brick et al. (2025) and Brick and Kakoulidou (2025) for public acute hospitals. This assumption should be kept under review as more data from community services becomes available.

Model assumption: Model a 10 per cent reduction in acute inpatient length of stay by 2040.

(3) Occupancy rate

Data:

Acute adult: Acute adult services report bed numbers quarterly to the HRB. Both the number of beds registered (commissioned) with the MHC, and the number that were operational and available for patients are returned.[23] Differences may arise between the number of registered beds and the number of operational beds due to beds being unavailable for various reasons, such as staff shortages (MHC, 2024e) or building renovations (MHC, 2024f) in 2023.

All other bed types: Currently, other services do not report bed numbers to the HRB. For these services, we use data from the MHC inspection reports for 2023 and adjust for any noted reduction in operational beds.

Method: Occupancy rates for 2023 are estimated, by dividing the number of bed days used in 2023 by the number of annual available bed days. For all services, this is undertaken at national level and for acute and continuing care, it is also estimated at the HSE Health Region level.

Model assumptions: In our modelling scenarios, two occupancy rates are considered for acute units and CMH. In the first instance, the 2023 occupancy rates are maintained to 2040. In an alternative scenario, the occupancy rates reduce linearly to 85 per cent by 2040.

For continuing care, other adult services and CAMHS, we hold occupancy rates constant at the 2023 level in all scenarios. Although the estimated occupancy rates for 2023 were below 85 per cent in

[23] Registered/commissioned and operational beds reported by services to the HRB for Q4 2023.

some regions and nationally, there is insufficient evidence to conclude that this reflects genuine excess capacity. First, occupancy estimates may be subject to measurement error, as operational bed numbers for these services are compiled from point-in-time data reported in MHC annual reports. Second, occupancy rates may be affected by staffing constraints (MHC, 2023), service configuration or the availability of alternative forms of residential care, such that low occupancy does not necessarily indicate the availability of spare capacity.

Interpretation is further complicated by limited information on non-approved centres, such as high-support and other residential services outside the scope of the HRB data used in this analysis. These services are organised differently across regions, and capacity pressures may exist elsewhere in the system even where occupancy rates in approved centres appear relatively low. In the absence of more comprehensive information on bed availability, staffing levels and service provision by bed type, the most prudent assumption is for occupancy rates to remain unchanged for these services throughout the projection period. Therefore, projected bed capacity requirements increase or decrease in direct proportion to projected changes in bed day demand. This assumption should be kept under review as more data by bed type, particularly for continuing care services, become available.

3.5 Projection scenarios

Table 3.2 summarises the assumptions underlying the three projection scenarios employed. In the status quo scenario, we include the central population projections and no change in either the length of stay or occupancy rate. In the low-pressure scenario, we include the low fertility population assumption for CAMHS services and additionally model a 10 per cent reduction in acute adult length of stay. In the high-pressure scenario, we apply the high population assumption and a reduction in the occupancy rate to 85 per cent by 2040 for acute services and CMH.[24] This lower occupancy rate reflects the additional bed capacity required to manage demand safely and efficiently.

[24] A lower occupancy rate is assumed in the high-pressure scenario as meeting the same demand requires more beds to be available and operational, placing greater capacity demands on the system.

Table 3.3 Summary of projection scenarios

	Scenarios		
	Status quo	Low pressure	High pressure
Acute services			
Population growth and ageing	Central	Central	High migration
Length of stay	No change	10% reduction in bed days	
Occupancy rate	No change	No change	85% by 2040
CMH			
Population growth and ageing	Central	-	High migration
Occupancy rate	No change	-	85% by 2040
Continuing care, PICU and MHID			
Population growth and ageing	Central	-	High migration
CAMHS services			
Population growth and ageing	Central	Low fertility	High migration

For acute beds, we additionally examine the policy recommendation of 25 acute beds per 100,000 population (HSE, 2023). We calculate the number of recommended beds in 2023 and in 2040 and show how these figures compare to existing provision and projections from the main scenarios.

The report uses version 6 of the Hippocrates model and is automated using R software, with subsidiary analysis undertaken in SPSS and Microsoft Excel.

3.6 Summary

This chapter described the Hippocrates projection methodology and the data used to estimate future demand and bed capacity requirements. Consistent with previous Hippocrates reports, projections are presented under alternative scenarios to reflect uncertainty and provide a range of future capacity requirements.

Chapter 4

Findings | Activity and capacity profiles, 2023

4.1 Introduction

This chapter presents activity and capacity profiles for 2023 for all inpatient bed types nationally and by HSE Health Region for adult acute and continuing care. In addition to acute and continuing care, we also present activity profiles for psychiatric intensive care unit (PICU) beds, forensic beds – Central Mental Hospital (CMH), mental health intellectual disability (MHID) beds and Child and Adolescent Mental Health Services (CAMHS). It should be noted that while activity rates can and do vary across regions, the reasons for this are complex and numerous. It is beyond the scope of this work to determine why this is the case. Some possible reasons for differences in rates to consider when interpreting the analysis are listed below to provide a guide, but this is not exhaustive:

- The structure of service provision in particular regions can impact activity rates. For example, historic patterns of bed provision may lead to higher activity rates in particular regions. Or particularly in the case of continuing care (including rehabilitation) beds, a higher proportion of such care may be provided outside registered (approved) centres in some regions (e.g. high-support beds). Registration and inspection of such beds will be introduced in the coming years through the implementation of the Mental Health Act 2026.

- The separation of acute from continuing care activity in the small number of units that have both co-located may vary.

- Some regions may have a higher proportion of patients attending from outside the region.

- The presence of significant private capacity in Dublin may impact regional utilisation rates.

- The population structure differs by area.

4.2 Activity profiles for adult services, 2023

4.2.1 Acute services

In 2023, there were 12,600 inpatient episodes and almost 342,000 bed days recorded in public acute inpatient hospitals and units.[25,26] Nationally, females account for 48.0 per cent of episodes and 48.7 per cent of bed days. The average length of stay for females was 27.4 days compared to 26.7 days for males. Figure 4.1 presents age- and sex-specific inpatient episodes and bed days, with accompanying rates per 10,000 population for 2023. Nationally, there were 33.2 episodes per 10,000 population for males and 29.2 per 10,000 population for females.[27] The number of episodes is highest for both males (768) and females (710) in the 40–44 age group. The episode rate is highest for males in the 25–29 age group (49.1 per 10,000 population), which is 1.5 times greater than the female rate in this age group (32.6 per 10,000 population).[28] The rate for females is highest (34.8 per 10,000 population) in the 30–34 age group.

Nationally, there were 886 bed days per 10,000 population for males and 802 per 10,000 population for females. The distribution of bed days and the bed day rate differs between males and females. The number of male bed days peaks at 40–44 years (18,335) while the bed day rate peaks at 30–34 years (1,058 per 10,000 population). For females, the number of bed days peaks at 50–54 years (16,276) while the bed day rate peaks at 65–69 years (1,138 per 10,000 population).

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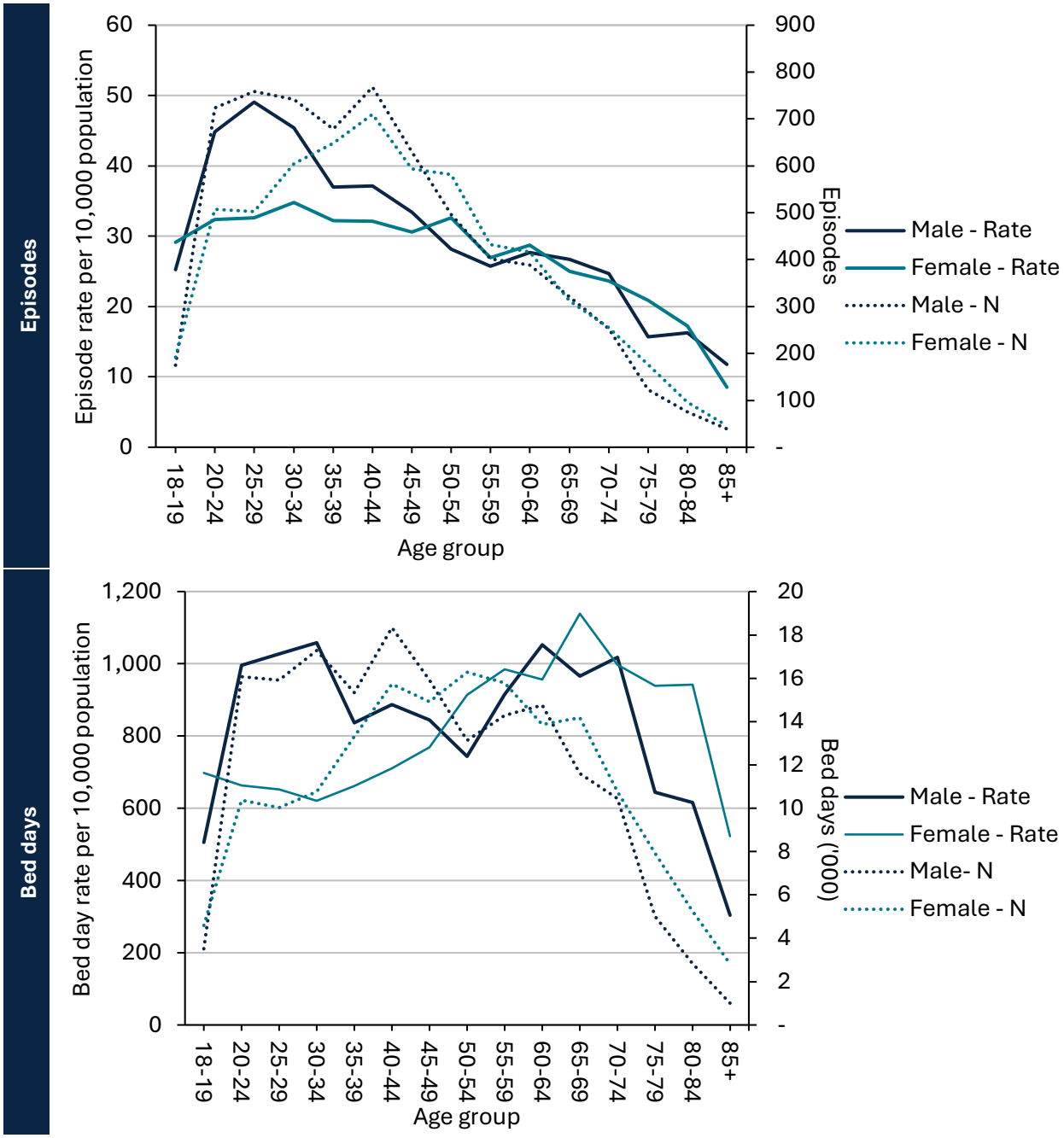
25 It should be noted that there were 14 children admitted to adult units in 2023, nine of whom were age 17 years (Daly et al. (2024) – Table 5.10).

26 For two hospitals in 2023, significantly fewer bed days were recorded due to bed closures. Therefore, we use 2022 bed days for these hospitals. This explains the difference between our aggregate figures and those published by the HRB.

27 Rates calculated using ESRI population estimates for 2023, 18 years and older.

28 This is due to differing diagnoses between males and females in these age groups. A high number of males have a diagnosis of 'F20–F29 Schizophrenia, schizotypal and delusional disorders', which is associated with a relatively high mean bed days per episode (Brick et al., 2020; Daly et al., 2024).

