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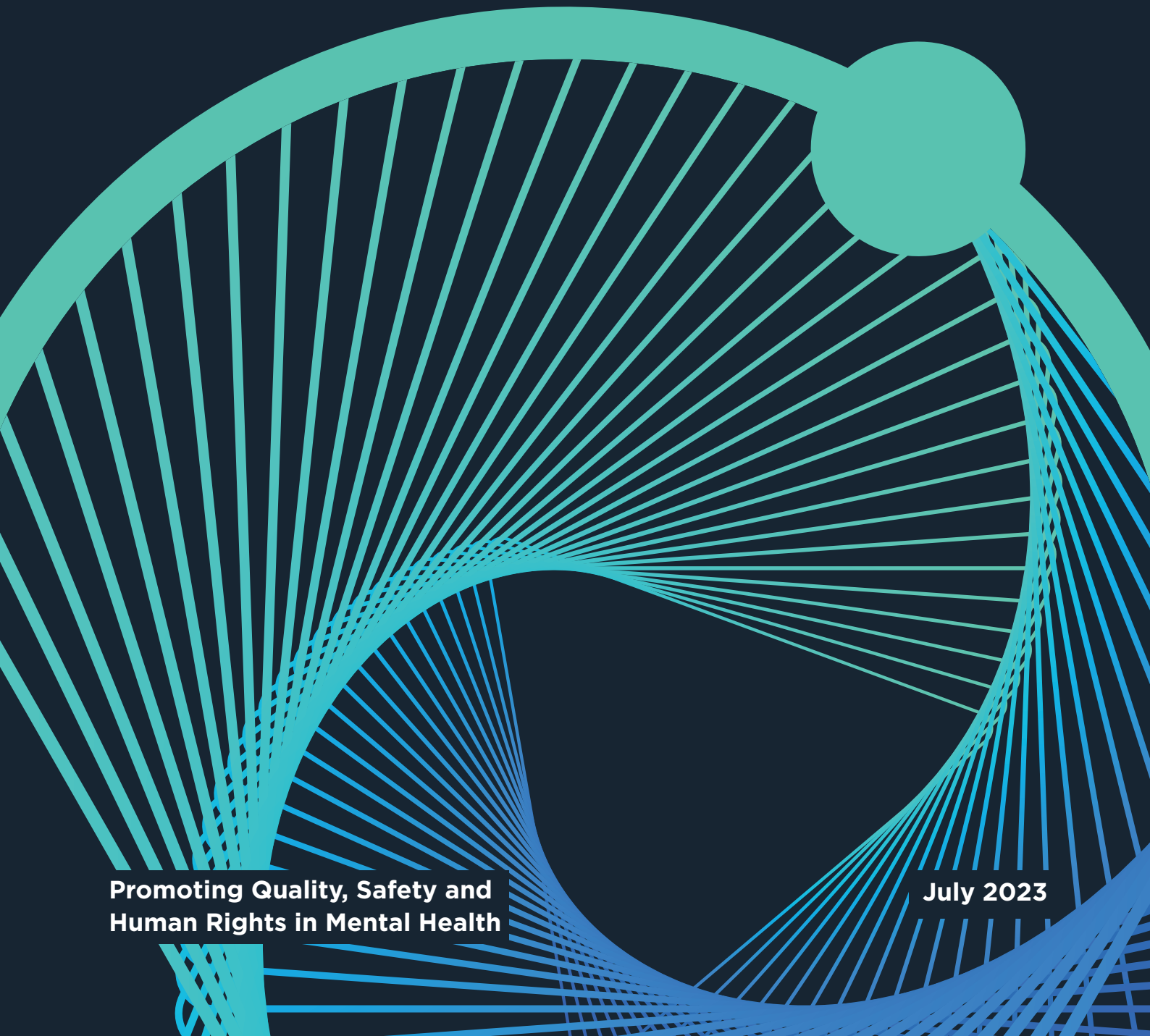
Independent Review of the provision of Child and Adolescent Mental Health Services (CAMHS) in the State by the Inspector of Mental Health Services



Promoting Quality, Safety and Human Rights in Mental Health

July 2023

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Independent Review of the provision of Child and Adolescent Mental Health Services (CAMHS) in the State by the Inspector of Mental Health Services

Promoting Quality, Safety and Human Rights in Mental Health

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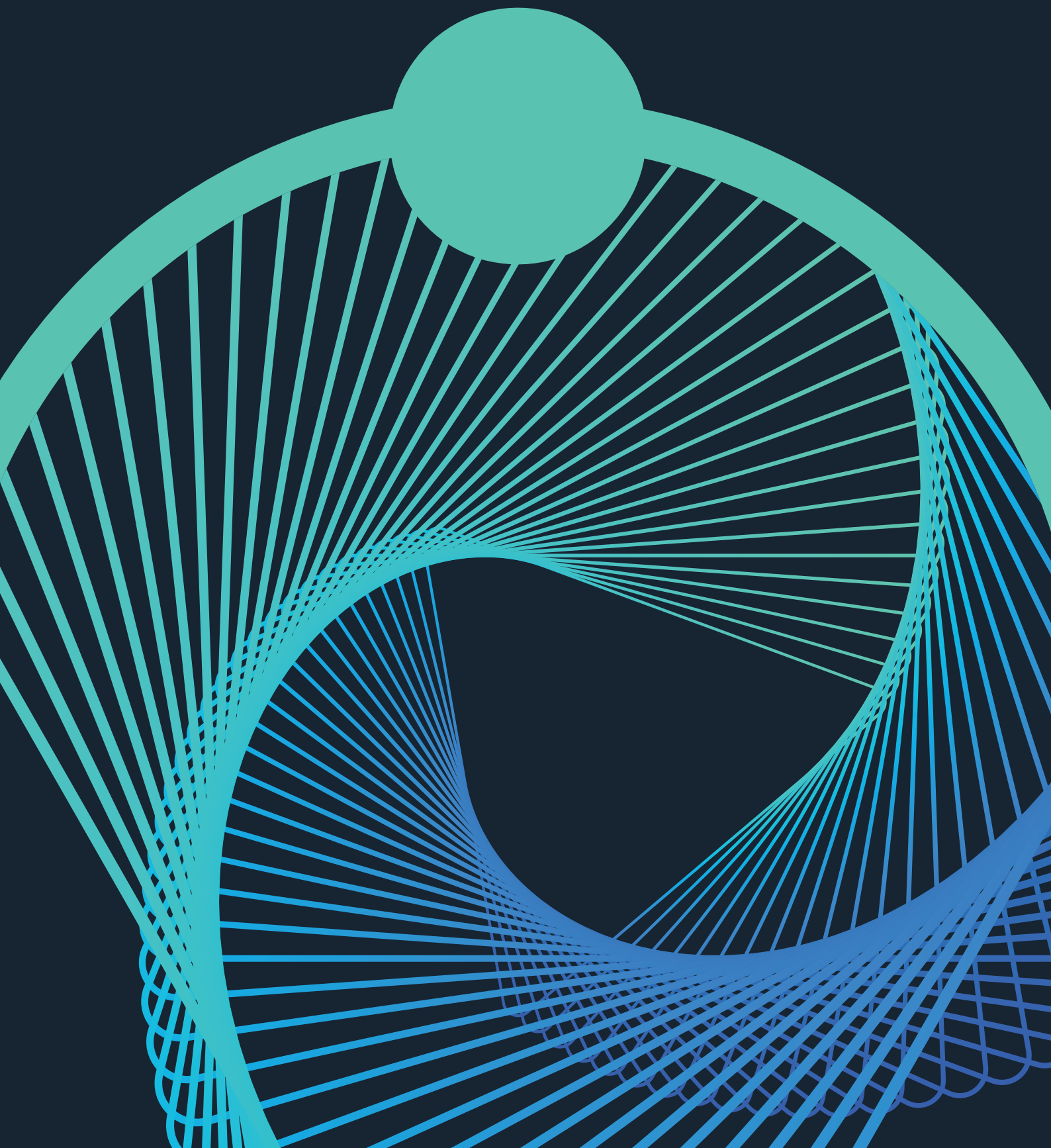
Executive Summary



Each year as part of my statutory duty under the Mental Health Act 2001–2018, I carry out a review of mental health services in the State. In 2022 and 2023, I reviewed the provision of Child and Adolescent Mental Health Services (CAMHS) in Ireland. During this review we were cognisant of the findings of the Maskey review[1] and the public concerns about the provision of CAMHS.

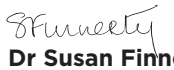
We would like to thank all the young people and their families who spoke with us and wrote to us during the review, with their experience of attending CAMHS. This had sometimes been distressing for them, but they spoke in order to assist in improving mental health services for themselves and for children and families who may attend CAMHS in the future. Certain themes were present in most accounts and these are detailed in Chapter 3 of this report and in the Community Healthcare Organisations (CHO) reports that have been published separately.

We would also like to thank stakeholders, individual teams, team members, area management teams and the HSE National Office who gave us their time and knowledge to provide us with an understanding of the provision of CAMHS both nationally and in local areas. HSE CAMHS staff and senior managers have engaged with the review and we recognise that this review is seen by the HSE as a contribution to ongoing work to improve their services. As this is a national independent review, it provides an opportunity to inform both the public and the HSE about CAMHS across the country, from senior HSE level to individual CAMHS Teams and the experience, care and treatment of individual young people receiving CAMHS.

The HSE has acknowledged to us that there are deficits in current service provision, including in access, capacity and the consistency in quality of services provided. It has stated that it has prioritised targeted improvements and investment over recent years including building capacity in CAMHS and youth mental health, developing specialist services and clinical programmes, suicide prevention, investing in mental health in Primary Care, modernising forensic services and modernising digital platforms for accessing services. Given that there are ongoing serious deficits in CAMHS (outlined in this report) which increases the risk to children and young people despite these targeted improvements, this is a major concern.

In January 2023, the Mental Health Commission decided to issue an 'Interim Report' due to the serious concerns and consequent risks for some patients that were found across areas in CAMHS in four CHOs. The concerns include the risk to safety and wellbeing of children receiving mental health services, the management of that risk, and the lack of clinical governance. Areas of concern where we were of the opinion there was a risk to children due to a lack of clinical governance were escalated to the Chief Officer of the relevant CHO and in one case to the Assistant National Director, (Head of Operations, Quality and Service Improvement in the HSE) who is responsible for mental health nationally. The Mental Health Commission continues to monitor the actions taken on foot of these escalations but it has no legal power to enforce any action as CAMHS Community Services are not regulated by the Mental Health Commission. Since the publication of the Interim Report, we have also escalated concerns related to one CHO to the Assistant National Director.

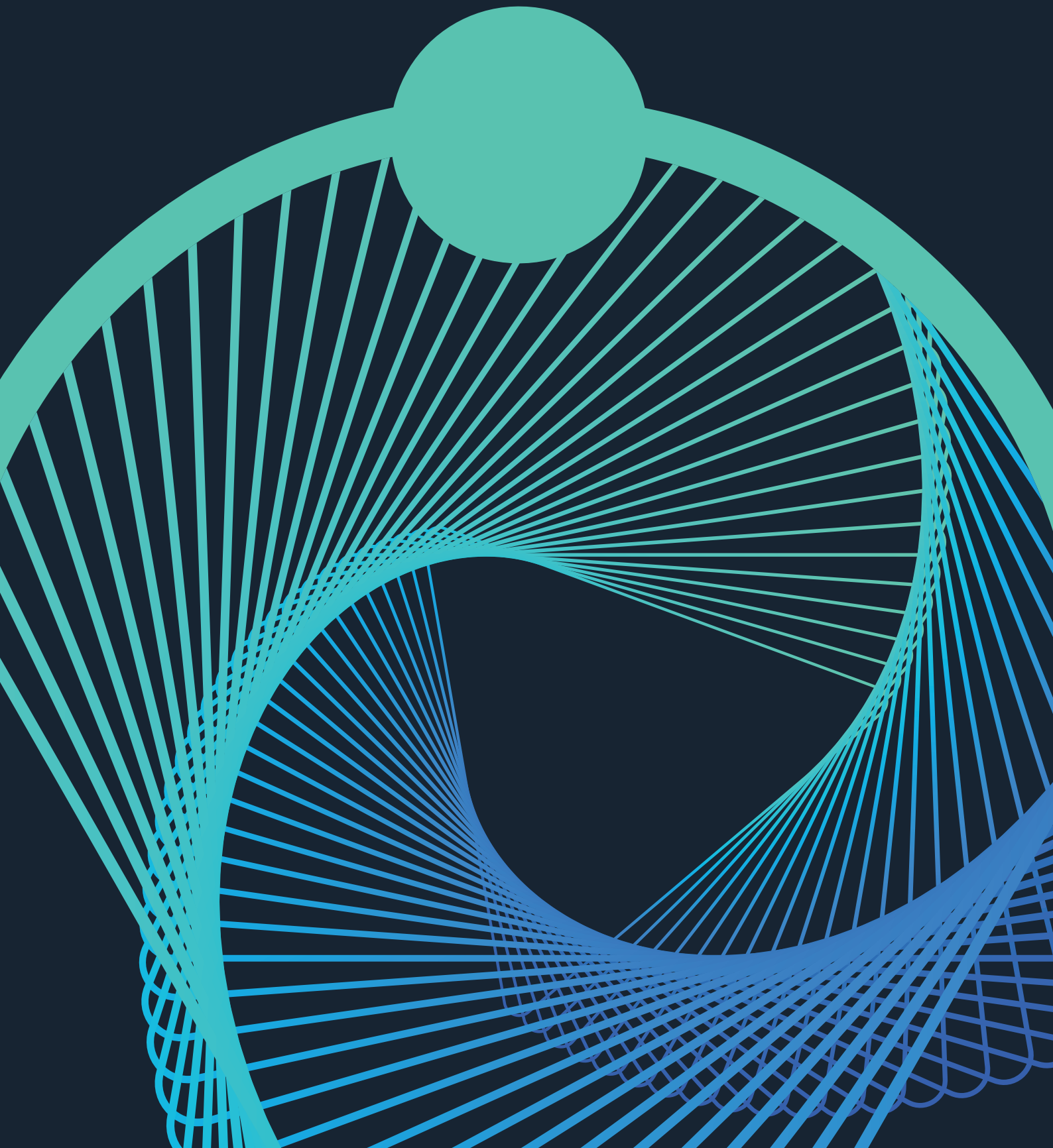
Throughout our review, we found CAMHS staff worked extremely hard to try to provide a good CAMH service. We are aware that many young people and their families have received excellent care and treatment within the often limited resources of the CAMHS Teams and we found that many teams were innovative in trying to mitigate the risk posed by a lack of staff. It is important to recognise that experience of good services with positive outcomes may get lost in the sometimes-heated discussions about CAMHS. However, based on my review, I cannot currently provide an assurance to all parents or guardians in all parts of Ireland that their children have access to a safe, effective, and evidence-based mental health service. To that end I am recommending the immediate and independent regulation of CAMHS by the Mental Health Commission to ensure the State and the HSE act swiftly to implement the governance and clinical reforms to help guarantee that all children have access to evidence-based and safe services, regardless of geographical location or ability to pay.



Dr Susan Finnerty
Inspector of Mental Health Services

[1] Maskey S. *Report on the Look-Back Review into Child & Adolescent Mental Health Services County MHS Area A*. 14 January 2022.

Summary of Findings



Rights of Children

All children have a right to enjoy the highest attainable standard of physical and mental health under Article 24 of the United Nations Convention on the Rights of the Child, which was ratified by Ireland in 1992. From our review, it appears that this right may have been breached for many children with mental illness. The long waiting lists, the lack of capacity to provide appropriate therapeutic interventions, the "lost" cases, the lack of emergency services and out-of-hours services, the difficulties in accessing Primary Care and Disability Services, and the absence of monitoring of certain medications all point to a possible breach of Article 24.

Governance

We found that lack of governance in some areas is contributing to inefficient and unsafe CAMHS, through failure to manage risk, failure to fund and recruit key staff, failure to look at alternative models of providing services when recruitment becomes difficult, and the failure to provide a standardised service across and within CHOs. The lack of a National Director for Mental Health has contributed to these difficulties. Clinical leadership was lacking in most CHOs, although a National Clinical Lead in CAMHS is being recruited.

The CAMHS depends heavily on a model of care which places the onus on a single profession, i.e. the consultant psychiatrist and all clinical responsibility rests with them. This is an outdated model in international practice, which favours a more multidisciplinary approach and increased individual clinician responsibility and accountability.

Budget for CAMHS

There is no ring-fenced budget for CAMHS, which must compete with other mental health services for resources. Currently, the HSE cannot provide a report on its annual budget and expenditure within CAMHS. The introduction of a Single Integrated Financial and Procurement Management System has commenced since the start of this review. The HSE has estimated that the current CAMHS budget is €137m or approximately 12% of the overall mental health budget. Within the past six years, €22.6m of development funding has been directed to enhance youth mental health, including building capacity in CAMHS and youth mental health, developing specialist services and clinical programmes, suicide prevention, investing in mental health in Primary Care, modernising forensic services and modernising digital services. While this has resulted in positive developments, there is evidence of under-resourced CAMHS Teams across the country.

Risk Management

We found there were deficits in the risk-management process across a number of CHOs. Risks were not identified due to a lack of auditing and review. There were two processes for management and escalation of risk at team level, with little or no information fed back on what actions were taken. This had frustrated some teams to the extent that they told us that they did not "bother" to escalate risk anymore as there was no point. This resulted in a haphazard approach and under-documenting of risks and minimalist generalised actions recorded on the CHO risk register.

Some CHO risk registers showed minimalist actions to address the risks contained within it. Furthermore, in some teams there was limited understanding as to what constituted a risk, how it was assessed and how it was escalated. Training in risk management was offered but was not mandatory although there was good uptake of this training. However, despite this training, there was still a lack of understanding about risk.

There were no risks pertaining to CAMHS documented within the HSE Corporate Risk Register when we commenced the review, but this was rectified as the review continued. The Quality and Safety Committee of the HSE Board discussed the risks in CAMHS in their meeting in January 2023.

The Draft Overarching National Standards for the Care and Support of Children Using Health and Social Care Services, jointly produced by the Mental Health Commission (MHC) and HIQA had not yet been finalised.

Digital Infrastructure

In three CHOs, the digital infrastructure was mostly absent apart from the use of Excel® spreadsheets and Word® documents. Most services do not have an IT system that manages appointments, schedules rotas, maintains clinical files and provides reports on activity.

Internationally, in comparable countries, these systems have been up and running for many years. Only one CHO had electronic records; this system was provided through an independent service provider. Other CHOs had a system such as FIOS and MAISY which did provide a patient management system but not electronic records. Most teams did not use Healthlink, which allows communication and reports to and from hospitals and GPs. This contributed to paper based clinical files being frequently disordered, incomplete, sometimes illegible, with little logic to the filing of documents within them. Some contained loose pages which was a risk to confidentiality of records.

The HSE is developing an Integrated Community Case Management system. However, the result of the current lack of digital infrastructure was inefficiency to a large scale within the teams, hindering integration, coordination and preventing service development.

Clinical Governance

The HSE has published the CAMHS Standard Operating Procedure [2] in 2015 which was followed by the CAMHS Operational Guidelines 2019[3]. The purpose of these documents was to provide consistency and standardisation in the service delivery of CAMHS throughout the country. Although the HSE had guidance, including a self-assessment template in clinical governance, this was not adhered to in many areas. There was a wide variation of services delivered within and externally among CHOs with little standardisation of treatment. Children and young people had been lost to follow-up in some areas, although following the publication of the Interim Report, the HSE had requested each team review their open caseload and this had commenced soon after. A draft report was made available to the Inspector in July 2023.

There were elements of good auditing practice in two CHOs. However, audits of clinical practice were rarely carried out by individual teams which cited lack of staff as the reason for failure to do so. Where the audits were carried out, it has been in response to the Maskey report and consists mainly of reviewing caseloads and medication reviews but nothing further. Outcome measuring is variable across the reviewed CHOs, although this is a key component of *Sharing the Vision*[4], the national mental health policy. Emphasis is placed on Key Performance Indicators (KPIs) which are collected nationally to measure waiting lists and number of patients seen but unfortunately, they do not measure the outcomes or quality of the service provided.

Staffing of CAMHS

In the absence of any other benchmarking for CAMHS staffing nationally, we used the recommended minimum staffing requirement in *A Vision for Change*[5] to assess the staffing of each team.

The vast majority of teams were significantly below the recommended staffing levels, some below 50% of recommended staffing. This was especially apparent in health and social care professional staffing, where there were deficits in occupational therapists, social care leaders, advanced nurse practitioners, clinical nurse specialists, psychologists, speech and language therapists and social workers. There was also limited access to dieticians and family therapists. This resulted in long waiting lists and lack of staff capacity to carry out many therapeutic interventions. We met staff who were working beyond their contracted hours, who were burnt out and frustrated by not being able to provide at the time of our review, what they saw as a safe and effective service.

Only one CHO told us that they had no problems recruiting staff. In this service there were high numbers of senior posts, considerable training opportunities and a robust governance structure.

Some teams had no consultant psychiatrist and their work was covered by a number of different consultants or by locums which has implications for the continuity of care. Telepsychiatry was used in a number of areas to mitigate the risk of lack of consultants. This patchwork of cover increases the risk of poor care being delivered to young people and families.

The inspectors were informed that one team had 140 “lost” cases. At the time of our Review a limited desk top review by an external consultant psychiatrist was taking place to identify these children. This was followed by a Healthcare Record Review where each young person was assessed and appropriate interventions provided.

[2] cahh.pdf (hse.ie)

[3] CAMHS Operational Guidline 2019 - HSE.ie

[4] Sharing the Vision - A Mental Health Policy for Everyone - HSE.ie

[5] Mental Health – *A Vision for Change* (hse.ie)

Another team were attempting to identify an unknown number of cases that had been lost to follow-up following a change in staffing. The HSE have assured us that all children and young people have been identified and their care reviewed and that no harm was found to have occurred as a result of being lost to follow-up.

Access to CAMHS

Access to evidence-based therapeutic interventions by CAMHS, in accordance with needs of children and young people is deficient in many areas. There was a large unacceptable variation in both the number of children on waiting lists and the length of those waiting lists both across CHOs and internally within CHOs. CAMHS Teams informed us about their rates for acceptance of referrals, which varied between 38% and 84%. In our sample between 64% and 79% of children and young people were accepted on first referral. There was also unacceptable variability in which services were provided across CHOs and within CHOs and were dependent on where the child lived and what team they attended. Individual teams did not have the necessary capacity and training to provide standardised therapy in many cases. There was very little access to day programmes in most CHOs.

Many young people and their families are frustrated, distressed and trying to cope with deteriorating mental health while waiting for lengthy periods on waiting lists for essential services including for Primary Care and Community Disability Network Teams (CDNTs) as well as CAMHS. GPs also told of frustrating attempts to get a child assessed by CAMHS and having to resort to sending a child to the Emergency Department in local hospitals to obtain a psychiatric assessment.

There was piecemeal emergency provision of CAMHS, with CHOs outside the Dublin area particularly deficient in this area. There were no CAMHS Liaison Teams outside Dublin and Cork, resulting in long waiting times for psychiatric reviews of children in the general hospitals. Eating Disorder Teams were in place in three CHOs and two more were in development, and an attention deficit hyperactivity disorder (ADHD) Team was operating in two CHOs with plans to set up a similar team in another CHO. There was a Forensic CAMHS with 1.4 Whole Time Equivalent (WTE) staff and an unopened 10-bedded Forensic CAMHS Unit in Portrane.. The CAMHS-ID model was launched in September 2022 with the aim that there should be 16 teams across the country, but nationally there are only nine teams in various stages of development and provision of services. There is slow progress at the new children's hospital on the St James's Hospital campus, which will accommodate the national specialist eating disorder service with eight inpatient beds and a 12-bed general inpatient unit.

Integration of Children's Mental Health Services

Children's needs frequently require them to move between Primary Care, Disability Services and specialist services such as CAMHS. All such care needs require to be child/young person-centred. CAMHS is a specialist service for *moderate-to-severe mental illness*, other agencies provide other aspects of a child's care and treatment needs. In most cases, the needs are complex and extend beyond a single agency. Waiting lists across different services such as CAMHS, Community Disability Network Teams (CDNTs) or Primary Care services were uncoordinated; poor relationships existed in many cases between the Primary Care services, CDNTs and CAMHS; and joint working was not always in place. There was clear evidence of silos existing in provision of these children's services with barriers in getting a holistic service based on need.

Transition to Adult Mental Health Services

There was a nationwide difficulty in providing a seamless transition of a young person from CAMHS Services to Adult Mental Health Services (AMHS). While the process is clearly outlined in the CAMHS Operational Guidelines, the absence of AMHS input into the transition was apparent.

Vulnerable Children

There are certain groups of children and their parents who have difficulties in accessing CAMHS due to language, culture, stigma, fears, and location. These include children in the Traveller Community, asylum seekers, refugees and migrants (including those in Direct Provision), children in care and young people who are LGBTI. While the HSE has health programmes for some groups, it is important that children in need of CAMHS reach the CAMH services where and when they are needed. Training for staff in these areas has not been provided in most teams.

CAMHS Facilities

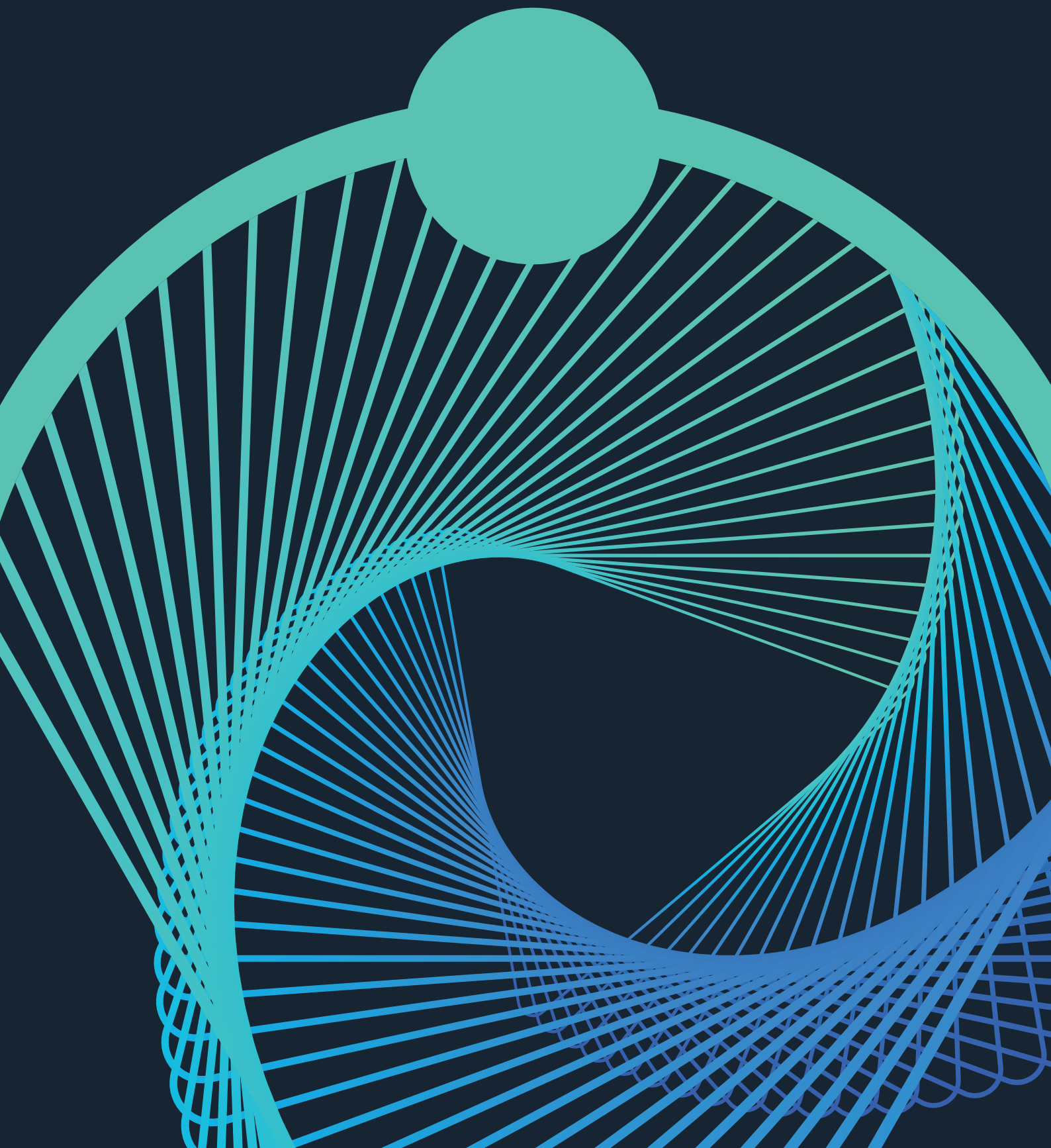
The offices/clinics of a number of CAMHS Teams are mostly located in new Primary Care Centres or other well-maintained buildings with adequate clinical, office and waiting spaces that are bright and cheerful with appropriate furnishings and decorations. Others are in old buildings, some of which are unsuitable due to being poorly decorated, having a lack of appropriate clinical space, insufficient support offices, a lack of soundproofing, inadequate and insecure spaces for storing clinical files, competition for clinical rooms with other services in the building, and inadequate parking. This issue is being addressed by a Sharing the Vision Specialist Group and being monitored by the HSE Implementation Group and the National Implementation Monitoring Committee.

Adherence to CAMHS Guidelines

The majority of CAMHS Teams monitored children and young people on attention deficit hyperactivity disorder (ADHD) and antidepressant medication. Antipsychotic medication (also called neuroleptic medication) can be used in psychosis or other mental illnesses. There was evidence that some teams were not monitoring antipsychotic medication in accordance with international standards (there are no national standards). Consequently, some children were taking medication without appropriate blood tests and physical monitoring that is essential when on this medication. Where we found this had occurred, we informed the Clinical Lead and escalated this to the Chief Officer (CO) of the CHO. This resulted in all the relevant teams undertaking a review of the identified files. Following the Interim Report recommendation, all CAMHS Teams nationally were requested to carry out an audit on all open cases.

Two-thirds of children in CAMHS Teams had a key worker but we found that care planning was either absent or of such poor quality as to be meaningless in many teams. Risk assessment and risk management was not documented in the clinical files in many cases.

Recommendations



Primary Recommendations	
1.	The immediate and independent regulation of CAMHS by the Mental Health Commission must be put in place to ensure the State and the HSE act swiftly to implement the governance and clinical reforms to help guarantee that all children have access to evidence-based and safe services, regardless of geographical location or ability to pay.
2.	The implementation of these recommendations must be monitored by the Mental Health Commission, who must publish a yearly report on the progress of implementation. While the HSE engaged with the Mental Health Commission during the review process, this engagement must continue in order to provide an improved CAMH Service.
3.	There must be oversight of CAMHS and all other mental health services for children and adolescents by the HSE Health and Safety Committees. Due to the seriousness of the concerns raised by Dr Maskey's report and this report, a comprehensive strategy for CAMHS and all other mental health services for children must be prepared and approved by the HSE Board. There must be, at a minimum, quarterly reports on the progress of that strategy to the HSE Board.

Governance	
4.	As a matter of urgency, the HSE should reinstate the post of National Director for Mental Health in the HSE. This would provide strategic overview and leadership in the improvement of access to and provision of all mental health services across Ireland.
5.	Alternative models of care must be considered by the HSE in providing clinical leadership in order to enhance multidisciplinary team approaches. Outcomes of different international models should be carefully analysed to see what model best fits Irish CAMHS needs.
6.	Each CHO must have a Clinical Director for CAMHS to provide clinical leadership.
7.	Each team must have a team/clinical coordinator whose role must be dedicated to coordinating children and young people's care.
8.	Data from public and private providers must be collected through a health information system to allow for resource, capacity and workforce planning.
9.	The HSE must implement *Sharing the Vision* in relation to CAMHS according to the *Sharing the Vision* Implementation Plan 2022–2023 as a matter of urgency.
10.	Progress in ICT projects under *Sharing the Vision* must be prioritised to contribute strongly to the ambition outlined within this policy for ongoing reform and continuous improvement. Clear timelines must be provided as to when each milestone on the ICT Strategy shall be achieved within CAMHS.
11.	A modern Health Information System must be developed, with clear timelines, which includes national individual health identifiers (IHIs) and electronic health records that include public and private services.
12.	Use of telepsychiatry in CAMHS should be carefully monitored and evaluated in the absence of national and international guidelines on its use.
13.	All CAMHS Teams must have access to Healthlink in order to share information from GPs, hospitals and laboratories.
14.	The budget allocated to CAMHS must be increased to develop timely mental health services for children and young people in line with best evidence, with adequately resourced teams and in appropriate facilities.
15.	There should be appointments of change coaches to each CHO to promote these recommendations and support the teams over the next 2–3 years.

Risk Management
16. The HSE Patient Safety Strategy must be implemented in full in CAMHS with ongoing monitoring by the HSE of its implementation, which should be published on the HSE website. The monitoring should also include feedback from service users.
17. The Board of the HSE must review, from a national perspective, the risks relating to CAMHS. The HSE Enterprise Risk-Management Policy and Procedures must be implemented as a matter of urgency in order to address the deficiencies in risk management in CAMHS.
18. All relevant HSE staff and managers must be trained in risk management in accordance with the HSE (2023) Enterprise Risk-Management Policy and Procedures to ensure implementation and consistency in risk-management practices at all levels and this training must be mandatory. Implementation of this policy and its procedures must be audited annually.
19. The *Draft Overarching National Standards for the Care and Support of Children Using Health and Social Care Services*, jointly produced by the MHC and HIQA, should be finalised at ministerial level and implemented in all health and social care services for children.

Clinical Governance
20. The HSE must apply the HSE Principles of Good Clinical Governance in CAMHS. Adherence to these principles by CAMHS in each CHO must be monitored by the HSE, leading to reports that are published on the HSE website.
21. As a matter of urgency, the care and treatment provided in CAMHS should be standardised across and within CHOs, so that each child/young person has the same opportunity to access the most appropriate evidence-based treatment according to their need.
22. Team/clinical coordinators must be funded for each CAMHS Team so that the core processes of referral, assessment and care planning, review and discharge are carried out consistently across CAMHS and that arrangements for staff supervision and continuous professional development are put in place.
23. Clinical audit must become a part of the function of CAMHS Teams. This should be supported and overseen by senior management. Regular forums for sharing information and learning from clinical audits across teams in CHOs should be facilitated.
24. An overview of clinical audits should be published as part of the National Clinical Lead's annual report.

Staffing of CAMHS
25. The recommendations for the staffing of CAMHS Teams contained in *A Vision for Change*, which is used by the HSE for CAMHS workforce planning, must be updated as part of the overall CAMHS strategy to reflect the current needs of children/young people attending CAMHS.
26. There must be development of a programme in each CHO of incentives to retain and recruit staff to CAMHS Teams. For staff, this should include improved access to training, career progression, supportive management, having a manageable workload, being able to evaluate and report on their work in a non-threatening environment, research opportunities and opportunities to meet with other teams through case discussions and other academic meetings. This programme should be developed with intensive input from staff who work on CAMHS Teams.