Figure 4.1 Acute | age- and sex-specific inpatient episodes/bed days and episode/bed day rates per 10,000 population, 2023



Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

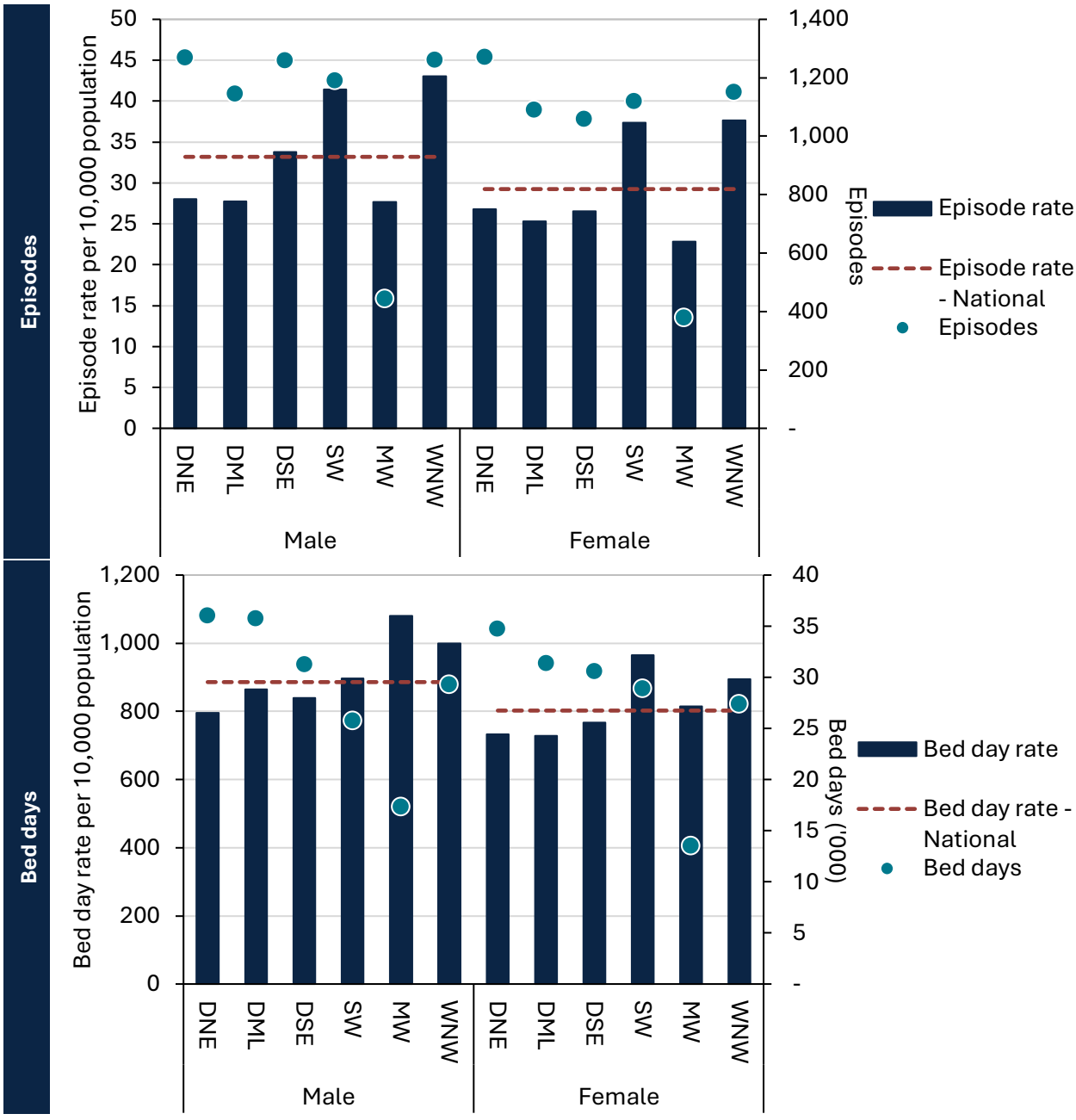
Figure 4.2 shows the variation in sex-specific inpatient episodes, bed days and associated rates per 10,000 population by HSE Health Region.[29] For males, the lowest episode rate is in DNE, DML and the MW at ~28 per 10,000 population and for females, it is lowest in the MW at 23 per 10,000 population. The episode rate for both males and

[29] See Appendix C for HSE Health Region age profiles. Episode and bed day profiles are very similar across regions.

females is highest in the WNW at 43 and 38 per 10,000 population respectively.

The bed day rate is lowest for males in DNE at 795 per 10,000 population and for females in DML at 728 per 10,000 population. The rate for males is highest in the MW (1,080 per 10,000 population), while for females it is highest in the SW (965 per 10,000 population).

Figure 4.2 Acute | sex-specific inpatient episodes/bed days and episode/bed day rates per 10,000 population by HSE Health Region, 2023



Note: Rates calculated using ESRI population estimates for 2023, 18 years and older.
Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

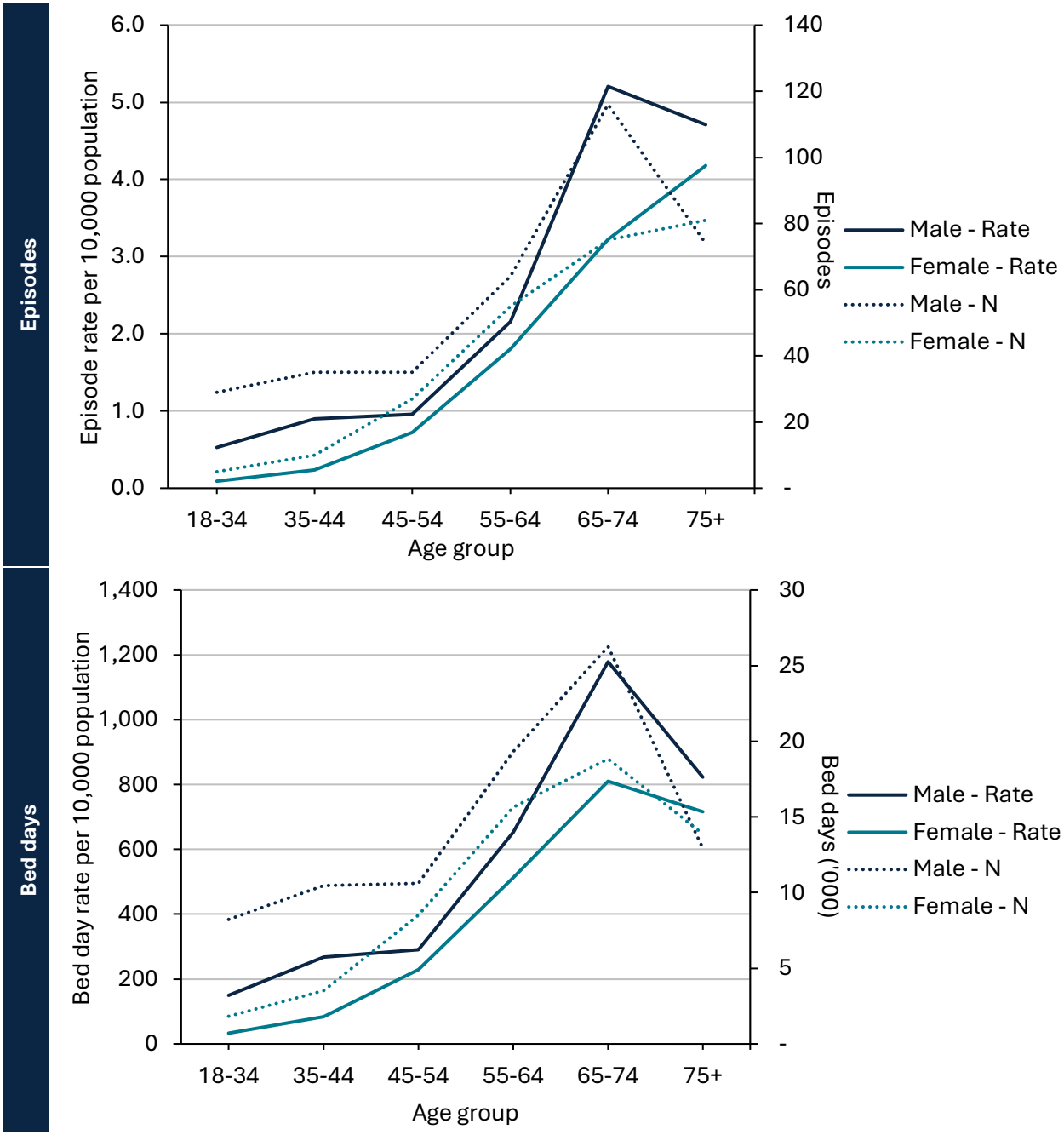
4.2.2 Continuing care services

In 2023, there were 600 inpatient episodes and almost 150,000 bed days recorded in public continuing care hospitals and units. Nationally, females account for 41.7 per cent of episodes and 41.5 per cent of bed days. The average length of stay for females was 246 days compared to 249 days for males. Figure 4.3 presents age- and sex-specific episodes and bed days, with accompanying rates per 10,000 population for 2023.[30] Nationally, there were 1.8 episodes per 10,000 population for males and 1.2 per 10,000 population for females.[31] The number of episodes (116) and the episode rate (5.2 per 10,000 population) is highest for males in the 65–74 age group. For females, the number of episodes (81) and the episode rate (4.2 per 10,000 population) is highest in the 75 years and older age group.

Nationally, there were 444 bed days per 10,000 population for males and 300 per 10,000 population for females. The distribution of bed days and the bed day rate are similar for males and females. The number of bed days peaks at 65–74 years for both males (26,259) and females (18,838). The bed day rate also peaks at 65–74 years (1,178 per 10,000 population) for males and females (810 per 10,000 population).

[30] Due to low numbers in some age categories, fewer age categories are presented for this service.
[31] Rates calculated using ESRI population estimates for 2023, 18 years and older.

Figure 4.3 Continuing care | age- and sex-specific inpatient episodes/bed days and episode/bed day rates per 10,000 population, 2023



Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

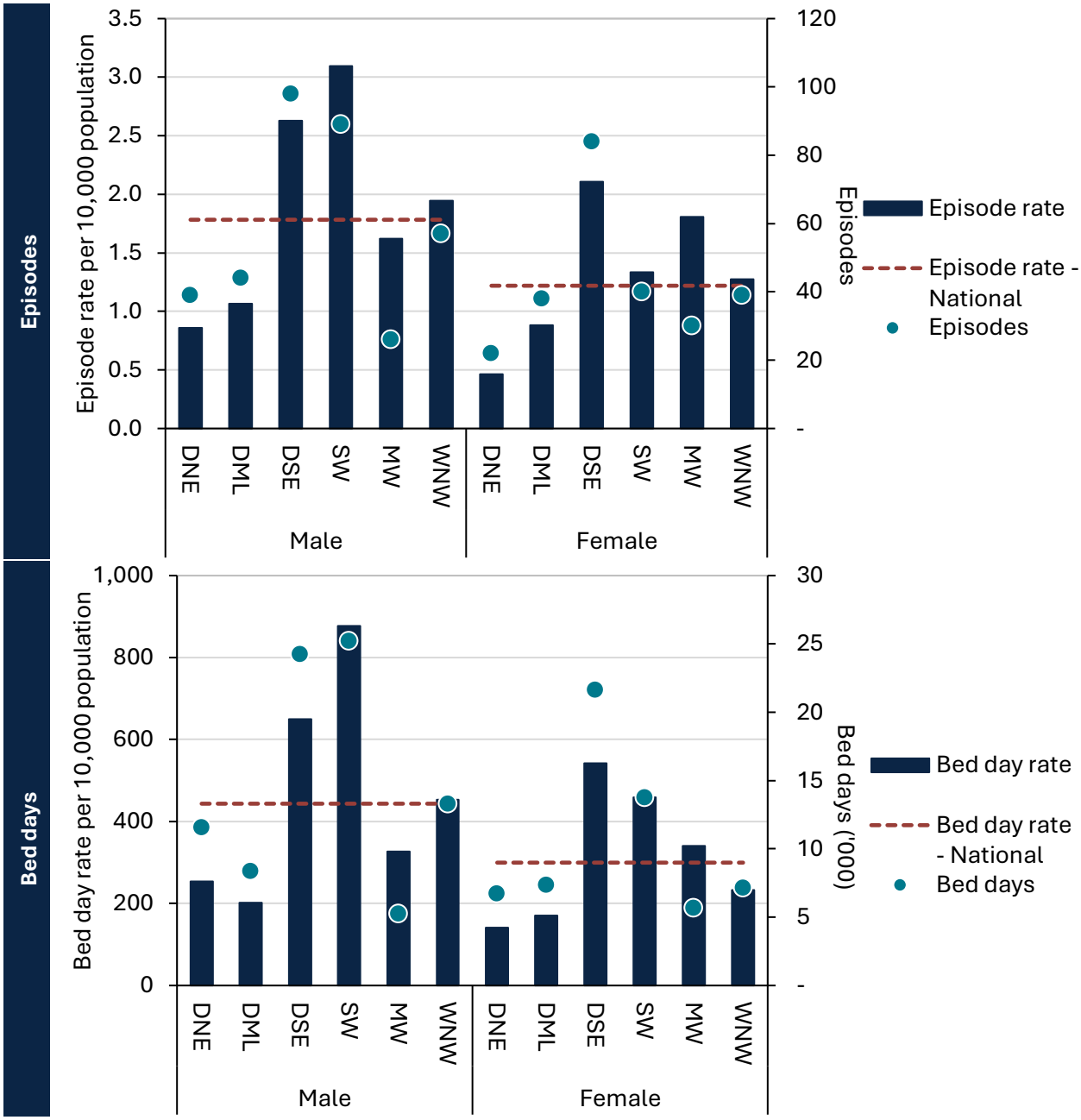
Figure 4.4 shows the variation in sex-specific inpatient episodes, bed days and associated rates per 10,000 population by HSE Health Region.[32] The episode rate is lowest in DNE for both males (0.9 per 10,000 population) and females (0.5 per 10,000 population). The episode rate for males is highest in the SW at 3.1 per 10,000

[32] See Appendix C for HSE Health Region age profiles. Episode and bed day profiles are very similar across regions.

population, and for females is highest in DSE at 2.1 per 10,000 population.

The bed day rate is lowest in DNE for both males (254 per 10,000 population) and for females (141 per 10,000 population). The rate for males is highest in SW (877 per 10,000 population), while for females it is highest in DSE (542 per 10,000 population).

Figure 4.4 Continuing care | sex-specific inpatient episodes/bed days and episode/bed day rates per 10,000 population by HSE Health Region, 2023



Note: Rates calculated using ESRI population estimates for 2023, 18 years and older.
Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

4.2.3 Other adult services

National sex-specific activity and rates for the three other adult unit types are presented in Table 4.1. Episode rates were low overall, ranging from 0.1 per 10,000 population in the MHID unit to 0.4 per 10,000 in PICUs and CMH. In contrast, bed day rates varied more substantially, with the highest observed in CMH (93.7 per 10,000 population). Across all unit types, males accounted for higher levels of activity than females, with differences particularly pronounced in CMH.[33] Average length of stay (ALOS) also varied considerably by unit type, at 92 days in PICUs, 264 days in CMH, and 352 days in the MHID unit.