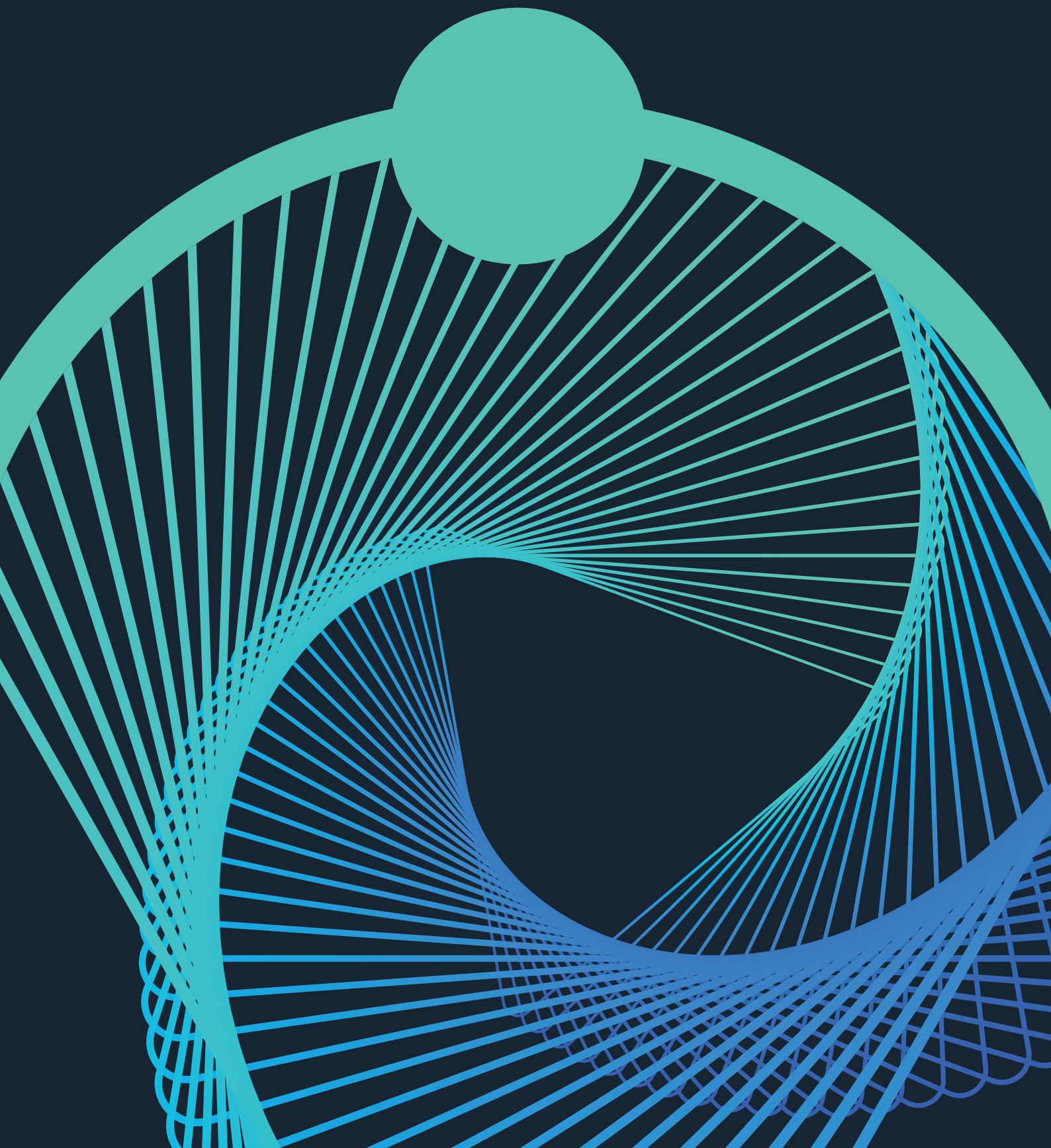
Access to CAMHS
27. All children and families should be able to access an urgent mental health assessment at a time of crisis that is provided in a safe suitable environment and delivered by trained supported staff.
28. Development of the Model of Care for ADHD in children and young people must be prioritised, with fast-tracking of the roll-out of ADHD Teams in each CHO.
29. Each major hospital and Emergency Department should have a dedicated Liaison CAMHS, supported by an on-call CAMHS Team. This service should be accessible 24/7 via a single point of contact.
30. CAMHS Liaison and emergency CAMHS must receive sufficient resourcing in order to bring their staffing levels up to international standards, and be supported through National Clinical Programmes. Clear care pathways for young people who require immediate mental healthcare must be established, with a care pathway for young people discharged from the care of liaison and out-of-hours teams.
31. Assertive outreach and crisis mental health teams appropriately resourced to accept emergency referrals at short notice and located within the CAMHS structure should be developed.
32. The HSE must expand the current limited Forensic CAMHS to the planned two fully staffed teams and provide a detailed timeline for when this will be achieved.
33. The HSE must expedite the opening of the 10-bed forensic unit in the National Forensic Mental Health Service (NFMHS) campus in Portrane. This should be done at the latest by 31 December 2023.
34. The NFMHS should develop a pathway to ensure Community Teams can receive advice, consultation, support, assessment and management when required.
35. Each CAMHS inpatient unit should reserve at least one bed for emergency out-of-hours admissions.
36. Community provision of CAMHS including the development of day programmes and CAMHS Hubs must take place, as a matter of urgency, to alleviate the pressure on CAMHS inpatient services. This will assist in preventing the admission of children and young people to paediatric units and adult psychiatric units and reduce risk to children and young people.
37. There must be a radical redesign of the CAMHS–AMHS transition practices, to provide a seamless new pathway for young people to access AMHS.
38. All CAMHS Teams must have clinicians trained in Family-Based Therapy to provide evidence-based interventions for children and young people with an eating disorder.

Integration of Children's Mental Health Services
39. All children and young people's mental health services should be fully integrated so that children can move seamlessly between services in a timely manner according to their needs.
40. The HSE must ensure that the mental health services for children are a continuum of services and resource these services so they can provide timely interventions whether children/young people have mild, moderate or severe mental illness.
41. A single-point-of-contact triage system within each CHO should be developed for all referrals to CAMHS, with the ability to prioritise assessments with CDNTs and Primary Care should this be required. This will result in the timely onward referral to the appropriate services and prevent children and young people sitting on waiting lists for CAMHS services for which they do not meet the criteria.

Vulnerable Children
42. Each child and young person in the Travelling Community must have equitable access to CAMHS. This includes provision of extra resources to support children and their families to attend CAMHS in a way that meets their needs.
43. Every child in care should be supported by the HSE to receive CAMHS Services that are child centred and in a location of their choice.
44. There should be a National Clinical Programme and Clinical Lead for Mental Health of asylum seekers, refugees and migrants.
45. Those who currently provide CAMHS for asylum seekers, refugees and migrants must have the necessary protected time, resources, mental health skills and appropriate training to provide this service.
46. Training in supporting LGBTI young people who have a moderate or serious mental illness must be rolled out to all CAMHS Teams.

Involvement of Young People and Their Families in CAMHS
47. Each young person and their family should be offered the opportunity to provide feedback on their experience in CAMHS. This information should be collected using standardised templates and used to improve quality of services both within the individual CAMHS Teams and across each CHO.
48. The HSE must make information about help and treatment for all levels of mental illness, widely available to the public, more coherent and more user friendly.
49. Young people and parents must be involved at every level of CAMHS service planning.

Review Team



Dr Susan Finnerty, Inspector of Mental Health Services, Mental Health Commission

Marianne Griffiths, Assistant Inspector

Noeleen Byrne, Assistant Inspector

Sarah Jones, Assistant Inspector

Sarah Moynihan, Assistant Inspector (until 21 August 2022)

Mary Smyth, Assistant Inspector (from November 2022 to March 2023)

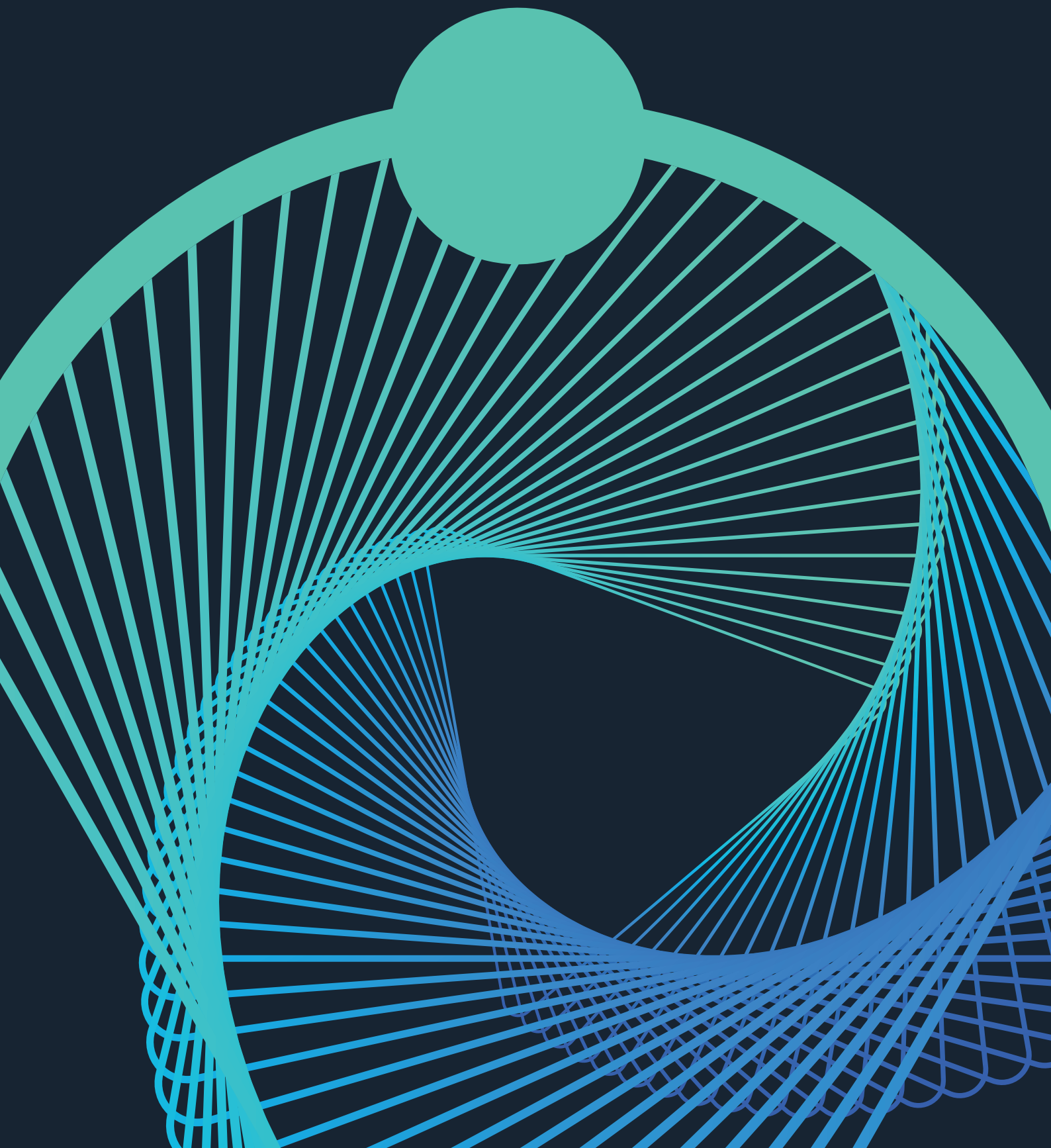
Rosemary Smyth, Assistant Inspector (from November 2022 to April 2023)

Martin McMenamin, Assistant Inspector (from January 2023 to March 2023)

Amy Weinmann, Research Assistant

Stephen O'Rourke, Business Manager and Project Manager for this review.

Advisors



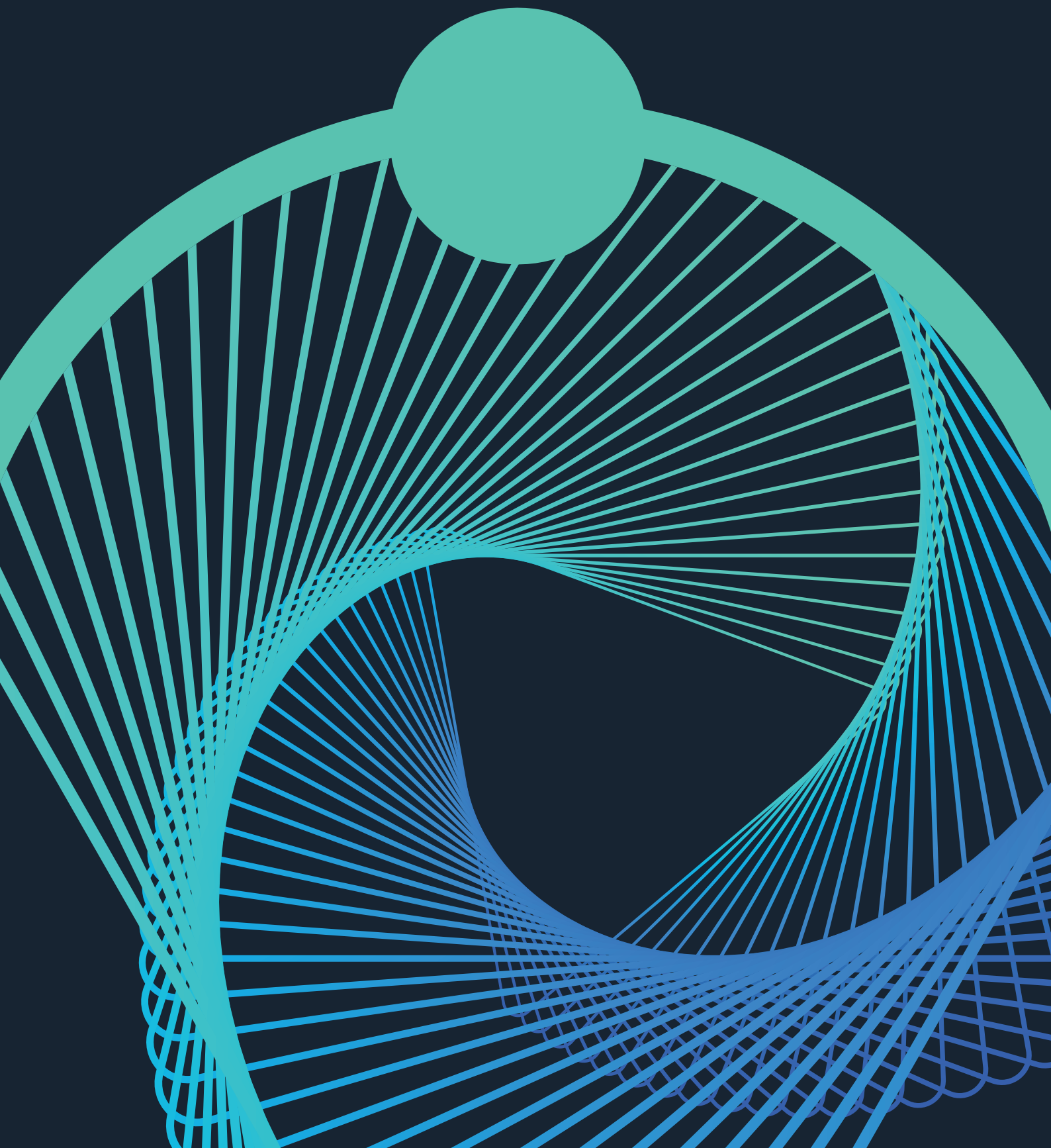
Professor Tom Keane, previous Director of the National Cancer Control Programme and past Chair of the Sláintecare Implementation Advisory Council

Dr Helen Smith, Consultant Forensic Child and Adolescent Psychiatrist, Clinical Director for CAMHS, Clinical Lead for West of Scotland CAMHS Network, Chair of Royal College of Psychiatry in Scotland CAMHS, South CAMHS/NSAIU Ayrshire, Scotland

Dr Struan Simpson, Specialist Registrar in CAMHS, ST6 Renfrewshire CAMHS Aranthrue Centre, Glasgow, Scotland

Dr Niall Muldoon, Ombudsman for Children, Ireland

Methodology



A mixed methods approach was taken to fulfil the objectives of the Review using quantitative and qualitative data.

In order to do this the following objectives were devised:

- To review the documentation of the care and treatment provided to young people.
- To map the services that are available to young people within the CAMHS Teams.
- To identify the challenges confronting the CAMHS Teams in providing mental healthcare and treatment to young people.
- To gain insight into the governance structure of each of the CHOs and subsequently the processes for the management of the CAMHS Teams.
- To reflect quality improvement and initiatives at all levels of CAMHS.

Sources of Data

Written Information Submitted by the CAMHS Teams

Containing staffing information, population, and therapies provided: March 2022 and updated February 2023.

Information from Young People and Parents

This included meetings with young people and parents, telephone calls, online survey and unsolicited submitted issues of concern to the Mental Health Commission.

Meetings with Stakeholders

List of stakeholders who spoke with the Review Team can be found in Appendix 2.

Meetings with All CAMHS Teams in Ireland

The Inspection Team visited every CAMHS Team in the country, including specialised teams – intellectual disability, Forensic CAMHS Teams, CAMHS Liaison Teams, ADHD Teams and Eating Disorder Teams. Each CAMHS Team completed a presentation to the Review Team on their service.

Meetings with All CHO Area Management Teams

This was to ascertain governance structures and processes.

Meetings with HSE

This was to ascertain governance structures and processes and included the Assistant National Director in Mental Health and the Chief Executive Officer (CEO) of the HSE.

Environmental Audit

Standardised information about the premises in which the CAMHS Services were delivered. This included inpatient units, day programmes, Community CAMHS.

Clinical File Review

1. A total of 1,178 files were reviewed by the Review Team across all CAMHS Teams. Meetings with all CAMHS teams in CHO 4.
2. Meeting with CHO 4 Area Management Team.
3. Meetings with individual staff and management.
4. Review of CAMHS teams' facilities.
5. Meetings with parents and young people who had experience of CAMHS in CHO 4.
6. We audited a stratified randomised sample of 10% of clinical files opened since January 2021 across all CAMHS Teams. The sample was stratified to include:
   - Young people who have a diagnosis of ADHD
   - Young people who have a diagnosis of an Eating Disorder
   - Young people who have a diagnosis of a Mood Disorder
   - Young people prescribed anti-psychotic medication
7. The data was collected from clinical files January 2021 to March 2022. The data collected also included data from clinical files for children who were discharged and those who transitioned to Adult Mental

Health Services. An audit trail was developed to assess if teams were meeting the criteria of existing guidelines and standards, NICE Guidelines and the CAMHS Operational Guidelines.

All identifying information was anonymised.

A feedback meeting was held with each CHO following their review.

Each CAMHS Team was provided with written feedback from the review.

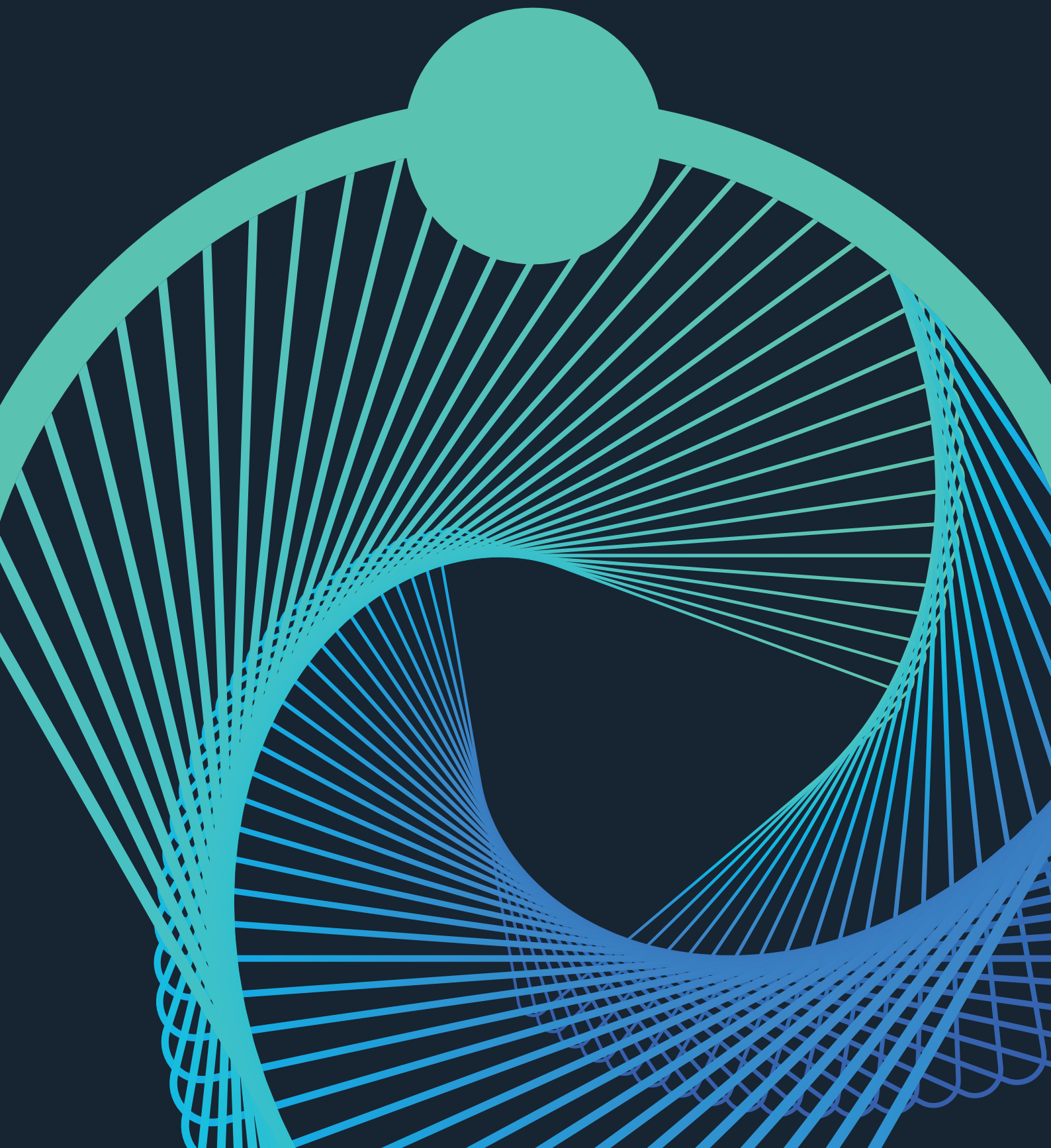
All CHO reports were sent to the Chief Officer for factual corrections and comments.

Our responses to their factual corrections and comments were sent to each CHO and the report amended where indicated.

The complete final report was sent to the Assistant National Director for Mental Health in the HSE for factual corrections and comments.

The Terms of Reference can be found in Appendix 1.

Introduction



What Is CAMHS?

CAMHS stands for Child and Adolescent Mental Health Services, which is a specialist mental health service which provides assessment and treatment for young people up to 18 years of age who experience moderate or severe mental illness. A child or young person is referred to CAMHS when treatment at primary care level has been unsuccessful, and/or the mental health issue is so severe and complex it requires specialist services.

This accounts for approximately 2% of all children. CAMHS treats:

- Moderate to severe Anxiety disorders.
- Moderate to severe Attention Deficit Hyperactive Disorder/ Attention Deficit Disorder (ADHD/ADD).
- Moderate to severe Depression.
- Bipolar Affective Disorder.
- Psychosis.
- Moderate to severe Eating Disorder.
- Suicidal ideation in the context of a mental disorder.

This is not an exhaustive list and not all children and young people will fit neatly into a diagnostic category.

While a broad range of services including Primary Care Teams, Community Disability Network Teams, Jigsaw and Tusla support the mental health of children and adolescents, the term "CAMHS" is usually applied very specifically to services that provide specialist mental health treatment and care to young people through a multidisciplinary team.

CAMHS are often organised in a stepped care approach with multi-agency collaborations across social services, education and healthcare. The aim is to ensure that milder mental health problems are treated in primary care settings (general practitioners, education and social services) and only children with moderate-to-severe mental disorders are referred to CAMHS[6].

Structure of Services for Young People with Mental Health Difficulties

Tier 1 – Tier 1 covers support groups, psychoeducation, mental health promotion advice and mental ill-health prevention programmes provided at community level. It includes funded websites, helplines, school initiatives, youth services and family centres. While they may provide educational input, **CAMHS does not provide Tier 1 services.**

Tier 2 – These services are involved with the assessment and/or support of children and young people who may have mild-to-moderate mental health problems/illness. **They are not primarily delivered as part of CAMHS.** Psychologists, occupational therapists and speech and language therapists in Primary Care; Tusla; Community Disability Network Teams (CDNTs); and Jigsaw are some of the organisations delivering this level of service.

Tier 3 – This tier is accessed via a referral from a GP because of a moderate-to-severe mental illness in a young person. These are services **delivered by a CAMHS multidisciplinary team** in a community setting or sometimes in a general hospital setting by CAMHS Liaison Teams. It also includes services for children with intellectual disability and moderate-to-severe mental illness.

Tier 4 – These cover both day and inpatient services and some specialist outpatient services, including forensic services. **These are services delivered by CAMHS.**

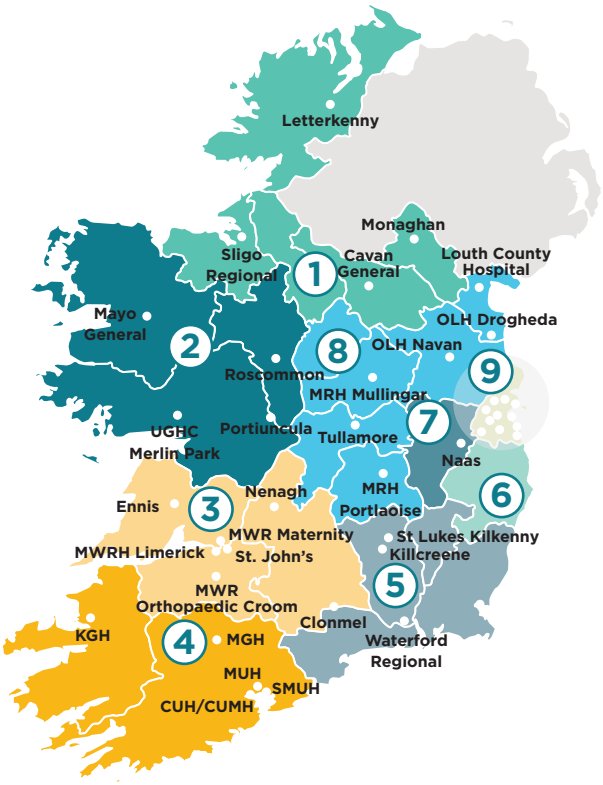
Structure of CAMHS Teams

CAMHS Services are delivered within nine Community Healthcare Organisations (CHO) by CAMHS Teams.

CAMHS Teams are multidisciplinary with a consultant psychiatrist, non-consultant hospital doctors (NCHD), nurses, social workers, occupational therapist, psychologists, speech and language therapists, and social care workers/leaders on the team. Other therapists may include family therapists, play therapists, creative arts therapists, cognitive behavioral psychotherapists, dialectial behaviour therapists, psychoanalytical psychotherapists, and dietitians. The multidisciplinary nature of CAMHS ensures that a range of disciplines, skills, experience and perspectives are provided in the assessment, treatment, and care of children/young people presenting with moderate-to-severe, and often complex, difficulties. As we shall see later in the report, the vast majority of CAMHS Teams in Ireland do not have the recommended number of multidisciplinary team members and very limited access to different types of therapy.

[6] Kelvin RG. 2005. Capacity of tier 2/3 CAMHS and service specification: a model to enable evidence-based service development. *Child and Adolescent Mental Health* 10(2): 63–73. https://doi.org/10.1111/j.1475-3588.2005.00120.x.

Figure 1 *CHOs in Ireland*



The consultant psychiatrist is the Clinical Lead in the CAMHS Team in Ireland. Each member of the team also has a professional and management reporting relationship through their discipline-specific line management structure. The consultant psychiatrist as Clinical Lead has clinical responsibility for all children and young people who are on the team's caseload, no matter how peripheral their clinical contract is with the child or young person. The Mental Health Commission's Teamwork resource paper (2010) stated (4.4.1):

> *'Not in keeping with current models of practice, it is inappropriate to interpret that consultant psychiatrists carry overall responsibility if they are involved, however peripherally, in the care of service users, or for all referrals received…' A 'distributed' model of responsibility is described, whereby clinical 'responsibility is distributed among the involved team members according to their role and contribution…With this model the consultant psychiatrist remains responsible for their own direct clinical involvement, including the quality of advice and assessment given. They also retain 'clinical primacy' in selected and specified cases, and work in a consultative fashion with other team members…'*

These 2010 recommendations were not acted on.

Evidence shows that a substantial proportion of mental health problems in adults originate during childhood and adolescence[7]. Approximately two-thirds of affected adults exhibit signs of a mental illness earlier in life. This applies to most if not all disorders, including substance use disorders, psychosis and emotional disorders[8].

Mental health is a key component of the person's ability to function well in their personal, social and work life as well as adopt strategies to cope with life events[9]. In this regard, early childhood years are highly important, in light of the greater sensitivity and vulnerability of early brain development, which may have long-lasting effects on academic, social, emotional and behavioural achievements in adulthood[10]. Most mental disorders have their peak of incidence during the transition from childhood to young adulthood, with up to one in five people experiencing clinically relevant mental health problems before the age of 25; 50% of whom were already symptomatic by the age of 14[11]. For those under 25 years old, mental health problems, especially anxiety and mood disorders, account for 45% of the global burden of disease[12]. Of grave concern is that following symptom onset, people aged 0–25 experience the greatest delay to initial care and treatment.

7 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. 2005. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch. Gen. Psychiatry* 62: 593–602.

8 Rutter M, Kim-Cohen J, Maughan B. 2006. Continuities and discontinuities in psychopathology between childhood and adult life. *J. Child Psychol. Psychiatry* 47: 276–295.

9 WHO. *Mental health action plan 2013–2020*. Geneva: World Health Organization 2013.

10 Black MM, Walker SP, Fernald LCH, Andersen CT, DiGirolamo AM, Lu C et al. Early childhood development coming of age: science through the life course. *Lancet*. 2017; 389(10064): 77–90.

11 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. 2005. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 62(6): 593–602.

12 Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C et al. 2011. Global burden of disease in young people aged 10–24 years: a systematic analysis. *Lancet*. 377(9783): 2093–2102.

Based on the evidence summarised above, it is obvious that there is a pressing need to develop and improve Child and Adolescent Mental Health Services, with the aim of implementing prevention and early-intervention strategies. Such strategies when implemented should assist in reducing later adult mental health problems and improve personal wellbeing and productivity.

It is therefore of great concern that there are considerable delays across Primary Care (up to four years in some areas), Community Disability Network Teams (up to five years) and CAMHS (up to 18 months). These delays have far-reaching consequences for children and young people as they struggle to deal with their mental health difficulties, whether mild, moderate or severe. Restricted school attendance and educational achievements, deterioration in symptoms of mental illness, loss of social interactions, deterioration of family relationships, self-medication with alcohol or drugs and behavioural difficulties may all be predictable consequences of not addressing children and young people's mental health needs.

Background

This review of CAMHS commenced in April 2022. As noted above, each year as part of my statutory duty under the Mental Health Act 2001, I carry out a review of mental health services in the State. In 2021, I decided that I would review the provision of Children and Adolescent Mental Health Services (CAMHS) in Ireland in 2022 as a follow-up to my report in 2017[13]. The Maskey review into South Kerry CAMHS reported that the care received by 240 young people did not meet the acceptable standards. Dr Maskey found "unreliable diagnoses, inappropriate prescriptions, poor monitoring of treatment and potential adverse effects" which exposed many children unnecessarily to the risk of significant harm in South Kerry CAMHS. The report also details that significant harm was caused to 46 children and young people, including weight gain; sedation; elevated blood pressure and galactorrhoea (the production of breast milk).

The Maskey report was confined to South Kerry CAMHS and did not look at CAMHS in the rest of the country. Concerns were expressed publicly and at government level whether similar concerns and risks were present in other parts of the country in CAMHS.

As a result of the Maskey report I decided to expand my review, which was agreed with the Board of the Mental Health Commission, as per the Terms of Reference at Appendix 1.

Epidemiology

The number of children and adolescents affected by mental disorders has been the focus of significant interest over recent decades and prevalence studies have become increasingly more important globally in planning mental health services for children and young people. A survey in England in 2017 found one in eight (12.8%) of 5–19 year-olds had a least one mental disorder and 5% met the criteria for two or more individual mental illnesses[14]. According to this survey, half of all long-term mental disorders are thought to start by age 14, and three-quarters by age 24. The prevalence of mental health conditions is not evenly distributed across the population, with key differences between groups based on age, sex and socioeconomic conditions, with older children, girls and those from deprived areas all more likely to present with poor mental wellbeing[15].

The proportion of young people who have ever experienced suicidal ideation increased by approximately 40% from 2012 to 2019, according to the latest Statistical Spotlight report[16].

The prevalence of mental disorders in Ireland decreased for all age groups from 2017 to 2019, with the largest decrease among those aged 15 – 19 (24% in 2017 to 22% in 2019)[17]. However, following the COVID-19 pandemic from 2020 to 2023, this was reversed. In 2020, following an initial decline, referrals to CAMHS increased consistently from September. Such

[13] Annual Report including Report of the Inspector of Mental Health Services. Dublin: Mental Health Commission 2017.

[14] Mental Health of Children and Young People in England, 2017. NHS Digital 2018.

[15] Ball WP, Black C, Gordon S et al. 2023. Inequalities in children's mental health care: analysis of routinely collected data on prescribing and referrals to secondary care. *BMC Psychiatry* 23, 22. https://doi.org/10.1186/s12888-022-04438-5

[16] Statistical Spotlight #10: The Mental Health of Children and Young People in Ireland. From Published on 27 April 2023. 255533_1a16e7f3-f24a-4f77-a98a-755d262ecab4 (2).pdf

[17] Kessler RC, Angermeyer M, Anthony JC, Graaf RD, Gasquet I, Girolamo GD, et al. 2007. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's world mental health survey initiative. *World Psychiatry* 6: 168–176.

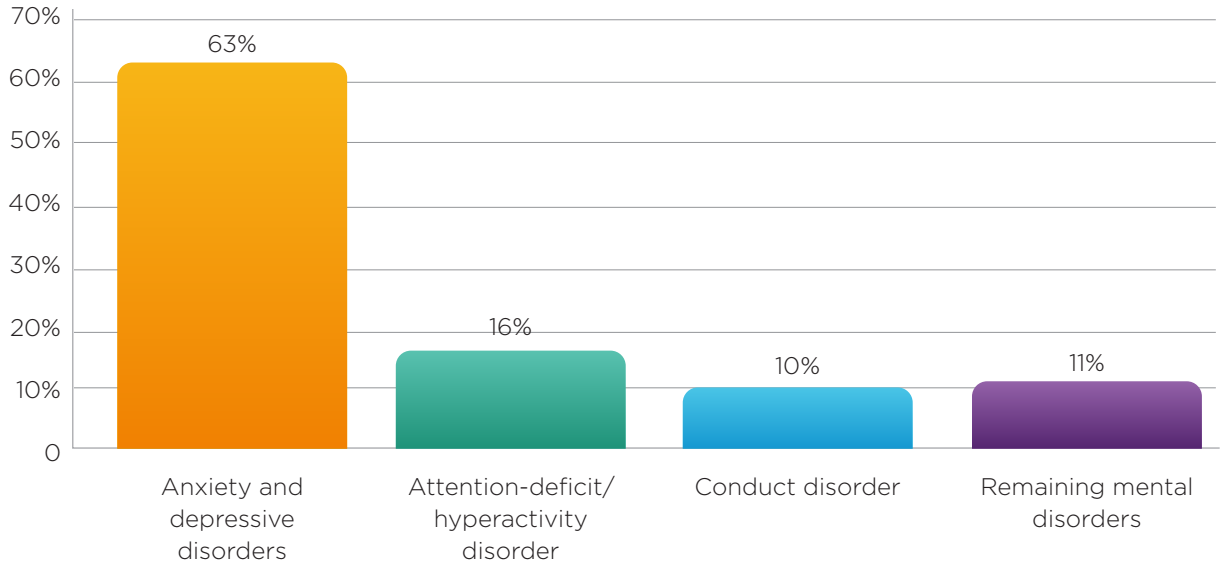
unprecedented increase in referrals places further strain on services that were already under-resourced and underfunded, with the likelihood of increased waiting lists post COVID-19. Referrals to specialist CAMHS were stable until the 2020 COVID-19 lockdown, after which there was an increase particularly among girls and those in older age groups. McNicholas et al. envisaged that once the pandemic was over, resources will be even more constrained, and CAMHS would be urgently in need of additional ring-fenced funding[18].

The wide variation in prevalence studies of mental health difficulties in children/young people is highlighted in a systematic review by Lynch et al. (2022) who point out that large epidemiological studies are essential for service planning but warn against conflating psychological distress with serious and enduring mental illness by using broad terminology and low cut-off scores[19].

Anxiety and depressive disorders accounted for almost two-thirds (63%) of mental disorders for young people in Ireland in 2019. The second most prevalent was ADHD (16%), followed by conduct disorders (10%). In 2012 and 2019, the prevalence of very severe anxiety and depression symptoms was higher among adolescents with low levels of support from a special adult and among young people who identified as Lesbian, Gay, Bisexual, Asexual and Pansexual. From 2017 to 2019, Ireland consistently had a higher prevalence of mental health disorders than the European Union (EU) 27 average across all age groups. The number of children in receipt of clinical psychology services in Ireland increased by over 150% between 2019 and 2020 while the number of children admitted to inpatient Child and Adolescent Mental Health Service (CAMHS) units increased by almost a third between 2017 and 2021. The number of child admissions to Adult Mental Health Units decreased by almost two-thirds during the same period[20].