Table 4.1 Other adult services | sex-specific episodes/bed days and episode/bed day rates per 10,000 population, 2023

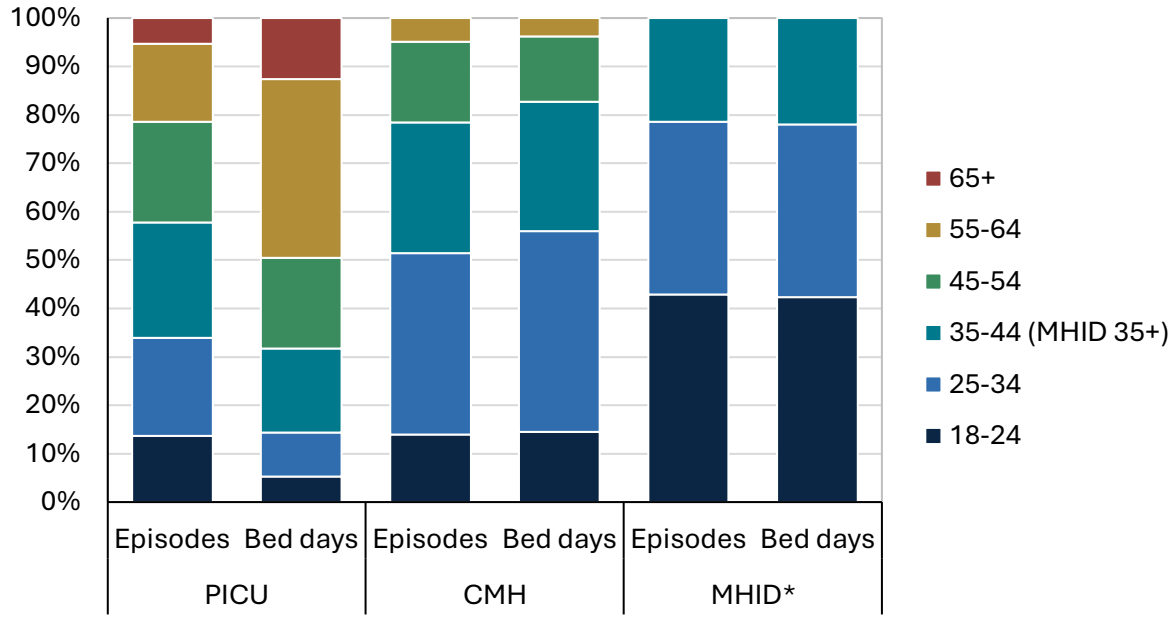
	Episode		Bed days		ALOS
	N	Rate	N	Rate	
PICUs	**168**	**0.4**	**15,384**	**37.9**	**92**
Male	112	0.6	9,570	48.3	85
Female	56	0.3	5,814	28.0	104
CMH	**144**	**0.4**	**38,018**	**93.7**	**264**
Male	128	0.6	34,134	172.4	267
Female	16	0.1	3,884	18.7	243
MHID unit	**56**	**0.1**	**19,724**	**48.6**	**352**
Male	41	0.2	14,304	72.2	349
Female	15	0.1	5,420	26.1	361

Notes: ALOS: average length of stay, within year bed days only.
Rates calculated using ESRI population estimates for 2023, 18 years and older.
Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

Figure 4.5 compares the age group distribution of episodes and bed days across the three other adult services. PICU had a more mixed age distribution, with activity spread across all adult cohorts. In contrast, CMH and MHID services are dominated by younger adults aged 18–34, who make up the majority of both episodes and bed days, with smaller shares in older age groups. Overall, this highlights how more intensive and specialist services (CMH and MHID) are used predominantly by younger populations, while PICU beds serve a broader age range.

[33] In 2023, 12.1 per cent of persons committed to prison were female and 87.9 per cent were male (Irish Prison Service, 2026).

Figure 4.5 Other adult services | episode and bed day age distribution, 2023



Note: *Due to small numbers, it was necessary to combine age categories for MHID services.
Sources: HRB NPIRS, 2023; authors' calculations.

4.3 Activity profile for CAMHS services, 2023

In 2023, there were 226 inpatient episodes in public CAMHS units, the majority of which were aged between 13 and 17 years.[34] Females accounted for a substantially higher share of activity, representing 69 per cent of episodes and 67 per cent of total bed days. Although females had slightly shorter stays on average (51 days) than males (56 days), utilisation rates were markedly higher with both episode and bed day rates more than twice as high for females than for males. The age profile of patients varied by sex. For males, 77 per cent were 16 or 17 years compared to 55 per cent of females.

Table 4.2 CAMHS | sex-specific episodes/bed days and episode/bed day rates per 10,000 population, 2023

	Episodes		Bed days		ALOS
	N	Rate	N	Rate	
CAMHS	**226**	**6.1**	**11,768**	**319**	**52**
Male	69	3.7	3,830	204	56
Female	157	8.7	7,938	441	51

Notes: ALOS: average length of stay, within year bed days only.
Rates calculated using ESRI population estimates for 2023, 13–17 years.
Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

[34] In the data provided by the HRB the minimum category is '13 years and under' and the maximum is 17 years.

4.4 Bed capacity and occupancy rates, 2023

In December 2023, there were 1,023 registered/commissioned beds in public acute adult inpatient psychiatric services nationally, as reported by services to the HRB (Table 4.3). This equates to 19.4 beds per 100,000 population nationally but varies by region, with 17.5 per 100,000 population in DNE compared to 22.5 in the SW. We calculate this figure from the total population in 2023 rather than the total adult population aged 18 years and older so that it is comparable with published HSE Specialist Group on Acute Bed Capacity report beds per 100,000 population recommendation. The difference between registered/commissioned and operational acute beds was less than 1 per cent nationally. As highlighted by the MHC (2020) report, high occupancy rates are an ongoing concern, and the 2023 data illustrate that rates have increased since publication of that report. Occupancy rates, based on operational beds, in all regions were over the 85 per cent recommended threshold. Rates in 2023 vary from 89.2 per cent in the SW to 97.2 per cent in the MW, averaging 92.3 per cent nationally (Table 4.3).

There were 538 registered continuing care beds in 2023. The difference between registered/commissioned and operational acute beds was 3.9 per cent nationally. Most of this difference is accounted for by a single unit which was in the process of closing in 2023. Reflecting the activity rates presented in section 4.2, significant variation in continuing care bed capacity is observed across regions with a national rate of 10.2 beds per 100,000 population, varying from 4.4 in DNE to 17.8 in the SW. The estimated national level occupancy rate for these units in 2023 is 79.5 per cent. This varies from 59.8 per cent in DML to 92.5 per cent in DNE. Some of this variation may be due to the inability to accurately split bed numbers in a small number of units.

There were 62 PICU beds registered and operational in 2023 with an estimated occupancy rate of 68 per cent. CMH had 130 registered beds, but only 108 were in operation in 2023, with an estimated occupancy rate of 96.4 per cent. The MHID unit had 82 registered and operational beds, with an occupancy rate of 65.9 per cent. Finally, there were 72 registered CAMHS beds in 2023, 53 were reported as operational, with an estimated occupancy rate of 60.8 per cent.

In 2023, the total number of public registered beds was 1,907 or 36.1 per 100,000 population. If private registered beds[35] were included, this reaches 2,648 or 50.1 per 100,000 population.

Table 4.3 Public beds, beds per 100,000 population and occupancy rate by bed type, 2023

	Registered/ Commissioned		Estimated operational	
	Beds	Beds per 100,000[d]	Beds	OR %[e]
Adult beds				
Acute	**1,023**	**19.4**	**1,015**	**92.3**
DNE	213	17.5	213	91.1
DML	204	18.5	204	90.1
DSE	181	18.2	178	95.1
SW	171	22.5	168	89.2
MW	89	21.0	87	97.2
WNW	165	21.2	165	94.1
Continuing care[b]	**538**	**10.2**	**517**	**79.5**
DNE	54	4.4	54	92.5
DML	72	6.5	72	59.8
DSE	163	16.4	160	78.5
SW[c]	135	17.8	117	91.2
MW	47	11.1	47	63.6
WNW	67	8.6	67	83.4
Other adult[b]				
PICUs	62	1.2	62	68.0
CMH	130	2.5	108	96.4
MHID unit	82	1.6	82	65.9
CAMHS[b]	**72**	**1.4**	**53**	**60.8**
Total public beds	**1,907**	**36.1**		

Notes: a. Registered/commissioned and operational beds reported by services to the HRB for Q4 2023.
Includes commissioned beds in St John of God University Hospital (Cluain Mhuire).
b. Registered beds reported in MHC annual inspection reports in 2023. Operational beds are adjusted based on significant differences noted in the reports.
c. The significant difference in registered and operational beds is mostly accounted for by a single unit in the process of closing down.
d. Calculated using ESRI population data for 2023, total population.
e. Bed days used / (estimated operational beds * 365 days).

Sources: HRB NPIRS, 2022 and 2023; MHC annual inspection reports, ESRI population data, 2024; authors' calculations.

[35] Using MHC annual inspection reports, we estimate that there were 741 private beds in 2023, 715 adult and 26 CAMHS. Adult beds are a mix of bed types including acute, specialist rehabilitation and other. We do not have a breakdown of the bed numbers by bed type (e.g. acute) so this figure is not comparable with the 50 per 100,000 recommendation of the Oireachtas Joint Committee on the Future of Mental Health.

As discussed in section 3.4, the lower occupancy rates observed for continuing care services in most regions, as well as for MHID and CAMHS services, should be interpreted cautiously. Low occupancy may reflect staffing shortages, service configuration and operational constraints rather than excess capacity. For CAMHS services, frequent publicly reported staffing shortages and temporary bed closures in recent years suggest that actual capacity may differ even from operational capacity gleaned from the MHC reports (MHC, 2023). As a result, occupancy rates for these services are assumed to remain unchanged from their observed base-year levels throughout the projection period. Under this assumption, projected changes in bed capacity requirements are driven solely by projected changes in bed day demand.

4.5 Summary

This chapter presented the baseline picture of psychiatric inpatient activity and capacity in 2023. Acute services accounted for the majority of activity, while continuing care services served a smaller but older patient cohort with substantially longer lengths of stay. Acute bed occupancy rates exceeded the commonly cited 85 per cent threshold in every HSE Health Region. The chapter provides the foundation for the demand and capacity projections presented in Chapter 5.

Chapter 5

Findings | Projected demand and bed capacity, 2023–2040

5.1 Introduction

This chapter presents national and regional projections for demand and bed capacity requirements to 2040.[36] Projections are based on the methodology outlined in Chapter 3 and use the 2023 activity profiles presented in Chapter 4 as a baseline. Three projection scenarios are applied for most services: status quo, low pressure, and high pressure. Each scenario incorporates assumptions regarding population growth and ageing, and for some services additional assumptions on the potential impact of community-based service expansion (length of stay reduction) and variation in the occupancy rate (see Table 3.3). These scenarios provide a range of estimates for future demand and capacity needs. For acute services we also compare to policy targets where possible.

5.2 Adult services

5.2.1 Acute services

Episodes and bed days projections, 2023–2040

Table 5.1 presents projected episodes and bed days by scenario, along with the average annual growth by scenario between 2023 and 2040. The number of episodes is projected to increase from 12,642 in 2023 to between 14,974 and 15,505 by 2040. This equates to average annual growth of between 1.0 per cent and 1.2 per cent. Regionally, following patterns of population growth and changing age structure, projected growth in the west (MW and WNW) is lower than in the east and south. Bed day demand in acute psychiatric inpatient units is projected to grow from 341,000 days in 2023 to between 377,000 days in the low-pressure scenario and 432,000 in the high-pressure scenario by 2040. This equates to average annual growth of between 0.6 per cent and 1.4 per cent. The results of the low-pressure scenario illustrate the impact of the assumed 10 per cent reduction in length of stay (LOS). Again, average annual growth is highest in the east.

[36] HSE Health Region projections are presented for acute adult and continuing care services. All other services are modelled at the national level.

Table 5.1 Acute | demand projections by scenario and HSE Health Region, 2023–2040

	2023[a]	Projected additional requirements 2040			Average annual growth 2023–2040		
		Status quo	Low pressure	High pressure	Status quo	Low pressure	High pressure
	N	N	N	N	%	%	%
Episodes	**12,642**	**2,332**	**2,332**	**2,863**	**1.0**	**1.0**	**1.2**
DNE	2,541	506	506	626	1.1	1.1	1.3
DML	2,236	465	465	565	1.1	1.1	1.3
DSE	2,318	389	389	474	0.9	0.9	1.1
SW	2,311	453	453	542	1.1	1.1	1.2
MW	823	117	117	151	0.8	0.8	1.0
WNW	2,413	402	402	504	0.9	0.9	1.1
Bed days	**341,985**	**77,669**	**35,704**	**90,076**	**1.2**	**0.6**	**1.4**
DNE	70,815	18,513	9,580	21,385	1.4	0.7	1.6
DML	67,120	19,542	10,876	22,113	1.5	0.9	1.7
DSE	61,869	12,702	5,245	14,672	1.1	0.5	1.3
SW	54,670	12,859	6,106	14,564	1.3	0.6	1.4
MW	30,868	4,324	804	5,476	0.8	0.2	1.0
WNW	56,643	9,730	3,092	11,866	0.9	0.3	1.1

Notes: a. For two hospitals in 2023, significantly lower bed days were recorded due to bed closures. Therefore, we use 2022 activity for these hospitals.

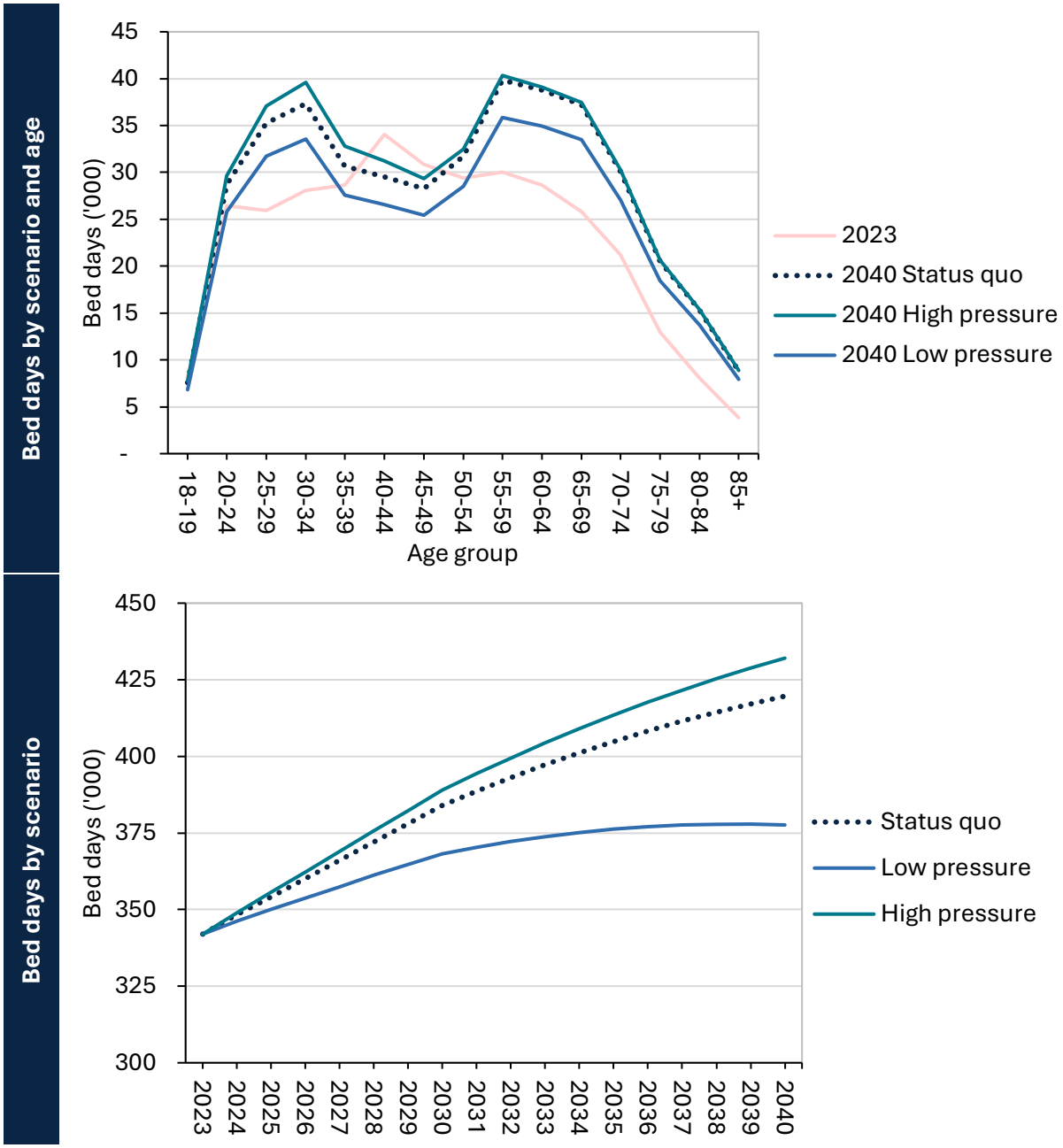
Source: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

Figure 5.1 presents age-specific bed day projections for acute psychiatric inpatient units by projection scenario.[37] Across all scenarios, a relatively large proportion of the projected bed day demand growth takes place at older ages (50 years and older). Substantial growth is also seen in the 20–29 age groups, particularly in the high-pressure scenario, reflecting the high migration population assumption. In the 40–49 age groups, demand for inpatient bed days is projected to decrease between 2023 and 2040 in all scenarios. These changes reflect the underlying demographic projections.[38] Overall, bed day demand is projected to increase by 10.4 per cent in the low-pressure scenario and 26.3 per cent in the high-pressure scenario by 2040.

[37] See Appendix D for episode charts.

[38] See Appendix B for single year of age and sex national population pyramid 2023 and 2040 (central).

Figure 5.1 Acute | bed day demand projections by age, year and scenario, 2023–2040



Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

Bed projections, 2023–2040

Table 5.2 presents 2023 beds and estimated bed capacity requirements across the projection scenarios. Estimated bed requirements for 2023 are based on reported activity in 2023 and the estimated occupancy rates presented in Table 4.3. The occupancy rate remains at the 2023 rate throughout the projection horizon in the status quo and low-pressure scenarios (national – 92.3%). In the high-pressure scenario, it is reduced to 85 per cent by 2040.

Between 107 and 377 additional beds are projected to be required by 2040. This equates to average annual growth requirements of between 0.6 and 1.9 per cent in the low- and high-pressure scenarios respectively. Growth requirements vary across regions. In the status quo scenario, a 0.8 per cent average annual growth requirement is projected in the MW compared to 1.5 per cent in DML.

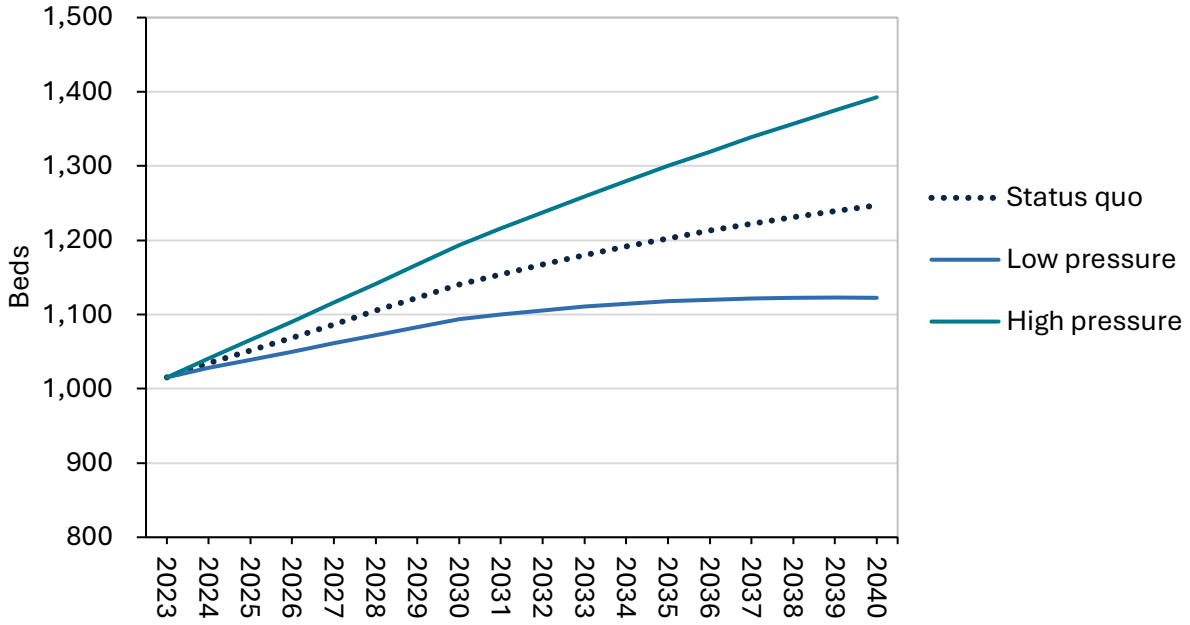
Table 5.2 Acute | bed requirements by projection scenario and region, 2023–2040

	2023	Projected additional requirements 2040			Average annual growth 2023–2040		
		Status quo	Low pressure	High pressure	Status quo	Low pressure	High pressure
	N	N	N	N	%	%	%
Total beds	**1,015**	**232**	**107**	**377**	**1.2**	**0.6**	**1.9**
DNE	213	56	29	84	1.4	0.7	2.0
DML	204	59	33	84	1.5	0.9	2.0
DSE	178	37	15	68	1.1	0.5	1.9
SW	168	40	19	55	1.3	0.6	1.7
MW	87	12	2	30	0.8	0.2	1.8
WNW	165	28	9	56	0.9	0.3	1.7

Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

Figure 5.2 illustrates the projected change in bed capacity requirements between 2023 and 2040. Bed requirements are projected to increase by between 10.5 per cent in the low-pressure scenario and 37.2 per cent in the high-pressure scenario by 2040. The differences across scenarios reflect the impact of the bed day reduction assumption in the low-pressure scenario and the introduction of the high migration population assumption and an 85 per cent occupancy rate in the high-pressure scenario.

Figure 5.2 Acute | bed requirements by projection scenario, 2023–2040



Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

5.2.2 Continuing care services

Episodes and bed days projections, 2023–2040

Table 5.3 presents projected episodes and bed days by scenario, along with the average annual growth by scenario between 2023 and 2040. For continuing care, we do not assume any length of stay reduction or alterations to the occupancy rates. The projections are therefore solely dependent on changes in the population size and age structure. As the low-pressure scenario is identical to the status quo scenario for this service it is not presented.

The number of episodes is projected to increase from 606 in 2023 to between 856 and 867 by 2040, which equates to average annual growth of 2.1 per cent. Bed day demand is projected to grow from 150,000 days in 2023 to between 202,000 days in the status quo scenario and 205,000 in the high-pressure scenario by 2040. This equates to an average annual growth of between 1.8 and 1.9 per cent.

Regionally, the age profile of patients varies significantly (see Appendix C) and this is reflected in the projected regional growth rates. Projected growth requirements in the SW and WNW are lower than in the east and MW. This is due to the younger age profile of patients in these regions compared to the others.

Table 5.3 Continuing care | demand projections by scenario and HSE Health Region, 2023–2040

	2023[a]	Projected additional requirements 2040		Average annual growth 2023–2040	
		Status quo	High pressure	Status quo	High pressure
	N	N	N	%	%
Episodes	**606**	**250**	**261**	**2.1**	**2.1**
DNE	61	29	31	2.3	2.4
DML	82	49	51	2.8	2.9
DSE	182	88	90	2.3	2.4
SW	129	28	32	1.2	1.3
MW	56	30	30	2.5	2.6
WNW	96	26	28	1.4	1.5
Bed days	**150,032**	**51,667**	**54,792**	**1.8**	**1.9**
DNE	18,234	8,460	8,856	2.3	2.4
DML	15,709	6,632	7,072	2.1	2.2
DSE	45,832	19,918	20,530	2.1	2.2
SW	38,954	8,399	9,487	1.2	1.3
MW	10,910	4,719	4,825	2.1	2.2
WNW	20,393	3,538	4,022	0.9	1.1

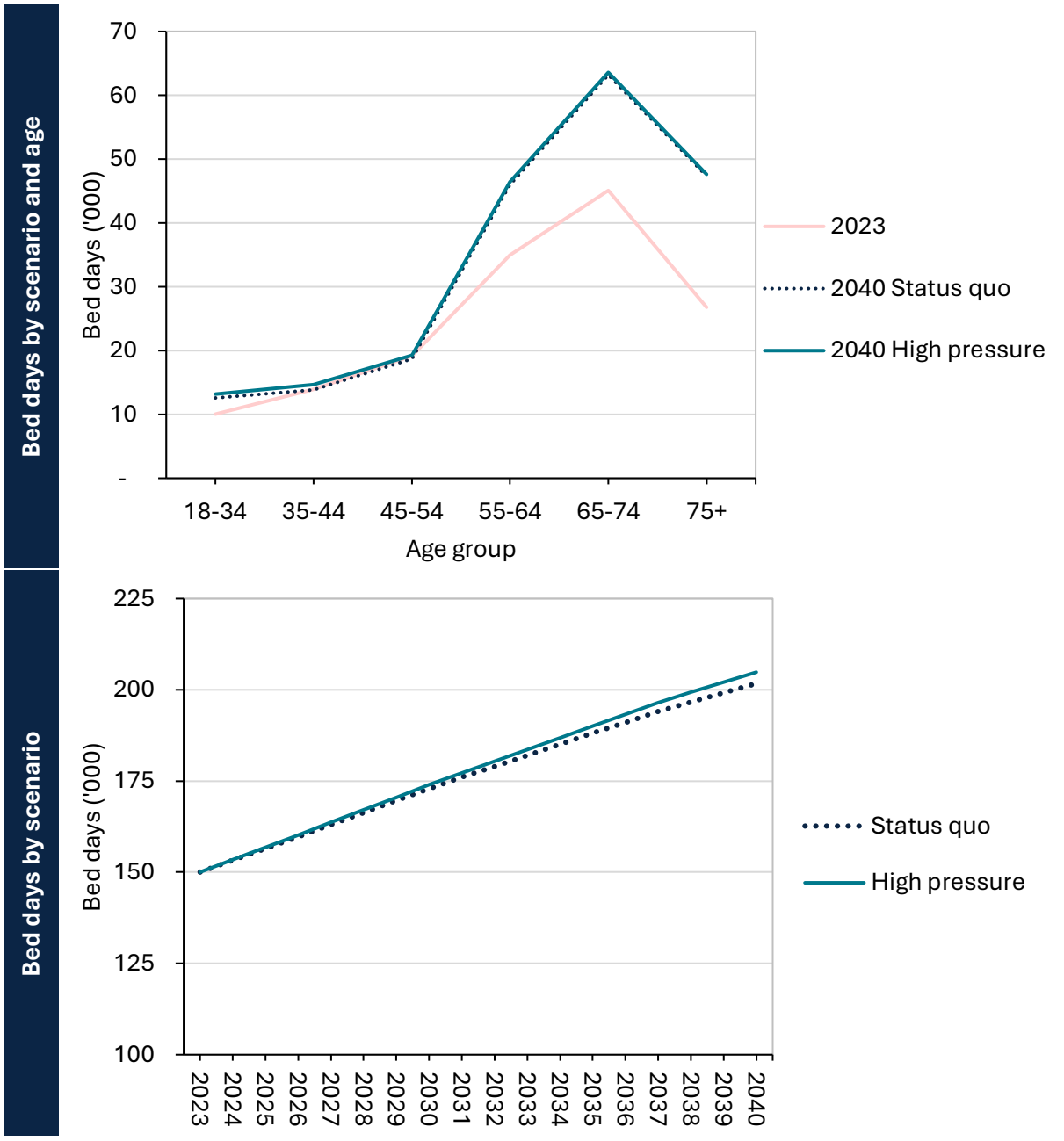
Note: The low-pressure scenario is identical to the status quo scenario for this service and is not presented.