Figure 2 *Estimates of key mental disorders among adolescents and young people aged 10 – 24 in Ireland*

Source: Mental Health of Children and Young People in Ireland Statistical Spotlight 10 #Minister for Children, Equality, Disability, Integration and Youth, 2023



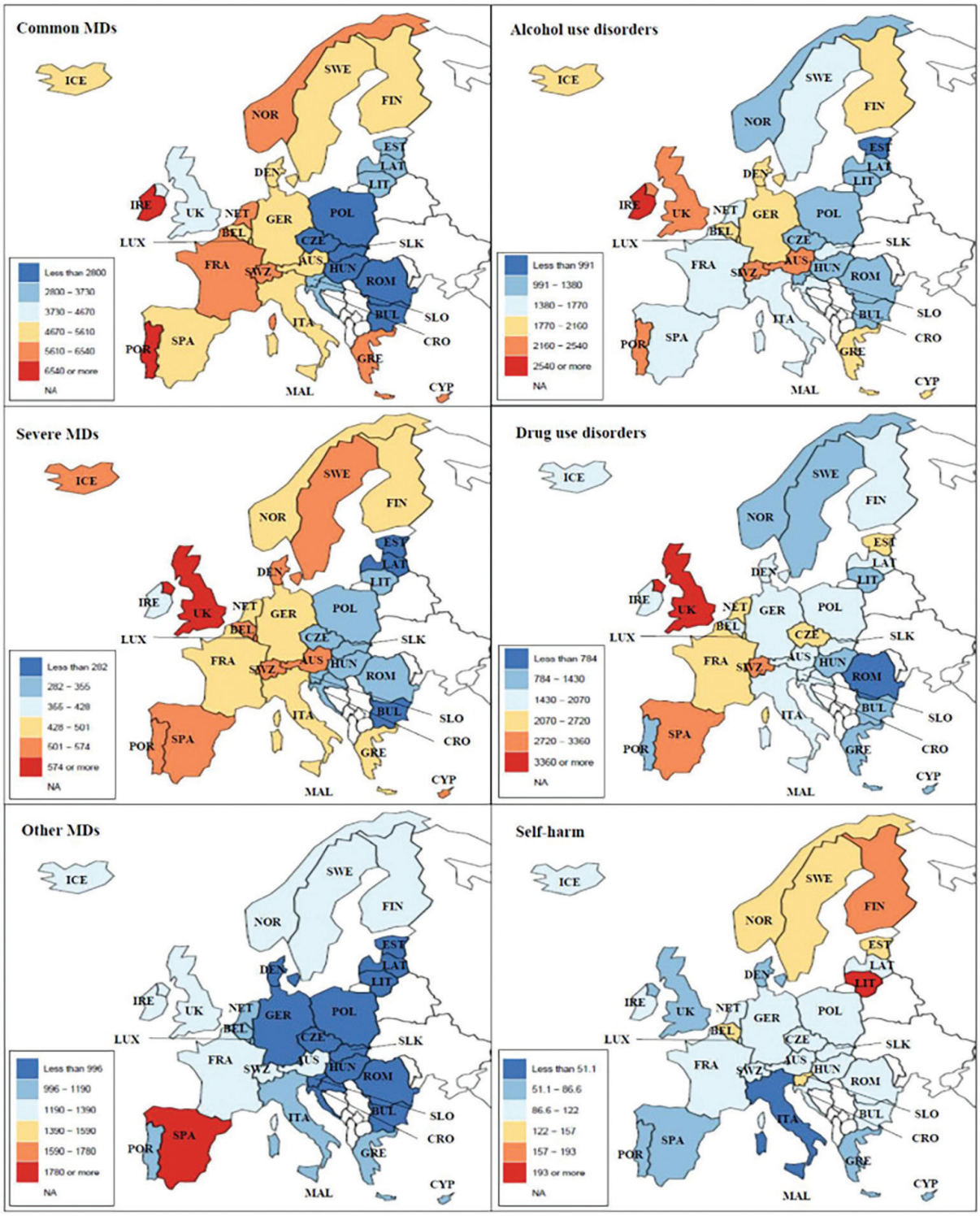
[18] McNicholas, F, Kelleher I, Hedderman E, Lynch F, Healy E, Migone M 2021. Referral Patterns for specialist child and adolescent mental health services in the Republic of Ireland during COVID-19 pandemic compared with 2019 and 2018. *BJPsych Open*, 7(3), E91. doi:10.1192/bjo.2021.48

[19] Lynch S, McDonnell T, Leahy D, Gavin B, McNicholas F. Prevalence of mental health disorders in children and adolescents in the Republic of Ireland: a systematic review. *Ir J Psychol Med*. 2023 Mar; 40(1): 51–62.

[20] Mental Health of Children and Young People in Ireland Statistical Spotlight 10 #Minister for Children, Equality, Disability, Integration and Youth, 2023.

Figure 3 *Prevalence per 100,000 population aged 10–24 years of common, severe and other mental disorders (MDs), alcohol and drug use disorders, and incidence rate of self-harm in 31 European countries, both sexes, age 10–24, year 2019*[21].

(MD = Mental Disorder)



[21] Astelpietra G, Skrindo Knudsen AK, et al. The burden of mental disorders, substance use disorders and self-harm among young people in Europe, 1990–2019: Findings from the Global Burden of Disease Study 2019.

Rights of the Child

All children have a right to health and social care services that are focused on their needs and that work to meet these needs in a consistent and coordinated way. To do this, children's needs must be assessed properly by these services, and the care and support they receive must be well planned, integrated, and tailored to their individual needs and circumstances. Ireland has ratified both the UN Convention on the Rights of the Child (UNCRC)[22] and the UN Convention on the Rights of People with Disabilities (UNCRPD)[23]. Article 7 of UNCRC explicitly focuses on the rights of children with disabilities. Both of these Conventions apply established human rights principles drawn from the UN Declaration on Human Rights and set benchmarks for signatories in the achievement of these rights. Rights include, but are not limited to:

- The right to non-discriminatory treatment, that is, that all children have the same right to develop their potential in all situations and at all times.
- Protection from abuse and neglect.
- That the views of children are considered in decisions that affect them.
- That the best interests of the child are paramount.

Ireland has committed itself to upholding the rights of all children and to the advancement of these rights through changes to legislation, and service provision.

Under Article 24 of the UN Convention on the Rights of the Child all children have a right to enjoy the highest attainable standard of physical and mental health.

Article 24 of the UN Convention on the Rights of the Child as it applies to mental health

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary healthcare

In this review, it appears that this right may been breached for many children with mental illness. The long waiting lists, the lack of capacity to provide appropriate therapeutic interventions, the "lost" cases, the lack of emergency CAMHS and out-of-hours services, and absence of monitoring for children on medication all point to a possible breach of Article 24.

The UN Committee on the Rights of the Child has emphasised the importance of the mental health of children and the need to tackle "behavioural and social issues that undermine children's mental health, psychosocial wellbeing and emotional development"[24].

The Concluding Observations from the UN Committee on the Rights of the Child[25] in 2023 are outlined below:

Concluding observations on the combined fifth and sixth periodic reports of Ireland (7/2/23)

Mental health

31. The Committee welcomes the adoption of a mental health policy in 2020 but is seriously concerned about:

(a) Insufficient and inadequate mental health services for children;
(b) Long waiting lists for children seeking mental health services, with some waiting for more

[22] United Nations Convention on the Rights of the Child, 1990.

[23] United Nations Convention on the Rights of Persons with Disabilities, 2006.

[24] UNCRC, 'General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art 24)' (2013) UN Doc CRC/C/GC/15 para 38.

[25] tbinternet.ohchr.org/_layouts/15/treatybodyexternal/SessionDetails1.aspx?SessionID=2600&Lang=en

than a year for an appointment;
(c) Placement of children with mental health issues in adult psychiatric wards;
(d) The identification of racism and discrimination as having the most detrimental impact on the mental health of children of ethnic minority groups;
(e) Insufficient progress in adopting a Traveller and Roma mental health action plan, despite commitments in this regard.

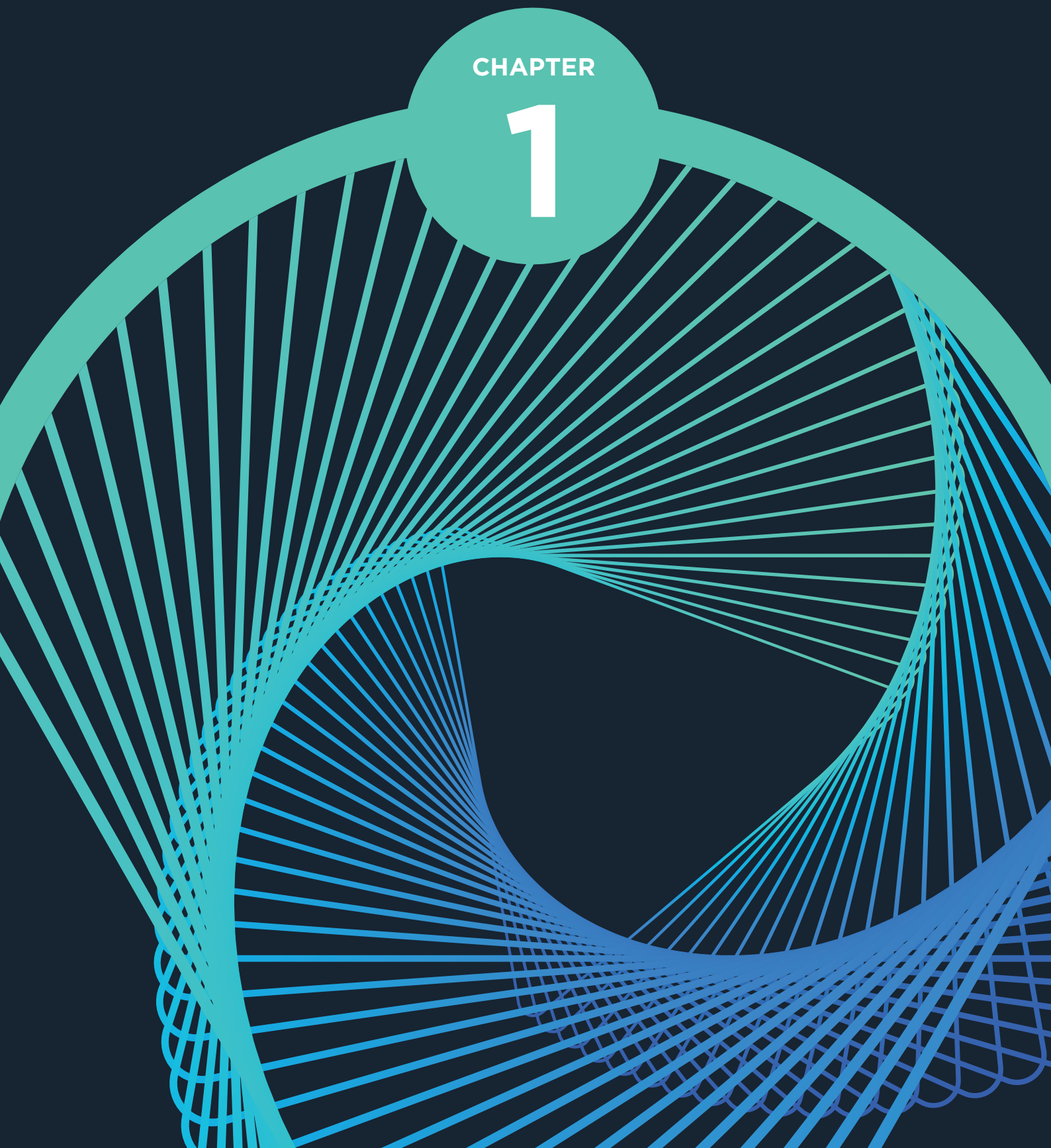
32. The Committee urges the State party to:

(a) Ensure the availability of therapeutic mental health services and programmes for children, including by:
  (i) significantly increasing the resources allocated for the implementation and monitoring of the mental health policy;
  (ii) providing comprehensive mental health promotion, screening for mental health issues and early intervention services in schools at all levels and in communities;
  (iii) ensuring that the number of qualified professionals, including child psychologists and psychiatrists, is sufficient to meet children's mental health needs in a timely manner;
  (iv) ensuring regular follow-up of children in treatment beyond the initial consultation and that the status of children under medication is adequately monitored;
(b) Ensure that the revisions of the Mental Health Act and the Assisted Decision-Making (Capacity) Act include:
  (i) an explicit prohibition of the practice of placing children with mental health issues in adult psychiatric units; and
  (ii) a recognition of children's right to be heard in decisions regarding their mental health-care and assistance from an independent advocate
(c) Progress the Traveller and Roma mental health action plans and develop a designated mental health support service for children of minority ethnic groups, with a focus on providing support to those who have experienced racial discrimination and related trauma;
(d) Invest in preventive measures, address the underlying causes of suicide and poor mental health among children, and ensure that children's perspectives are included in the development of response services;
(e) Allocate sufficient resources for the expansion of the mental health advocacy and information service for children.

Corporate Governance

CHAPTER

1



Good governance requires a balance between technical and social dimensions and permeates throughout systemic, organisational and individual levels and is a key component of effective national health systems[26]. Good governance is defined as "developing and setting effective rules in the institutional arenas for policies, programmes and activities relevant to fulfil public health functions to achieve the objectives of the health sector"[27]. The World Health Organisation (WHO) defined governance alongside leadership as "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, attention to system design and accountability".

Corporate Governance can be defined as "the system by which organisations are directed and controlled".[28] It is concerned with the structures and processes in place throughout an organisation for decision-making, accountability, financial performance, controls and behaviours.

Current Governance Structures in the HSE

The HSE provides all the public health services in Ireland and has been given the responsibility by the Government to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public[29]. The HSE, as per legislation, is governed by a Board, which is collectively responsible for leading and directing the HSE activities[30]. Certain functions of the Board are delegated to the Chief Executive Officer of the HSE and have been further subdelegated. The HSE is obliged to comply with the Code of Governance for State Bodies[31]. In addition, the HSE has its own Code of Governance (2021) which provides an overview of the principles, policies, procedures and guidelines by which the HSE directs and controls its functions and manages its business. The Code is intended to guide the directorate, and leadership teams and all those working within the HSE, and the agencies funded by the HSE, in performing their duties to the highest standards[32].

[26] Gilson L, Lehmann U, Schneider H. Practicing governance towards equity in health systems: LMIC perspectives and experience. *Int J Equity Health.* 2017;16(1): 171. doi:10.1186/s12939-017-0665-0 2.

[27] Brinkerhoff DW, Bossert TJ. Health governance: principal-agent linkages and health system strengthening. *Health Policy Plan.* 2014; 29(6): 685–693. doi:10.1093/heapol/czs132 4.

[28] Report of the Committee on the Financial Aspects of Corporate Governance 1992 ('The Cadbury Report').

[29] The Health Act 2004 (as amended) is the legislation which established the HSE, and sets outs the HSE's functions, powers and governance arrangements.

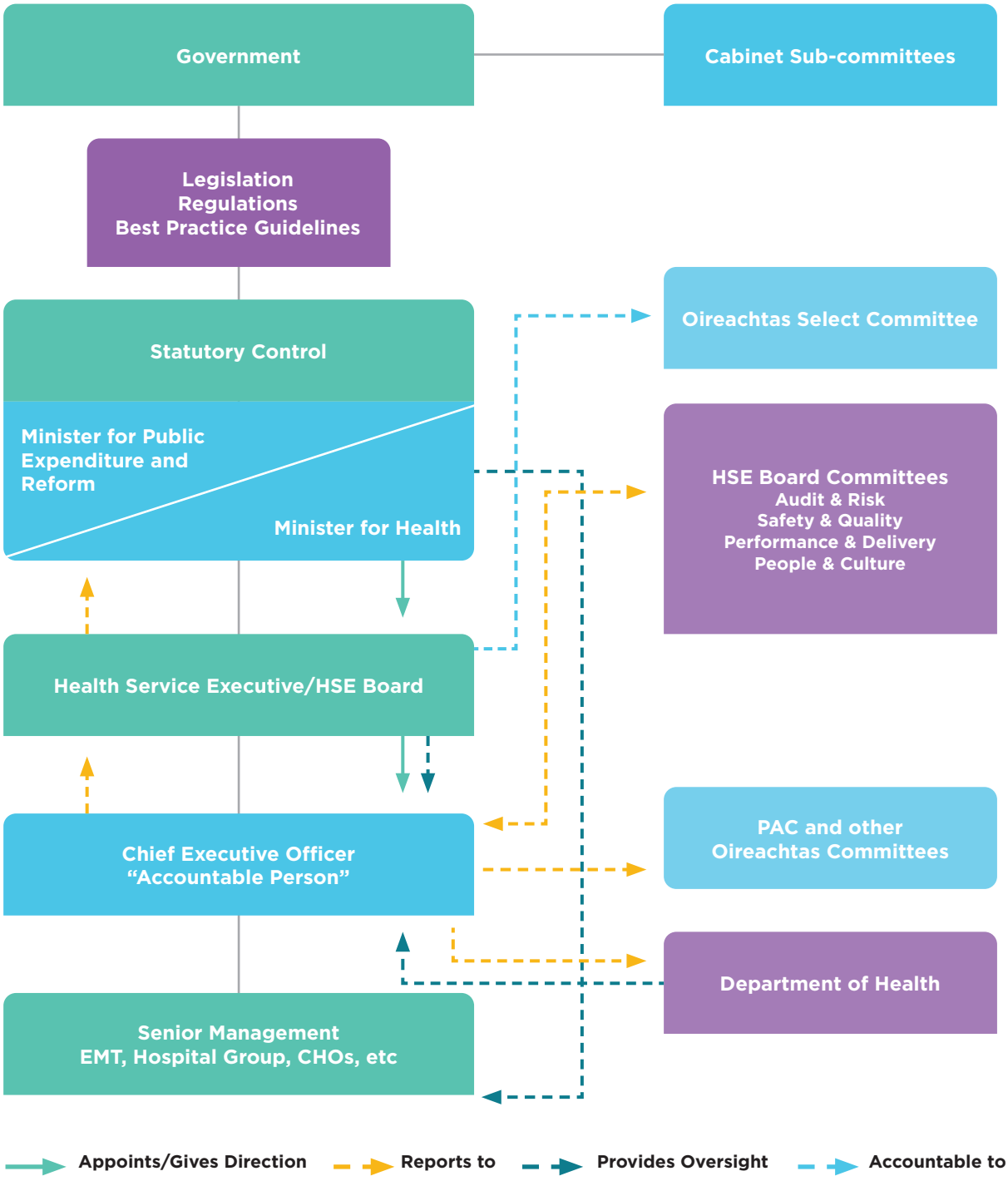
[30] Health Act 2004 as amended.

[31] https://www.gov.ie/en/publication/0918ef-code-of-practice-for-the-governance-of-state-bodies/

[32] HSE Code of Governance 2021

The Governance Framework in Figure 4 below shows the main features of the governance relationship between government, departments of the State and the HSE.

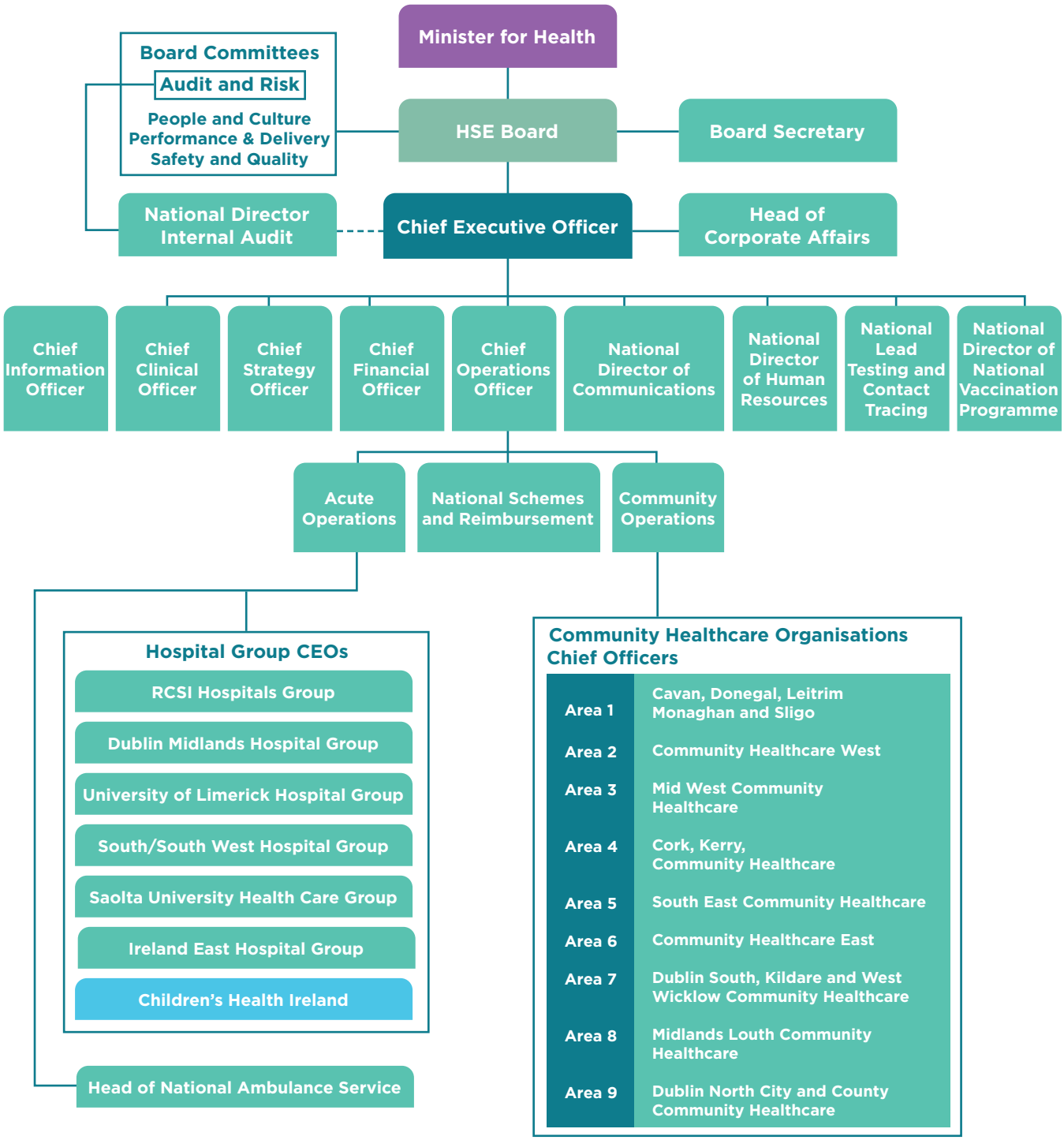
Figure 4 *HSE Governance Framework*



Adapted from "Governance Framework" as Represented in the Code of Practice for the Governance of State Bodies (2016). Also included under Board Committees, but not shown in this diagram, is the Technology and Transformation Committee.

The HSE Executive Management Team have functions delegated to them by the Board of the HSE who are ultimately responsible for all operations of the HSE.

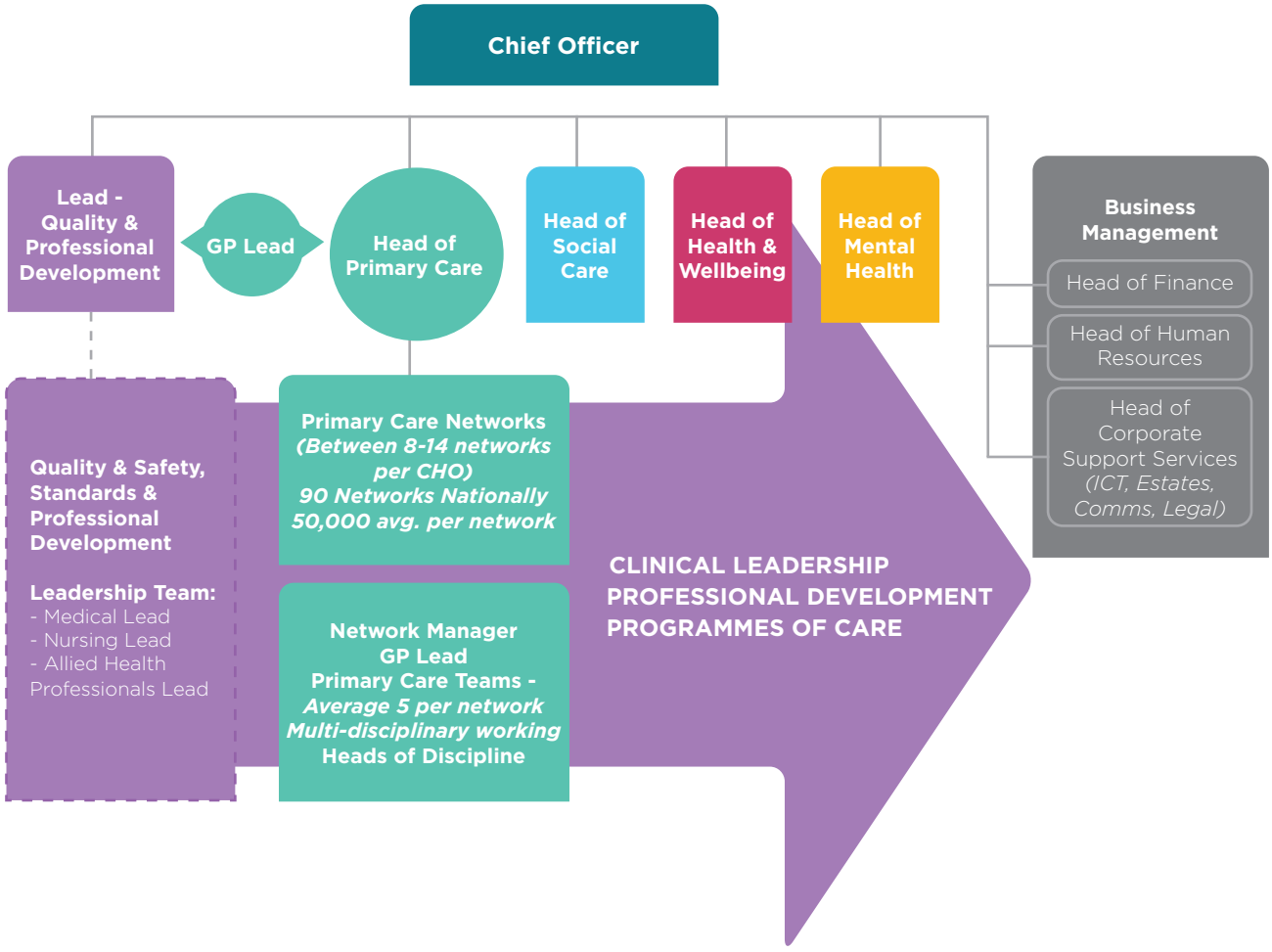
Figure 5 *HSE Organisational Structure as per HSE Website*



The Chief Executive Officer reports to the Board of the HSE and to the Minister of Health. The management of the health services are administrated through a "function structure" with nine Community Healthcare Organisations providing all non-acute services, and the six national hospital group services. The Community Healthcare Organisations are responsible for the delivery of primary and community-based services within national frameworks responsive to the needs of local communities. Community healthcare services are the broad range of services that are provided outside of the acute hospital system and includes Primary Care, Social Care, Mental Health and Health & Wellbeing Services. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people's homes[33]. The management arrangements for the CHOs are illustrated below in Figure 6.

Mental Health Services are organised by CHO, and include inpatient centres (approved centres), residential homes, and community-based teams. There are specialised services for Child and Adolescent Mental Health, General Adult Mental Health, and Psychiatry of Old Age.

Figure 6 *Management of Community Healthcare Organisations*



From: Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group (2014)

[33] *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group'*, (2014) Community Healthcare Organisations Report - HSE.ie

CAMHS Governance Structures

As stated earlier in the report the CAMHS provide mental health services to children and young people up to the age of 18 years, who have moderate-to-severe mental health disorders that require help from a multidisciplinary team[34]. The majority of CAMHS is provided publicly by the HSE in the CHOs, with the exception of CHO 6 and part of CHO 7 where it is provided by St John of God Community Services through Lucena CAMHS. These services are provided through a Service-Level Agreement with the HSE on an annual basis. There is a bimonthly integrated management reporting (IMR) meeting held between S38 and CHO 6.

Nationally, the Mental Health Operations Team is led by an Assistant National Director (titled Head of Operations, Quality and Service Improvement). The Assistant National Director oversees operational management of mental health services including continuous improvement programmes and management of Service Plan deliverables. The National Operations Team falls within the Community Operations Mental Health which has responsibility for all mental health services nationally, including CAMHS.

The remit of the Community Operations Mental Health extends from promoting positive mental health through to supporting those experiencing severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons and those with an intellectual disability and a mental illness.

The National Director for Community Operations oversees all community services including primary care and disability services at a national level. The Assistant National Directors for Mental Health, Disability and Primary Care all report into the National Director for Community Operations. This structure.

This structure in which CAMHS is provided is a major problem in delivering child-centred integrated care and has led to children falling between gaps in services, long waiting lists and deterioration of children's mental states. These silos of service provision are one of the fundamental root causes for the lack of adequate and timely mental health services for children across all services (CAMHS, CDNTs and Primary Care). This problem is evident in all CHOs and efforts to improve integration of services by the HSE have been largely unsuccessful. In 2017, the Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services[35] was established to produce an agreed operational protocol for children whose needs may cross these services. The Working Group identified gaps in how children and young people access support across health services when required. They made a number of recommendations, including setting up the Integrated Children's Services Forums. These Forums meet and discuss individual children whose needs are not clear or who require some level of joint assessment or intervention and for whom direct consultation between the relevant services has not led to a decision on the best arrangement for the child.

A Child and Youth Mental Health Lead in the HSE has been appointed and the successful candidate is due to commence their role in September 2023. The post holder will report to the HSE National Director for Community Operations and will be supported by a dedicated team for which funding has been provided. The urgency of providing integrated care must be one of the key tasks for the role.

A National Clinical lead for CAMHS has been appointed and took up their post in June 2023. They will report to the National Clinical Advisor Group Lead for Mental Health.

Both Leads will be supported by a dedicated team for which funding has been provided. These new roles should provide leadership, operational oversight, and delegated management of all service delivery across child and youth mental health services across the country.

In February 2023, a recruitment process commenced for a post of Child and Youth Mental Health Lead in the HSE. This new role is expected to provide leadership, operational oversight, and delegated management of all service delivery across Child and Youth Mental Health services across the country. The post holder will report to the HSE National Director for Community Operations and will be supported by a dedicated team for which funding has been provided. The urgency of providing integrated care must be one of the key tasks for the role.

[34] HSE (2019). HSE Mental Health Division: Delivering Specialist Mental Health Services

[35] Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services

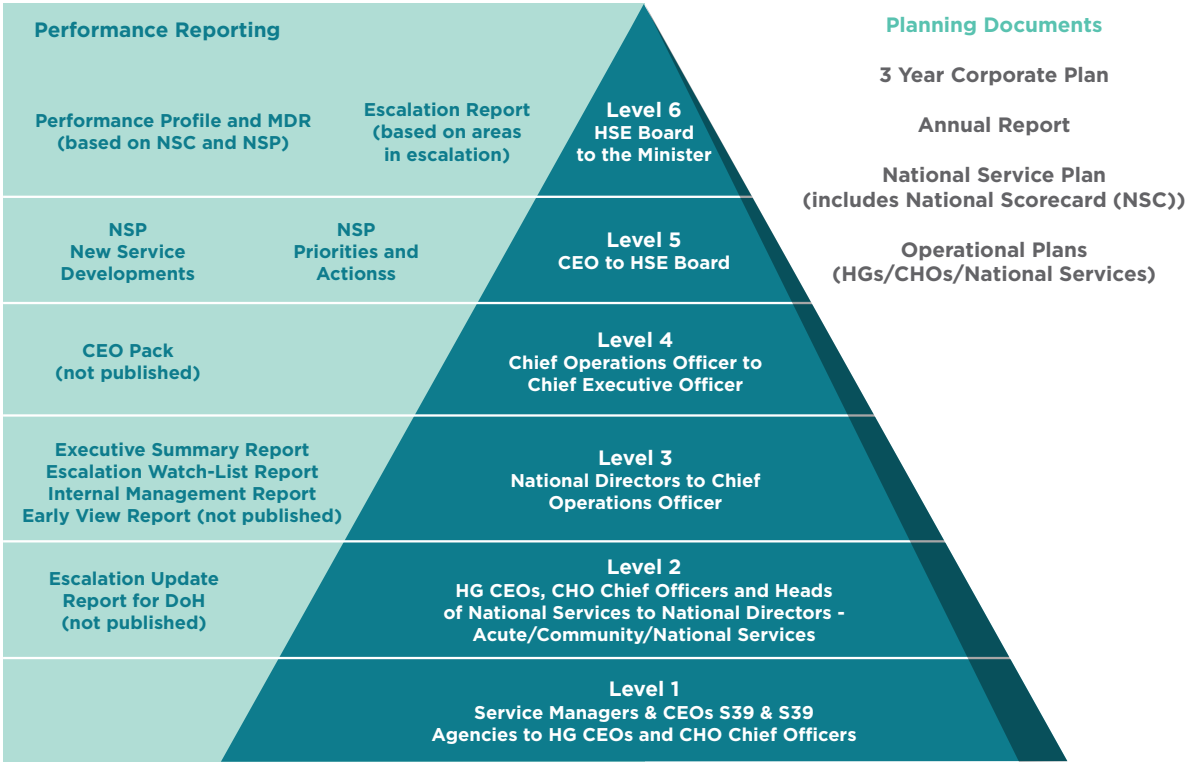
Currently, each of the CHOs has responsibility for the delivery of CAMHS Services in their geographical area. The Chief Officer of the CHO has overall responsibility, the Head of Service for Mental Health within each CHO in conjunction with the Executive Clinical Director within each CHO, is responsible for the delivery of mental health services in the CHOs, including CAMHS. The National Team, as referred to above, provides support and facilitates the CHO teams to make their own decisions within the overall governance process and national guidelines[36].

The HSE's Performance and Accountability Framework (2020)[37] sets out the means by which accountable officers (this is not to be confused with the accountable person which is the CEO as per the Health Act 2004 as amended) within the HSE are held to account for their performance, ensuring that the system has clear authority, responsibilities and accountability structures.

The accountability structure for the HSE is set out below.

1. Service Managers and the CEOs of section 38 and 39 agencies to the Hospital Group CEOs and CHO Chief Officers
2. Hospital Group CEOs, CHO Chief Officers, the Head of the National Ambulance Service, the Head of Primary Care Reimbursement Service and the Heads of other national services to the National Directors Acute Operations, Community Operations and National Services
3. National Directors Acute Operations, Community Operations, Operational Performance/Integration, National Schemes/Reimbursement and National Operations Planning to the Chief Operations Officer
4. The Chief Operations Officer to the Chief Executive Officer
5. The Chief Executive Officer to the Board
6. The Board to the Minister

Figure 7 *Performance and Accountability Framework*



[36] HSE (2019) Child and Adolescent Mental Health Services Operational Guidelines, 2nd edition.

[37] HSE (2020) Performance and Accountability Framework Microsoft Word - PAF 2020 DRAFT FINAL (hse.ie)

Accountable officers

For the purpose of the HSE's Delegation and Performance and Accountability Frameworks, Hospital Group CEOs, CHO Chief Officers, the Head of the NAS, the Head of PCRS and the Heads of other national services are considered the accountable officers for their areas of responsibility. They are therefore fully responsible and accountable for the services they lead and deliver. Accountable officers are required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets[38].

The Review Team was advised by the HSE that a National Oversight Group – Child and Youth Mental Health Service Improvement Programme was established following the publication of the Maskey report[39]. The group is chaired by the National Clinical Lead and the Head of Operations, who report to the HSE Board as per Figure 7. The HSE advised that the Terms of Reference for this group are currently being updated and expected to be finalised shortly. At the time of writing this had not yet been completed.

A national self-audit of prescribing practice commenced in all CAMHS Teams in July 2022. The Expert Team undertaking this audit had not yet reported on the findings in the first half of this year.

Also since 2022, all CAMHS Teams have been undertaking an audit of compliance with the HSE CAMHS Operating Guidelines, 2019. There has been no report on the findings of this audit as yet. An update (July 2023) from the HSE states: The Expert Audit Group have completed the report on the Prescribing Practice Audit which is due for publication in the coming weeks. All CAMHS teams have undertaken an audit of compliance with the HSE CAMHS Operating Guidelines, 2019. The report is being finalised and is due for publication in the coming weeks.

The Mental Health Commission's Interim Report on CAMHS and the management response to the report was discussed initially at the HSE Health and Safety Committee in January 2023 and then brought to the HSE Board Meeting. While it is noted that the Board considered the serious concerns raised, is keeping the matter on its agenda and requires updates on the implementation of recommendations from the report at regular intervals[40], minutes from the HSE Board Meetings in February, March and April 2023 (the latest minutes published at the time of writing) show that CAMHS was not on the agenda nor was it discussed at those meetings. Furthermore, minutes from the HSE Quality and Safety Meetings in February merely state that:

> *The Committee welcomed that 92.7% of urgent CAMHS cases were responded to within three working days, which is above the 90% target, however, they sought further discussion and analysis of CH0 5, where it was confirmed that recruitment of a consultant remains extremely challenging.*

Of concern is that there has been no more fundamental review and plan of action discussed at the February or March meeting of the Health and Safety Committee according to minutes of the meetings. The HSE formed a National Oversight Group to oversee, monitor and report on the the implementation of the Maskey Report and is jointly chaired by the Chief Operating Officers and the Chief Clinical Officer. More recently the National Oversight Group has been reconstituted to cover a broader Child and Youth Mental Health Improvement Programme. The Mental Health Commission Interim Report and the Maskey Report is a standing item on the agenda and progress on the CAMHS teams review of open cases is discussed at each monthly meeting.

Risk Management

The HSE Patient Safety Strategy 2019–2024, launched by the HSE Board in December 2019, sets out strategy commitments and actions to improve the safety of all patients by identifying and reducing preventable harm within the health and social care system in Ireland. It recognises that key to patient safety and person-centred care is a culture where patients, carers, families, advocates and healthcare professionals work together in partnership to ensure positive patient experiences, maximise positive health outcomes and minimise the risk of error and harm. The goal is to achieve a culture that welcomes authentic patient-partnership in their care and in

[38] Performance and Accountability Framework 2023 (hse.ie)

[39] gov.ie - Minister Butler confirms comprehensive Audit of CAMHS teams nationally including prescribing practices and operational guidelines across all diagnosis and all CAMHS teams (www.gov.ie)

[40] HSE Minutes of HSE Board Meeting Friday 27 January 2023 minutes-hse-board-meeting-27th-january-2023.pdf

the process of co-producing, delivering and improving care.

The Patient Safety Strategy set out the following commitments when it was published in 2019:

Patient Safety Commitments:	
1.	Empowering and Engaging Patients to Improve Patient Safety. We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care.
2.	Empowering and Engaging Staff to Improve Patient Safety. We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practise safely, including identifying and reporting safety deficits and managing and improving patient safety.
3.	Anticipating and Responding to Risks to Patient Safety We will place an increased emphasis on proactively identifying risks to patient safety to create and maintain safe and resilient systems of care, designed to reduce adverse events and improve outcomes.
4.	Reducing Common Causes of Harm. We will undertake to reduce patient harm, with particular focus on the most common causes of harm.
5.	Using Information to Improve Patient Safety. We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.
6.	Leadership and Governance to Improve Patient Safety. We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance.

The national awareness campaign and implementation plan for the strategy were not initiated due to the corresponding timing with COVID in February/March 2020. The HSE states that: Many frontline staff would not have had the opportunity to consciously integrate the Patient Safety Strategy and framework into their work.

We listened to parents say they were concerned about risk of their children not receiving mental healthcare, either in CAMHS or in other Primary Care services and CDNTs. They were also concerned about whether their child was safely taking medications prescribed in CAMHS. We found that in a number of areas waiting lists were long, that some children were receiving no mental health interventions at any level and that medication was not always monitored in accordance with guidelines. While most teams worked with parents as well as the child, we found incidences where some health professionals did not always listen to concerns of parents. There were archaic intelligence gathering systems, with little evidence of proactively identifying risks in some CHOs and we did not find a universal culture of patient safety improvement.

Following publication of the Maskey report, and as we progressed with our country-wide review, we found that services at all levels were moving to audit clinical files and medication, addressing concerns that may have been present, increasing reporting of risks and putting enhanced governance structures and leadership roles in place.

This is, of course, welcome and will no doubt lead to improvements. However, good governance and maintaining the safety of children and young people is not founded in responding to crises as they occur. It is evident that good governance and oversight was not in place prior to the publication of the Maskey report and on completing this review, we are still not convinced that it is in place. As late as February 2023, we found evidence of poor information gathering, poor risk management, concerns about children and young people's safety and wellbeing. A fundamental shift is required with a proactive approach and a new strategy. Simply reacting to matters as they arise cannot continue.

Managing risk is part of governance and leadership and is fundamental to how the organisation is managed at all levels and it contributes to the improvement of management systems. Risk assessment is a process consisting of the following three steps: Risk Identification; Risk Analysis (including Risk Rating) and Risk Evaluation.

Risk management in healthcare consists of administrative and clinical systems, processes and reports used to detect, monitor, assess, mitigate and prevent risks. By using risk management, the HSE can proactively and systematically safeguard children's safety while they are receiving CAMHS.

The risk-management process identified to the Review Team consisted of operational risks in the first instance raised with the mental health area management team with further escalation through the Head of Service to the Chief Officer. HSE informed us that CHO risks that are beyond the capacity or scope of CHO management and are escalated to the National Director for Community Operations for consideration on their risk register and for review and discussion at the performance meetings between CHO Chief Officers and National Director of Community Operations. There is no process in place for CHOs to escalate risks directly to Mental Health Operations. However, the Head of Operations for Mental Health is part of the Community Operations management team where risks/risk registers and the mitigation of risk would be included as part of management team meeting agendas.

The identification and management of risk was strongly criticised by Dr Maskey[41] in his report:

> *"Risk management for Team A, from the front line to the area management level, was generally considered in terms of making the problem go away, fixing something broken or recruiting to a vacant post, rather than considering the breadth of potential consequences of the identified risk, and taking steps to avert them occurring and monitoring to ensure the system is working safely."*

Our review also found that there appeared to be a disconnect between CHO management level regarding risk escalation and the Mental Health Operations Team in the HSE. For example, we noted one serious risk that had been communicated to the Mental Health Operations Team in January 2022 which was not on the National Risk Register, and we could find no evidence that this risk had been actioned or monitored. There appeared to be no action following the escalation apart from a visit to the CHO by the Mental Health Operations Team. In fact, despite ongoing concerns about CAMHS following the Maskey report, we were informed by the Mental Health Operations Team that the National Risk Register contained no risks about CAMHS. We repeatedly sought clarification about this from the Mental Health Operations Office.

After some delay, the Review Team was notified in April 2023 that there was one specific risk on the HSE Community Operations risk register which relates to a risk of reputational damage arising from the Maskey report. The existing control in place in relation to this risk is the establishment of the Maskey Oversight group chaired by the Chief Operations Officer and Chief Clinical Officer.

We were also advised that there are additional risks on the Community Operations risk register that relate to all community services, including CAMHS. These risks have been amalgamated as they have relevance to a number of community services and include risk to service delivery due to a lack of fit-for-purpose IT systems in community healthcare, risk of loss of service capacity and prosecution due to regulatory non-compliance, and risk that the National Service Plan may not be delivered in full due to challenges recruiting and retaining the required workforce. The Mental Health Operations Team advised that the risk register for Community Operations is reviewed quarterly.

The HSE has recently published a revised risk-management framework: HSE (2023) Enterprise Risk-Management Policy and Procedures, making it a priority to develop and strengthen the HSE's risk-management framework[42].
The new framework sets out the policy and procedures by which the HSE manages risk will:

- Set out the systems and processes that are required to ensure that risks are managed consistently across the HSE.
- Assist staff in understanding their role and the need to adopt a consistent approach to the assessment and management of risk.
- Outline the commitment of the HSE to the proactive management of risk in line with ISO 31000:2018.[43]

[41] Maskey S. *Report on the Look-Back Review into Child & Adolescent Mental Health Services County MHS Area A*.14 January 2022.

[42] HSE (2023) Enterprise Risk Management Policy and Procedures HSE Enterprise risk management policy and procedures 2023

[43] ISO 31000:2018 Risk Management – Guidelines ISO 31000:2018 - Risk management — Guidelines

This replaces the HSE Integrated Risk-Management Policy 2017[44], which was in place at the time of our review. The HSE (2023) Enterprise Risk-Management Policy and Procedures applies to all HSE services and notes that the policy covers all organisational risks.

Leadership and Accountability

The previous National Policy for Mental Health *A Vision for Change* (2006)[45], in its recommendations for the management and organisation of the mental health services, included the following:

- The appointment of the National Mental Health Service Directorate.
- The reorganisation of Mental Health Catchment Areas into the larger catchments proposed in this policy.
- The appointment of local Catchment Area Management Teams in these catchment areas.

The policy's vision was the National Directorate and the local Catchment Area Management Teams would lead the implementation of this policy. Despite this recommendation a National Director for Mental Health was not appointed until 2013 and remained in place until 2016, when an internal restructuring process removed the position. There have been consistent calls for the role to be reinstated from mental health organisations and the Mental Health Commission. The HSE mental health services, including Child and Adolescent Mental Health Services, have since fallen under a "National Director of Community Health Service Operations" which also includes Primary Care, social care, as well as health and wellbeing. This is not working.

The lack of leadership within CAMHS has contributed to the "gap" between what happens at CHO level and how that contributes to service planning, resourcing, monitoring and evaluation. Without leadership, CAMHS has not significantly improved and appears to have stagnated, operating in silos with wide variations in the service provided. This is not necessarily a criticism of the teams who are providing the services but of an overall short-sightedness of what happens when you remove leadership roles, such as the National Mental Health Service Director, and expect services to just 'get on with it'.

As outlined above, the post of Child and Youth Mental Health Lead in the HSE has been filled. The post of National Clinical lead for CAMHS has been appointed and took up their post in June 2023. These new roles are expected to provide leadership, operational oversight, and delegated management of all service delivery across child and youth mental health services across the country. They will also be responsible for managing and coordinating service planning activities, partnership and capacity building, the development of service plans, and setting of service standards across Child and Youth Mental Health services in Ireland. They will be supported by a dedicated team for which funding has been provided.

Although the Community Operations Mental Health team has an established relationship with the National Clinical Advisor Group Lead Mental Health and has worked closely with their office on the development of youth mental health related clinical and operational strategies, it is anticipated that these roles, and the wider Child and Youth Mental Health office, will result in improved links with the National Clinical Advisor Group Lead Mental Health, which in turn will support the development of current and future youth mental health-related National Clinical Programmes. It is important that these roles are not simply "another layer of management", but that they are true leadership roles which lead to real changes in how CAMHS and other mental health services for children are delivered with an emphasis on child-centred care and upholding the rights of children.

Notwithstanding the above, I remain of the view that the reinstatement of the National Director for Mental Health services is essential if there is ever going to be true parity between general and mental health services.

CAMHS Teams Structures

The current CAMHS Team structure depends heavily on a model of care which places the onus on a single profession, with all clinical responsibility resting with the consultant psychiatrist. This is outdated in international practice, which favours a multidisciplinary approach, with a strong focus on collaboration, achieving a balance between autonomy and accountability, and improving patient

[44] 2017 Integrated Risk Management Policy - HSE.ie

[45] Department of Health & Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy. Dublin:* The Stationery Office, 2006.

outcomes[46]. Added to this is that the model in operation in Ireland currently is not sustainable with the current medical workforce. There are ongoing difficulties filling consultant posts, with an over-reliance of locums when they can be recruited, complicated cross cover where available and telepsychiatry. There is no sign that the current recruitment difficulties will improve in the medium term. Each team requires a dedicated permanent Clinical Lead or it will not function effectively. Any CAMHS clinician filling this position must have the organisational and interpersonal skills required to lead and coordinate the activities of the team, otherwise they will not succeed.

Budget

The HSE gathers monthly data on each of the community mental health teams which deliver services across the country. This enables monthly reporting on staffing, cost and Key Performance Indicators for each team, which can be reported across a multitude of requirements. Similarly, monthly data around mental health acute unit bed usage is captured to enable national reporting in this regard. The total allocation for mental health services in Budget 2023 is €1.2 billion[47].

The introduction of a Single Integrated Financial and Procurement Management System has commenced. Only when this system is fully implemented will mental health be in a position to report on expenditure and budget in CAMHS. Currently, the HSE are not in a position to do so. However, on the basis of a manual data-collection exercise in January 2023, it is estimated that the current CAMHS budget is €137m, or approximately 12% of the overall mental health budget. Due to the significant human resource required to conduct such an exercise, the HSE was not in a position to provide a breakdown of budget specifically for CAMHS for each of the past 5 years.

Under Sláintecare recommendations, the Government has set a target for total mental health funding to be at 10% of overall health expenditure by 2025. At present it is just over 6%. Funding for CAMHS accounts for approximately 12% of the overall mental health budget on an ongoing basis[48]. The population of under 18s in Ireland is approximately 26% or a quarter of the population (1,190,502 Census 2016).

Between 2017 and 2022, a total of €22.56m in development funding was allocated specifically to service developments in CAMHS and directed to enhance youth mental health services across a number of prioritised areas of service enhancement, including building capacity in CAMHS and youth mental health, developing specialist services and clinical programmes, suicide prevention, investing in mental health in Primary Care, modernising forensic services and digital services.

The HSE states that a number of factors are taken into consideration when allocating development funding, including the size and socio-demographic profile of populations served, assessed need and relative per capita funding across mental health services. However, the budget for CAMHS was contained within the overall mental health budget nationally. The HSE advised that currently they cannot provide a specific mental health budget and expenditure by service category; however, they will be able to do so in the future once the Single Integrated Financial and Procurement Management System is fully introduced. A manual exercise was undertaken to provide the following budget information for the review team.

[46] van Diggele et al. BMC Medical Education 2020, 20 (Suppl 2): 456 https://doi.org/10.1186/s12909-020-02288-

[47] Dáil Eireann Debate 20 October 2022. Vol 1028, No. 2.

[48] Information provided to Inspector by Assistant Director of Mental Health.

Table 1 *Mental Health CAMHS Budget 2022*

Mental Health CAMHS Budget – 2022					
CHO	**National CAMHS Units €**	**All other CAMHS (primarily Community Teams) €**	**Total budget 2022 €**	**CAMHS development funding held centrally (unfilled posts) €**	**Community CAMHS budget €**
CHO1	0	8,979,023	8,979,023	71,503	9,050,527
CHO 2	6,747,148	10,325,012	17,072,160	282,600	17,354,760
CHO 3	0	7,245,630	7,245,630	561,890	7,807,520
CHO 4	5,000,785	13,893,768	18,894,554	703,278	19,597,831
CHO 5	0	8,426,075	8,426,075	469,065	8,895,140
CHO 6	0	12,747,200	12,747,200	550,765	13,297,966
CHO 7	8,703,691	13,595,631	22,299,321	541,407	22,840,728
CHO 8	0	12,888,885	12,888,885	975,995	13,864,880
CHO 9	3,427,917	9,260,803	12,688,720	65,997	12,754,717
National		11,510,000	11,510,000		11,510,000
Total	23,879,541	108,872,029	132,751,569	4,222,500	136,974,069
	18%	82%			

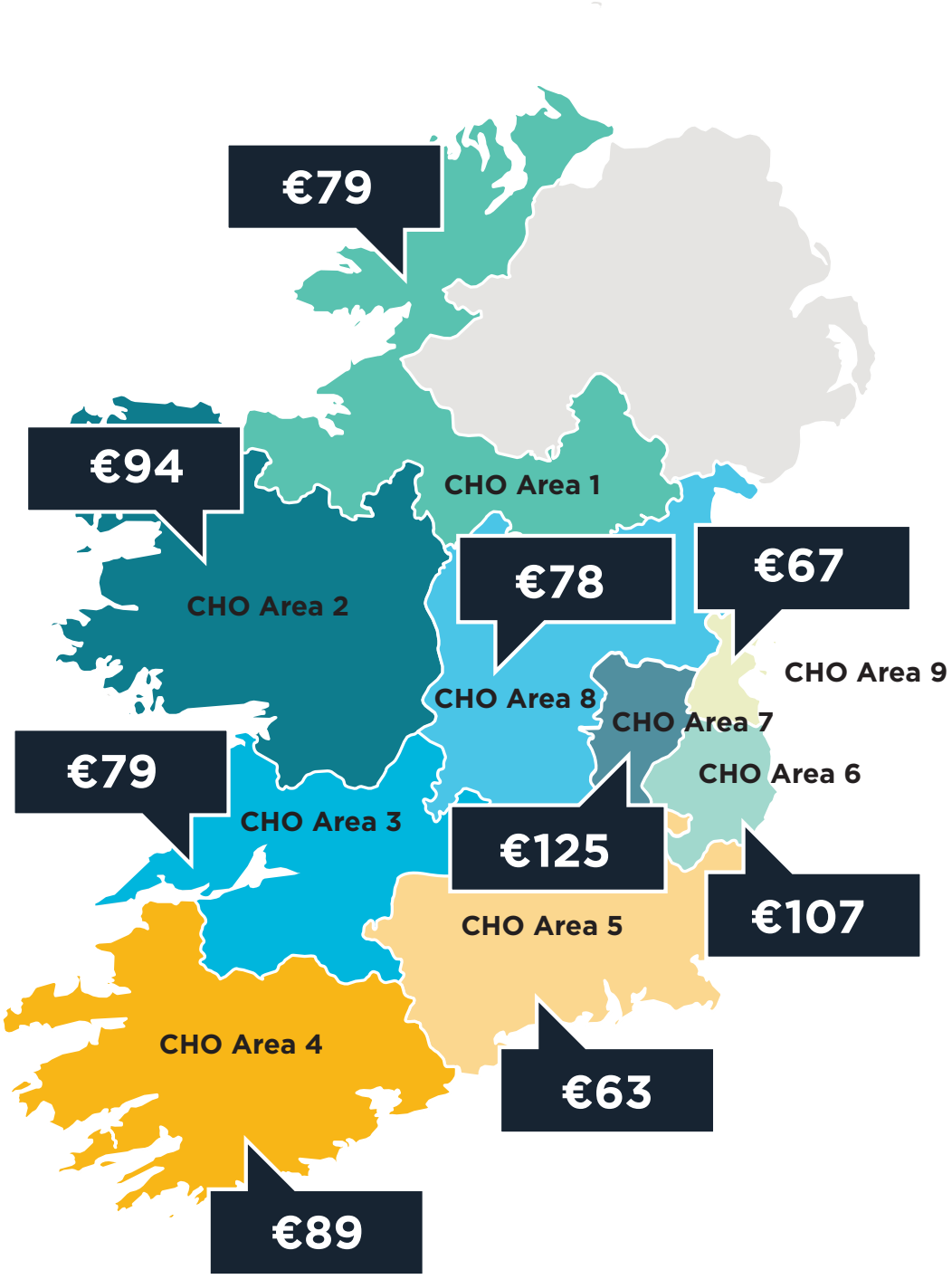
The CHO 6 CAMHS budget of €12.7m includes an element which relates to the provision of services into CHO 7. St John of God Lucena provide CAMHS services on behalf of CHO 6, however Lucena Tallaght teams 1 and 2 along with elements of Lucena teams A and C span into CHO 7. Effectively €4.8m (or 37.7%) of the CHO 6 CAMHS budget relates to the provision of services into CHO 7. In Table 2 below this is reflected through a population adjustment between CHO's 6 and 7 hence the per capita funding reflects this.

Table 2 *CAMHS per capita budget*

CAMHS per capita budget						
CHO	**Population 0–17**	**SJOG Lucena population adjustment**	**Adjusted population**	**Deprivation indices**	**CAMHS Community Team budget €**	**Per capita budget per CHO Community Teams (adj. for deprivation) €**
CHO1	103,778		103,778	4.09	9,050,527	78.8
CHO 2	111,880		111,880	4.48	10,607,612	93.9
CHO 3	96,266		96,266	4.40	7,807,520	78.8
CHO 4	168,542		168,542	4.64	14,597,046	88.6
CHO 5	131,522		131,522	4.19	8,895,140	62.6
CHO 6	116,264	29,030	145,294	5.30	13,297,966	107.1
CHO 7	144,296	(29,030)	115,266	4.64	14,137,038	125.5
CHO 8	172,373		172,373	4.31	13,864,880	78.4
CHO 9	145,581		145,581	4.76	9,326,800	67.3
	1,190,502	0	1,190,502	4.53	101,584,528	85.3

Provided by the HSE Mental Health Operations Team April 2023

Figure 8 *Comparison of community CAMHS per capita budget for under 18s*



It was clear during our review that the current budget allocations cannot provide for the needs of children and adolescents who require CAMHS, particularly in resourcing of teams, reducing waiting lists, and providing appropriate facilities.

Information Technology

> *The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting their care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting."*
>
> **The Health Information Management Systems Society (HIMSS)**

Good information technology is critical to good clinical care. Effective, reliable and sustainable ways to record and communicate information between patients, professionals and organisations will be a foundation for further innovation and continuous improvement. More comprehensive electronic health records (EHRs) and personal health records (PHRs) and greater linkage of data promise to enable the redesign of care pathways.

Strategic Action 10[49] **in Sláintecare states** a modern eHealth infrastructure and improved data, research and evaluation capabilities need to be put in place by:

- Implementing the national acute electronic health record (EHR), starting with the new National Children's Hospital.
- Designing and rolling out community-based electronic health records, connecting data across the system and, over time, making data available to patients.
- Designing and rolling out a range of primary and community-based ICT services that will improve the lives of patients, including ePrescribing, summary care records (Shared Record) and implementation of telehealth solutions to support care in the community.

In *Sharing the Vision (2019)*[50], there is a framework for ICT-enabled supports for the mental health services which included three projects:

- National Mental Health ICT Infrastructure Improvement Project.
- National Mental Health e-Rostering Project.
- National Electronic Mental Health Record Project.

Sharing the Vision states that a National Mental Health Information System should be implemented within three years to report on the performance of health and social care services in line with this policy. Now, in 2023, this has not happened.

Findings

The lack of IT systems in HSE CAMHS is a major concern as it leads to inefficiency, the risk of not identifying cases that may become lost to follow-up, and the inability to comprehensively audit practice. Digital infrastructure was absent in many cases apart from the use of spreadsheets. Computers and other digital infrastructure were out of date and need updating. One team was using Windows 7. There was widespread use of Excel® but many teams had no database of open cases. Our request to get a list of open cases since 2021 required manual searching by a number of teams and in one case took three days. One team had no idea which cases were open or closed in their filing room. This lack of digital infrastructure prohibited all but the most rudimentary forms of clinical audit.

We found that paper-based clinical files were usually handwritten, often illegible, frequently bulky, had loose pages, were not in chronological order, and were incomplete.

Most teams do not have a patient management

[49] Sláintecare Implementation Strategy and Next Steps. gov.ie - Sláintecare Implementation Strategy (www.gov.ie)

[50] *Sharing the Vision: A Mental Health Policy for Everyone*. Department of Health. health.gov.ie Sharing the Vision - A Mental Health Policy for Everyone - HSE.ie

system which helps clinics streamline complex administrative tasks such as managing appointments, schedules, rotas, maintaining clinical files and providing reports on activity. There were no SMS reminders and consequently the number of DNAs (patients who failed to attend their appointments without cancelling) was high in many teams.

We did find evidence of MAISY software system used in some teams in CHO 8, a package which generates a database of open cases, with the ability to manage appointments and generate reports but is limited in other areas of information. In CHO 9 and CHO 7, the FIOS information system was in use, a client information system that supports the complete workflow of a service. The system allows for the collection of demographic, episodic, referral, appointment and clinical information pertaining to any episode of care for a CAMHS client. An audit trail is available that allows for complete tracking of who updated or viewed a client's electronic record. Physical or virtual appointments are supported including room/ resource bookings, letters and client text messaging. The FIOS system required updating.

In CHO 6 CAMHS (provided by Lucena, St John of God Community Services), there was a Mental Health Information System (MHIS) which included an electronic patient record. This system worked well and improved efficiency, auditing, case management and research. CHO 6 and part of CHO 7 were the only areas that had electronic patient records; this system was provided through an independent agency, St John of God Community Services, which provided the CAMH service through the Lucena Clinic. The electronic records were easy to access and update by staff and contained all sections of a CAMHS patient clinical file. It allowed detailed audits to be carried out which improved the quality of healthcare provided. However, this system was in need of updating.

There was very minimal use of Healthlink, which transfers a range of messages in real-time including laboratory and radiology reports, discharge information and waiting list updates. The system interfaces with hospitals, clinical centres, healthcare agencies and GP practice management systems and transfers data via a secure network to its messaging servers and is funded by the HSE. GPs and hospital laboratories use Healthlink and it seems incomprehensible that the CAMH Services would not have automatic access to this system.

Nationally, only two CAMHS teams out of 73 community teams were set up to receive referrals via Healthlink. Both sites receive their referrals electronically on the attached national general referral form. Seven CAMHS Teams are set up to receive their lab reports electronically via Healthlink. Setting up Healthlink is straightforward and could be rolled out to all CAMHS Teams, which would greatly improve efficiency within the teams.

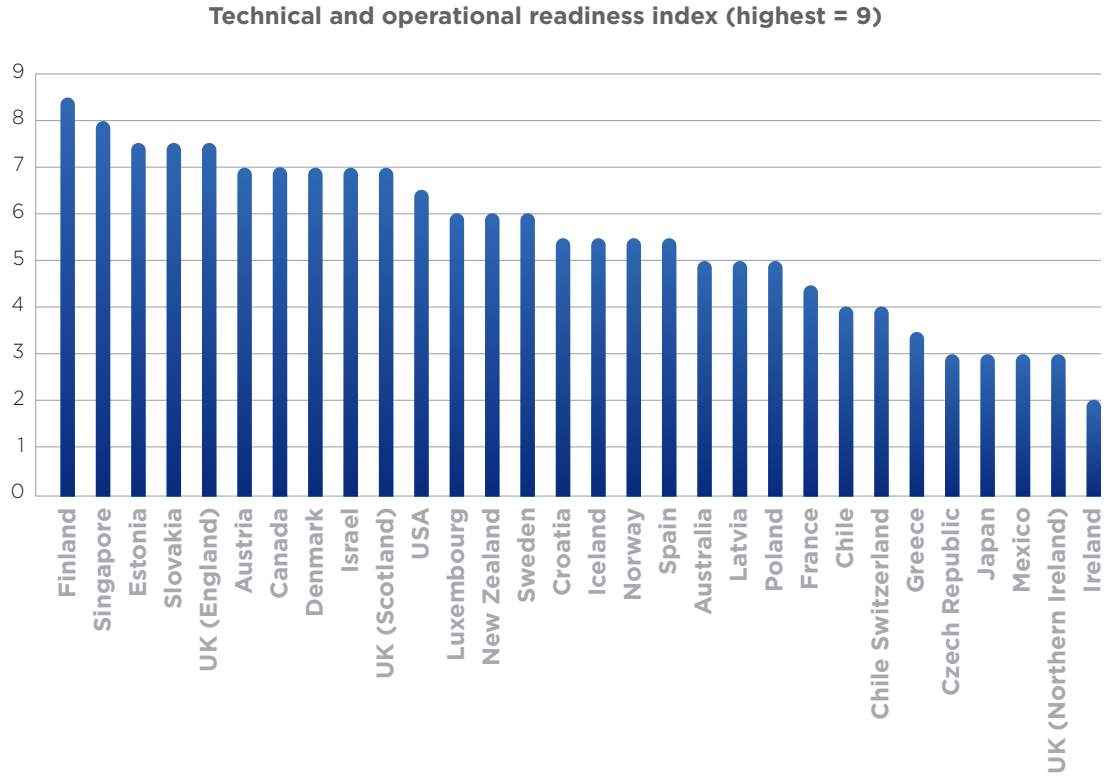
International Comparisons

Internationally, in comparable countries, these patient information systems and electronic records have been up and running for many years. As of 2018, all NHS mental healthcare providers national data sets contain data on every patient treated in mental healthcare services or in the Improving Access to Psychological Therapies (IAPT) programme. Improved interfaces and visualisations can make this data more useful and accessible to policy makers, commissioners, providers, clinicians and patients and improve the quality of data submitted. Upgrading the infrastructure supporting these data sets (through NHS Digital's Data Services Platform) provides more timely and easily linked data that can support decision support, prediction, benchmarking, health surveillance and research[51].

The Health Care Quality Indicator survey in the UK looked at the readiness for electronic records in 30 countries worldwide in 2016. Ireland was found to be the country least ready for electronic record introduction. The position does not appear to have changed since that time.

[51] *The Digital Future of Mental Healthcare and Its Workforce. A report on a mental health stakeholder engagement to inform the Topol Review,* Dr Tom Foley and Dr James Woollard. (The Topol Review explores how to prepare the healthcare workforce, through education and training, to deliver the digital future in the UK.)

Figure 9 *Readiness for electronic records in 30 countries in 2016*



Note: Cumulative score of nine indicators each valued at one point: EMR coverage, information sharing among physicians and hospitals, defined minimum data set, use of structured data, unique record identification, national standardisation of terminology and electronic messaging, legal requirements for adoption, software vendor certification and incentives for adoption (see Table 1 for the technical and operational readiness indicators).

Source: HCQI Survey of Electronic Health Record System Development and Use, 2016

In Scotland, a mandated unique patient identifier, the Community Health Index (CHI), has been established and integrated across the Scottish system and would provide a useful template for Ireland in the development of a modern health information system across the HSE. eReferrals and ePrescribing are also well established together with a 'Safe Haven' approach which has allowed for the safe and secure use of collated data by researchers to further understand optimal patient care.

The available evidence indicates that an integrated national electronic Healthcare Record (HER) is a key enabler of the collection, secure storage and confidential communication of health information from disparate settings within a health system. Examples such as NHS Spine (England) and AORTA (the Netherlands) have been shown to be particularly effective. Integrating EHRs within cloud-based systems further improves the use and accessibility of such data. Countries such as Denmark and Estonia have empowered patients in the management of their health and healthcare by allowing them to have greater access to and control of the use of their data[52].

[52] Developments in Healthcare Information Systems in Ireland and Internationally, Brendan Walsh, Ciarán mac Domhnaill, Gretta Mohan. June 2021. ESRI survey and statistical report series number 105. www.esri.ie https://doi.org/10.26504/sustat105

Response from HSE

The Review Team followed up on the lack of digital infrastructure with the National Director of Mental Health Services in March 2023. They were advised that:

(1) There is progress on an interim ICT system, with procurement expected to take place in Q2 2023, with roll-out commencing once procurement is secured.

(2) An integrated Community Management System (ICCMS) is the long-term plan and it was reported that this is on track and is progressing through the Digital Government Oversight governance arrangements.

(3) A task group has been set up to progress a phased scaling up of Referral in community mental health, with an initial focus on CAMHS. It is proposed the initial phase will build on the HIQA approved Referral form, supported by Healthlink (a messaging service that allows patient information to be securely transferred between Hospitals and Medical Practitioners).

(4) ePrescribing is now a key feature of some healthcare in Ireland.

(5) On 3 April 2020, the Minister for Health signed legislation that enabled a patient's prescription to be sent directly to pharmacies using the HSE's Healthmail. In addition to reducing the burden placed on individuals, there is evidence that ePrescribing greatly reduces prescribing errors for patients (Devin et al., 2020). While electronic referrals (eReferrals) were being developed within the Irish health system before COVID-19, the pandemic saw increased use of eReferrals. This was enabled by Healthlink whereby GPs can electronically refer patients to both public and private hospitals and clinics. There has been a strong increase in eReferrals in recent years in many healthcare areas but not in CAMHS.

The response from HSE to queries about the progress of the ICCMS stated that:

ICCMS Programme is on track against all milestones. The ICCMS is progressing through the Digital Government Oversight Unit (DGOU) governance arrangements, including the Peer Review Group. The next Peer Review Group scheduled for the beginning of May (2023) will be focused on considering the draft procurement documentation with a view to commencing procurement as soon as possible following this.

Tender documentation seeking a suitably qualified operator for ICCMS was published on 6 July 2023. In parallel with preparing for the introduction of ICCMS in CAMHS, the HSE is currently developing a programme of targeted short-term digital enhancements, which will include shared team diaries, digital dictation and further roll-out of e-referral in CAMHS via Healthlink .

A task group has been stood up to progress a phased scaling up of e-referral in community mental health, with an initial focus on CAMHS. The initial phase will likely build on the general HIQA approved e-referral form, supported by Healthlink. Preparatory work and information gathering is currently underway with a view to scale up use across CAMHS Community Teams. A specialised CAMHS e-referral form has been developed and approved by the ICGP and HSE with the aim of making this available for use on the Healthlink system in the coming months.

The HSE's 2015 Knowledge and Information Strategy[53] built on the eHealth Strategy for Ireland and outlined future required healthcare system capabilities, including the digital collection and use of data to support clinical and care capabilities, an electronic Healthcare Record (HER) system. This is to improve the integration of information across healthcare settings.

Telemedicine

Telemedicine involves the use of technologies to deliver healthcare remotely or at a distance. It can occur via the telephone, video conferencing, mobile applications, or remote patient monitoring. In the last decade, telemedicine has gradually emerged as an increasing component of healthcare across OECD countries. The onset of the COVID-19 pandemic has expedited the adoption of telemedicine to aid communication between patients and clinicians in a socially distanced, safe manner. The increased use of telemedicine during COVID-19 may provide a catalyst for greater integration of telemedicine as an option for care services in the future. Guidance and solutions have been published to

[53] Office of the CIO Knowledge & Information Strategy Delivering the Benefits of eHealth in Ireland May 2015.

support communication and collaboration across the health service[54].

A growing body of evidence suggests that care delivered via telemedicine can be both safe and effective, in some cases with better outcomes than conventional face-to-face care. Telemedicine services can also be cost-effective in different settings and contexts. However, international research in this area is only just emerging. Initial studies examining experiences of care during COVID-19 have shown that while some people adapted quickly and appreciated the flexibility offered by remote care, others experienced exacerbated feelings of loneliness, isolation, a sense of disconnection from communities and an overall deterioration of mental health[55].

These services still represent a small fraction of all healthcare activity and spending. Important barriers to wider use remain, with providers and patients facing regulatory uncertainty, patchy financing and reimbursement, and vague governance. Due to inequalities in health and digital literacy, patients that most stand to benefit are also often those that are least able to access and make use of telemedicine[56].

A number of CHOs had resorted to telepsychiatry as an effective tool to overcome the physical barrier between patients and healthcare providers to give mental healthcare during COVID-19. Telepsychiatry is described as the use of technology through audio and video telecommunications to offer mental healthcare across long distances, to enable information sharing between healthcare practitioners, or to provide healthcare when face-to-face contact is not feasible[57].

In some areas of CHOs reviewed, there was use of telepsychiatry to mitigate the risk of having no on-site consultant psychiatrist. Remote appointments increase flexibility within the service so that a clinician does not have to be on site. For example, one team had no consultant psychiatrist on site during the working week. However, some clinicians said that they are less able to examine vital forms of non-verbal communication during telepsychiatry sessions, which were considered instrumental in assessing and engaging people experiencing difficulties. Others noted that it was more difficult to engage with the child or maintain their attention during a telepsychiatry session. Of importance is that some service users might find it difficult to build a relationship of trust with health professionals without face-to-face contact[58]. This may have implications for clinical outcomes, given the importance of the therapeutic relationships for the recovery process.

There are calls for more research on the effects of cultivating therapeutic relationships with non-human agents[59]. Despite recent advances in affective computing (the study and development of systems that can recognise, process, and simulate human affects), automated systems are still a long way from understanding a person's subjective experience of mental illness[60].

Telepsychiatry is at an early stage in Ireland and safety and effectiveness require evaluation.

Mental Health Policy: *Sharing the Vision*

Sláintecare, the government healthcare policy, sets out a 10-year roadmap to deliver whole-system reform, focusing on a universal single-tier health and social care system[61]. The planned reform is for services to be delivered nearer to the patient with an expansion of primary and community services.

In mental health similar developments have been underway since 2006 under the then government policy for mental health, *A Vision*

54 https://healthservice.hse.ie/staff/coronavirus/working-from-home/virtual-health/virtual-health.html

55 Mind (2021) Trying to connect – The importance of choice in remote mental health services; Liberati E, et al. (2021) Remote care for mental health: qualitative study with service users, carers and staff during the COVID-19 pandemic.

56 Oliveira Hashiguchi, T (2020), Bringing health care to the patient: An overview of the use of telemedicine in OECD countries, OECD Health Working Papers, No. 116, OECD Publishing, Paris, https://doi.org/10.1787/8e56ede7-en.

57 Monaghesh E, Hajizadeh A. The role of telehealth during COVID-19 outbreak: a systematic review based on current evidence. *BMC Public Health*. 2020; 20(1): 1–9.

58 Rethink Mental Illness (2022) Summary paper: Engaging experts by experience about the role of digital technology in the future of mental healthcare.

59 Henson P et al. (2019) Digital mental health apps and the therapeutic alliance: initial review.

60 Gillett G (2020) A day in the life of a psychiatrist in 2050: where will the algorithm take us? Bioethics briefing note: The role of technology in mental healthcare Nuffield Council on Bioethics.