Source: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

Figure 5.3 presents age-specific bed day projections for continuing care by projection scenario.[39] Across all scenarios, the largest bed day demand growth takes place at older ages (55 years and older). Overall, bed day demand is projected to increase by 34.4 per cent in the status quo scenario and 36.5 per cent in the high-pressure scenario between 2023 and 2040. The small difference across scenarios for this service reflects the limited impact of the high migration population assumption in the high-pressure scenario on demand for this service at the national level.

[39] See Appendix D for episode charts.

Figure 5.3 Continuing care | bed day demand projections by age, year and scenario, 2023–2040



Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

Bed projections, 2023–2040

Table 5.4 presents 2023 beds and projected bed requirements across the projection scenarios. Estimated bed requirements for 2023 are based on reported activity in 2023 and the estimated occupancy rates presented in Table 4.3. Occupancy rates are assumed to remain at their 2023 levels throughout the projection horizon in all scenarios.[40] Consequently, projected average annual growth requirements for beds are the same as those presented for bed day demand in Table 5.3. Between 182 and 193 additional beds are projected to be required by 2040.

Table 5.4 Continuing care | bed requirements by projection scenario and region, 2023–2040

	2023	Projected additional requirements 2040		Average annual growth 2023–2040	
		Status quo	High pressure	Status quo	High pressure
	N	N	N	%	%
Total beds	**517**	**182**	**193**	**1.8**	**1.9**
DNE	54	25	26	2.3	2.4
DML	72	30	32	2.1	2.2
DSE	160	70	72	2.1	2.2
SW	117	25	28	1.2	1.3
MW	47	20	21	2.1	2.2
WNW	67	12	13	0.9	1.1

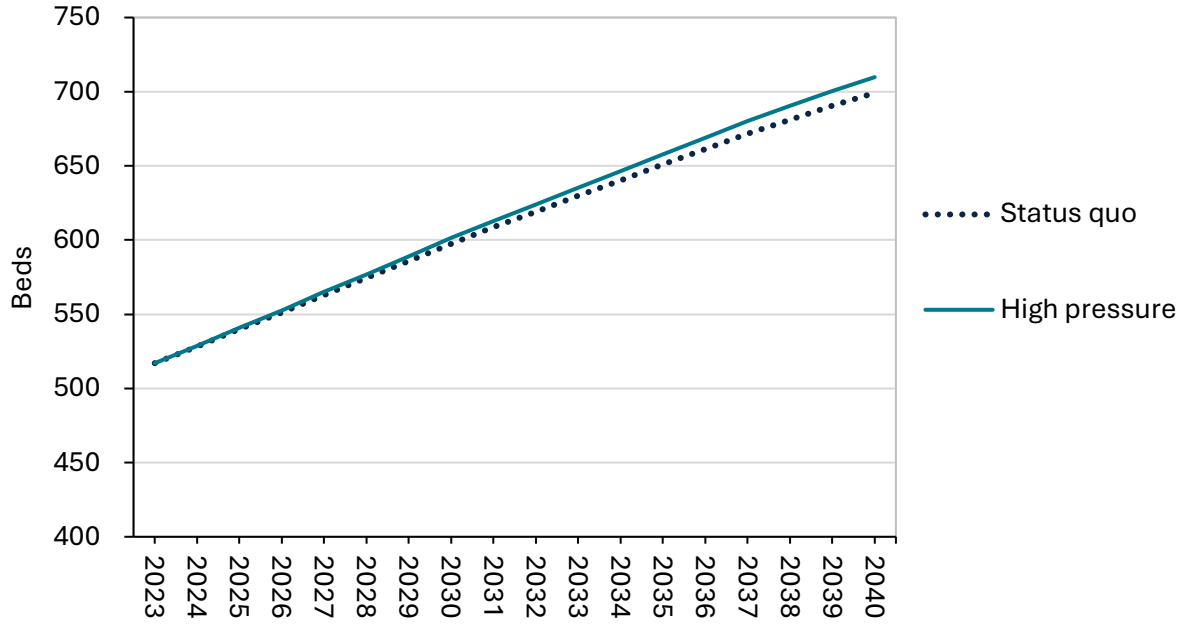
Note: The low-pressure scenario is identical to the status quo scenario for this service and is not presented.

Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

Figure 5.4 illustrates the change in bed capacity requirements over the projection horizon. Bed requirements are projected to increase by between 35.2 per cent in the status quo scenario and 37.3 per cent in the high-pressure scenario between 2023 and 2040. The small difference between scenarios again reflects the limited impact of the high migration population assumption in the high-pressure scenario at the national level.

[40] The 2023 national occupancy rate is 79.5 per cent.

Figure 5.4 Continuing care | bed requirements by projection scenario, 2023–2040



Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

5.2.3 Other adult services

Table 5.5 presents demand and bed capacity projections for the other adult services under consideration.[41] Like continuing care, we do not assume any length of stay reduction and a lower occupancy rate is modelled only for CMH. The projections are primarily dependent on changes in the population size and age structure. As the low-pressure scenario is identical to the status quo scenario for these services, it is not presented.

For PICUs, episodes are projected to increase from 168 in 2023 to between 193 and 200 in 2040, representing average annual growth of 0.8 to 1.0 per cent across scenarios. Bed days are projected to increase from 15,384 to between 18,909 and 19,404, with a somewhat higher average annual growth of between 1.2 and 1.4 per cent. This corresponds to a projected requirement for an additional 14 to 16 beds by 2040, equivalent to growth of between 22.9 and 26.1 per cent.

For CMH, episodes are projected to increase from 144 in 2023 to between 164 and 172 in 2040. Bed days are projected to increase from 38,018 to between 43,630 and 45,853. Additional requirements for between 16 and 40 beds are projected, equivalent to growth of between 14.8 and 36.8 per cent. Average annual growth requirements

[41] See Table 4.3 for the occupancy rate of each service.

range from 0.8 to 1.1 per cent for episodes and bed days, and from 0.8 to 1.9 per cent for beds. The higher projected growth in bed requirements reflects the reduction in occupancy rates to 85 per cent assumed under the high-pressure scenario.

For the MHID unit, episodes are projected to increase from 56 in 2023 to between 62 and 65 in 2040. Bed days are projected to increase from 19,724 to between 22,013 and 23,044. This results in projected additional requirements for between 10 and 14 beds, equivalent to growth of between 11.6 and 16.8 per cent, with average annual growth of between 0.6 and 0.9 per cent across episodes, bed days and beds.

Table 5.5 Other adult services | demand and bed capacity projections by scenario, 2023–2040

	2023	Projected additional requirements 2040		Average annual growth 2023–2040	
		Status quo	High pressure	Status quo	High pressure
	N	N	N	%	%
PICUs					
Episodes	168	25	32	0.8	1.0
Bed days	15,384	3,525	4,020	1.2	1.4
Beds	62	14	16	1.2	1.4
CMH					
Episodes	144	20	28	0.8	1.1
Bed days	38,018	5,612	7,835	0.8	1.1
Beds	108	16	40	0.8	1.9
MHID unit					
Episodes	56	6	9	0.6	0.9
Bed days	19,724	2,289	3,320	0.6	0.9
Beds	82	10	14	0.6	0.9

Note: The low-pressure scenario is identical to the status quo scenario for this service and is not presented.

Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

5.3 CAMHS services

Table 5.6 presents projections for CAMHS services. Demand and capacity requirements are expected to decline across all scenarios over the period to 2040, reflecting projected changes in the population.[42] Episodes are projected to decrease from 226 in 2023 to between 187 and 199 in 2040, while bed days are projected to decrease to between 9,658 and 10,339 from a baseline of 11,768. Correspondingly, bed capacity requirements are estimated to reduce by between 6 and 10 beds from the current level of operational beds of 53, equivalent to a reduction of between -17.9 and -12.1 per cent. Average annual growth ranges from -1.2 to -0.7 per cent across episodes, bed days and beds. The largest reductions are observed in the low-pressure scenario which incorporates the low fertility population projection.

Table 5.6 CAMHS services | demand and bed capacity projections by scenario, 2023–2040

	2023	Projected additional requirements 2040			Average annual growth 2023–2040		
		Status quo	Low pressure	High pressure	Status quo	Low pressure	High pressure
	N	N	N	N	%	%	%
Episodes	226	-32	-39	-27	-0.9	-1.1	-0.7
Bed days	11,768	-1,693	-2,110	-1,429	-0.9	-1.2	-0.8
Beds	53	-8	-10	-6	-0.9	-1.2	-0.8

Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.

[42] The share of people aged 17 and under is projected to fall by about 4 percentage points in all regions—for example, from 23.7 to 19.4 per cent at HSE Dublin and North East. Importantly, for CAMHS inpatient services, most service users are aged 13–17 years. This narrower age cohort is projected to experience a substantially greater population decline over the period, ranging from 20.4 per cent under the low fertility scenario to 13.5 per cent under the high migration scenario.

5.4 Decomposition analysis

Table 5.7 decomposes projected changes in bed requirements into the contributions of population growth and age structure, and occupancy rate (where applicable) assumptions across scenarios and service types.[43] For acute beds, population growth is the primary driver of changing bed requirements across all regions, with age structure making a relatively small contribution. Under the high scenario, the higher migration assumption further increases projected requirements through population growth. The lower occupancy rate assumption also increases bed requirements, although magnitude of this effect varies across regions from 6.2 per cent in the SW to 16.9 per cent in the MW.

For continuing care beds, both population growth and age structure contribute substantially to increased bed requirements, although the relative contributions vary across regions. Age structure contributes more than population growth in DSE and the MW and almost as much as population growth in DNE. These differences reflect the variation in the age profile of services users (see Appendix C). Under the high scenario, the additional requirement arising from stronger population growth is largely offset by a more negative age-structure effect, resulting in only modest differences in projected requirements between the status quo and high scenarios.

For other adult bed categories, age structure effects are generally smaller and more mixed, increasing projected requirements for PICUs while reducing requirements for CMH and MHID units. This again reflects the difference in the age profile of service users.

For CAMHS, the status quo scenario projects a 14.4 per cent reduction in bed requirements over the projection horizon, primarily driven by the projected fall in the number of children aged 13–17 years. Changes in the age structure of the reference population only minimally offsets the reduction.[44] Under the high scenario, the high migration population scenario offsets the reduction in demand by 2.4 per cent.

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[43] Decompositions for acute beds are based on the adult population (aged 18 and over), as adults account for the service users of acute inpatient services. In contrast, decompositions for CAMHS are based on the population aged 13–17, who comprise the service users considered in this analysis.

[44] The slight positive effect reflects the increased proportion of 17-year-olds in the reference population (individuals aged 13–17), a group with relatively high service use.