61 Committee on the Future of Healthcare (2017), Sláintecare Report, Houses of the Oireachtas, Dublin.

for Change[62] *(AVfC)*, which led to the closure of many acute and institutional care settings and the move to a community care model. While it progressed a number of matters in relation to mental health, many of the objectives were not met.

Sharing the Vision – A Mental Health Policy for Everyone was published in June 2020[63] and followed *AVfC*. *Sharing the Vision* outlines for mental healthcare what 'Sláintecare' does for healthcare in general, recommending that the organisation of mental health services should be aligned with emerging integrated care structures, including the six Regional Health Areas and within these, the Community Health Networks corresponding to populations of approximately 50,000. The policy supports the main goals and objectives of Sláintecare and seeks to create easier access to multidisciplinary, service user-centred supports at primary care level that will result in better outcomes.

Sharing the Vision focuses on 15 outcomes, across four domains: (1) promotion, prevention, and early intervention; (2) service access, coordination and continuity of care; (3) social inclusion; and (4) accountability and continuous improvement. It is welcomed that an Implementation Plan has been developed and will be overseen by the National Implementation and Monitoring Committee (NIMC), which comprises a Steering Committee, the HSE Implementation Group, the Reference Group, and an associated Specialist Group Panel . The Implementation Plan 2022 to 2024 provides a high-level description of intended outputs between 2022 to 2024, with further implementation plans to be developed for the periods 2025 to 2027 and 2028. The plan provides for a three-year roadmap for the continued development of youth mental health services, including CAMHS. This is intended to enhance capacity and access to services, shared governance, team coordination, digital case management, use of digital mental health, transitions between CAMHS and adult services and investment in early-intervention and upstream youth mental health services.

Some of the intended outcomes in *Sharing the Vision* are:

- The creation of a mental health system that focuses on the requirements of the individual.
- The development and delivery of a range of integrated activities to promote positive mental health in the community.
- Increased participation of service users, families, carers and supporters in the design of mental health services.
- The enhanced provision of accessible, comprehensive and community-based mental health services.
- Enhanced capacity of Primary Care services to respond to mental health needs, in which specialist mental health services are not required.

All of the above intended outcomes in *Sharing the Vision* are relevant to the provision of mental health services for children and young people. From the information provided to us, we found that progress on all of the above intended outcomes has been slow in CAMHS: child-centred care is not provided due to the structures of CAMHS provision; there is lack of integration of care across children's mental health and disability services; the involvement of families and young people in the design of mental health services has been minimal; many CAMHS services that should be provided are not provided due to lack of required specialist teams and staffing deficits; and Primary Care services are stretched so that there are lengthy waiting lists for these services.

Suitability of CAMHS Premises

There are a number of CAMHS clinics and offices in what are mostly new Primary Care Centres or other well-maintained buildings with adequate clinical, office and waiting spaces that are bright and cheerful with appropriate furnishings and decorations. However, others are in old buildings, some of which are unsuitable, poorly decorated and too small. This can include lack of clinical space, too few offices, inadequate and insecure spaces for storing clinical files, competition for clinical rooms with other services in the building, and inadequate parking. It was evident in some areas that there was a lack of adequate sound proofing. Some of the facilities that provided care and treatment to young people with mental illness and intellectual disabilities are

[62] Department of Health and Children. *A Vision for Change – Report of the Expert Group on Mental Health Policy.* Dublin 2006.

[63] Department of Health, *Sharing the Vision: A Mental Health Policy for Everyone*, Government of Ireland. Dublin 2020.

not designed, furnished or developed with the specific needs of these young people in mind.

The variations in the quality and suitability of premises where children and young people are assessed and treated and where team members work is evident both across CHOs and within CHOs. The aim of the HSE is to have all CAMHS Teams working from Primary Care Centres. This work is continuing and many teams are now working in Primary Care Centres. It is important that the space provided in these centres is adequate for a possibly expanding CAMHS Team.

Clinical Governance

CHAPTER

2

Clinical governance may be defined as the framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high quality care by creating an environment in which excellence in clinical care will thrive[64]. The focus is on improving and sustaining high standards of care, in addition to reassuring the public that the care delivered within the health and social care service is of the highest standard. It can be simply defined as doing the right thing, at the right time, by the right person i.e. applying the best evidence to care while respecting the person's wishes, by an appropriately trained and resourced individual or team.

Clinical governance encompasses quality assurance, quality improvement and risk and incident management. The HSE define clinical governance as a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. The individual or team work within an organisation that is accountable for the actions of its staff, values staff, minimises risk and learns from good practice, including mistakes[65].

Clinical and corporate governance systems are intrinsically linked, although each has its own objectives. Effective governance recognises the interdependence between corporate and clinical governance. Clinical governance requires staff to deliver measurable and effective patient care that is also consistent and safe and must incorporate structures that help the organisation to continually assess and monitor clinical risks to achieve the best possible outcomes. The structures required can be seen as a framework of seven pillars in which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver[66].

Figure 10 *Principles of good clinical governance*

[64] Scally G and Donaldson LJ (1998) Clinical Governance and the drive for quality improvement in the new NHS England. British Medical Journal 317 (7150) 4 July, 61–65.

[65] Gray C (2005) What is Clinical Governance, BMJ 2005; 330:s254

[66] Pearson, B. (2017), The clinical governance of multidisciplinary care, International Journal of Health Governance, Vol. 22 No. 4, 246–250. https://doi.org/10.1108/IJHG-03-2017-0007

The HSE document Clinical Governance outlines the following principles:

Figure 11 *Guiding principles for clinical governance development*

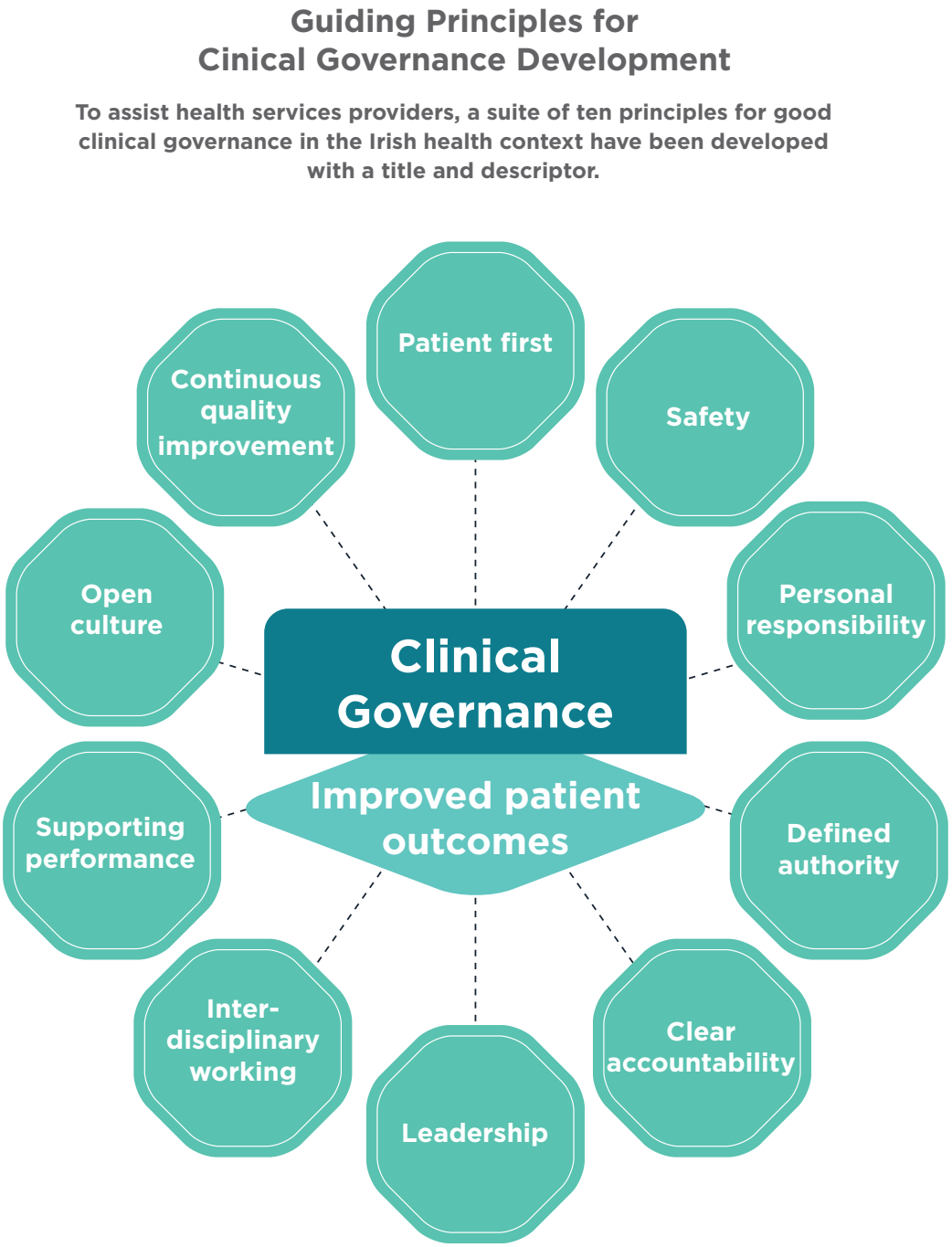


Figure 12 *Principles of good clinical governance with descriptors*

Principal	Descriptor
Patient first	Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
Safety	Identification and control of risks to achieve effective efficient and positive outcomes for patients and staff.
Personal responsibility	Where individuals, whether members of healthcare teams, patients or members of the public, take personal responsibility for their own and others, health needs. Where each employee has a current job description setting out the purpose, responsibilities, accountabilities and standards of their role.
Defined authority	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.
Clear accountability	A system whereby individuals, functions or committees agree accountability to a single individual.
Leadership	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
Inter-disciplinary working	Work processes that respect and support the unique contribution of each individual working member of a team in the provision of clinical and social care. Inter-disciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
Supporting performance	In a continuous process, managing performance in a supportive way, taking performance account of clinical professionalism and autonomy in the organisational setting. Supporting a director/ manager in managing the service and employees thereby contributing to the capability and the capacity of the individual and organisation. Measurement of patients and staff experience is central in performance measurement (as set out in the National Charter, 2010).
Open culture	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research, improvement, and appropriate action taken where there have been failings in the delivery of care.
Continuous quality improvement	A learning environment and system that seeks to improve the provision of services with an emphasis on maintaining quality in the future and not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing.

Source: HSE 223415: Clinical Gov 4 pp V3 (No ICGP (hse.ie).

These principles of good clinical governance can be used to measure how teams are providing their CAMH Service. The HSE clinical governance document, at Figure 12, provides a matrix which is designed to assist discussions on clinical governance. It is based on the principles, required structures, process and anticipated outcomes of good clinical governance. This could easily be developed as a mandatory audit tool, to improve the CAMHS Teams, performance and to feed into CHO management, who should be collecting such information but are not doing so.

Variations in Care and Treatment

There are unacceptable variations in care being delivered across and within the CHOs. Some services can offer, for example, treatment for eating disorders, with family-based therapy, dietetics and cognitive behavioural therapy for Eating Disorders (CBT-E) with ready access to inpatient beds if required. Other teams cannot offer such a service due to lack of resources. Some teams can offer different parenting groups while others cannot. Play therapy is provided in only a handful of teams. Not only is there variation in the delivery of care across the country but there is also considerable variations of care *within* a CHO. It is difficult to see this as anything except a postcode lottery for children and their families in the treatment that they receive. This means inequalities of care for children dependent on their address, which should be seen as unacceptable in any modern CAMHS service.

CAMHS should be delivered by a multidisciplinary team (MDT) working in line with CAMHS Operational Guidelines. Recommendation 32 in *Sharing the Vision*[67] states that the composition and skill mix of each cccommunity mentl health team, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills. As long as the core skills of CMHTs are met, there should be flexibility in how the teams are resourced to meet the full range of needs where there is strong population-based needs assessment data. CAMHS teams may consist of a range of professionals including psychiatrists, psychologists, social workers, nurses, speech and language therapists, occupational therapists, social care workers, administrators, team coordinators, dieticians and other therapists as required. The precise number of mental health professionals on a CAMHS team will vary according to the particular requirements of the sector population and within the available resources[68].

Team Coordinators

A Vision for Change – Report of the Expert Group on Mental Health Policy, 2006 proposes a Team Coordinator role for each CAMHS team. This individual carries out a clinical and administrative function to ensure the smooth running of CAMHS and is an integral part of the CAMHS team. The role of the Team Coordinator can only be taken on by a clinical member of the CAMHS team. The Team Coordinator's functions may include the administration and triage of referrals in consultation with the Consultant Psychiatrist and the MDT, coordination of waiting lists, organisation of team meetings, and liaison and consultation with GPs and Primary Care professionals and other community agencies and resources (HSE Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and Towards Continuous Quality Improvement, 2017).

The team coordinator's role is to ensure that the overall governance and operational management of the CAMHS runs smoothly; to ensure the quality and safety of service. They ensure that the core processes of referral, assessment and care planning, review and discharge are carried out consistently across CAMHS. They are partners with the clinical leads to manage the single process of referral and case load management within the service. They sometimes have a clinical caseload to maintain their professional competence but enable the service to run smoothly and support clinicians to deliver the highest possible standards of care and treatment in terms of quality and safety.

The Review Team found most teams did not have a team coordinator in place. In five CHOs, no team had a team coordinator in place (CHO 2, CHO 3, CHO 5, CHO 7, CHO 8).

CHO 1 had clinical coordinators across Sligo and Cavan/Monaghan but these were not allocated to any specific team, and there were no coordinators in the Donegal CAMHS Teams.

CHO 3 advised the Review Team that six positions have been approved for funding in 2023 but had not been recruited at the time of writing.

[67] Sharing the Vision b142b216-f2ca-48e6-a551-79c208f1a247.pdf (www.gov.ie)

[68] CAMHS Operational Guidelines camhs-operational-guideline-2019.pdf (hse.ie)

CHO 4 had two team coordinators in place in the Kerry teams but none for the Cork CAMHS Teams;

CHO 6 implemented a pilot 0.5 whole time equivalents (WTE) clinical coordinator role in two teams and a business case has been made to the HSE to increase this to five clinical team coordinators. Both teams reported that this development was beneficial in coordinating children's and young people's care and increasing efficiency. While this has improved the efficiency and coordination of the team, it is insufficient to meet the demands of the team, which include planning, coordination of follow-up appointments and ensuring that no child is lost to follow-up. A formal evaluation of the role is due to take place.

CHO 9 has two team coordinators who rotates between team members on a voluntary basis, with the team coordinators carrying a smaller caseload. Some teams are using existing clinical staff as team coordinators instead of a dedicated team coordinator post, as the post is not an approved and funded post. This reduces therapeutic availability to young people in what are under-resourced teams.

The current piecemeal approach is not sustainable. There is no clear policy that team coordinators should be provided on each team, so we have some teams working more efficiently with their version of a team coordinator and other teams who spend precious clinical time trying to triage referrals, manage waiting lists and coordinate different aspects of care and treatment.

Clinical Risk

Clinical risk in mental health covers a broad spectrum of risk which includes risk of suicide, self-neglect, harm to self and/or others and which requires practitioners to help service users manage their behaviour in relation to these. Risk assessment is the systematic collection and analysis of information to identify hazards which might cause harm. Following this, a risk-management plan is used to put in control measures to reduce the likelihood of an untoward event happening. Risk assessment and management reduces the likelihood of an untoward (negative) event occurring. However, it cannot completely eliminate risk. Levels of risk can fluctuate over time. As such, periodic reassessments should be scheduled in the event that new risk information becomes evident.

Evidence suggests that risk assessment instruments and tools perform very poorly for suicide prediction and can provide dangerous false reassurance to clinicians. The majority of suicides occur in individuals who score as "low risk" on risk assessment instruments[69]. A systematic review and meta-analysis of suicide risk prediction instruments found that the positive predictive value of such instruments was extremely low (just 5.5%) for suicide[70]. The review concluded that "no 'high-risk' classification was useful". In line with the evidence, NICE Guidelines state, "Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm".

This does not mean that risk should not be assessed but that it should be assessed dynamically. Assessment processes need to be consistent across mental health services and include adequate training on how to assess, formulate and manage suicide risk. An emphasis on patient and carer involvement is needed. In line with international guidance, risk assessment should not be seen as a way to predict future behaviour and should not be used as a means of allocating treatment. Risk-management plans should be personalised and developed collaboratively with young people and their families and carers. When standardised risk assessment is implemented, it will allow for a collaborative approach focusing on recovery, recognition of a person's strengths, and the need for organisational level support[71].

We found that clinical risk was identified as part of the initial assessment; however, the documentation of risk-management plans was poor in many teams. Risk management was addressed throughout the clinical notes, but it was not explicit – the reader often needed to search for it. Many of the files reviewed did not use a standardised risk assessment, despite a template being provided in the CAMH Operational Guideline[72]. Approximately 19% of the files reviewed had stansdardised risk assessments.

[69] Jane Graney, Isabelle M Hunt, Leah Quinlivan, Cathryn Rodway, Pauline Turnbull, Myrsini Gianatsi, Louis Appleby, Nav Kapur, Suicide risk assessment in UK mental health services: a national mixed-methods study. *The Lancet Psychiatry*, Volume 7, Issue 12, 2020, 1046–1053.

[70] Carter G, Milner A, McGill K, Pirkis J, Kapur N, Spittal MJ. Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *Br J Psychiatry*. 2017 Jun; 210(6): 387–395.

[71] HSE (2019) Child and Adolescent Mental Health Services Operational Guidelines, 2nd edition

[72] HSE (2019) Child and Adolescent Mental Health Services Operational Guidelines, 2nd edition

Risks Identified by the Review Team

Areas of concern where we considered there was a risk to children due to lack of clinical governance were escalated to the Chief Officer of the relevant CHO and in one case to the Assistant Director of Operations for the HSE. In total, we made six escalations of risk to the HSE due to risks to the wellbeing and safety of children.

Operational Risk Management

We were concerned that in some CAMHS Teams children and young people with open cases had been lost to follow-up; these young people were in need of an appointment with CAMHS but had not been contacted with an appointment for the necessary review. Those lost to follow-up included children on medication, with some reaching their 18th birthday with no discharge or transition to adult services planning or advice about medication. We heard from parents and young people of the efforts that they made to get a review appointment, a prescription renewal or advice about their child's care while on medication. On one team, 140 children who had open cases had been lost to follow-up. The relevant CAMHS Team had already started the process of a 'desk top review' of these cases (i.e. reviewing their files) before our review had commenced but after the findings in the Maskey report. These cases had been identified through a Healthcare Record Review. However, at the time of our review, we found that the actions taken were minimal and did not involve face-to-face assessments of the child and it was unclear at what stage these children would be re-assessed. These concerns were escalated and subsequently the HSE stated that a resulting Healthcare Record Review report was being compiled and will be examined by the Serious Incident Management Team (SIMT) in line with the HSEs Incident Management Framework. A comprehensive response from the CHO was received which detailed all actions being taken.

In another team in the same CHO, the previous consultant psychiatrist had left without re-allocating their case load and the team were trying to identify which of these children required follow-up.

Another team in another CHO did not follow up their patients for up to two years despite these children being on continuing medication.

Even following the publication of the Interim Report, we found that there were serious risks to the wellbeing of children and young people in a small number of teams. The risks had been identified by members of the teams and communicated through line managers and onto the Executive Management Team and while some actions were taken, there had been, in our opinion, little if any progress in mitigating these risks. We immediately escalated these risks to the Assistant National Director in Mental Health.

Across the country, the Review Team identified several areas of operational risk as identified in Table 3, which on many occasions did not appear on the local risk register or were not escalated as per the HSE Risk-Management Policy. Table 3 shows the risks identified by the Review Team across different teams in the CHOs. The risks outlined do not apply to all teams or CHO areas.

Table 3 *Risks identified by Review Team*

Risks identified by the Review Team		
No clinical coordination	Lack of clinical review	No coordination of children who require urgent follow-up
Retention & recruitment of staff	Lack of therapeutic interventions	No out-of-hours service
Staff burnout	No formal feedback from children or parents	Poor management of clinical files
Poor team dynamic	Inadequate premises	No standardised documentation
Poor completion of clinical risk assessments	Lone working	Limited access to inpatient beds
No mandatory training on risk management	No electronic files or integrated patient management	No access to medical screening tests
Consultant vacancies	Waiting lists	Lack of ADHD pathway
Access to CDNT Teams	Inadequate escalation of risk	Inadequate response & feedback of management of escalated risks

These issues require a national response rather than a piecemeal *ad hoc* approach of trying to remedy each situation within each CHO or CAMHS Team. Some teams had identified risks such as a dangerous window opening, risks to patient confidentiality, lack of essential CAMHS therapeutic interventions, and lack of inpatient beds resulting in clinicians holding children with significant risk in the community, and had escalated these with some success in obtaining actions to address them.

But there was only limited identification of some of these risks at team and at CHO level and actions documented in the risk registers were mainly minimalistic and generalised. There was little sense that a coordinated approach to risk management had taken place at national or local level.

For example, in the case of one CHO, staff appeared to be unaware of the operational risk-management process. Risk assessment forms were completed for risks that were to be escalated to senior management but no feedback as to actions taken or progress was received by the team. The team stated that they had *"given up"* escalating risks as there was little response when they did so. This resulted in identified risks remaining unaddressed including those related to staffing and service continuity. A number of teams expressed the view that it was pointless escalating risk as *"nothing happened"*. This had frustrated some teams to the extent that they told us that they didn't *"bother"* to escalate risk anymore as there was no point. This is simply unacceptable. It also confirms the point that you can have all the risk policies and procedures you like but if they are not properly implemented, audited and monitored they are of little use and it will be the child/young person that will lose out.

Staff in this situation were anxious about the potential impact of these risks on their own practice and as a result on the quality of care delivered to young people receiving CAMHS. Some CAMHS Teams had their own local risk register which was discussed at the multidisciplinary team meetings while other teams did not. Some staff members were not familiar with how a risk register operated or how to rate risks.

In one CHO we found that risk was escalated through emails to the Executive Clinical Director or Service Manager and not through the risk escalation process. This caused difficulties between the Executive Management Team and CAMHS consultants who had withdrawn from the CHO governance structures. Again, this is not acceptable.

Staff in most areas had received training about risk management but this was not mandatory nor was it always evident when we enquired about how they managed risk. There was a sense of disconnect between the Community CAMHS Teams and area management with regard to risk. Staff on teams reported risk through their line management and sometimes through the multidisciplinary process and Clinical Lead. This could result in the same risk being escalated twice through different pathways.

In the absence of proper risk escalation, there is no central collection of risks. The HSE Integrated Risk Policy[73] is clear that the outcome of any considerations in the management of risk must be communicated back to the service that notified the risk. This was not happening and this becomes a risk in itself: staff may not escalate risks if they are of the opinion that nothing happens.

It should be noted that in some areas, it was found that risk identification and management was well understood by the Community CAMHS Teams and the inpatient unit staff. In addition, the process of reviewing risk registers and escalation through line managers or by the teams was evident. An electronic risk management system was in place in CHO 6, which contributed to a good reporting system, risks were discussed at the Integrated Management Reporting meeting, with the risk register submitted before each meeting and regular reporting to the Head of Service in Mental Health. It was found in CHO 7 that there has been a good appetite from CAMHS staff for risk training, although this is not compulsory training. The training has emphasised the need to identify risks early in order that they do not become a more serious incident.

[73] HSE Integrated Risk Management Policy – Part 3: Managing and Monitoring Risk Registers Guidance for Managers accessed 4/11/2022.

Clinical Audit

In modern healthcare systems, clinical audit is an essential tool for improving patient care. The following definition is used by the HSE to define clinical audit:

> *Clinical audit is a clinically led (clinically led includes the breadth of clinical professionals working in health and social care services) quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met.*[74]

The purpose of clinical audit is to evaluate whether healthcare services are adhering to set standards, and providing evidence to both people who use the service and those that provide services as to how well they are doing and if there could be improvements. It is a requirement of the Medical Council[75] that all registered medical practitioners will be actively engaged in audit and participate in one audit exercise annually that relates directly to their area of clinical practice and that clinically led audits include the breadth of clinical professionals working in health and social care services[76]. In addition, one of the recommendations of the Maskey report is the monitoring of clinical practice through the use of clinical audit[77].

The Review Team found that there was considerable inconsistency in clinical audit. For example, in two CHOs there was evidence within the clinical files that some children and young people had not been reviewed regularly or had adequate monitoring of medication and it was clear in some teams that audit of clinical files had not taken place, as recommended in the Interim Report. It is very difficult to understand how such an audit of all files could miss what we discovered within our sample of 10% of caseloads. In view of this a review of all clinical files on the current caseload of one team was requested by the Review Team. In addition, there was a lack of compliance with CAMHS Operational Guidelines[78] proforma for individual care plans, risk management and completed consent forms for medication. This was despite a reported clinical file audit, a documentation audit and a completed CAMHS Operational Guidelines self-assessment tool.

One team which ran two ADHD Clinics, had a well-defined pathway based on the ADMiRE Team (a specialist service for the assessment and management of children with attention deficit hyperactivity disorder). They complete bi-annual audits of open caseload and also have a monthly team development meeting. Care plans were in place with a revised template from the CAMHS Operational Guidelines (COG) and they are actively working on a key worker system. The amount of work being done to improve the quality of care was impressive.

It was evident in CHO 4 that audits of caseloads and medication audits were being conducted following the Maskey report. There were also audits of waiting lists to ascertain which children were on the waiting list the longest and arrange an assessment for them. Some teams were actively monitoring their DNAs (those who did not attend for an appointment with no notice), resulting in follow-up by the key worker.

In teams where we found very few clinical audits carried out, it was noted that teams were aware of the importance of regular clinical audits such as medication audits but said that due to the poor staffing of teams, all their time was spent on assessments and interventions with children and their families. For example, an experienced team in one CHO which put an emphasis on measurement of outcomes and processes, stated there were no resources to carry out clinical audits. However, we did find evidence of two audits carried out every six months: a clinical file audit and an audit of case files to ensure that each child has a follow-up appointment and there was also an annual audit of referrals by this team. Other audits included prescribing practices; growth and cardiovascular monitoring in ADHD; and an audit of individual care

[74] Department of Health and Children (2008) *Report of the Commission on Patient Safety and Quality: Building a Culture of Patient Safety*. Dublin: Safety Office, p. 152.

[75] Clinical Audit Guide Medical Council – Clinical Audit Guides

[76] HSE (2023) National Centre for Clinical Audit A Practical Guide HSE National Centre for Clinical Audit - A Practical Guide 2023

[77] Maskey S. *Report on the Look-Back Review Into Child & Adolescent Mental Health Services County MHS Area* A. 14 January 2022.

[78] HSE (2019) Child and Adolescent Mental Health Services Operational Guidelines, 2nd edition.

plans and attendance records. A satisfaction questionnaire was sent to young people and their families every six months.

In some teams, there were evidence of regular case file audits and audits of referrals. However, like other teams, there was limited IT systems in place and what was there appeared to be antiquated; thus it was difficult to identify files for auditing and in some cases identify the actual open caseload. Serious staff shortages resulted in clinicians spending the majority of their time engaged in essential clinical work, leaving no time to carry out evaluations or audits.

One CHO it was reported that due to low staff numbers, most teams found it difficult to find time out of their clinical time to complete audits; however, it was found that each team routinely audited caseloads, activities and documentation. The IT system in place facilitated the collection of data and provision of reports. Electronic medical records and care plans were audited every six months for all open cases. All eating disorder cases had been audited. There was also an audit of referrals to CAMHS across all teams during the COVID-19 pandemic. Satisfaction scales were administered to parents and children pre and post therapy by individual clinicians. A distinct difference from HSE-provided CAMHS is the information system that is used throughout the St John of God Service – the Mental Health Information System. This allows for electronic medical records, scheduling appointments, reporting of data for the purposes of audits, KPIs, monitoring of children and young people on medication, and service planning at all levels. The implementation of this was demonstrated in action during our review of the service and was impressive.

Quality Improvements

The Review Team found many innovative quality improvements within different teams and these are outlined in each CHO report, which we have published separately. However, often these were not generalised across the CHO when they had been found to be effective. This resulted in different teams providing services differently, depending on choice rather than in a standardised way.

In June 2023, The Mental Health Engagement and Recovery Office launched its three year Strategic Plan. The Plan includes a number of priority areas including CAMHS. By the end of 2026 the MHER Office will have provided an overarching framework for Engagement across MHS to sustain, measure and ensure consistency of approaches nationwide.

In CHO 2, a CAMHS Hub had been established, which included the integration of a day hospital, outreach and the inpatient unit. This hybrid model offered a service where children could be seen at home, on site or via telepsychiatry. It is welcomed that this service operates seven days a week and provides an emergency service also. The National Mental Health Office advised that this will be a phased development in line with available resources and access to pilot sites, with additional hubs planned for CHOs 3, 4, 6, and 8. The CHO 6 pilot is to commence in Quarter 2 2023 with the remaining sites by year end subject to recruitment.

All Area Mental Health Leads are the figures accordingly available to CAMHs with CHO 6 having the first CAMHS Area Leads.

There is a CAMHS Discovery Recovery Education College up and running in CH0 2. The Working Group has produced guidelines and operational procedures for delivery of Recovery Education in the Discovery College.

A National Enhancing Engagement Steering Group was established in early 2022 which is currently co-creating an Enhanced Framework for Engagement with multiple supporting documents and pilot projects including CAMHS.

University College Cork has been engaged by the HSE as an academic partner to conduct qualitative research into CAMHS experiences. This research involves a qualitative study of CAMHS experiences in order to determine the lived experience of service users, families and carers, staff, referrers and other key stakeholders interacting with the CAMHS service. The research is currently underway, and a report will be available in August 2023.

Young People and Their Families' Views of Access to CAMHS

CHAPTER

3

The Review Team had the opportunity to speak with parents and young people from each CHO. In total, we spoke to 43 families and 9 young people. We found that, in general, young people did not want to speak with us. We also received 35 unsolicited issues of concerns from parents about CAMHS between 1 January 2021 and 31 May 2023.

The most frequent theme was the lack of access to CAMHS and other services for children and young people. We heard multiple accounts of long waiting lists and parents spoke of their child deteriorating on waiting lists and of sourcing expensive and geographically distant private care. One family spoke of spending €90 a week to see a private occupational therapist and driving a round trip of 3 hours to do so. They also spoke of spending long periods on a waiting list for CAMHS, to then be told that their child did not meet the criteria for CAMHS. They were then signposted, not referred, to another service where they joined what was usually a longer waiting list for their child to be assessed by CDNTs or Primary Care. Many of their children were out of school, or spent long periods away from school and were not interacting with peers.

Parents were unclear about the CAMHS criteria for acceptance for an assessment and found it difficult to understand why their child could not receive a service for their mental illness when they needed it. Many were unaware of the strict boundaries between CAMHS, Primary Care and CDNTs.

Some spoke of a lack of contact and reviews with CAMHS, with phones not being answered or call-backs not made. Some parents said that they were told that if they did not consent to their child taking ADHD medication that they would be discharged without further input. Three sets of parents felt their children had had early discharge before their child was ready, so that another child could be taken off the waiting list.

Some parents and young people stated that they saw a different doctor on each visit and they had to tell their whole story over and over. Sometimes they received different diagnoses from different doctors.

It is important to note that some parents spoke about excellent care that their child received once accepted from the waiting lists and about the support they received as parents. Many spoke about individual therapists who were helpful and kind and of the thorough assessments that their child received once accepted to CAMHS.

Other Stakeholders

Stakeholder organisations also spoke of difficulties for children accessing CAMHS, the lack of ability to refer children to CAMHS, the long waiting lists and lack of ongoing communication from CAMHS about the child, even with parental consent.

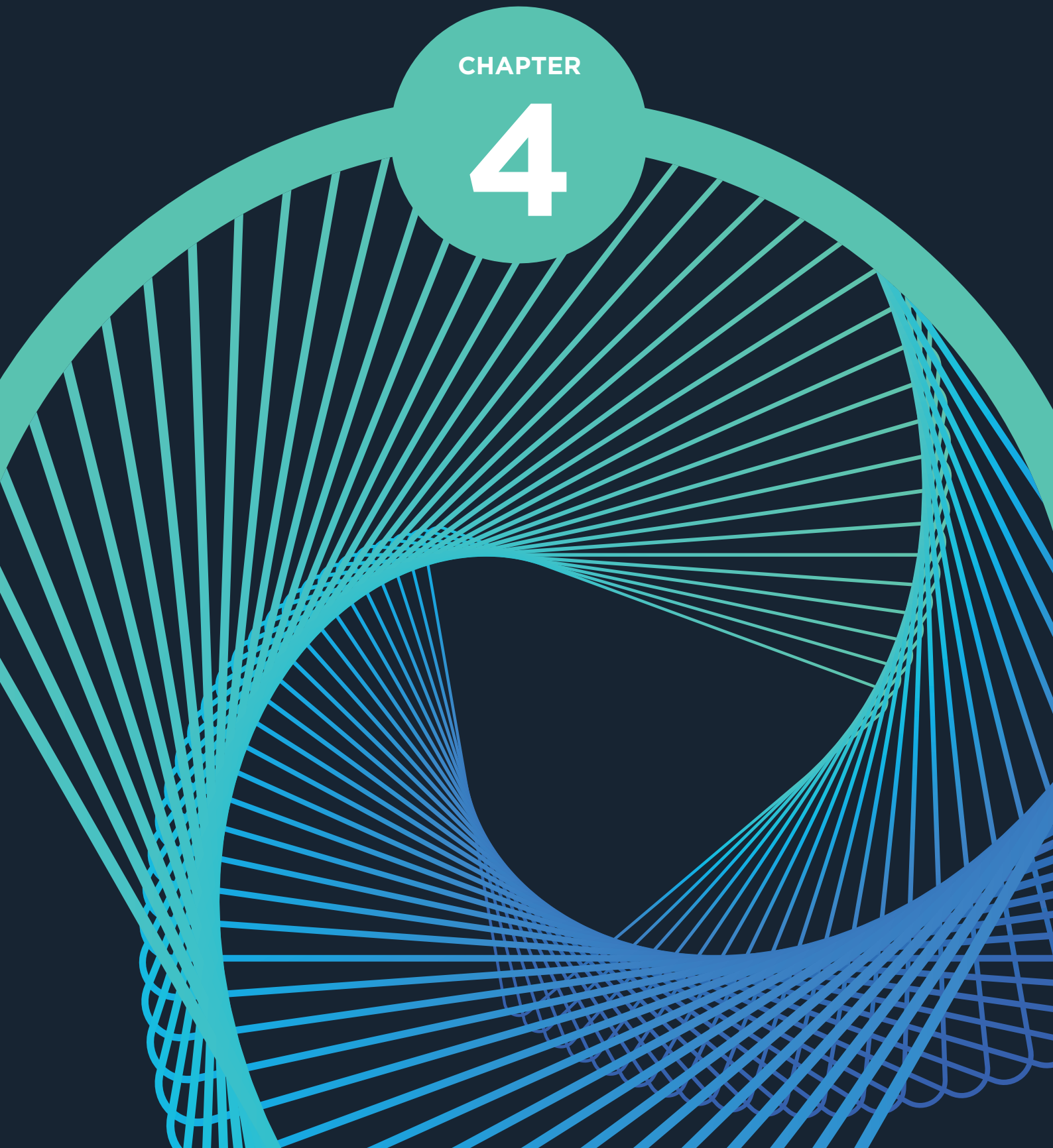
Lack of clarity about the CAMHS criteria for acceptance for an assessment was prevalent among most stakeholders, including families of children. This was despite the fact that in 2015, the CAMHS Standard Operating Procedure was published and circulated to all CAMHS Teams and CAMHS stakeholders. This was subsequently reviewed and updated in 2019 to the CAMHS Operational Guideline and again disseminated to all teams and external stakeholders. It was printed and circulated as well as being available online. The CAMHS Operational Guideline contains detailed referral criteria and pathways into CAMHS. Some stakeholders spoke of having to try and manage distressed and mentally ill children that were beyond their resources to deal with when the young person had been refused by CAMHS.

Currently, the majority of children and young people can only access out-of-hours mental health treatment through hospital Emergency Departments as most CAMHS do not offer this support. The HSE Service Plan 2019 included a commitment to develop a seven-day-per-week CAMHS service. This had not been achieved in three CHOs in 2022.

Staffing

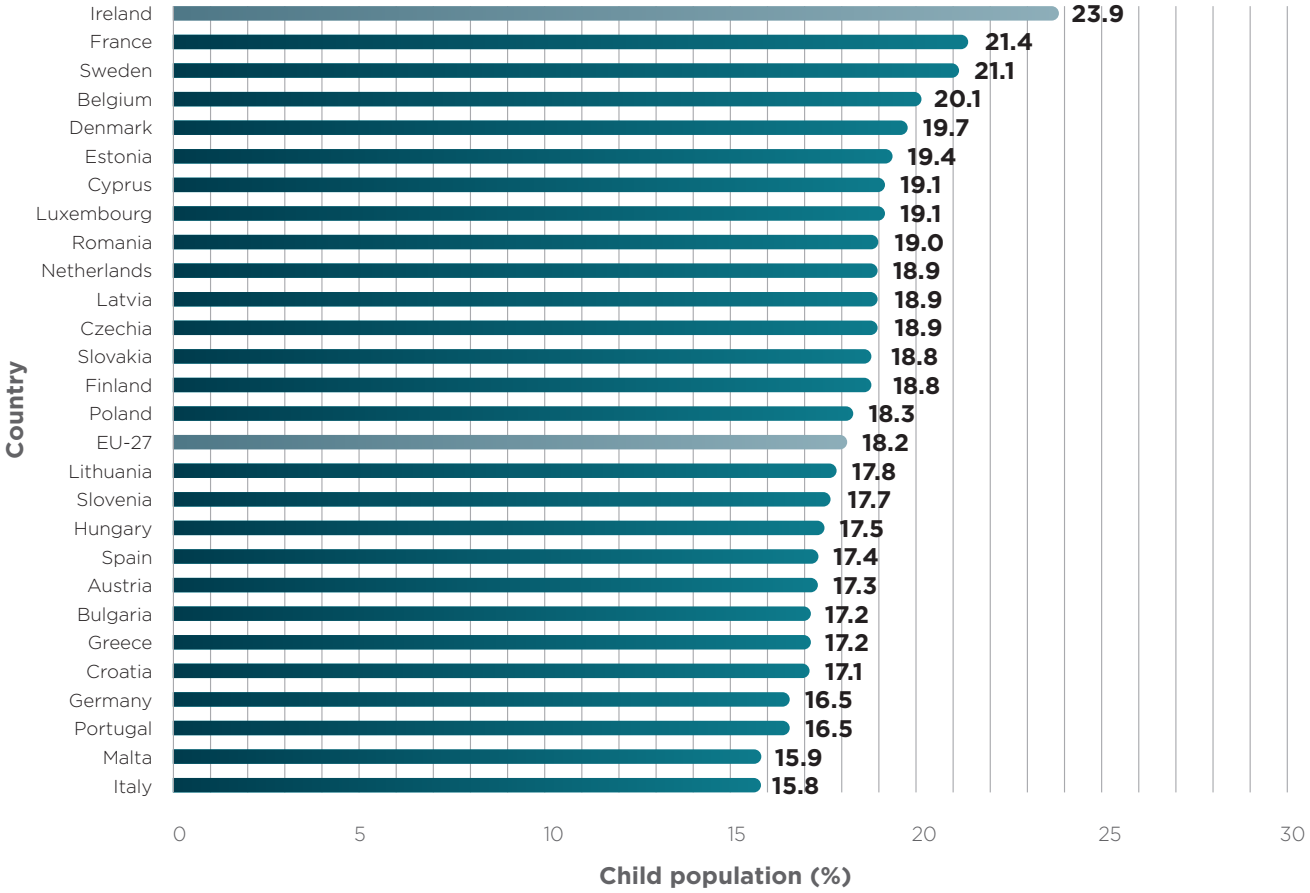
CHAPTER

4



According to CSO 2022, there are 1,201,618 young people under the age of 18 living in Ireland. This is 23.6% of the total population. In 2021, Ireland had the highest estimated proportion of children in the European Union (23.9%). The EU-27 average was 18.2%.

Figure 13 *Child population as a percentage of total population by EU-27 country 2021*



Source: Eurostat Database - Eurostat (europa.eu)

For the past number of years, there have been significant difficulties in staffing CAMHS Teams, due to recruitment and retention difficulties.

Sharing the Vision, our national mental health policy, does not make any recommendations as regards minimum staffing levels. In the absence of any other benchmarking for staffing nationally, we applied the recommendations in the previous mental health policy, *A Vision for Change*, to analyse and compare staffing across Community Healthcare Organisations. As *Sharing the Vision* is focused on outcomes, we need some benchmark in staffing required to achieve these outcomes. HSE workforce planning also relies on *AVfC* to allocate approved posts. However, with the passing of time, these recommendations are outdated and mental health needs of children/young people have changed. Speech and language therapists, occupational therapists, social care leaders, dietitians, play therapists, family therapists all play a much greater role in providing interventions for children and young people with a moderate or severe mental illness than envisaged by *AVfC*.

For tables 4,5,6,and 7 the recommended staffing figures are for Community CAMHS teams only in AVFC and do not include specialist community CAMHS teams such as Eating Disorder of ADHD teams.

Table 4 *Community CAMHS staffing – during inspection*

Community CAMHS Staffing – During Inspection (Excluding Specialist Teams)				
	Population	Total Clinical Staffing	Recommended Staffing	Total Clinical Staff *AVfC* %
CHO 1	394,333	70.1	86.8	81%
CHO 2	453,109	57.1	99.7	57%
CHO 3	384,998	52.9	84.7	62%
CHO 4	690,675	88.8	151.9	58%
CHO 5	510,333	54.5	112.3	49%
CHO 6	549,531	56.9	102.9	47%
CHO 7	548,875	86	120.8	71%
CHO 8	616,229	80.8	135.6	60%
CHO 9	621,405	98.3	136.7	72%
Total	4,769,488	645.3	1049.3	61%

*CHO7 calculations include two Tallaght teams which are governed by CHO6.

Table 5 *Community CAMHS staffing – March/April 2023*

Community CAMHS Staffing – March/April 2023 (Excluding Specialist Teams)				
	Population	Total Clinical Staffing	Recommended Staffing	Total Clinical Staff *AVfC* %
CHO 1	394,333	69.1	86.8	80%
CHO 2	453,109	61.7	99.7	62%
CHO 3	384,998	57	84.7	67%
CHO 4	690,675	113.6	151.9	75%
CHO 5	510,333	61.9	112.3	55%
CHO 6	549,531	59	120.9	49%
CHO 7	548,875	90.3	120.8	75%
CHO 8	616,229	77.4	135.6	57%
CHO 9	621,405	98.6	136.7	72%
Total	4,769,488	688.6	1049.3	66%

However, not even *AVfC* recommendations for staffing are being met. Many teams are working at less than 60% of recommended staffing and some are below 50% of recommended staffing. Certainly, there are difficulties in retention and recruitment in the past number of years which have led to a deficit of staff working in CAMHS, but there are a significant number of recommended posts that have not been approved or funded.

There was no evidence that a national coordinated approach is being taken. Instead, there are consultant psychiatrists from different areas seeing children over weekends or online; multiple consultant cover from other teams which is confusing for staff and families alike; CHOs not aware of the budget they have to implement urgent and extensive changes; and auditing only happening when a crisis occurs and not routinely as a safety and quality improvement.

Table 6 *Community CAMHS staffing during inspection – percentage of AVfC recommendations per discipline*

Community CAMHS Staffing During Inspection – AVfC% per discipline									
	Consultant	NCHD	Nursing	Psychologists	Social Workers	Occupational therapists	Speech and Language therapists	Child Care Leaders	Admin officers
CHO 1	94%	127%	162%	40%	41%	61%	60%	50%	106%
CHO 2	72%	99%	56%	37%	51%	58%	49%	15%	55%
CHO 3	71%	79%	81%	62%	60%	26%	68%	23%	45%
CHO 4	71%	88%	33%	62%	52%	49%	72%	36%	65%
CHO 5	78%	69%	68%	34%	20%	46%	37%	36%	57%
CHO 6	59%	82%	50%	41%	34%	31%	55%	18%	49%
CHO 7*	92%	77%	71%	41%	41%	70%	78%	76%	48%
CHO 8	80%	105%	65%	34%	45%	67%	21%	52%	67%
CHO 9	112%	105%	53%	72%	72%	64%	80%	0%	42%
Total	81%	92%	67%	48%	47%	53%	58%	34%	58%

*CHO7 calculations include two Tallaght teams which are governed by CHO6.

Table 7 *Community CAMHS staffing March/April 2023 – percentage of AVfC recommendations per discipline*

Community CAMHS Staffing per Discipline – AVfC% in March/April 2023									
	Consultant	NCHD	Nursing	Psychologists	Social Workers	Occupational therapists	Speech and Language therapists	Child Care Leaders	Admin officers
CHO 1	94%	127%	156%	33%	48%	61%	60%	50%	99%
CHO 2	75%	121%	71%	41%	51%	61%	30%	12%	63%
CHO 3	114%	105%	104%	73%	69%	65%	78%	23%	64%
CHO 4	74%	87%	49%	76%	71%	71%	97%	43%	76%
CHO 5	78%	69%	79%	42%	24%	54%	42%	52%	63%
CHO 6	59%	83%	52%	40%	34%	45%	64%	18%	48%
CHO 7*	101%	105%	87%	38	39%	67%	109%	49%	69%
CHO 8	80%	104%	61%	33%	49%	42%	21%	52%	67%
CHO 9	112%	89%	55%	74%	72%	64%	84%	0%	34%
Total	86%	97%	75%	51%	51%	59%	66%	34%	64%

*CHO7 calculations include two Tallaght teams which are governed by CHO6.

There are serious deficits in health and social care professionals staffing as recommended by *AVfC* with only marginal improvements since our review. While difficulties in recruitment to fill approved posts for existing vacancies is a serious problem, many recommended posts are not approved and funded.

Filling posts is dependent on training nurses, psychiatrists and health and social care professionals so that there are sufficient numbers to fill vacancies as they arise. Student placements in CAMHS are important, both to train and to give a positive experience of working in CAMHS. Student placements cannot take place without the presence of staff on a team to supervise students.

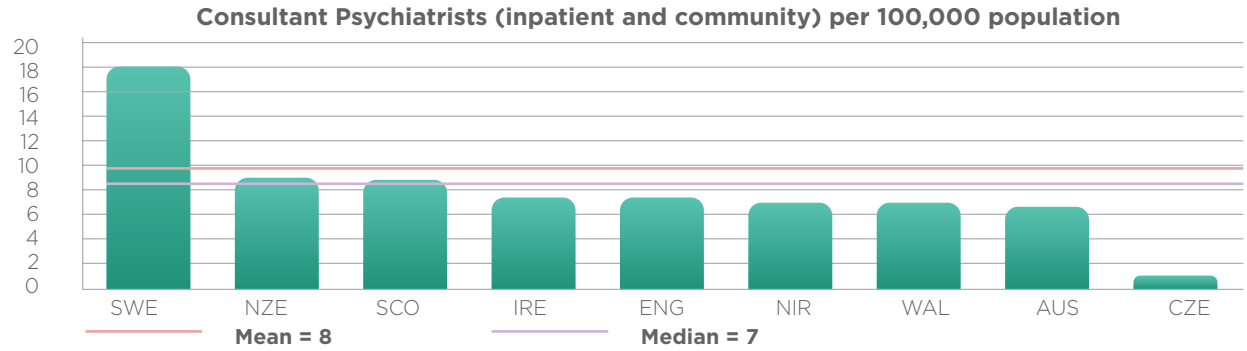
In order to be a consultant psychiatrist in CAMHS a person must first train as a medical doctor, followed by basic training in psychiatry which includes a rotation to a CAMHS team and then higher training in CAMHS as a senior registrar. It can take in excess of 12 years, training to become a consultant psychiatrist in CAMHS. The senior registrars must be supervised by a permanent psychiatrist on the Medical Council's CAMHS specialist register. The number of senior registrars is decided by the HSE and the College of Psychiatrists in Ireland and is dependent on funding and available suitable posts. There are ongoing discussions between the College of Psychiatrists in Ireland and the HSE on the number of senior registers required.

Many professionals are finishing their training here in Ireland and then emigrating to work elsewhere for a variety of reasons, leaving a shortage of staff to fill vacancies as they arise.

International Comparisons

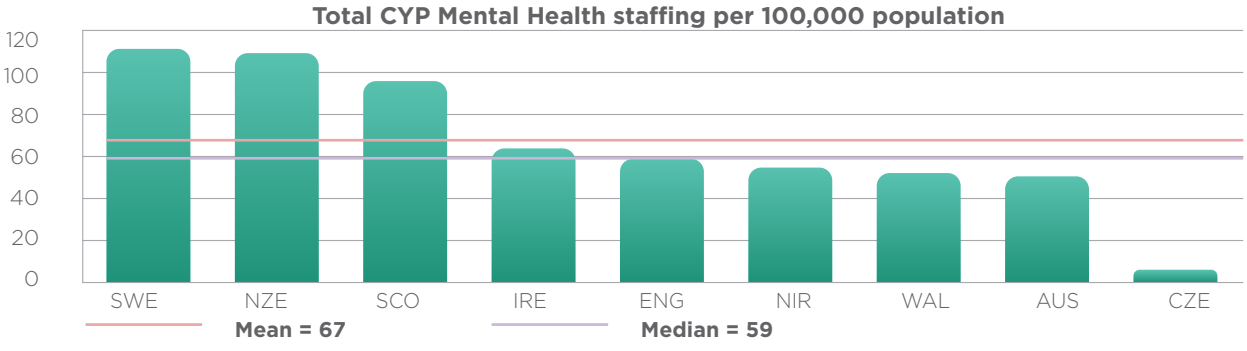
In 2018, the NHS Benchmarking Network compared health services for children and adolescents across nine countries, with Ireland being one of the countries included[79]. Some of the results of benchmarking process of staffing are included below:

Figure 15 *Consultant CAMMHS Psychiatrists per 100,000*



- Consultant Psychiatrists per 100,000 population shows the WTE (whole time equivalent) number against a 0-18 year old population. Staff working in inpatient and community settings are included.
- Sweden reports the highest levels at 18 per 100,000 population, and the Czech Republic the lowest at 1 per 100,000 population.
- The remaining 8 countries report similar levels to each other, ranging between 7 and 8 WTE per 100,000 population aged 0-18.
- The mean position across all countries is a 8 WTE and the median is 7 WTE.

Figure 15 *International comparisons of staffing of CAMHS Teams*



- The CAMHS workforce is typically formed from a multidisciplinary team involving Child and Adolescent Psychiatrists, specialist Therapists and Nurses.
- This section of the report explores the number of specialist staff deployed in each country. Of the 13 countries participating in the study, 10 were able to provide data on workforce.
- Sweden reported the largest workforce figure at 112 per 100,000 population in the 0-18 group. This figure includes consultant psychiatrists, registered nurses, clinical psychologists and other clinical therapists and practitioners.
- New Zealand reported the second highest rates at 109 per 100,000 population.
- UK countries reported workforce levels in the range 52 WTE to 96 WTE per 100,000 population aged 0-18.
- The mean value of 67 is marginally skewed by the higher numbers of staff reported by Sweden, New Zealand, and Scotland. The median value is 59 WTE per 100,000 population aged 0-18.

[79] International Comparisons of Mental Health Services for Children and Young People. Summary report by the NHS Benchmarking Network 30th May 2018.

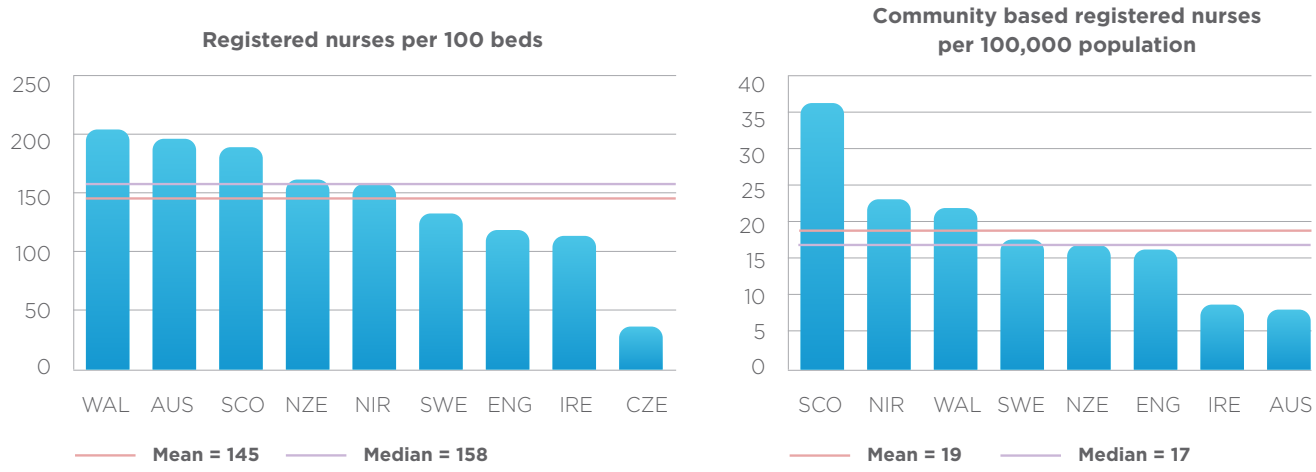
Figure 15 relates to total CAMHS staffing in 2018. In Ireland, total CAMHS staffing was 65 per 100,000. In 2023, based on the increased population, the HSE total CAMHS staffing is 67 per 100,000.

The number of consultant psychiatrists per 100,000 in Ireland was seven, compared to 18 per 100,000 in Sweden and one per 100,000 in the Czech Republic. There had been an increase of approved posts in Ireland by 2022. However, a significant number of these posts remain unfilled due to recruitment difficulties.

The analysis of the nursing workforce only focuses on qualified/registered nurses. In the inpatient context, the number of CAMHS Nurses employed per 100 beds has a mean average of 145. Wales employs most nursing staff (204) and Czech Republic the fewest (37). In the community context, the number of CAMHS Nurses employed per 100,000 children in the 0–18 age group averages 19 whole time equivalent staff. Scotland employs the most staff (36 WTE) and Australia the fewest (8 WTE). Ireland employed the second-lowest number of both community nursing staff and inpatient nursing staff.

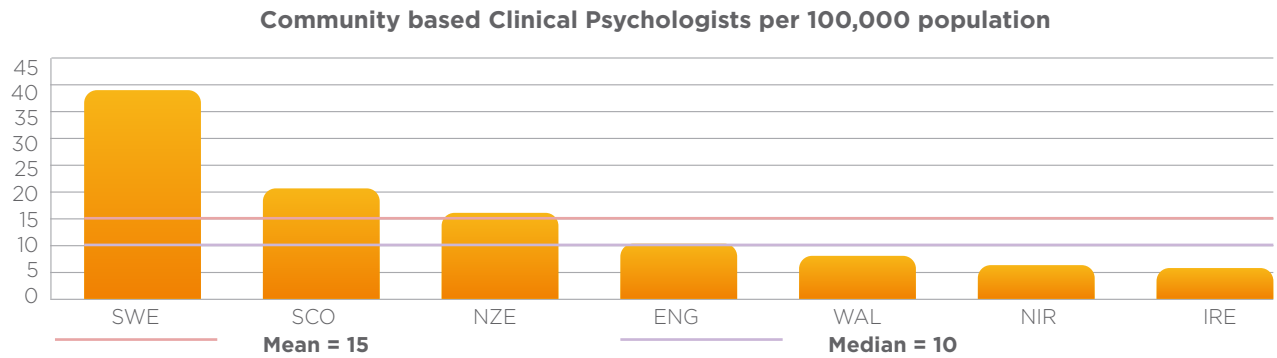
The Benchmarking Network also looked at the community-based clinical psychologists per 100,000, where we had the lowest number of community psychologists per 100,000 out of seven European countries.

Figure 16: *International comparisons of mental health services for Children and Young People*



Source: Summary report by the NHS Benchmarking Network 30th May 2018

Figure 17 *Community-based clinical psychologists per 100,000*



Source: International Comparisons of Mental Health Services for Children and Young People Summary report by the NHS Benchmarking Network 30th May 2018

Significant variation in the organisation and provision of mental health services can be observed between countries. One of the challenges in drawing comparisons between countries is comparability of health care structures, which makes it difficult to directly compare data.

The Review Team found great variations in staffing levels and availability of different disciplines across CAMHS. It is unclear how decisions to provide a discipline in one area and not in others are made. For example, one team may have two social workers while another team, even in the same CHO, has none, yet the need for social work intervention is the same or similar across all CAMHS. This inequality leads to some services not being able to provide basic treatments such as Family-Based Therapy or Cognitive Behavioural Therapy.

In Ireland, consultant psychiatrists are the clinical leads in each team, but due to the difficulty in recruiting and retaining CAMHS consultant psychiatrists, there were difficulties in filling some permanent consultant posts. Some were covered by locums, which had implications for the continuity of care. In CHO 3, no consultant worked fulltime and no other consultant covered their work while they were absent. This resulted in seriously ill children waiting until that consultant was back on duty, with other team members trying to "hold" the child safely until the consultant returned. This resulted in incidents being logged as there was no clinical cover to assess and treat emergency cases. One child waited 4 days in the Emergency Department until they could be assessed by a consultant psychiatrist. This is completely unacceptable in what is supposed to be a modern mental health service.

In one CHO, in three teams up to three different consultants provided cover. This caused confusion for the teams and in some cases the team was unsure how this consultant cover was actually working. In CHOs where there are difficulties in providing a full CAMHS service, other consultants from outside the CHO provided clinics at weekends or in the evenings.

In one team in this CHO, a consultant psychiatrist covers 23.5 hours a week by telepsychiatry from the Middle East and attended in person every two to three months. The remainder is covered by phone from a fulltime consultant in another part of the service for urgent cases only. While this mitigates against having no psychiatrist at all, it is not an adequate substitute for at least a hybrid mix of face-to-face and online review. Long term, this is not a sustainable solution.

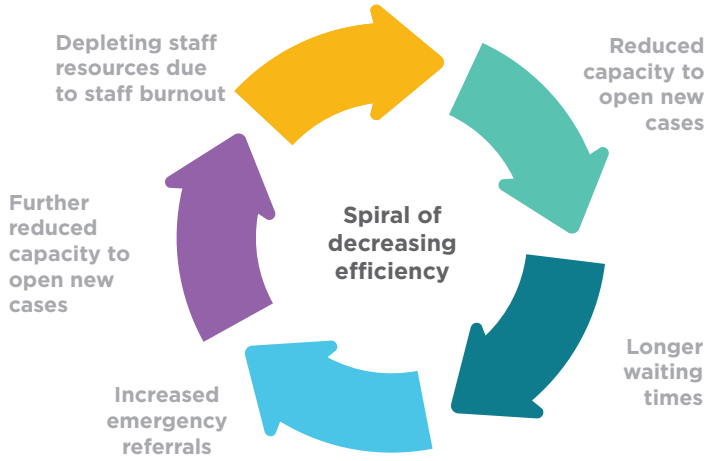
The work done by locum consultants to cover vacant consultant psychiatrist posts is valued; however it does lead to instability within teams as well as, a lack of continuity of care. The latter is particularly difficult for children and adolescents, many of whom are attending services in part due to trauma within their relationships with adults. The higher training posts to become a consultant psychiatrist are insufficient to fill the gaps in consultant psychiatrist posts.

We found team members working beyond their contracted hours, often without compensation, to continue to provide a service. We found evidence of stress and burnout in a significant number of team members. This has a potential impact on job satisfaction and morale with staff expressing concerns about the quality of the service delivered to young people. Retention of staff then becomes a problem as staff leave to pursue a career in less stressful environments.

The HSE informed us that, supported by development funding, 42 Whole Time Equivalents (WTEs) are currently in the recruitment process to enhance existing CAMHS Teams and meet service demands.

The HSE also informed us that, as of February 2023, the overall staffing across the 75 CAMHS Teams amounted to 799.1 WTEs or 64.5% of

Figure 18 *Spiral of decreasing efficiency*



Source: Dr Tom Foley, Inishowen CAMHS.

the recommended *AVfC* staffing for the current number of teams. The HSE informed us that, supported by development funding and in line with service plans, the HSE is adding an additional 50 WTE to CAMHS Teams across the nine CHOs in 2023, with 42 of these WTEs currently in the recruitment process.

Staffing of teams is difficult due to retention and recruitment difficulties and it is unlikely that this will change unless incentives are used to entice professionals to work in CAMHS. Currently, the average staffing of teams is 66% of *AVfC* recommended levels. In listening to members of staff teams, we heard that incentives should include improved accessibility to training, career progression, supportive management that listens to staff and acts on their concerns, a manageable workload, being able to evaluate and report on their work in a non-threatening environment, research opportunities and opportunities to meet with other teams through case discussions and other academic meetings. Staff also stated cost of living issues, availability of suitable affordable accommodation and travel costs which make recruitment and retention a challenge in the Dublin Area. There are also higher remuneration packages in the private/ independent sector. Consulting and listening to staff on the ground about what they need to remain in the service and then acting on that information, would be a major step in increasing retention.

The *Sharing the Vision* Implementation Plan 2022 – 2024 provides a three-year roadmap for the continued development of youth mental health services, including CAMHS. This will include enhanced capacity and access to services; shared governance and team coordination; digital case management; enhanced used of digital mental health; improved transitions between CAMHS and adult services; and investment in early-intervention and 'upstream' youth mental health services.

However, by mid-2023, the HSE has very little time left to implement the Plan. For example, we found that there was no improvement to access to digital case management or enhanced use of digital mental health. Transitioning from CAMHS to Adult Mental Health Services was not working in accordance with guidelines. While in some areas waiting lists to access CAMHS had decreased, in other areas they had increased. There were no early-intervention teams catering for CAMHS and we had concerns about governance processes and structures.

It is unlikely that recruitment of staff will improve in the medium term as this is both a national and international problem. The current situation is not sustainable. Repeatedly stating that "there is a recruitment problem and we can't get staff" is not going to solve the difficulty and other models of delivering a mental health service for children must now be considered.

There are 75 Community CAMHS Teams which are not staffed adequately. There is currently very little sharing of resources across teams, even when they are based close to one another in cities. The hub and spoke model of CAMHS appears to be working well in CHO 2, and addresses some of the difficulties outlined above.

There are, in addition, 6 specialist teams:

1. CAMHS Hub – CHO2
2. CAREDS (Eating disorder Team) – CHO4
3. ADMIRE (ADHD) – CHO 7
4. Specialist Eating Disorder Team – CHO 7
5. CAMHS-ID Team – CHO 7
6. Specialist ADHD – CHO 9

While there is strong evidence of good multidisciplinary working in most teams, the CAMHS depends heavily on a model of care in which the consultant psychiatrist has responsibility for all children accepted for treatment. This is outdated by international practice which favours a more multidisciplinary approach. As this model places the onus on a single profession, the level of increased responsibility disempowers other professions in the multidisciplinary team and may reduce the attractiveness of consultant CAMHS posts to potential international recruits, as the burden is greater. It is also unsustainable with the current medical workforce. *Sharing the Vision* (2020) recommends a review of existing clinical leadership models of governance: The engagement for this policy indicates that models of leadership for the community mental health teams should be reviewed in line with international practice. Clinical leadership, as described in *AVfC* (2006) was vested in the consultant psychiatrist role, in keeping with the requirements of legislation. An alternative model is one of distributed clinical responsibility whereby responsibility is distributed among the involved team members according to their role and contribution. Good clinical governance allows for a model of clinical responsibility that recognises that each individual clinician carries clinical autonomy (and responsibility) with regard to their own specific treatment/ intervention[80].

[80] Teamwork within Mental Health Services in Ireland, Mental Health Commission 2010.

Access to CAMHS

CHAPTER

5

Lack of access to CAMHS Community Teams and CAMHS specialist services (Eating Disorder Teams, CAMHS Forensic Teams, ADHD Teams, CAMHS-ID and CAMHS Liaison Teams) was the most distressing and frustrating aspect of CAMHS as outlined by the parents and young people that we interviewed.

The availability of CAMHS Teams over the past five years was as follows:

Table 8 *Number of CAMHS Teams nationally*

	2018	2019	2020	2021	2022	2023	HSE Target
Number of CAMHS Teams nationally	70	71	72	73	73	75	79

There are six additional specialist CAMHS Teams that have been established over the past two to three years under the National Clinical Programmes. These include the CAREDS (Eating Disorder) in CHO 4 along with a specialist Eating Disorder Team in CHO 7, four CAMHS Intellectual Disability Teams and a specialist ADHD Team in Linn Dara community services (ADMiRE).

Waiting Times

Access to CAMH Services varies across the CHOs reviewed. Table 9 shows the wait time in months in each CHO for the top five reasons for referral in the sample of files we reviewed.

Table 9 *Average wait time in months for top five reasons for referral across CHOs*

	CHO1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	Overall
Query ADHD	7	4	5	7	6	6	4	9	5	6
Query anxiety	3	1	2	3	2	3	3	4	4	3
Query eating disorder	1	0	0	1	2	1	1	1	4	1
Query depression	0	2	0	4	2	2	1	2	2	2
Query anxiety & query depression	3	1	1	3	5	2	1	3	5	3

The CAMHS Operating Guidelines state that when a referral has been screened, it is then categorised into:

- Emergency
- Urgent
- Routine
- Not appropriate for CAMHS.

From Table 9, the CHO with the longest average wait time from referral to assessment is query ADHD in CHO 8, where the average wait time from referral to assessment is nine months. The CHO with the shortest wait time from referral to assessment is query eating disorder in CHO 3 with an average wait time from referral to assessment of 19 days.

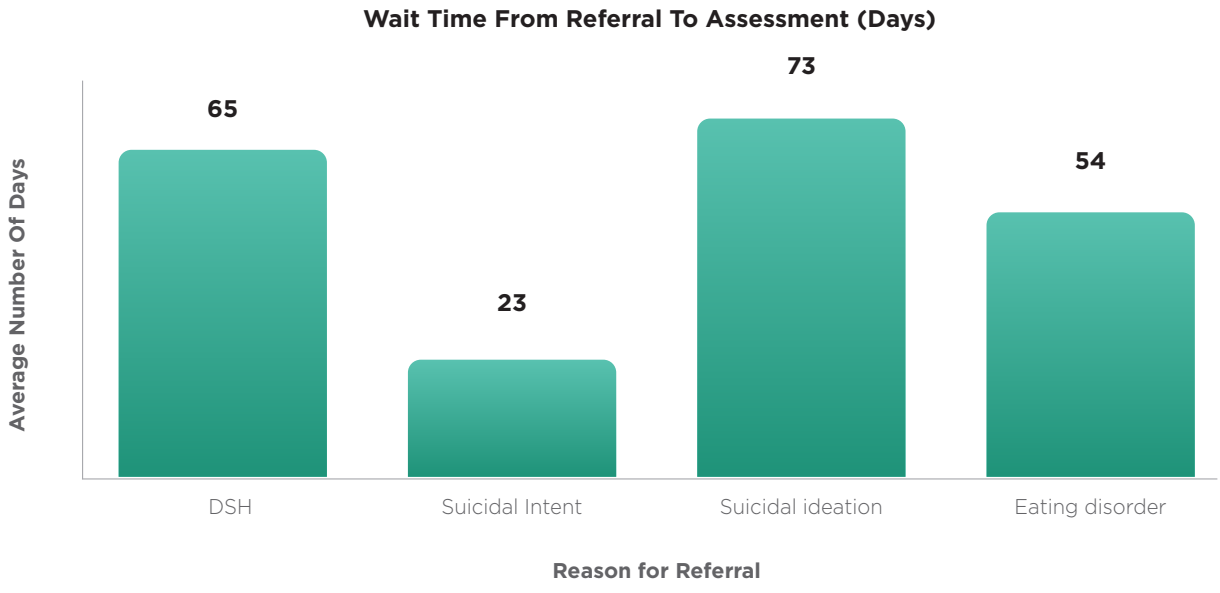
Referrals	2019
Emergency Referrals	During office hours CAMHS Community Teams operate from Monday to Friday 9.00 a.m. to 5.00 p.m. CAMHS Community Teams can be contacted during these hours to discuss emergency referrals in consultation with the Consultant Psychiatrist. They can provide advice and consultation when the emergency or crisis is due to a diagnosed or suspected mental disorder.
Urgent referrals	An urgent referral is one where there is a clear and present level of acute symptoms of mental disorder and where there is a strong likelihood of considerable deterioration in mental state if left untreated. Urgent referrals should be responded to within three working days of rec
Routine referral	A routine referral is one where there are clear and present levels of acute symptoms of moderate to severe mental disorder which have been ongoing but can be managed in the short-term by the child or adolescent's support network (i.e. parent(s) or other agencies.) Routine referrals should be seen within 12 weeks or sooner depending on service demands.

Source: CAMHS Operational Guidelines

Cases classified as Routine are placed on a waiting list and if there is a change or deterioration in their condition parents are advised to contact the team as the case may need to be re pioritised.

In the below analysis we have focused on analysing the wait time from referral to assessment for the following reasons for referral by the GP: deliberate self-harm (DSH), suicidal intent, suicidal ideation and eating disorder (ED). Please note that a child/adolescent can be referred based on more than one condition or because they are queried to have more than one condition. This may impact the child/adolescent's wait time from referral to assessment. The graph below displays the average wait time from referral to assessment in days for each of the conditions mentioned above.

Figure 19 *Wait time from referral to first assessment*



In order to deal with lengthy waiting list, which were also there before COVID-19, there have been various waiting list initiatives, which has resulted in a reduction in the number of children waiting for initial assessments from CAMHS. This, however, can result in internal waiting lists, as following an initial assessment there may be a waiting list for therapies and therapists within the CAMHS Team due to shortages of staff. These are not captured in any KPIs and therefore not measured and can be up to six months or more. These are hidden waiting lists; parents have told us that they are so pleased to be accepted by CAMHS, and do not want to complain about the length of time waiting for treatment as they are afraid they will lose their place for CAMHS.

We observed that from information provided by the CHOs, waiting lists in a significant number of teams had increased between the time of our review of the teams and March 2023.

The average wait time across all CHOs in CAMHS from referral to assessment is three months. The table below displays the average wait time from referral to assessment for all CHOs.

Table 10 *Average wait time in days from referral to assessment*

CHO	Average wait time from referral to assessment (days)
CHO 1	102
CHO 2	64
CHO 3	72
CHO 4	131
CHO 5	120
CHO 6	96
CHO 7	89
CHO 8	121
CHO 9	128
Total	105

Referrals

The referral acceptance by CAMHS in the nine CHOs reviewed ranged from 38% to 84%, showing wide variation in acceptance rates in CAMHS. It was difficult to find a reason for this. Some teams interpretated criteria for acceptance of referrals more loosely than others, being more likely to accept children with autism and intellectual disabilities. Another team looked for IQ assessments from the GP or Primary Care before considering a referral and others refused referrals if the referral form from the GP was not completely filled in (a process which GPs say takes too much time, eating into their own clinical time). The reasons for the variation may be complex including the availability of primary care and disability services locally.

Referrals to CAMHS have increased in the last two years and the severity and complexity of cases have also risen. Between 2020 and 2021, referral rates into CAMHS increased by 33%, while the number of new cases seen increased by 21% in that same period[81]. It is likely that these changes may have happened partly as a result of COVID-19 and enforced lockdowns but the full reasons for this are not known as no formal studies have been done. This has put pressure on already understaffed teams, resulting in more children on waiting lists for longer.

There is a lack of knowledge among the public about the divisions between the different providers of mental health services for children/young people. "Meeting the criteria for CAMHS" or "not meeting the criteria for CAMHS" is an enormous issue for parents but nobody has told them what those criteria are. The HSE CAMHS website does not make it clear, nor is the website particularly user friendly. GPs are often unsure where the cut-off points for mild–moderate–severe mental illness lie. In the absence of a one-stop-shop for triaging referrals to all mental health services for children/young people, referrals are often made to the "wrong" service and the children/young people end up on two or more consecutive waiting lists.