Table 5.7 Decomposition of growth by projection scenario

	SQ scenario		SQ scenario total growth 2023–2040	High-pressure scenario			High scenario total growth 2023–2040
	Pop growth	Pop age structure		Pop growth	Pop age structure	OR 85	
	%	%	%	%	%	%	%
Adult beds							
Acute	**22.0**	**0.9**	**22.8**	**3.8**	**-0.1**	**10.7**	**37.2**
DNE	24.0	2.2	26.1	4.4	-0.4	9.3	39.5
DML	24.6	4.5	29.1	4.2	-0.3	8.0	41.0
DSE	21.2	-0.7	20.5	3.2	-0.1	14.6	38.4
SW	21.7	1.8	23.5	3.5	-0.4	6.2	32.8
MW	18.4	-4.4	14.0	3.5	0.3	16.9	34.6
WNW	19.0	-1.8	17.2	3.4	0.4	12.9	33.8
Continuing care	**21.3**	**13.9**	**35.2**	**3.6**	**-1.5**		**37.3**
DNE	23.6	22.8	46.4	4.5	-2.3		48.6
DML	24.6	17.6	42.2	4.2	-1.3		45.0
DSE	21.2	22.3	43.5	3.2	-1.9		44.8
SW	21.2	0.4	21.6	3.5	-0.7		24.4
MW	18.8	24.4	43.3	3.5	-2.5		44.2
WNW	18.4	-1.0	17.4	3.4	-1.0		19.7
Other adult							
PICUs	22.0	0.9	22.9	3.8	-0.6		26.1
CMH	21.8	-7.0	14.8	3.9	2.0	16.2	36.9
MHID unit	21.9	-10.3	11.6	3.8	1.4		16.8
CAMHS	**-15.6**	**1.2**	**-14.4**	**2.4**	**-0.1**		**-12.2**

Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

5.5 Acute beds policy recommendation comparison

In the report prepared by the HSE Specialist Group on Acute Bed Capacity, 25 acute beds per 100,000 population was an interim recommendation for acute bed provision, which we estimate equated to 1,320 beds in 2023. The differential between the number of operational beds (1,015 acute adult) and the number recommended by the HSE Specialist Group in 2023 was a shortfall of 305 beds.[45] Table 5.8 presents the projected 2040 bed requirements across the examined scenarios compared to the recommendation (adjusted for population in 2040).

Based on the scenarios outlined in Table 3.3, average annual growth requirements of between 0.6 and 1.9 per cent are projected. Reaching

[45] Based on registered beds (1,023) the shortfall was 297 beds.

the HSE Specialist Group recommendation would require average annual growth of between 2.4 and 2.6 per cent.

Table 5.8 HSE Specialist Group on Acute Bed Capacity comparison, 2023–2040

	Beds	Average annual growth 2023–2040 (%)
2023		
Operational beds	1,015	-
HSE specialist group	1,320	-
2040 Hippocrates projected requirements		
Status quo	1,247	1.2
Low pressure	1,122	0.6
High pressure	1,393	1.9
2040 HSE specialist group recommendation 25 beds per 100,000 population		
Central population	1,527	2.4
High population	1,577	2.6

Sources: HRB NPIRS, 2022 and 2023; MHC annual inspection reports, ESRI population data, 2024; authors' calculations.

5.6 Summary

This chapter presented projections of demand and bed capacity requirements to 2040 and finds that adult psychiatric inpatient services will require significant expansion as the population grows and ages. The largest increases are projected for acute adult, continuing care and CMH, while more modest growth is projected for PICU and MHID services. For CAMHS inpatient services, no increase in bed requirements is projected over the period, reflecting demographic trends. Population growth is the primary driver of future demand across adult services, while the influence of population ageing varies by service type and is particularly important for continuing care services.

Chapter 6

Summary and discussion

6.1 Summary of findings

This report has provided baseline demand (episodes and bed days) profiles for public psychiatric inpatient hospitals and units registered with the MHC in 2023 at national and regional level (where appropriate). It also provided demand (episode and bed day) and bed capacity projections to 2040 across a range of scenarios. In addition to the Hippocrates projection scenarios, we also estimate acute bed requirements in 2040 based on the HSE Specialist Group recommended acute bed target of 25 acute beds per 100,000 of the total population.

We estimate baseline activity in 2023 of 12,600 episodes and 340,000 bed days in acute adult services, 600 episodes and 150,000 bed days in continuing care adult services, 368 episodes and 73,000 bed days in other adult units and 230 episodes and 12,000 bed days in CAMHS units. The profile of service users differs markedly between the acute adult and continuing care adult units. Bed day rates are relatively evenly distributed across the age distribution for acute services and more highly concentrated in older age cohorts in continuing care units. In addition, the average length of stay in acute units in 2023 was 27 days compared to 247 in continuing care.

We project significant growth in demand for adult inpatient services between 2023 and 2040, with variation across service types. For acute adult services, total demand for bed days is projected to increase by between 10 per cent and 26 per cent, equivalent to average annual growth rates of 0.6 per cent to 1.4 per cent. This translates into an additional requirement of between 107 and 377 beds (0.6% to 1.9% average annual growth). The lower end of the projected range reflects the low-pressure scenario which incorporates a reduction in length of stay, while the upper end reflects the high-pressure scenario which combines the high migration population assumption, no reduction in length of stay and a transition to a lower occupancy rate of 85 per cent. To achieve the HSE Specialist Group recommendation for acute beds, capacity would need to increase by 50 to 55 per cent, corresponding to an additional 512 to 562 beds and average annual growth of 2.4 to 2.6 per cent.

Continuing care services are projected to experience higher levels of growth, with bed days projected to increase by between 34 and 37 per cent over the period (1.8% to 1.9% average annual growth), corresponding to an additional requirement of 182 to 193 beds. As no alternative assumptions regarding length of stay or occupancy rates are modelled, variation across the projection scenarios is driven solely by differences in the population assumptions. Given the older age profile of service users, the impact of the high migration population assumption is relatively modest, resulting in a narrow projection range.

For PICU and MHID services, variation across the projection scenarios is driven solely by differences in the population assumptions. For PICU services, bed days are projected to increase by between 23 per cent and 26 per cent over the period, equivalent to average annual growth of 1.2 per cent to 1.4 per cent. This corresponds to an additional requirement of between 14 and 16 beds to 2040. For MHID services, bed days are projected to increase by between 11.6 per cent and 16.8 per cent, corresponding to average annual growth of 0.6 per cent to 0.9 per cent and an additional requirement of between 10 and 14 beds. The relatively narrow projection ranges for both services reflect the absence of alternative assumptions regarding length of stay or occupancy rates.

For CMH services, bed days are projected to increase by between 14.8 per cent and 20.7 per cent over the period, equivalent to average annual growth of 0.8 per cent to 1.1 per cent. This translates into an additional requirement of between 16 and 40 beds (0.8% to 1.9% average annual growth). While variation in bed-day projections is driven solely by differences in the population assumptions, the upper end of the projected bed requirement range reflects the application of a reduction in the occupancy rate to 85 per cent.

For CAMHS inpatient services, variation across the projection scenarios is driven solely by differences in the population assumptions. As the population aged 13–17 years is projected to fall by up to 20.4 per cent demand for CAMHS inpatient services is not projected to increase between 2023 and 2040.

As highlighted by the decomposition analysis presented in Chapter 5, population growth is the primary driver of projected increases in bed requirements across most adult services, while population ageing is particularly important for continuing care. The projected decline in the

population aged 13–17 years has the most significant impact on projections for CAMHS services.

6.2 Sensitivity analysis – bed capacity

The uncertainty arising from any projections exercise means that it is prudent to undertake sensitivity analysis. To illustrate the impact of varying individual assumptions independently of others, we run multiple separate analyses to see the impact on bed capacity requirements for acute adult beds (Table 6.1). Given the limited assumptions applied to continuing care, PICU, MHID and CAMHS units, we run the full sensitivity analysis for acute adult services only. One additional sensitivity relates to the occupancy rate for CMH which is discussed below.

Population growth and ageing: First, we illustrate the impact of varying our population assumptions. Relative to the status quo scenario, the high/low population assumptions change bed requirements by ±3.0 per cent nationally. This varies from ±2.5 to ±3.3 per cent across the regions.

LOS reduction: The LOS reduction assumption is applied equally across all regions. Relative to the status quo scenario, this assumption reduces bed requirements by between 10 and 27 beds across the regions and by 125 nationally.

Occupancy rate assumptions: For acute adult services and CMH, the impact of reducing occupancy to 90 per cent and 85 per cent by 2040 was examined. For acute adult services, converging to these lower occupancy rates by 2040 increases projected bed requirements by 2.4 per cent in the case of the 90 per cent rate nationally and by 8.5 per cent in the case of an 85 per cent rate. Given the variation in base year occupancy rates (Table 4.3) across HSE Health Regions, the largest increases in projected requirements are projected for DSE, MW and WNW.

For CMH, reducing the occupancy rate to 90 per cent by 2040 increases the projected requirement by nine beds relative to the status quo projection of 124 beds, an increase of 7.2 per cent. Reducing occupancy further to 85 per cent increases the projected requirement by 17 beds to 141 beds, equivalent to a 13.5 per cent increase relative to the status quo scenario.

Table 6.1 Acute | sensitivity analysis – effect on projected additional bed capacity requirements of varying key assumptions

Fewer beds More beds

	Difference from status quo beds 2040						
	National	DNE	DML	DSE	SW	MW	WNW
Status quo scenario 2040	1,247	269	263	215	208	99	193
Effect of changing one assumption on 2040 beds:							
Population growth and ageing							
High migration scenario	37	9	8	6	5	3	6
	(3.0)	(3.2)	(3.0)	(2.6)	(2.5)	(3.3)	(3.2)
Low migration scenario	-37	-9	-8	-6	-5	-3	-6
	(-3.0)	(-3.2)	(-3.0)	(-2.6)	(-2.5)	(-3.3)	(-3.2)
LOS reduction							
10%	-125	-27	-26	-21	-21	-10	-19
	(-10.0)	(-10.0)	(-10.0)	(-10.0)	(-10.0)	(-10.0)	(-10.0)
Occupancy rate reduction							
90% by 2040	30	3	0.4	12	-[a]	8	9
	(2.4)	(1.2)	(0.2)	(5.6)	-	(8.0)	(4.5)
85% by 2040	106	19	16	25	10	14	21
	(8.5)	(7.2)	(6.0)	(11.8)	(4.9)	(14.4)	(10.6)

Notes: Percentage change from status quo beds in parentheses.
a. SW OR in 2023 was lower than 90 per cent and thus the sensitivity does not apply.
Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

6.3 Limitations

There are several limitations to this analysis. The most significant constraint is the inability to disaggregate activity data by bed type. While activity can be distinguished across the main service categories examined in this report, including acute adult, continuing care, other adult services and CAMHS, more detailed information on sub-categories of beds is not available. This limits the capacity to generate more granular and clinically meaningful projections, as the absence of bed-type level data prevents the development of activity profiles for more specific sub-categories of care (e.g. eating disorders, psychiatry of later life).

Related to this, not all relevant bed types are currently captured within the registration and inspection remit of the Mental Health Commission (MHC), for example high-support beds. While this gap is expected to be addressed in the coming years under the Mental Health Act 2026, the

current analysis cannot fully account for the totality of bed provision or accurately assess variation in provision across HSE Health Regions. These constraints limit the extent to which existing provision can be robustly benchmarked against policy recommendations, particularly where definitions of bed categories differ between data sources and policy frameworks.

A further limitation relates to bed data coverage. At present, only public acute units routinely report bed data, including commissioned beds, operational beds and occupancy rates, to the Health Research Board (HRB). For continuing care beds, other adult services and CAMHS services, the bed data used in the analysis were compiled from MHC annual inspection reports. Reliance on multiple data sources introduces inconsistencies in measurement and timing and reduces comparability across service types.

A further limitation is that the projection scenarios are constrained by the availability of data on community-based mental health services and the absence of a unique patient identifier to link service users across care settings. These data limitations prevent the analysis from explicitly modelling patient pathways through the mental health system or quantifying the impact of changes in community service capacity on demand for inpatient care. Addressing these gaps would facilitate the development of more sophisticated projection scenarios and provide a more comprehensive understanding of how investments in community services may affect future inpatient bed requirements.

There are currently no published data on waiting times for admission to inpatient mental health services. Incorporating waiting times for all services would provide a more complete picture of service demand and capacity constraints. This limitation is compounded by the absence of detailed bed-type data, which means that shortages for particular categories of beds may not be evident from the bed data reported at an aggregate hospital/unit level. Furthermore, as bed availability is measured at a single point in time, the reported figures may not fully reflect capacity constraints experienced over the course of the year.

6.4 Discussion

Historically, Ireland had an overreliance on hospital-based treatment, but in the last 20 years the policy direction has been to move the balance of care towards community-based treatment, thus reducing reliance on inpatient services (Daly et al., 2024). Analysis of published HRB data over time is challenging due to changes in reporting of activity for individual units. Our estimates suggest that between 2018 and 2023, inpatient episodes in public adult mental health services declined by approximately 8 per cent, while inpatient bed days declined by approximately 13 per cent. The larger reduction in bed days than episodes is consistent with a reduction in average length of stay over this period.[46,47] While these trends are consistent with a gradual shift towards community-based care, the available data do not allow a robust assessment of how changes have differed across individual service types. Community-based alternatives to acute inpatient admission, such as home-based crisis resolution teams or crisis houses (MHC, 2020) continue to develop. However, significant deficits in available community mental health data (Brick et al., 2024) mean that it is not currently possible to examine their impact on admissions or length of stay in inpatient units.

This analysis projects requirements for additional mental health beds across all adult services. For acute beds, the lower bound of projected need is strongly influenced by the assumed reduction in inpatient length of stay under the low-pressure scenario. While shorter lengths of stay may reduce the number of acute beds required, achieving this in practice would likely depend on substantial investment in community-based services to support earlier discharge and prevent readmission. Without such expansion, reductions in length of stay may not be achievable. The expansion of National Clinical Programmes for Mental Health, which deliver specialist/tertiary mental health care primarily through community-based teams, should contribute to reductions in inpatient length of stay but as services are not yet fully rolled out, with some only recently partially resourced (Department of Health, 2025), evidence on the extent of this is not yet available.

In the status quo scenario, higher growth in bed requirements is projected for continuing care services (35.2%) than for acute services

[46] Changes in the classification and reporting of activity for individual units over time do not permit robust trend analysis for episodes and bed days for the service categories in this report.

[47] Table 3.11 – Annual reports on the activities of Irish psychiatric units and hospitals 2018 to 2023.

(22.8%), reflecting the older age profile of the populations served. While most regions are currently operating below an 85 per cent occupancy threshold, this should not be interpreted as evidence of excess capacity, as aggregate occupancy measures may mask shortages in specific bed types and reflect availability at only a single point in time. A lack of comprehensive data on non-approved service provision limits visibility of overall system capacity. Consequently, relatively low occupancy in some approved centres may coexist with capacity pressures in other parts of the system, particularly high-support units which are not captured in the HRB data used for this analysis. Evidence from a census undertaken by the HSE Specialist Group on Acute Bed Capacity found that operational beds in high-support units had a national occupancy rate of 93 per cent (HSE, 2023). In addition, staffing shortages may constrain the effective capacity of some services, meaning that beds may not always be available in practice even where occupancy rates appear relatively low.

It is also important to recognise that these projections do not account for the type of beds occupied. As highlighted in Sharing the Vision and subsequent HSE Specialist Group recommendations, planning for additional acute capacity must consider not only demographic change but also the distribution of beds by clinical need. This includes ensuring sufficient provision for older people (recommendations 42 and 43), alongside alignment with National Clinical Programmes such as Perinatal Mental Health, Eating Disorders, and Dual Diagnosis services (recommendation 53) (HSE, 2023; HSE and Department of Health, 2025). A failure to incorporate these distinctions risks creating mismatches between service need and available capacity, even where overall bed numbers appear adequate.

Regarding future planned service expansion, the HSE National Service Plan 2026 and HSE Capital Plan 2026 outlined a significant programme of work in train to replace existing adult sites with new facilities (five at design stage and one at design feasibility stage) but there are no specific bed numbers currently published (HSE, 2026b).

For most services in 2023, the number of commissioned/registered beds was the same as the number of operational beds (Table 4.3). This was not the case for CMH, where only 108 of the 130 commissioned bed were operational, with an estimated occupancy rate of 96.4 per cent. This additional capacity has now been opened (Department of

Health, 2026b). Alongside the opening of these beds, a further 30-bed intensive care rehabilitation unit will be opened on a phased basis from the end of 2026. As highlighted by the High Level Taskforce (HLTF) on Mental Health and Addiction, these beds will allow patients to be treated in the most appropriate setting for their circumstances and alleviate pressures in the prison system (Department of Health and Department of Justice, Home Affairs and Migration, 2026).

The picture for CAMHS inpatient services is also nuanced. In 2023, 53 of the 72 approved centre beds were operational nationally, with an estimated occupancy rate of 61 per cent. However, there was considerable variation across units, with occupancy ranging from 41 to 87 per cent. Notably, the unit operating at 87 per cent occupancy also accounted for approximately 60 per cent of non-operational beds, suggesting that staffing or operational constraints are limiting effective capacity in areas of highest demand. This uneven distribution suggests possible inefficiencies, where unmet need in one location may coexist with underutilised capacity elsewhere.

Projections based on current utilisation patterns, adjusted for population growth and changing age structure, indicate a reduced requirement for CAMHS inpatient beds over the projection horizon. ESRI population projections indicate a substantial reduction in the population aged 13–17 years, between 14 and 20 per cent by 2040, depending on fertility and migration assumptions. However, the extent to which demographic change translates into lower demand for inpatient care is uncertain. The projections should be interpreted cautiously, as they do not account for unmet demand, potential changes in service delivery models, the expansion of community-based supports, or evolving patterns of mental health need among young people (HSE, 2024a; b; Fonagy, 2025; OECD, 2026). Current utilisation patterns may understate underlying demand for inpatient services, as capacity constraints within community services, evidenced by substantial waiting lists, may be limiting access to referral pathways.

Data for May 2026 show that nationally almost 5,000 individuals were waiting to be seen by a CAMHS community team, with 40 per cent waiting more than six months and 13 per cent waiting more than one year (HSE, 2026c). Waiting times also varied considerably across HSE Health Regions. For example, in HSE South West, 59 per cent of those on the waiting list had waited more than six months and 32 per cent

more than one year. These findings suggest that, while demographic change is likely to mitigate demand for CAMHS inpatient services, the scale of any reduction in bed requirements should be interpreted in the context of broader capacity constraints within community CAMHS services.

Recent developments in Dublin have resulted in a consolidation of CAMHS inpatient services. This has involved the closure of beds at St Vincent's Hospital Fairview and the opening of all registered beds at Linn Dara (Department of Health, 2026c). In addition, seven new CAMHS beds are planned as part of the National Children's Hospital (HSE, 2026b). A further 10-bed forensic CAMHS unit remains included in the planned full operational capacity of the National Forensic Mental Health Service site at Portrane; however, no further information on its delivery timeline is currently available (Department of Health, 2026b).

The findings of this report highlight the importance of interpreting bed capacity and occupancy within the wider system context. Bed availability in some services may mask pressures elsewhere, reflecting issues of service configuration, geographic distribution and operational constraints rather than true surplus capacity. This reinforces the need for an integrated, system-wide approach to capacity planning that considers how services interact across the continuum of care, rather than assessing individual service areas in isolation. However, achieving such an approach requires a more complete understanding of patient pathways and patterns of service use across settings than is currently possible.

At present, analyses are constrained by limitations in the availability and linkage of patient-level data across services. The introduction of the Community Care Record, alongside a national electronic health record (EHR) and unique patient identifier, represents a significant step towards addressing these limitations by creating a centralised, real-time and standardised source of patient information across community and inpatient services (HSE, 2025b; c).[48] Planned for phased implementation from 2026 (HSE, 2025c), these systems are expected to improve data quality, enable more comprehensive tracking of patient pathways, and support greater integration across service settings. In turn, they should provide a more complete understanding of relationships between services and capacity

[48] https://about.hse.ie/our-work/technology/community-care-record/

pressures across the system, strengthening the evidence base for future capacity planning. This enhanced data infrastructure will also support further development of the Hippocrates model through the ongoing refinement of assumptions, projections and scenario analyses, enabling more robust and evidence-informed service planning.

In addition to the infrastructure expansion necessary to meet the projected demand and bed capacity requirements, there is a parallel requirement for an expansion in the workforce. Work is currently underway at the ESRI to project workforce requirements for HSE specialist mental health services, drawing on the demand projections presented in this report.

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Appendices

Appendix A | Hospitals and units by service type and HSE Health Region

Table A.1 Hospitals and units by service type and HSE Health Region

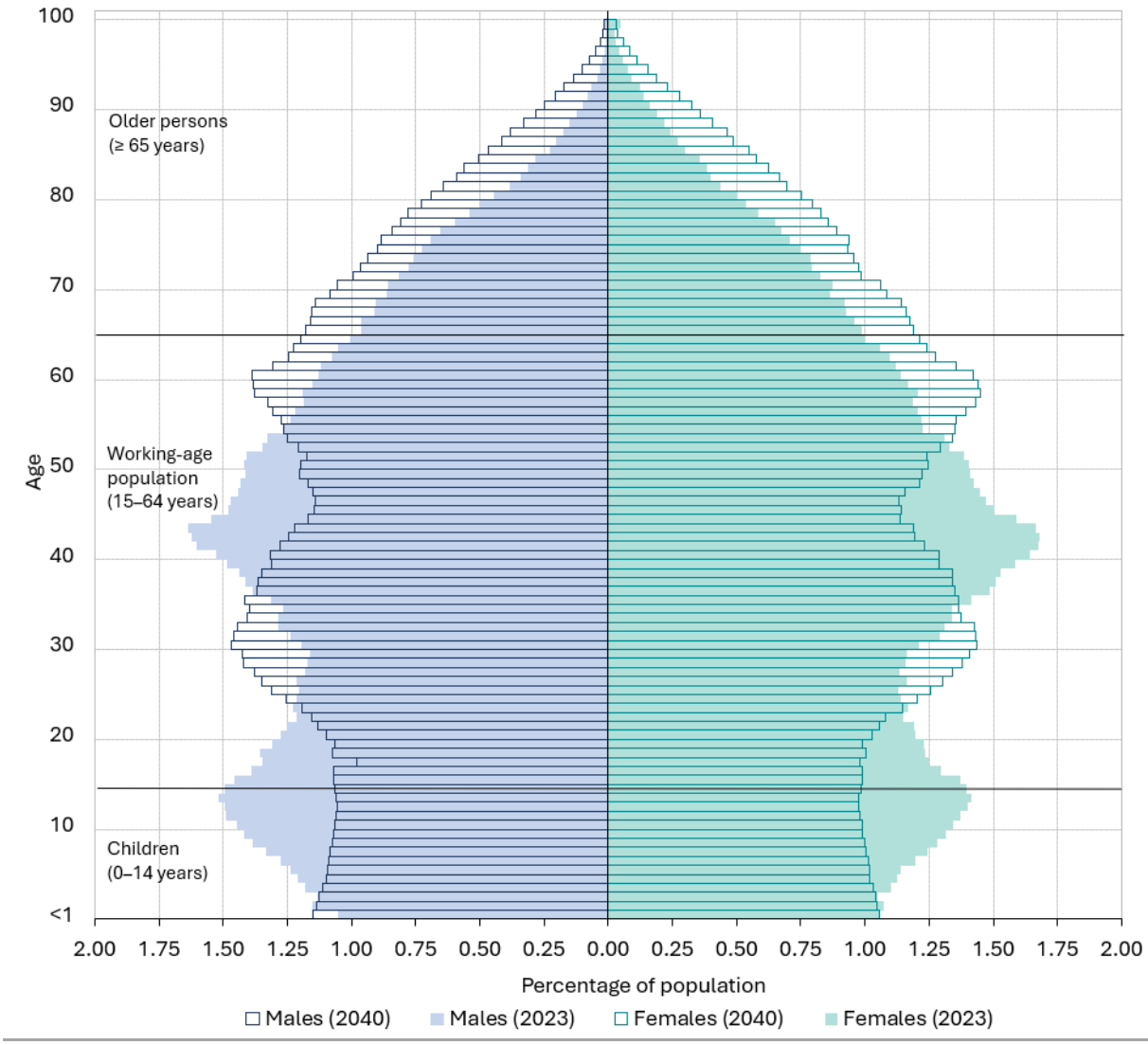
Service	HSE Health Region	Hospital/unit name
General adult – acute	Dublin and North East (DNE)	Ashlin Centre, Beaumont Hospital, Dublin
		Cavan General Hospital
		Connolly Hospital, Dublin
		Drogheda Department of Psychiatry, Louth
		Mater Misericordiae University Hospital, Dublin
		St Vincent's Hospital, Fairview, Dublin
	Dublin and Midlands (DML)	Cluain Lir Care Centre, Westmeath
		Midland Regional Hospital, Portlaoise, Laois
		Naas General Hospital, Kildare
		St James's Hospital, Dublin
		St Loman's Hospital, Westmeath
		Tallaght University Hospital, Dublin
	Dublin and South East (DSE)	Newcastle Hospital, Wicklow
		St Luke's Hospital, Kilkenny
		St Vincent's University Hospital, Dublin
		University Hospital Waterford
	South West (SW)	Bantry General Hospital, Cork
		Cork University Hospital
		Mercy University Hospital, Cork
		St Stephen's Hospital, Cork
		University Hospital Kerry
	Mid West (MW)	Ennis General Hospital, Clare
		University Hospital Limerick
	West and North West (WNW)	Letterkenny University Hospital
		Mayo University Hospital
		Roscommon University Hospital
		Sligo University Hospital
		University Hospital Galway
General adult – other	DML	Cluain Lir Care Centre, Westmeath
		St Fintan's Hospital, Portlaoise/Silver Lodge, Offaly
		St Loman's Hospital, Westmeath

Service	HSE Health Region	Hospital/unit name
	DNE	Blackwater House, St Davnet's Hospital, Monaghan
		O'Casey Rooms, Fairview Community Unit, Dublin
		St Brigid's Hospital, Louth
		St Vincent's Hospital, Fairview, Dublin
	DSE	Aidan's Residential Healthcare Unit, Waterford
		Haywood Lodge, Tipperary
		Le Brun House and Whitethorn House, Vergemount Mental Health Facility, Dublin
		Newcastle Hospital, Wicklow
		Selskar House, Farnogue Residential Healthcare Unit, Wexford
		St Canice's Hospital, Kilkenny
		St Otteran's Hospital, Waterford
	MW	Cappahard Lodge, Clare
		Tearmann Ward, St Camillus' Hospital, Limerick
	SW	Deer Lodge, Kerry
		Owenacurra Centre, Cork (closed in 2024)
		St Finbarr's Hospital, Cork
		St Stephen's Hospital, Cork
	WNW	An Coilín, Mayo
		Creagh Suite, St Brigid's Hospital, Galway
		St Anne's Unit, Sacred Heart Hospital, Mayo
		Teach Aisling, Mayo
		Woodview, Galway
Psychiatric Intensive Care Unit (PICU)	National	Carraig Mór, Cork
		Phoenix Care Centre, Dublin
Forensic	National	Central Mental Hospital, Portrane, Dublin
Mental Health Intellectual Disability (MHID)	National	St Joseph's Intellectual Disability Service, Dublin
Child and Adolescent Mental Health Services (CAMHS)	National	Adolescent In-patient Unit, St Vincent's Hospital, Fairview, Dublin
		CAMHS Unit, Merlin Park, Galway
		Éist Linn, Cork
		Linn Dara CAMHS Unit, Dublin

Source: Health Research Board, National Psychiatric Inpatient Reporting System, 2023.