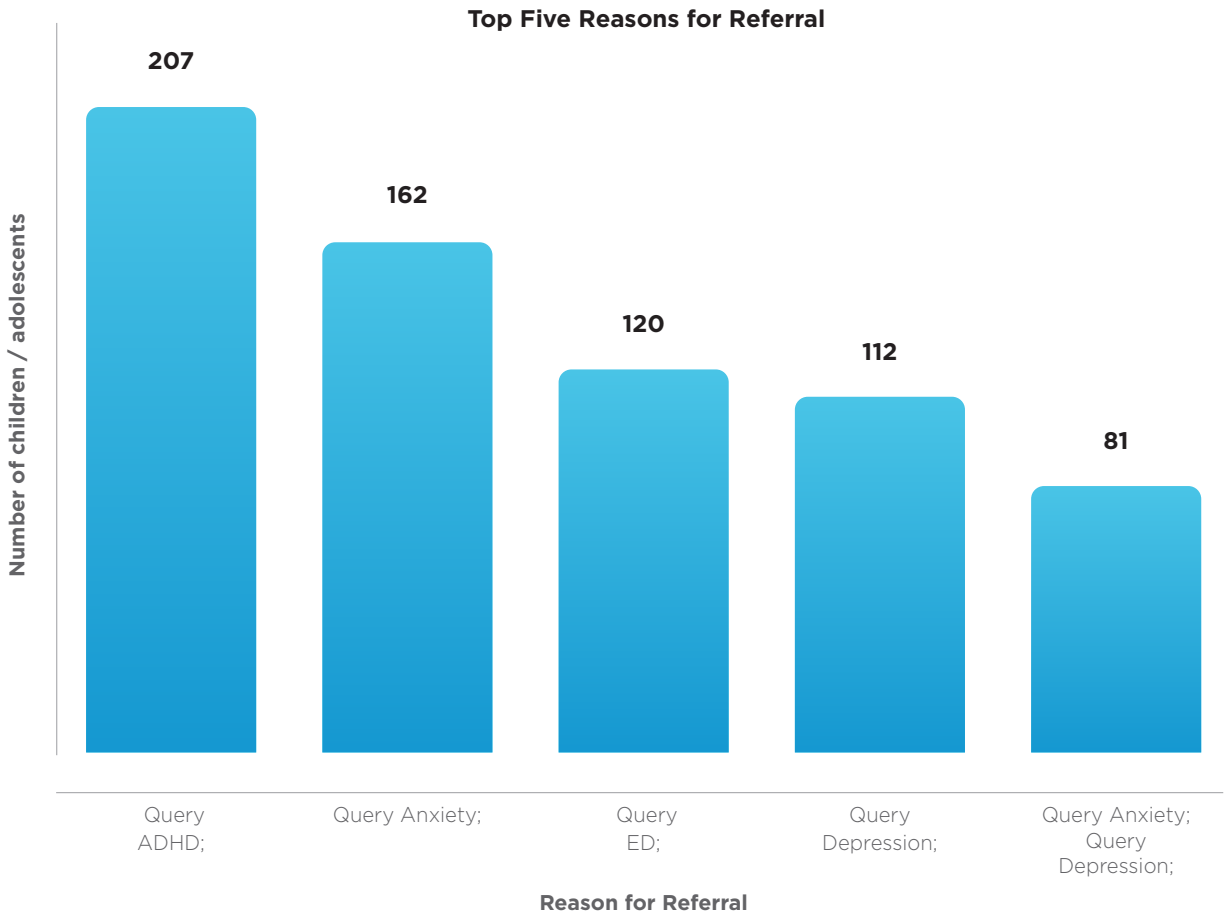
In our sample (1,178) of the clinical files of children attending CAMHS, 72% of children/adolescents were accepted to CAMHS on their first referral. The table below displays the percentage of children in each CHO that were accepted to CAMHS on first referral in our sample.

[81] Dáil Éireann debate Minister of Health Mr Stephen Donnelly. Thursday, 26 Jan 2023, Vol. 1032 No. 3.

Table 11 *Percentage of children/adolescents accepted to CAMHS on first referral*

CHO	Percentage of children/adolescents accepted to CAMHS on first referral
CHO 1	72%
CHO 2	79%
CHO 3	79%
CHO 4	64%
CHO 5	66%
CHO 6	69%
CHO 7	79%
CHO 8	72%
CHO 9	73%
Total	72%

Figure 20 *Main reasons for referrals to CAMHS*



CHO 2, CHO 3 and CHO 7 have the highest acceptance on first referral while CHO 4 has the lowest acceptance on first referral.

The Danish study referred to above found more than a third of the referrals were re-referrals (35.9%)[82]. This is comparable to previous findings from the UK[83] (30%) and Canada[84]. Despite high re-referral rates, there is a paucity of research on predicters of re-referral to outpatient CAMHS. There are several possible explanations for the high proportion of re-referrals. The nature of childhood mental disorders is that they are often persistent, and recurrence rates for disorders such as depression and anxiety are high. In addition heterogeneity in psychopathological development can result in a need for renewed assessment by CAMHS[85]. Rutter et al. also make the point that co-morbidity rates for childhood mental disorders are high and although comorbid conditions might not develop until after initial assessment, there is also the possibility that co-morbidity is missed at initial assessment.

The re-referral rates for CAMHS are high with some children and young people being referred two or three times for the same difficulties, as can be seen in the Table 12 below.

Table 12 *Re-referral rates to CAMHS*

Top five reasons for referral	First referral accepted	One or more previous referrals to CAMHS refused	Unknown
Query ADHD	69%	30%	1%
Query Anxiety	72%	27%	1%
Query Eating Disorder	85%	14%	1%
Query Depression	76%	24%	0%
Query Anxiety & Query Depression	73%	27%	0%

In all cases, when refused for CAMHS, the children/young people were signposted to other services. The long waiting lists for Primary Care (sometimes three years or more) meant that children/young people's mental state deteriorated while waiting to the point that they now had a moderate or serious mental illness and required CAMHS treatment or made a crisis presentation to the Emergency Department.

It is completely unacceptable that children/young people are allowed to linger on long waiting lists in many cases for years, until they get to the point where they become seriously ill. A seriously ill young person with depression may develop suicidal behaviour, an anxious child may deteriorate to the point where they are absent from school or social interactions and a child with ADHD may develop behaviour problems that prevent them from attending school or interacting with their peers.

The acceptance rates for referrals to CAMHS varies considerably from 30% in one team to over 80% in others. Some teams see children with uncomplicated autism despite the fact that autism without concurrent mental illness is an exclusion criterium for CAMHS. Other teams are slow to discharge children due to the lack of alternative services or appropriate adult services available. Many teams wrestled with the ethical dilemma of turning away children and young people who did not meet the criteria for CAMHS but for whom there was no timely alternative provision of services. The difficulty with not discharging or accepting children who did not meet the criteria was that other children who did meet the criteria were left on a waiting list that would increase in size and in the length of time waiting for an assessment.

There is also a variation in the emergency/out-of-hours provision of CAMHS across the five CHOs reviewed. For example, one CHO had an on-call Registrar available with consultant support whereas in more rural areas it depended on the day of the week, i.e. if consultant cover was available. Consequently some children were left for long periods in the Emergency Department or in paediatric beds.

[82] Hansen, AS, Christoffersen, CH, Telléus, GK et al. Referral patterns to outpatient child and adolescent mental health services and factors associated with referrals being rejected. A cross-sectional observational study. *BMC Health Serv Res* 21, 1063 (2021).

[83] Hinrichs S, Owens M, Dunn V, Goodyer I. General practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways: a multimethod research study. *BMJ Open*. 2012; 2(6): e001573.

[84] Reid GJ, Stewart SL, Barwick M, Carter J, Leschied A, Neufeld RWJ, et al. Predicting patterns of service utilization within children's mental health agencies. *BMC Health Serv* Res. 2019; 19(1): 993.

[85] Rutter M, Kim-Cohen J, Maughan B. Continuities and discontinuities in psychopathology between childhood and adult life. *J Child Psychol Psychiatry Allied Discip*. 2006; 47(3–4): 276–295.

Specialist Teams

Eating Disorder Teams

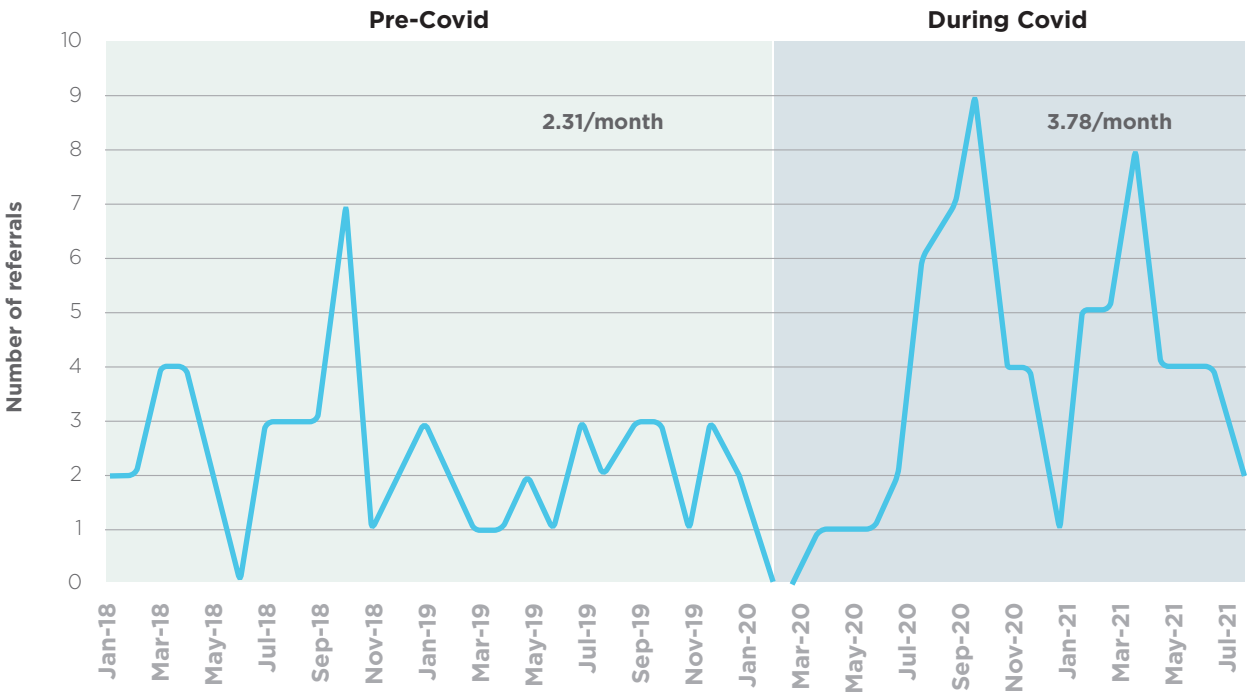
Eating Disorders (EDs) are caused by a combination of genetic, biological and psychosocial factors and occur across gender, age and cultural, ethnic and socioeconomic groupings. Although not common, eating disorders result in very high psychosocial and economic cost to individuals, families, healthcare and society when not treated or treated ineffectively[86]. EDs have the highest mortality and morbidity of all of the mental health conditions[87].

Galmiche et al. carried out a systematic literature review of the prevalence of eating disorders over the 2000–2018 period. They found that for eating disorders the point prevalence was 5.7% for women and 2.2% for men. Eating Disorders (EDs) are highly prevalent in adolescents ranging from 6% to 8% in total in several studies of point prevalence, and studies report the early onset of EDs, especially Anorexia Nervosa and Bulimia Nervosa. The authors of this review found that the point prevalence increased over the time of the research reviewed "which is a real challenge for public health and healthcare providers"[88].

COVID-19

Many recent studies internationally showed an increase in young people with eating disorders presenting to CAMHS during COVID. The pandemic, which was a time of lockdowns, uncertainty and self-perceived lack of control, could be particularly difficult for a group of vulnerable young people and might account for the reported rise in ED cases.

Figure 21 *Number of Family-Based Therapy referrals January 2018–August 2021*



Source: Campbell et al. The Long-Term Impact of COVID-19 on Presentations to a Specialist Child and Adolescent Eating Disorder Program, Ir Med J; September 2022; Vol 115; No. 8; 2022.

[86] Investment in Need. Cost effective interventions for Eating Disorders 2015. The Butterfly Foundation.

[87] Arcelus J, Mitchell AJ, Wales J, Nielsen S. Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders: A Meta-analysis of 36 Studies. Arch Gen Psychiatry 2011; 68(7): 724–731. doi:10.1001/archgenpsychiatry.2011.74

[88] Galmiche M, Déchelotte P, Lambert G, Tavolacci MP. Prevalence of eating disorders over the 2000–2018 period: a systematic literature review. Am J Clin Nutr. 2019 May 1;109(5):1402–1413. doi: 10.1093/ajcn/nqy342. PMID: 31051507.

Irish national data saw a 66% and 120% rise in ED referrals in 2020 and 2021 respectively[89 90]. Campbell et al., in an Irish study in 2022 which examined the rate of referrals pre-COVID-19 (January 2018–February 2020) compared to during COVID-19 (March 2020–August 2021), found that there were significantly higher rates of referrals each month during COVID-19 compared to pre-COVID-19 to a specialist ED programme embedded in CAMHS[91]. They found that 80% of the young people referred self-declared COVID-19 as a contributory factor in the development of their ED.

National Clinical Programme for Eating Disorders

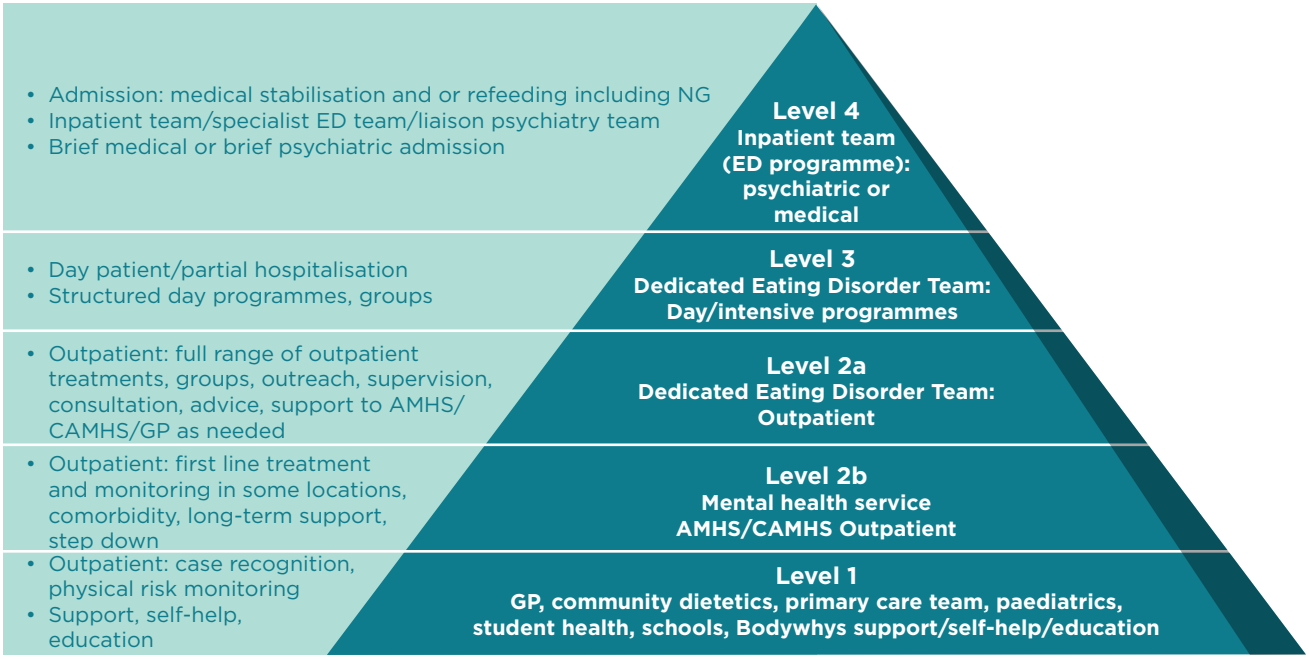
The National Clinical Programme for Eating Disorders[92] recommends that a national network of dedicated Eating Disorder Teams be established to support existing adult and child mental health teams in the delivery of eating disorder care. It is recommended that adult and child Eating Disorder Teams be established in each area to form "Eating Disorder Hubs" in order to collaborate on developing eating disorder services in their sector.

The HSE National Clinical Programme for Eating Disorders and its model of care is linked with the following DSM-5 Eating Disorder categories:

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Avoid/Restrictive Food Intake Disorder (AFRID)
- Other Specified Feeding and Eating Disorders (OSFED).

The aim of this model of care is to provide a stepped approach to respond to the various degrees of complexity across a range of settings from inpatient to day hospital and enhanced community outpatient clinics.

Figure 22 *Stepped Model of Care for Eating Disorders*



[89] Barrett, E.; Richardson, S. Invited Editorial: Eating Disorders during the COVID-19 Pandemic in Ireland. *Ir. Med. J.* 2021, 114, 233.

[90] Parsons, H.; Murphy, B.; Malone, D.; Holme, I. Review of Ireland's First Year of the COVID-19 Pandemic Impact on People Affected by Eating Disorders: 'Behind Every Screen There Was a Family Supporting a Person with an Eating Disorder'. *J Clin Med.* 2021, 10, 3385. https://doi.org/10.3390/jcm10153385

[91] S. Campbell, K. Maunder, O. Lehmann, M. McKeown, F. McNicholas. The Long-Term Impact of COVID-19 on Presentations to a Specialist Child and Adolescent Eating Disorder Program, *Ir Med J;* September 2022; Vol 115; No. 8; 2022.

[92] Eating Disorders - HSE.ie accessed 1 May 2023

The HSE National Clinical Programme for Eating Disorders (NCP-ED) is a collaborative initiative between the HSE, the College of Psychiatrists of Ireland, and BodyWhys – the national support group for people with eating disorders.

The HSE is developing an Eating Disorder Hub Network throughout Ireland with recruitment of additional specialist community Eating Disorder Teams across the CHOs in line with the model of care[93].

There were two fully operational Eating Disorder Teams (CHO 4 and CHO 7), and further teams were in development in two other CHOs which were not fully operational at the time of writing. As per the above, there should be at least one Eating Disorder Team in each of the nine CHOs in order to provide equality of access.

In our sample of clinical files of children/young people referred to CAMHS, 15% had eating disorder as their reason for referral. The average wait time from referral to assessment for a child/young person with eating disorder as one of their reasons for referral was one month.

Table 13 *Average wait time from referral to assessment for a child/young person with eating disorder*

CHO	Percentage of children/ adolescents with eating disorder	Average wait time from referral to assessment (days)
CHO 1	23%	60
CHO 2	12%	30
CHO 3	15%	21
CHO 4	12%	45
CHO 5	16%	63
CHO 6	14%	49
CHO 7*	12%	45
CHO 8	18%	46
CHO 9	22%	108
Total	15%	54

* In CHO 7 The Linn Dara Community Eating Disorder Team see children with eating disorders in CHO 7. Urgent cases are seen within a week, less urgent cases within four to six weeks.

From Table 13 it can be seen that CHO 1 has the greatest percentage of children/young people with eating disorder as one of their reasons for referral. As per the above, there should be at least one Eating Disorder Team in each of the nine CHOs in order to provide equality of access.

Family-based treatment (FBT) has emerged as the leading evidence-based treatment for adolescents with eating disorders and is recommended as the first-line treatment for patients who are medically stable for outpatient care. FBT is meant to be practised by trained mental health providers experienced in the treatment of adolescents with eating disorders and skilled in working with families. Given the medical complications and prevalent psychiatric comorbidities of these patients, a multidisciplinary team is essential to provide the required care.

Enhanced Cognitive Behavioural Therapy (CBT-E) is an evidence-based treatment for eating disorders. It is a modified version of Cognitive Behavioural Therapy (CBT) created specifically for eating disorders and their difficulties.

Dietitians play a major role in providing care as part of a multidisciplinary team. They often work alongside mental health professionals, therapists, doctors and nurses to provide services for people who are suffering from eating disorders.

There are currently 20 dedicated eating disorder beds across the four CAMHS inpatient units, as follows.

Table 14 *Dedicated eating disorder beds*

Inpatient Unit	CHO	Number of beds
Linn Dara	CHO 7	8
CAMHS Inpatient Unit Merlin Park	CHO 2	6
Eist Linn	CHO 4	3
Adolescent Inpatient Unit (AIPU), St Vincent's Hospital Fairview	CHO 9	3

As part of the new children's hospital development, there will be an additional eight specialist eating disorder beds as part of a new 20-bed CAMHS inpatient approved centre.

[93] hse-eating-disorder-services-model-of-care.pdf

There have been some additional developments within the HSE:

- Development of online and face-to-face training and education for all clinicians including supervision and support in the delivery of evidence-based outcomes.
- E-tender to develop online platform for capturing real-time information on clinical service.
- Service user outcome measures.
- Continued close collaboration with BodyWhys, including delivery of the Pilar programme, which supports family members caring for a person with an eating disorder.

ADHD Teams

Attention deficit hyperactivity disorder has become a major aspect of the work of child and adolescent psychiatrists and paediatricians across many countries. In Scotland, Child and Adolescent Mental Health Services were required to address an increase in referral rates and changes in evidence-based medicine and guidelines without additional funding. In response to this, clinicians in Dundee have, over the past 15 years, pioneered the use of integrated psychiatric, paediatric, nursing, occupational therapy, dietetic and psychological care, with the development of a clearly structured, evidence-based assessment and treatment pathway to provide effective therapy for children and adolescents with ADHD. The Dundee ADHD Clinical Care Pathway (DACCP) or Dundee Model, uses standard protocols for assessment, titration and routine monitoring of clinical care and treatment outcomes, with much of the clinical work being nurse-led. The DACCP has received international attention and has been used as a template for service development in many countries[94].

In Ireland, an inequity of service provision has arisen due to urgent cases (e.g., suicidal ideation/intent, severe depression, eating disorder, psychosis) being necessarily prioritised ahead of routine referrals, including ADHD assessments, leading to a delay in access to ADHD services. A consequence of untreated/delayed treatment of ADHD is more complex presentations, and delayed delivery and progression of care provision for this group of children/young people.

Assessing the developmental comorbidities of ADHD can be a challenge. Striking a balance between having timely access to CAMHS while at the same time having the right amount of support from disability, social and Primary Care services is a difficult process.

An ADHD in Adults Model of Care was launched in 2021, which was needed. Disappointingly, there was no similar model of care for children/young people with ADHD. We were informed by the HSE that a Clinical Lead for attention deficit hyperactivity disorder in children and adolescents has been appointed. Once the Clinical Lead has taken up the post, work will commence on the development of a model of care for ADHD CAMHS.

We found one ADHD Team (ADMiRE) in CHO 7 with plans to roll out two more ADHD Teams. There was an ADHD Neurodevelopmental Team in CHO 9. Funding had been approved in CHO 4 for the rollout of an ADHD Team.

CAMHS-ID Services

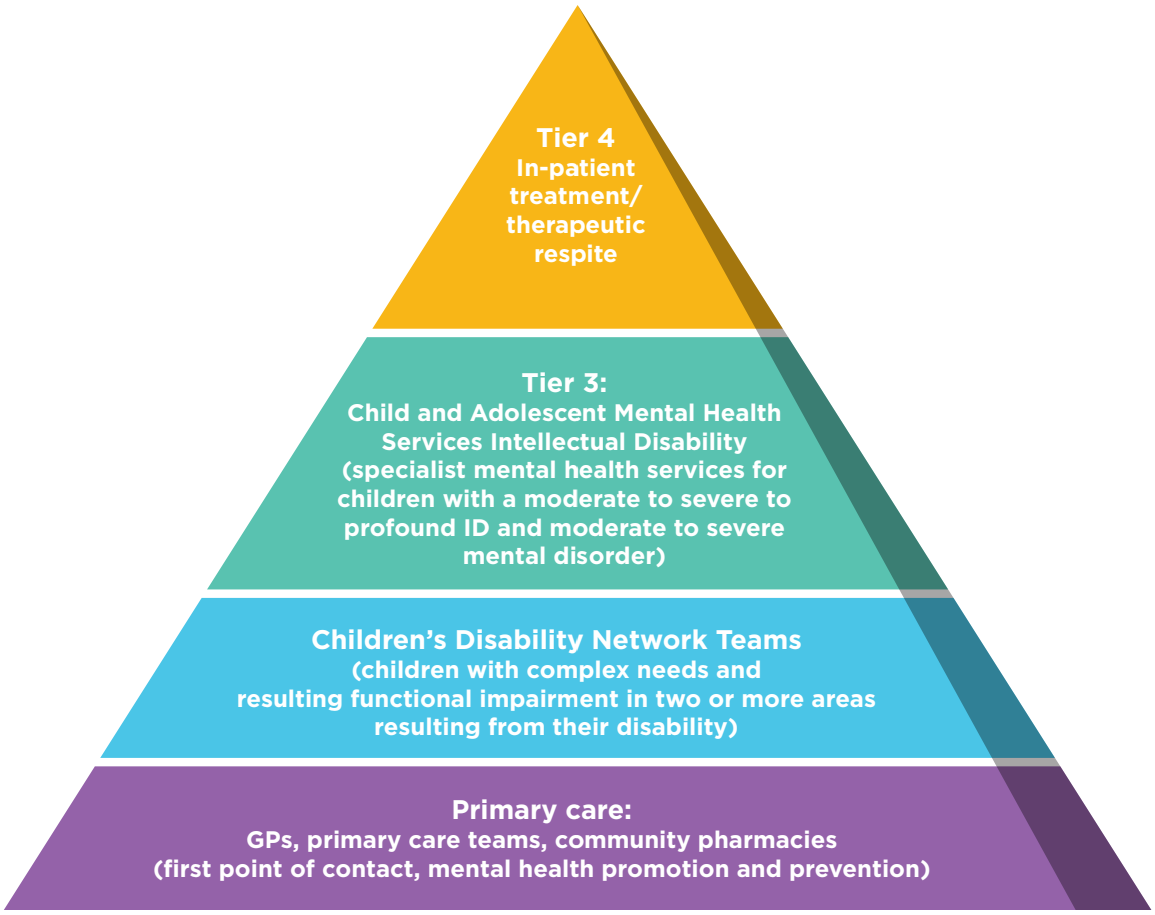
Over 1.4% of the population were described as having an intellectual disability in the Irish Census of 2016, of which 24,474 were under the age of 19 years. It is well recognised that children with an intellectual disability have a higher incidence of mental health problems than children who do not have a cognitive disability.

CAMHS-ID Teams provide a specialist mental health service to children and adolescents with an intellectual disability and comorbid moderate-to-severe mental disorder. These teams are distinct and separate from, but closely linked to, the multidisciplinary Children's Disability Network Teams, who provide a health and social care service for children with intellectual disability. The CAMHS-ID Model of Service[95] states *that it would be best practice for multidisciplinary intervention to be provided initially by the Children's Disability Network Team prior to a referral to CAMHS-ID.*

[94] Coghill D, Seth S. Effective management of attention-deficit/hyperactivity disorder (ADHD) through structured re-assessment: the Dundee ADHD Clinical Care Pathway. *Child Adolesc Psychiatry Ment Health.* 2015 Nov 19; 9: 52. doi: 10.1186/s13034-015-0083-2. PMID: 26587055; PMCID: PMC4652349.C Effective management of attention-deficit/hyperactivity disorder (ADHD) through structured re-assessment: the Dundee ADHD Clinical Care Pathway - PubMed (nih.gov)

[95] Specialist Child and Adolescent Mental Health Services for Children with Intellectual Disability (CAMHS-ID) National Model of Service. HSE, CAMHS ID Model of Service

Figure 23 *Specialist Child and Adolescent Mental Health Services for Children with Intellectual Disability (CAMHS-ID)*



Source: Specialist Child and Adolescent Mental Health Services for Children with Intellectual Disability (CAMHS-ID) National Model of Service, HSE.

Children and adolescents with intellectual disability living with a mental disorder may not only need support from a specialist mental health service, but also, at various points or simultaneously, from all community services (Primary Care, CDNT, CAMHS-ID and inpatient services) during their illness, treatment and recovery. There is no clinical governance structure linking these staff members with mental health colleagues and hence they do not provide a CAMHS-ID service structure.

The CAMHS-ID Model of Service[96] was launched in September 2022 and states that

> *Children and adolescents with an intellectual disability should have access to mental health services in the same way as those of normal cognitive ability, within a framework which is multidisciplinary and catchment area based. Team members should have appropriate training and expertise, and teams should be suitably resourced.*

It is welcome that this model of service has a rights-based approach in its guidance and that it spells out clearly what resources are required to provide a CAMHS-ID service. The

[96] CAMHS-ID - Model of Service (hse.ie)

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) commits to ensuring the right of people with disability to the highest attainable standard of health, without discrimination. Article 24 of the United Nations Convention on the Rights of the Child specifies that

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

The model of service recommends one CAMHS-ID Team per 300,000 total population, as did *A Vision for Change* in 2006. Progress with *AVfC* recommendations has been disappointing in that it has been piecemeal and slow. However, over the last 18 months, there has been a significant recruitment drive in mental health intellectual disability (MHID)/CAMHS-ID services nationally. A total of 31 multidisciplinary staff have been employed and there is a recruitment process in place for another 23 posts. CAMHS-ID services are at 23% of the required service levels outlined in *AVfC*.

The HSE stated to the Joint Sub-Committee of the Oireachtas this year, 2023, that, in relation to CAMHS-ID (or "MHID in children" as it is referred to in the statement):

> *We completed a model of care two years ago for mental health intellectual disability, MHID, in children, which was launched last year. We have funding available for 14 posts. We need 18 posts for full programme roll-out, but we have nine people at present. Nine teams have been added to the 73 teams. There are nine MHID Teams*[97]

There should be one CAMHS-ID ("MHID" referred to above) per 300,000 population, i.e. 17 CAMHS-ID Teams across the country. There currently are sparsely staffed teams in CHO 5, CHO 7, CHO 4 and CHO 8, with two others in development in CHO 2 and CHO 3. There are some areas where difficulties in staff recruitment have contributed to lack of progress in developing CAMHS-ID Teams. In those areas, local arrangements exist whereby other CAMHS Teams provide services or consultant psychiatrists provide a consultative service. CAMHS-ID Teams have increased their staff capacity from 14% to 21% over the last 18 months, but we did not find nine teams, referred to above, fully developed as yet. Funding for 18 posts referred to above will not provide a comprehensive CAMHS-ID service across the country.

Recruitment issues, especially for consultant psychiatrists in CAMHS-ID, are a significant challenge. The reasons for this are more complex than can be addressed by the MHID Service Improvement Programme[98] (a framework for providing specialist mental health services for people with an intellectual disability), and there are multi-agency efforts to address this.

Psychiatry of Learning Disability is one of the four specialty registers maintained by the Irish Medical Council. Specialists in child and adolescent psychiatry in Ireland receive their certificate of specialist training in child and adolescent psychiatry and are registered on the specialist register for child and adolescent psychiatry and must have completed one year of training in child and adolescent intellectual disability psychiatry.

Careful thought should be put into designing suitable facilities for assessment and interventions with children with an intellectual disability. The model of service recommends:

[97] Joint subcommittee on Mental Health debate Tuesday 14 February 2023.

[98] Mental Health Services for Adults with Intellectual Disabilities: National Model of Service HSE 2019.

Physical access	For wheelchair users – walking aids, handrails, ramps, lifts and lowered counters.
Sensory access	For people with hearing and visual impairment – tactile markings, signs and labels, hearing-augmentation listening systems, audio cues for lifts and lights.
Communication access	For people who have difficulties with the written word, vision, speech and language problems or who are non-English speakers – ideally the support of a speech and language therapist.
Accessible systems	Detailed service information should be provided. This may include information on services on noticeboards and the HSE website; documents in plain English, Easy Read and video formats; and digital accessibility tools.

We did not always find suitable facilities for CAMHS-ID services. One facility consisted of two small rooms furnished as offices in the middle of an old psychiatric asylum. The consultant psychiatrist had no team and carried out most of his assessment in schools.

Paediatric Liaison Services

A Paediatric Liaison Service (PLP) team's main focus is: identification and management of mental health problems in children with physical conditions (e.g. depression in the context of terminal illness such as cancer); the management of unexplained medical symptoms (e.g. conversion disorder, complex pain in the context of psychosocial difficulties); and the overall promotion of positive mental health in the acute hospital setting.

Where PLP services exist in hospitals that have an emergency department, they also provide consultations to consultant physicians in the ED. Typical roles involve the urgent assessment and acute management of psychiatric emergencies (self-harm, delirium, acute disturbance of behaviours, acute psychosis). Decisions are made based on clinical risk and safety as to subsequent management plans, such as DC with/without referral to CAMHS, admission to hospital or further assessment, or onward referral to IPU.

According to *AVfC*, the composition of a liaison mental health team should be as follows:

- one consultant liaison psychiatrist,
- one doctor in training,
- two clinical psychologists, and
- five clinical nurse specialists to include two specialist nurse behaviour therapists or psychotherapists and two secretaries/ administrators.

Other staff usually required include:

- one neuropsychologist (sites with neurology/ neurosurgery departments),
- one mental health social worker,
- one occupational therapist with vocational rehabilitation skills,
- one substance misuse counsellor, and
- one family therapist.

Each team should have a clearly identified clinical leader, team coordinator and practice manager. Adequate facilities should be provided for the Liaison Mental Health Services (LMHS) Team to carry out its functions.

There are three major pediatric hospitals in Dublin, each managed by the Children's Health Ireland group. Each of these hospitals provides a national pediatric service to adolescents and children. As such, cases in which the PLP teams are consulted may come from any catchment area in Ireland. Each of the three Paediatric Liaison Services reported a significant increase in emergency psychiatric presentations in recent years. Emergency departments in regional hospitals also provide services to young people who present to them with a mental health crisis. The majority of these presentations are due to self-harm and suicidal behaviours.

Other reasons for presentation at Emergency Departments include eating disorders and disordered eating, low mood, challenging behaviour, anxiety, psychosis and obsessive compulsive disorder (OCD).

Findings from the wider MHC CAMHS review revealed that the Community CAMHS Teams often relied on the services provided by out-of-hours and Liaison CAMHS Teams as an additional safety measure for their services. CAMHS Teams generally close at 5pm and not all CHO CAMHS are resourced to offer emergency services after this time. Therefore, it was not unusual for the Community Teams to advise young people to attend their local Emergency Department if they required emergency care and treatment in the evenings or overnight as part of the young person's 'Safety Plan' within the care and treatment received from the Community CAMHS Teams.

The aim of this part of the report is to describe the national psychiatric liaison services within the three main paediatric hospitals and to present the strengths of and challenges facing each of these three services. This section also aims to describe some of the regional out-of-hours CAMHS Liaison Services that are in place outside of Dublin and to present the challenges to these services.

Paediatric Liaison Service at CHI Crumlin

Description of Service

Children's Health Ireland at Crumlin is an acute national paediatric teaching hospital. It is Ireland's largest paediatric hospital and is responsible nationally for the provision of the majority of tertiary healthcare services for children. The hospital also provides secondary care for the local catchment area. It is the national centre in Ireland for a range of specialities including childhood cancers and blood disorders, cardiac diseases, major burns, cystic fibrosis and rheumatology. CHI Crumlin has 350 paediatric inpatient beds, none of which are dedicated to paediatric psychiatry. At any one time up to 18 young people receive inpatient treatment for acute mental health needs in CHI Crumlin.

The Paediatric Liaison Service (PLS) is located within the governance structures of the hospital. This is a consultant psychiatrist-led service and staffing is currently as follows:

- Consultant psychiatrist 2.2 WTE (1.3 WTE of which is permanent)
- 0.5 Academic Senior Registrar
- Two WTE Registrars
- Four WTE Nurses
- One Advanced Nurse Practitioner

The PLS in Crumlin also specialises in delivering psychiatric care and treatment to young people experiencing a range of genetic conditions including 22Q11 Deletion Syndrome.

Paediatric Liaison Service at CHI Temple Street

Description of Service

CHI at Temple Street is an acute national paediatric hospital. Major specialities at CHI at Temple Street today include neonatal and paediatric surgery, neurology, neurosurgery, nephrology, orthopaedics, ENT and plastic surgery. The National Centre For Paediatric Ophthalmology, the National Paediatric Craniofacial Centre (NPCC), the National Airways Management Centre, the National Meningococcal Laboratory, the National Centre for Inherited Metabolic Disorders (NCIMD), the National New-born Screening Service (NNSS) and the Irish Meningitis and Sepsis Reference Laboratory (IMSRL) are also based at CHI at Temple Street. Historically Temple Street PLS had an outpatient component to its service. However, due to pressures from the volume of emergency presentations, this has been difficult to sustain and is not currently operating.

The Paediatric Liaison Service at Temple Street also sits within the acute hospital governance structures with:

- 2.2 Consultants
- Three WTE Nursing
- Input from the Temple Street Occupational Therapy and Social Work departments. Outpatient work was previously multidisciplinary but is currently largely supported by psychology.

The service recently recruited two new medical appointees – non-consultant hospital doctors – to vacant posts.

It is a multidisciplinary team which works with children and families who are attending the hospital and presenting with psychological, behavioural and/or psychiatric symptoms associated with their medical condition. The aim of the PLS is to reduce child and family stress.

The PLS have expertise in treating mental health symptoms experienced by young people living with diabetes, epilepsy and cystic fibrosis among other conditions.