Appendix B | Population pyramids 2023 and 2040 (central)

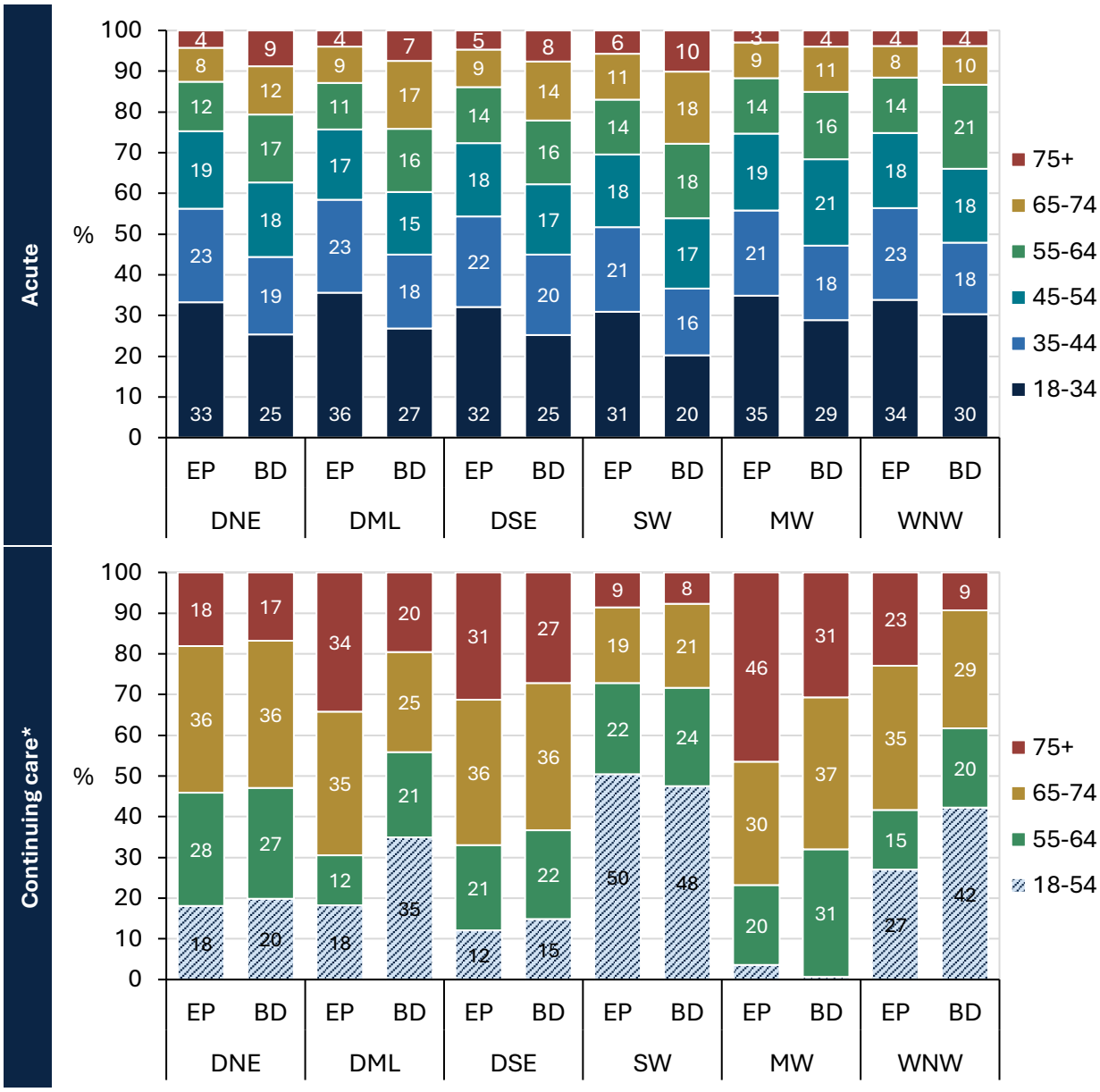
Figure B.1 Central scenario | population pyramids for 2023 and 2040 (% of population)



Source: Generated by the authors from additional tables provided by Bergin and Egan (2024).

Appendix C | HSE Health Region age profiles

Figure C.1 Age profiles by service and HSE Health Region, 2023

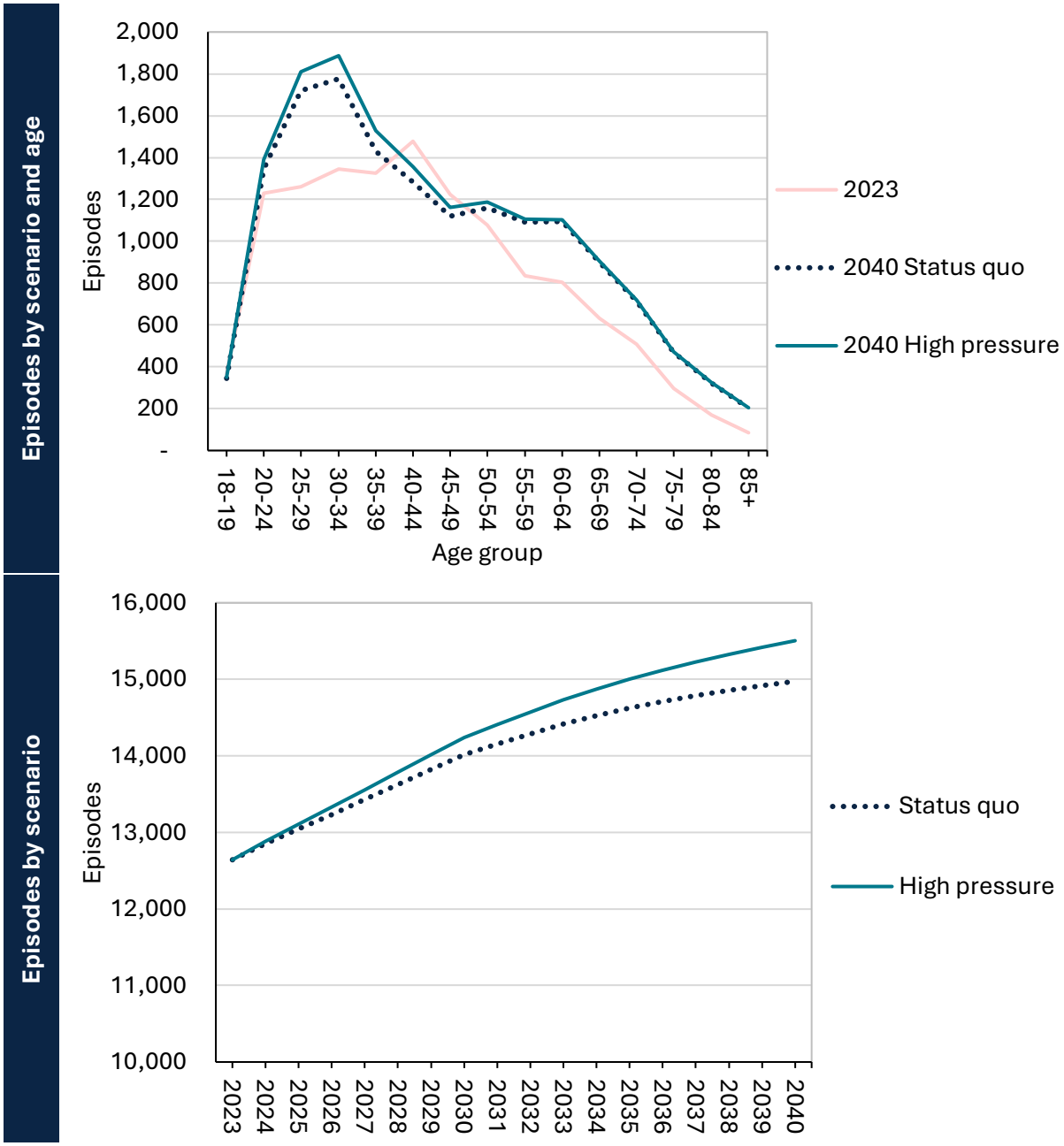


Note: EP: episodes; BD: bed days
*Due to small numbers in some regions it was necessary to combine age categories.

Sources: HRB NPIRS, 2022 and 2023; authors' calculations.

Appendix D | Episode demand projections, 2023–2040

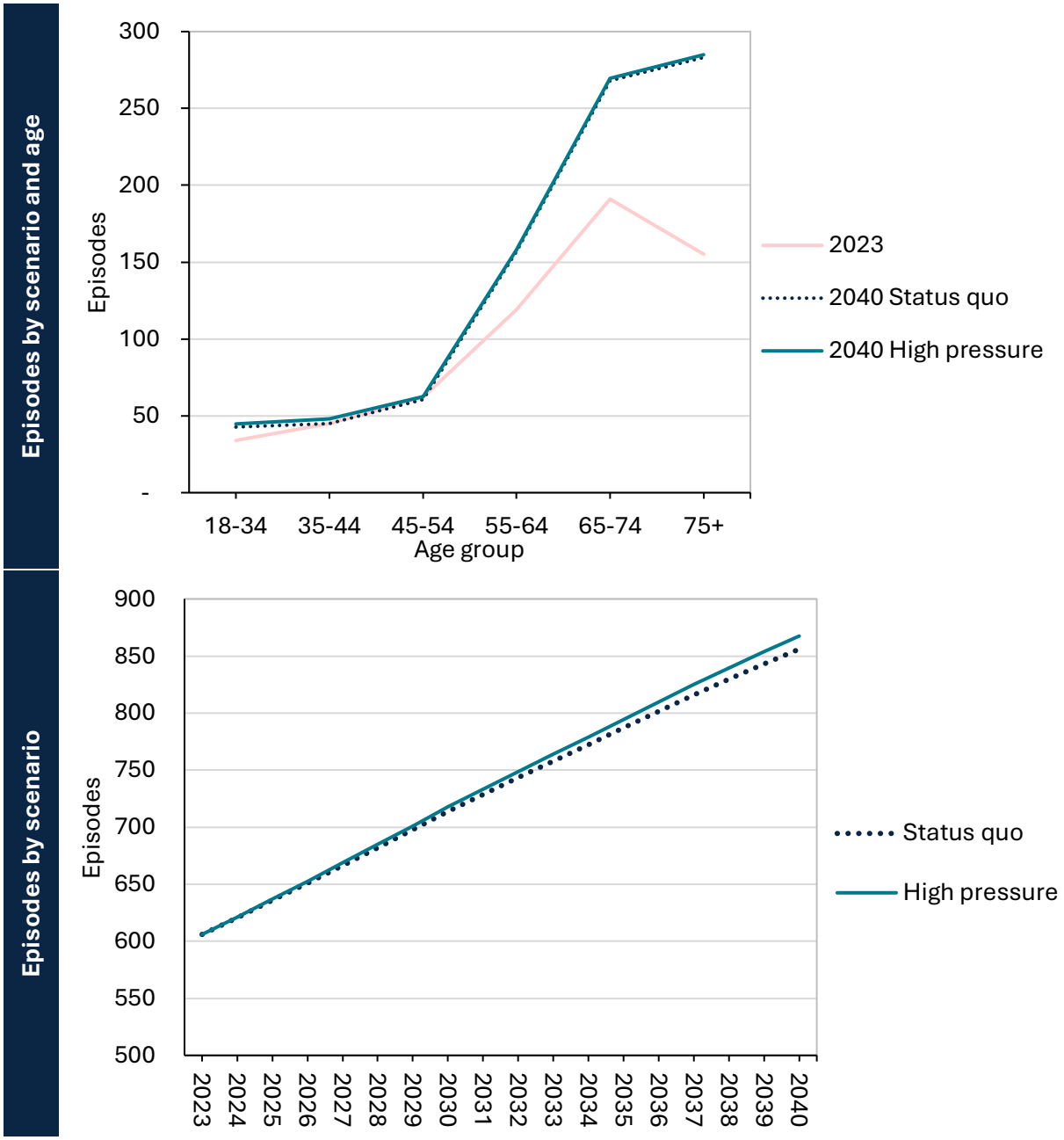
Figure D.1 Acute | episode demand projections by age, year and scenario, 2023–2040



Note: The low-pressure scenario is identical to the status quo scenario for episodes and is not presented.

Sources: HRB NPIRS, 2022 and 2023; ESRI population data, 2024; authors' calculations.

Figure D.2 Continuing care | episode demand projections by age, year and scenario, 2023–2040



Note: The low-pressure scenario is identical to the status quo scenario for this service and is not presented.

Sources: HRB NPIRS, 2023; ESRI population data, 2024; authors' calculations.



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