Paediatric Liaison Service Provision

The PLS in Crumlin and Temple Street provide services to three main case types:

1. **Paediatric Liaison Psychiatry Services:** These are for children/young people referred by paediatric consultants who wish to have a psychiatry review of their medically unwell patients. These young people may or may not have an Axis 1 Mental Health diagnosis. The benefits of providing psychiatric consultation to medically admitted patients are better outcomes, shorter admissions and support for colleagues.
2. **Acute Mental Healthcare:** When young people present to the Emergency Department with suspected acute mental healthcare needs, they are risk-assessed by the PLS. These young people may or may not have a mental health disorder. Where appropriate the young people are then treated by the PLS as inpatients within the hospital or referred on to a more suitable service.
3. **Other speciality services** such as tertiary opinions, psychiatry cases referred from another mental health unit, or consultation for a second opinion or treatment. Previously, a large cohort of young people with ongoing mental and medical co-morbidity were supported as outpatients. Currently this service is closed to new referrals, although existing patients continue to be supported.

A significant proportion of cases who attend ED do so during normal working times. Examining cases presenting from 2016 to 2022, there is an even distribution in that 50.9% presented outside of normal working times, and 49.1% presented between 9am and 5pm.

Strengths and Quality Initiatives by the PLS Teams in CHI Crumlin and CHI Temple Street

Both teams provided a high-quality service to the children and young people who require care and treatment including therapeutic assessment of mental health crises, pharmacological treatment of psychiatric illness, medical stabilisation of eating disorders, liaison with allied health professional colleagues and instant comorbid medical opinions (ECGs, blood tests and neurological examinations).

CHI Temple Street provide equitable 24/7 access to their service through the Emergency Department. CHI Crumlin only provides a service Monday-Friday 9-5pm and three hours, emergency cover on Saturday and Sunday. All young people who required a psychiatric assessment following triage were able to access a psychiatric evaluation in these hospitals.

CHI Temple Street also provides an outpatient paediatric liaison service. CHI Crumlin cannot provide this service due to lack of resources.

A culture of research and data collection existed in both teams. Despite the absence of investment in integrated computerised data-collection systems within the service, medical and nursing staff endeavoured to collect data relevant to the service. These initiatives included but were not limited to:

- Data collection to contribute to national suicide data
- Quality Innovation Music Therapy
- SPACE Project to support parents and young people who have deliberately self-harmed
- A series of academic papers.

Challenges for the PLS Teams in CHI Crumlin and CHI Temple Street

Both PLS Teams provide a crucial service to patients in terms of psychiatric support to young people with chronic physical conditions. Both teams consider this a fundamental aspect of the service they are mandated to provide, and work hard to prioritise this care for their patients. The teams are located within their respective acute hospital structures. Both teams considered this to be entirely appropriate in terms of the provision of liaison services to medically unwell patients who require PLS.

However, the provision of this service has become increasingly challenging in recent years:

1. Both teams reported that there was no parity of esteem between mental health and physical health services for children.
2. This leads to a risk of failure to provide young people with optimal child-centred mental healthcare in a time of crisis,
3. The significant increase in emergency presentations through the Emergency Departments has not resulted in a corresponding increase in resources and staffing for either of the teams. In 2006, Temple Street reported 60; this number had risen ten-fold to 600 by 2022. The rate of emergency presentations in CHI Crumlin has also increased by 49% from 189 to 281 between 2016 and 2022.

4. Given the sheer increase in the volume of emergency presentations through EDs, the teams believe that other structures should also be provided to support this service provision, such as emergency crisis teams.
5. The situation of the PLS within the governance structures of both acute tertiary hospitals gave rise to challenges in terms of the discharge process for young people who had presented with a mental health crisis. Onward referrals to CAMHS Teams were not always accepted. The referral process to CAMHS Inpatient Teams was presented as bureaucratic and time consuming. Referrals were often refused by the CAMHS inpatient services with the assessing team disagreeing with the risk assessment presented by the PLS Teams. Similarly, referrals to CAMHS Community Teams were not automatically accepted and the PLS Teams were often left frustrated by the lack of access and clear care pathways for very unwell young people at discharge. CAMHS Operational Guideline outlines clearly the pathways of referral and the clinical information required for referrals to CAMHS Inpatient Units and Community Teams. It also provides templates that are required by all referring clinicians.
6. The fragmentation of other children's services including CDNT, community psychology, NEPS, social work and Tusla services has an impact on the number of children presenting to the Emergency Department in a crisis. The under-resourcing of these services has led to some children presenting to EDs due to a lack of availability in community services. Many young people with psychological difficulties but no underlying mental health issue present to the EDs at times of crisis. Both teams were particularly concerned about the apparent lack of community autistic spectrum disorder services, which has led to the presentation of young people with autism to the EDs in crisis. Both services reported that young people were brought to their ED by An Garda Síochána, by schoolteachers and by Tusla in order to locate a place of safety for that child. In these cases, a paediatric inpatient bed remains in use as part of what has now become an inappropriate admission. However, in these cases in the absence of a suitable alternative placement for the young person, the team have no option but to prioritise the immediate safety of that young person by continuing to treat them in hospital. This has negatively impacted on the provision of mental health services to other paediatric inpatients in a timely fashion. These admissions are not currently being counted on any register. The teams reported that the increased volume of emergency psychiatric presentations coupled with the lack of matching investment in resources within the teams creates a risk of staff burnout for the clinicians providing the services and makes the PLS Teams a less attractive working environment for potential team members.
7. The teams also highlighted that the *Sharing the Vision* mental health policy fails to address the role of paediatric liaison psychiatry in Child and Adolescent Mental Health Services.

Paediatric Liaison Service at CHI Tallaght

CHI at Tallaght Children's Outpatient and Emergency Care Unit is a new modern facility, purpose-built for families, children and young people. It provides urgent care services to babies and children in the areas of burns and scalds, sprains, strains and broken bones, asthma, croup and other breathing difficulties, seizures and emergency mental health concerns.

The PLS Team primarily provides an acute psychosocial assessment service. The model of psychiatric assessment is assessment, with rapid discharge as soon as possible to appropriate treatment providers to include CAMHS (community or inpatient as appropriate)/Primary Care/disability/Tusla. Decisions for onward care planning are made following a comprehensive psychosocial and mental health assessment. Referrals to community or inpatient services are made in line with the CAMHS Operational Guidelines 2019.

The team consists of:

- (0.4) consultant child and adolescent psychiatrist (locum)
- (0.2) consultant child and adolescent psychiatrist vacancy
- One WTE locum consultant psychiatrist who is transitioning to fulltime at present
- Higher specialist trainee (rotating)
- Two Basic specialist trainees (rotating)
- CNS (employed by CHI)
- CNS self-harm (employed by Linn Dara in CHO 7)
- Admin (0.5 WTE, employed by Linn Dara).

The future plan is to increase the staffing to 2.5 consultant psychiatrist WTEs. Recruitment for these roles is currently in process.

The PLS Team in Tallaght differs from the teams in Temple Street and Crumlin Hospitals in that it comes under a structured shared governance model which views the network of services as one model. The shared governance structure includes Linn Dara CAMHS Services in CHO 7 and Children's Health Ireland (based in Tallaght Hospital).

This shared structure facilitates bridging the gap of transition periods between services, which provides a seamless transition for the child/young person and their family. The team emphasised the importance of good relationships within the formal shared structure. These relationships support the shared structure to facilitate the sharing of resources, which is key for delivery of high-quality care. The PLS Team do not provide tertiary services and some complex cases are referred onwards to CHI Crumlin for treatment where necessary. Similar to Temple Street and Crumlin, the PLS Team have a high volume of emergency presentations, which increased from 171 in 2014 to 411 in 2022. The success of this shared working model is evident by the number of onward referrals to Community CAMHS Teams: 321 in 2022, 17 young people referred to the Community Eating Disorder Service, and 45% of young people discharged were reviewed by their Community CAMHS Team within 24 hours of discharge. The remainder received a follow-up phone call as part of the bridging process to the next point of care.

PLS Team at CHI Tallaght – Successes

The team reported excellent working relationships with their CHI colleagues – Paediatricians, Nursing, Non-Consultant Hospital Doctors, Health and Social Care Professionals and Management. This has helped to foster clinical integration and facilitates attendance at MDT meetings and multi-agency assessments and meetings. They also report exceptional relationships with CAMHS and paediatric colleagues.

The service was recently reviewed by the National Clinical Programme for Self-Harm and Suicide-Related Ideation. Findings from this review illustrated that 99% of young people received a written emergency plan as part of their care and 97% received a biopsychosocial assessment from the PLS Team. The team also provided specialised eating disorder services and linked with the Community Eating Disorder Service in CHO 7. The service is currently working on the development of an electronic health record.

PLS Team at CHI Tallaght – Challenges

The team reported a number of current challenges regarding their premises as they prepare to move to the new CHI site in St James's Campus. The waiting lists for external agencies such as the CDNTs (Community Disability Network Teams), Primary Care Psychology and voluntary organisations also presented difficulties.

Out-of-Hours CAMHS

Fitzgerald et al. found a 526% increase in mental health presentations to one of the Irish paediatric EDs over a 10-year period, from 2006 to 2016[99]. A detailed analysis of presentations in 2014 found that the most common presenting complaint was suicidal ideation at 34.7% (n=103), followed by self-harm at 31% (N=92). Lynch et al.[100] found that, in another paediatric hospital in Dublin over a six-month period, 52% (n=44) engaged in self-harm behaviour, and that almost half of those presenting (46% n=50) were known to CAMHS.

The HSE *Sharing the Vision* Implementation Group has set up a dedicated children and young people's workstream, which has been tasked with progressing a range of policy recommendations, including *Sharing the Vision* Recommendation 35. This recommendation relates to the requirement for a comprehensive out-of-hours response for children and adolescents in all geographical areas. In addition to the continued development of CAMHS Hubs, work is now underway to scope a specialist mental health out-of-hours model using a tiered approach. There are several work programmes under way to improve access to services for children and young people who are experiencing a mental health crisis.

Out-of-Hours CAMHS Within Regional Hospitals

CAMHS Liaison and out-of-hours services outside Dublin vary considerably. Information gathered as part of the wider CAMHS study

[99] Fitzgerald, E. Foley, D, McNamara, R, Barrett, E, Boylan, C, Butler, J, Morgan S, Okafor, I. (2020) Trends in Mental Health Presentations to a Paediatric Emergency Department. *Ir Med J* 133: No. 2 P20.

[100] Lynch, F, Kehoe, C, MacMahon, S, McCarra, E, McKenna, R, D'alton, A, Barrett, E., Twohig, A, McNicholas, F. (2017) Paediatric Consultation Liaison Psychiatry Services (PCLPS) What are they actually doing? *IMJ* 110; No. 10 P. 652.

indicated that although there is an increasing number of young people presenting to EDs with symptoms of acute mental illness, the services provided are not uniform and considerable gaps exist.

Below is a table containing the details of some of the CAMHS Liaison Services and out-of-hours services that exist within the regional hospitals. This list is not exhaustive but provides examples of the services that can be accessed by young people experiencing an out-of-hours psychiatric emergency.

Area	Out-of-hours service
CHO 2	*CAMHS Liaison Service* An Advanced Nurse Practitioner in CAMHS Liaison has just started in University Hospital Galway. *Out-of-Hours CAMHS* Out-of-hours CAMHS is provided 24 hours a day, seven days a week. The NCHD on the general on-call rota (all CAMHS NCHDs participate in this rota) assesses the young person and then contact one of the CAMHS Senior Registrars on call. A CAMHS consultant psychiatrist is on call at all times. A day hospital support on Sundays and Bank Holidays is commencing and a Clinical Nurse Specialist will join the emerging CAMHS Liaison team.
Drogheda	*CAMHS Liaison Service* Up until the end of 2020, there was a CAMHS Liaison Service in place. There is currently no dedicated CAMHS Liaison Team. At the present time, children/young people are assessed by paediatric team or medical ward and Our Lady of Lourdes makes a referral to the CAMHS Team, who will review the young person in their clinic on the understanding that the medical bed is kept. There are three urgent slots per week for these assessments. *Out-of-hours CAMHS* Currently there is no out-of-hours CAMHS.
Cavan/ Monaghan	*CAMHS Liaison Service* There is no specific CAMHS Liaison Service in Cavan/Monaghan. *Out-of-hours CAMHS* Young people presenting to the ED out of hours in the under-16 age group are generally admitted to the Paediatric Unit in Cavan General Hospital and assessed by the relevant CAMHS Team. These referrals are treated as urgent and usually seen on the day of referral. Young people in the 16–18 age group who present to the ED out of hours are assessed by the on-call NCHD. This on-call arrangement is primarily for the adult service. The team have an agreement locally that this also covers 16–18-year-old presentations out of hours.

Area	Out-of-hours service
Cork	*CAMHS Liaison Service* The service currently provides emergency CAMHS assessments to young people under the age of 18 who attend Cork University Hospital and Mercy University Hospital from 9am to 5pm five days a week. The service also offers consultation and assessments for paediatric inpatients by direct referral from paediatricians. The Cork CAMHS Liaison Service comprises: • One WTE Consultant Child and Adolescent Psychiatrist • One WTE CAMHS CNM2 • 0.5 WTE CAMHS Clinical Nurse Specialist. There is currently a vacancy for the CAMHS Registrar post. *Out of Hours CAMHS* Emergency cover is provided until 9pm at the Emergency Departments in Cork University Hospital and the Mercy University Hospital. This service is provided by CAMHS Consultant Psychiatrists, Senior Registrars and Registrars. The night-time on-call service operates from 5pm (4pm on Fridays) until 9am. In the absence of a bed in Eist Linn a child may be admitted to the paediatric wards or if over 16 years to the adult medical ward. The registrar and Senior Registrar and Consultant also provide an on-call service to Eist Linn inpatient unit from 5pm until 9am. Eist Linn inpatient unit is available for emergency out of hour's admissions. There is no out-of-hours CAMHS in Kerry.
Tullamore & Portlaoise	*CAMHS Liaison Service* There is currently no dedicated CAMHS Liaison Team. Young people from Offaly can attend Offaly Regional Hospital [Tullamore], Portiuncula, Portlaoise or Mullingar. Tullamore does not have a paediatric department; however, the other three hospitals do. Staff from the paediatric departments will organise a review by the Psychiatric Registrar and then contact the relevant CAMHS consultant as appropriate. There is a CAMHS Registrar on call from 5pm until 9am who covers Tullamore and Portlaoise hospitals seven days a week. The Tullamore and Portlaoise hospitals share a CAMHS Liaison Registrar (one WTE medical). Portlaoise also has a 24/7 walk-in service for anyone aged over 16 in the general hospital. *Out-of-hours CAMHS* There is no out-of-hours CAMHS.

Area	Out-of-hours service
Limerick	*CAMHS Liaison Service* There is currently no dedicated CAMHS Liaison Team. Any liaison work in the hospital is provided by CAMHS Community Teams, who work Monday to Friday 9am to 5pm. The CAMHS Community-based Teams will review emergency referral patients on the wards and in the ED between 9am and 5pm on the same day as the request. Community-based appointments have to be cancelled at short notice because of these assessments. In general, the interventions are multidisciplinary with two individuals performing the assessment. Non-acute emergency clients (for example children with eating disorders who need medical stabilisation in hospital) are also seen in the hospital by the Community Teams, in an appropriate timeframe. *Out-of-hours CAMHS* There is no out-of-hours CAMHS in place in the Community Teams; the hospital essentially operates as a place of safety for these children until the Community Teams next start work.
Sligo, Leitrim, Donegal	*CAMHS Liaison Service* There is no CAMHS Liaison Service. *Out-of-hours CAMHS* Emergencies out of hours are referred to ED by the GP or NowDoc or self-present to Letterkenny ED or Sligo General Hospital ED. There they are assessed by the on-call NCHDs, who are on call for all service users, child and adult. The NCHD then calls the CAMHS consultant on call. The Sligo/Leitrim and Donegal CAMHS consultants share the call rota. Currently there are three Donegal CAMHS consultants on the rota, and one Sligo consultant; therefore, each consultant covers a one-in-four rota. If emergencies arise for Sligo or Letterkenny Hospital inpatients out of hours, they are covered also by the on-call NCHDs and consultants.
CHO 5 **Waterford Wexford, Kilkenny and Carlow South Tipperary**	*CAMHS Liaison Service* There is no CAMHS Liaison Team in CHO 5, although strong and persistent business cases have been made. *Out-of-Hours CAMHS* In Waterford/Wexford, the two CAMHS consultant psychiatrists work on call with the paediatric department (or medical ward for over 16-year-olds). This service is covered by a colleague when the CAMHS consultant psychiatrist is not available. In South Tipperary an extra contractual consultant psychiatrist covers from 5pm until 9pm - as required.

Challenges Facing the Out-of-Hours Services in Regional Hospitals

The fragmented provision of out-of-hours services within the regional general hospitals presents a gap in terms of service provision for young people aged under 18. It can lead to young people waiting for considerable periods of time within EDs for assessment by a CAMHS Team. The lack of service provision in this area also contributes to added pressure on the Community CAMHS Teams, who are frequently expected to provide in-reach CAMHS consultations, care and treatment to young people within the general hospitals. There are often expectations that this service will be provided by the CAMHS Team without any additional resources being provided to those teams. There is a reliance on good quality personal relationships between staff members within the paediatric and CAMHS systems in order to facilitate timely care to young people. Some areas have little or no CAMHS out-of-hours service and the paediatric hospital system functions as a 'place of safety' for the young person for a period of time as they await an in-reach service from a CAMHS Team.

The regional hospital services have faced similar challenges to those in Dublin. These include:

- A substantial increase in terms of emergency presentations of young people with acute psychiatric needs. For example, one hospital reported a 30% increase in emergency attendances of young people with acute psychiatric needs in recent years.
- An uncoordinated environment in terms of children's services provision, inadequate support in terms of disability and child protection services, as well as a notable absence of community psychology, all contributing to a failure to provide a safety net for the emergency presentation.
- A lack of care pathways for young people who have presented with acute psychiatric needs who require CAMHS inpatient care at the time of discharge. This absence can lead to prolonged stays in a paediatric ward and risks that the young person would not receive the full MDT treatment that they require for their recovery.
- A lack of coordinated social care services, which can delay discharge, for example, in cases where a young person requires a Tusla placement or their family is experiencing homelessness.

Similar to the paediatric hospitals, staff within the CAMHS Teams indicated grave concern that a failure to sufficiently resource out-of-hours CAMHS within the regional hospitals may lead to sub-optimal outcomes for children and young people requiring emergency mental healthcare at a time of crisis. The unprecedented increase in demand for such services over recent years has left existing services stretched.

The above concerns were raised with the HSE and the following response was received from the HSE when asked about the future plans for the CAMHS Liaison and Out-of-Hours Teams:

> *The HSE is committed to a continued expansion of Liaison Mental Health Services (LMHS) for all age groups within the context of an integrated LMHS Model of Care. Work to develop this model of care is at an advanced stage and engagement with stakeholders is currently underway to inform a final draft. Funding has been provided to the three Dublin paediatric hospitals (Our Lady's Hospital, Crumlin, Tallaght Hospital and Temple Street Hospital) for LMHS which are at varying stages of development.*

At present there are no plans to develop crisis teams for children and young people under the age of 18.

CAMHS Forensic Teams

A Forensic CAMHS (F-CAMHS) Team was set up in 2012 with one WTE consultant psychiatrist, one WTE nursing and one WTE social worker, but the in reach to Oberstown was 0.4 Consultant Psychiatrist, 0.2 nursing and 0.2 social worker as this was the assessed need in Oberstown at that time. A Child and Adolescent Psychiatrist was appointed in 2018 who has benefitted from forensic training also. This team provides psychiatric input for residents in Oberstown Children's Detention Campus, Ireland's national facility for the detention of children remanded or sentenced by the courts. The team also provide advice to the Community CAMHS Teams regarding complex cases.

Funding was approved for two full multidisciplinary CAMHS Forensic Teams. Unfortunately, recruitment has not commenced for the remaining staff and no dates/plans were available as to when this will take place. With the exception of advice given for complex

cases, the Community CAMHS Teams have little access to forensic services within the HSE. We found one young person who clearly needed a forensic assessment and treatment but this was not provided by the HSE. A forensic assessment from a private provider was eventually sourced in Ireland.

A 10-bed Forensic CAMHS Unit has been built in the National Forensic Mental Health Service campus in Portrane (Brandon Unit). It has not yet opened and there are no current plans to do so due to difficulty in recruiting staff. The HSE stated that an analysis of needs will be undertaken to evaluate the current in reach service to Oberstown and to determine the current and future needs for Forensic CAMHS beds in the new forensic mental health service in Portrane.

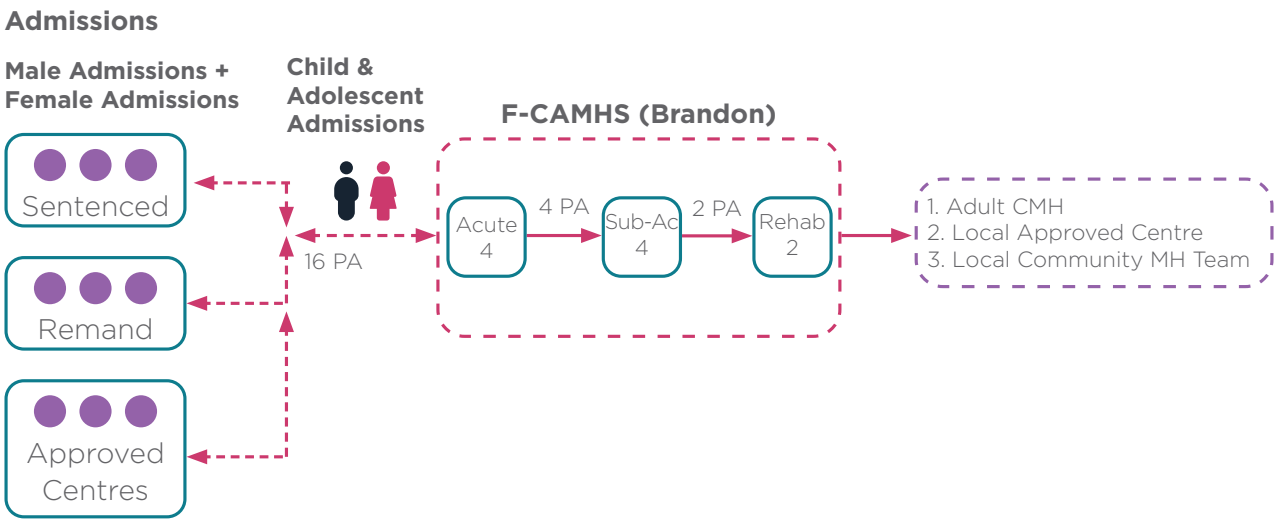
The National Forensic Mental Health Services (NFMHS) Model of Care November 2019 states that the F-CAMHS service will primarily provide for those aged 12 to 18 with at-risk mental states and first-episode psychosis who require inpatient treatment in a therapeutically safe and secure setting, who cannot be accommodated in the inpatient CAMHS units, who are in detention through the youth justice courts (Oberstown Childrens Detention Campus) or who have other severe mental disorders requiring inpatient treatment in conditions of therapeutic safety and security. This will be achieved by providing two fully staffed Forensic CAMHS Teams. The Forensic CAMHS service will work in liaison with the youth justice system at Oberstown Children's Detention Centre, with the HSE's approved centres (inpatient units) for child and adolescent mental health and with Community CAMHS Teams. Tusla's secure care units have HSE CAMHS in-reach services from the inpatient CAMHS Teams and local Community CAMHS Teams. The F-CAMHS Teams will provide specialist consultation and liaison to those colleagues. The F-CAMHS secure children's hospital will not be a secure care unit as defined in the Children's Act and will not admit under a special care order.

The majority of those admitted to inpatient care (Brandon Unit) will be returned to the units from which they were admitted (inpatient CAMHS or Oberstown Children's Detention Centre) or to their homes when the mental illness has resolved. In some instances, bespoke community packages may be required, requiring multi-agency working and planning[101].

The NFMHS Model of Care 2019 does not explore bespoke community packages involving multi-agency working and planning pre-admission. DNCC CHO9 operates a Day Hospital from a community setting on a Mon-Fri basis offering step-up/step- down/enhance support services to Community teams, CHI Temple St., and the Adolescent Approved Centre(s). Bespoke programmes including group/individual and parent support are provided. The current capacity of the service is up to 16 young people.

Figure 24 [102]

NFMHS Patient Pathway: Child and Adolescent



[101] NFMHS Model of Care 2019.

[102] NFMHS Model of Care November 2019.

The use of telepsychiatry may be planned to allow advice and reviews of children/young people to be provided. Overall, the research literature supports the diagnostic accuracy and reliability of remote psychiatric assessments, with many studies demonstrating equivalence with face-to-face encounters. However, there is a significant lack of robust evidence especially in forensic psychiatry, with most data emerging from case reports, descriptive studies and uncontrolled trials[103]. There is limited evidence for its use in adult forensic services[104] and little research in Forensic CAMHS provision of telepsychiatry.

The consequences of failure to provide a comprehensive Forensic CAMHS are:

1. Lack of appropriate specialist forensic treatment
2. Loss of school placement
3. Loss of opportunity for purposeful structure and routine in life, school, leisure and self-care/rest
4. Delayed development of life skills, activities of daily living skills (meal preparation, cooking, organisational skills and money management)
5. Loss of self-regulation skills, interpersonal skills, and access to vocational outlets
6. Inability to access therapies such as talk therapies.

Day Programmes

Access to a day programme provides intensive assessment and treatment programmes (individual, family and group). This helps maintain the adolescent in the community and in many cases reduces the need for inpatient admission. It also provides a very important stepdown service following a period of inpatient treatment. This transition can otherwise be somewhat abrupt and is dealt with by having a graduated discharge from the inpatient unit, creating further demand on an already scarce resource.

The availability of the day programme facilitates earlier discharge from the inpatient unit back into the community, thus embracing the recovery model of care. There are different models of how day programmes can be delivered. One is through a day hospital. There is one day hospital operating in Ireland, in CHO 2. This is part of the CAMHS Hub and is provided by the Connect Team. In CHO 6, a day hospital was in operation but had to close due to unforeseen circumstances. Plans are under way to reopen this facility. In Linn Dara services in CHO 7, the day programme operates through Linn Dara Schools. In Tipperary, individual CAMHS Teams provide a day programme for children and young people attending their service. DNCC CHO9 operates a Day Hospital from a community setting on a Mon-Fri basis offering step-up/step-down/enhance support services to Community teams, CHI Temple St., and the Adolescent Approved Centre(s). Bespoke programmes including group/individual and parent support are provided. The current capacity of the service is up to 16 young people.

CAMHS Hubs

A CAMHS Hub provides intensive brief mental health interventions to support CAMHS teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis, in the young person's own environment/ community facility and with the active involvement of the young person and their family/carers/supporters and interagency liaison with local partners. Support from these hubs is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different young people's or parent/carer needs. Typically, this entails a range of evidenced-informed therapeutic approaches, including medication management, psychotherapeutic based individual, group and family interventions.

The Model of Care for CAMHS Hubs proposes a phased development of the CAMHS Hub model in line with resources available and access to existing services available.

CAMHS Hubs provide a seven-day service as an alternative to inpatient admission for children/ young people who require more than a CAMHS Team can offer. It allows children/young people to remain at home while also attending intensive interventions.

[103] Chakrabarti S. Usefulness of telepsychiatry: a critical evaluation of video-conferencing based approaches. *World J Psychiatry* 2015; 5: 286–304.

[104] Hewson T, Robinson L, Khalifa N, Hard J, Shaw J. Remote consultations in prison mental healthcare in England: impacts of COVID-19. *BJPsych Open.* 2021 Feb 8; 7(2): e49. doi: 10.1192/bjo.2021.13. PMID: 33551008; PMCID: PMC7870917.

The Connect Team in CHO 2, set up as a pilot site for hubs, provide a well-integrated CAMHS Hub which can deliver services, including out-of-hours services across CHO 2. The Connect Team has shown significant decreases in inpatient admissions as well as shortened stays in the inpatient unit. Assertive outreach is part of the Connect Team services and advice is provided to other teams in the CHO regarding hospital admission, day hospital and other interventions.

A total of nine hubs are envisaged by the HSE, one for each CHO. In addition to the Connect Team in CHO 2, four more are in development, in CHOs 3, 4, 6 and 8. In CHO 4, CAMHS HUB Cork - a consultant psychiatrist has accepted the post and is due to commence in post in October 2023.

Substance Misuse Teams

My World Survey 2, developed by University College Dublin (UCD) and Jigsaw, the National Centre for Youth Mental Health, is a comprehensive study of young people's mental health and wellbeing and a follow-up to the 2012 My World Survey[105]. They found that adolescents who drink engaged in riskier alcohol behaviour. Most young people had engaged in at least one occasion of illicit drug use in their lifetime. Six in ten young people had tried cannabis at least once, with a considerable minority engaging in occasional or weekly use. Almost three in ten young adults reported having tried other illicit drugs such as cocaine and ecstasy. Significant associations were found between alcohol and illicit drug use and anxiety and depression, which indicated a relationship between substance use and poorer mental wellbeing among young people in Ireland. Alcohol use was also strongly associated with illicit drug use, indicating evidence for polydrug use among young people.

In a cross-sectional descriptive study and retrospective review of medical records on the 144 admissions at the Youth Drug and Alcohol (YoDA) service, Dublin, James et al. found that 48% of the patients had a lifetime history of psychiatric disorders, 27.1% had a history of deliberate self-harm (DSH), followed by ADHD (20.8%), and depression (10.4%). Conduct disorder and oppositional defiant disorder were infrequently diagnosed. Compared with boys, girls were more likely to have a lifetime history of psychiatric disorders[106].

Substance misuse services are not provided by CAMHS. The HSE provides two CAMHS consultant psychiatrist-led teams in North Dublin and South Dublin which provide substance misuse services to young people. CAMHS can refer to these to services and also receive referrals from them. The service encourages self- referral by the young people themselves. Depression and anxiety are common in young people referred to the substance misuse services. Cannabis and alcohol are the main substances used. Binge drinking is the most common behaviour where alcohol is involved. Cannabis use accounts for approximately 75% all referrals. Of concern is that a significant number of young people smoke cannabis on a daily basis[107]. The HSE also funds other substance misuse services for young people in most areas around the country.

[105] Dooley B, O'Connor C, Fitzgerald A and O'Reilly A (2019) My World Survey 2: the national study of youth mental health in Ireland. Dublin: UCD and Jigsaw. https://www.drugsandalcohol.ie/31343/; 2) Dooley B and Fitzgerald A (2012) My World Survey: national study of youth mental health in Ireland. Dublin: Headstrong, National Centre for Youth Mental Health/UCD School of Psychology. https://www.drugsandalcohol.ie/17589/

[106] Philip D. James, Bobby P. Smyth & Tunde Apantaku-Olajide (2013) Substance use and psychiatric disorders in Irish adolescents: a cross-sectional study of patients attending substance abuse treatment service, Mental Health and Substance Use, 6: 2, 124–132, DOI: 10.1080/17523281.2012.693519

[107] Information provided by Professor Bobby Smyth, Consultant Child & Adolescent Psychiatrist Adolescent Addiction Service – HSE.

Independent Provision of CAMHS

CHAPTER

6

Independent Provision of CAMHS

Two independent not-for-profit organisations provide inpatient beds for children and adolescents: St John of God Hospital and St Patrick's Mental Health Service. Both are located in Dublin and accept referrals from across Ireland from GPs and other mental health services.

Ginesa Suite St John of God Hospital

Ginesa Suite was located in St. John of God Hospital in Stillorgan, Co. Dublin and was on the first floor of the main building. It provided inpatient treatment to young people aged from 13 to 17 years of age under the care of a one multi-disciplinary team. Ginesa Suite was registered with the Mental Health Commission for 12 beds.

Ginesa Suite had therapeutic and recreational areas internally with access to a gym and outdoor recreational facilities which were located on the grounds of St. John of God Hospital. There were two single bedrooms and five double bedrooms, none of which were ensuite. There were showers and toilets adjacent to the bedrooms. The unit was bright, and comfortably furnished.

Ginesa Suite was under the governance of St. John of God Hospital CLG and there was a robust governance structure in place. The service was governed by a board of directors and there was an established organisational and clinical governance structure. The Chief Executive Officer and Clinical Director reported to the board monthly. There was a Clinical Governance Quality and Safety Executive Committee (CGQSE) which met on a monthly basis and reported to a board sub-committee for clinical governance, quality and safety. The CGQSE was, in turn, informed by multiple committees including risk, health and safety, clinical audit, and the clinical effectiveness and quality improvement committees. There was also a Ginesa Management Team meeting which convened six times a year.

The CAMHS team consisted of

- Administrator
- Consultant Psychiatrist
- Senior Registrar;
- Registrar
- Senior Clinical Psychologist
- Senior Social Worker/ Family Therapist
- Clinical Nurse Specialist
- CNM1, CNM2, and staff nurses
- Senior Occupational Therapist
- Teacher

The inpatient team provided comprehensive assessments and inpatient treatment to children and adolescents with suspected clinical psychiatric conditions such as schizophrenia, depression, bipolar affective disorder, eating disorders, obsessive compulsive disorder, high risk states such suicidal behaviours. It provided longitudinal assessment and observation in a supervised environment for the purpose of diagnostic clarity. Referral came predominantly from consultant psychiatrists due to patients poor response to treatment as outpatient. GPs also referred to the service.

There was a school facility in Ginesa Suite. This facility had one teacher, which was below the staffing level of two teachers for a resident cohort of twelve, identified in the Department of Education[108]. The school urgently required two teachers to provide an appropriate and comprehensive school provision. The teacher works with the young person to design an individualized education plan based on academic needs. There is close liaison with their school placement while they are in hospital, with parental consent and the education programme is incorporated into the young person's weekly therapeutic timetable.

An enhanced Clinical Pharmacy Service to Ginesa was in place since December 2021. A senior pharmacist provides services to both young people and the multidisciplinary team. There is one-to-one provision of information to patients by the pharmacist. The pharmacists oversee physical health monitoring relevant to medication as well as monitoring for side effects as well as other clinical queries such as recommendations and information on guidelines. The pharmacist also provides a medicines reconciliation which creates an accurate list of all medication the young person is taking and compares it to the prescription by the consultant psychiatrist or NCHD. A smoking cessation programme is also available if requested. Other interventions provided include de-prescribing and reducing anticholinergic side effects of medication and optimisation of medication check list.

[108] Review of educational provision for children attending hospital schools (2021) Department of Education

The young people had access to advocacy services if required through Youth Advocate Programmes (YAP) Ireland.

Future planning included possibility of expansion and increased bed occupancy; enhanced treatment pathways for Eating Disorders, incorporating assessment of neurodevelopmental disorders to inpatient programs, Recruiting, training and education programs for staff and service evaluation and research opportunities.

Willow Grove St. Patrick's Mental Health Services

Willow Grove Adolescent Unit provides inpatient care for young people aged 12 to 17 and is located in St Patrick's Hospital in Dublin 8. It is governed by the Board of St. Patrick's Mental Health Services, with the senior management team responsible to the Board for the direct operation of the approved centre. The involvement of young people and their parents or guardians was an important part of the governance processes.

The unit has accommodation for up to 14 young people. Willow Grove CAMHS treats mood disorders including depression, anxiety disorders, eating disorders and psychosis. Referrals come through Child and Adolescent Mental Health Services teams and GPs from across Ireland.

In Willow Grove Adolescent Unit, there are adequate communal areas and young people have access to outdoor recreational facilities. The unit was welcoming, bright and appropriately decorated for young people. All bedrooms were single and included ensuite and shower facilities. There was a gym, a relaxation room and an outdoor space providing an area for games and leisure.

The Willow Grove team also provides Adolescent Homecare where young people can access 24-hour, comprehensive mental health treatment and one-to-one support from their own homes. This homecare services can treat anxiety and panic attacks, depression, mood disturbance, obsessive compulsive disorder and ADHD, and can be delivered to the young person remotely through telecommunications. The approved centre Homecare Service was named as the Mental Health Initiative of the year at the Irish Healthcare Awards 2020.

CAMHS community-based, outpatient services are provided by the Adolescent Dean Clinic in Dublin and Cork.

There was one multi-disciplinary team (MDT) and members of the team included a consultant psychiatrist, registrars, nurses, social workers, occupational therapy, psychologists, a family therapist, a teacher and a dietitian. Speech and language therapy was also available.

The Willow Grove Services provides therapeutic services which included counselling and clinical psychology, occupational therapy, family therapy and social work, both one-to-one and through groups. The Group Programme includes:

- Psychotherapy
- Occupational therapy groups
- Self-esteem
- Assertiveness
- Psychology interventions
- Communication skills
- Wellness and Recovery Group (WRAP)
- Music, drama
- Gym, sports and activity groups
- Creative Arts: music and art
- Social skills
- Sensory Groups
- Cookery
- Relaxation and stress management

Young people receiving care through both inpatient and Homecare services take part in the group programme. Education is part of the therapeutic programme and there is a school attached to the unit.

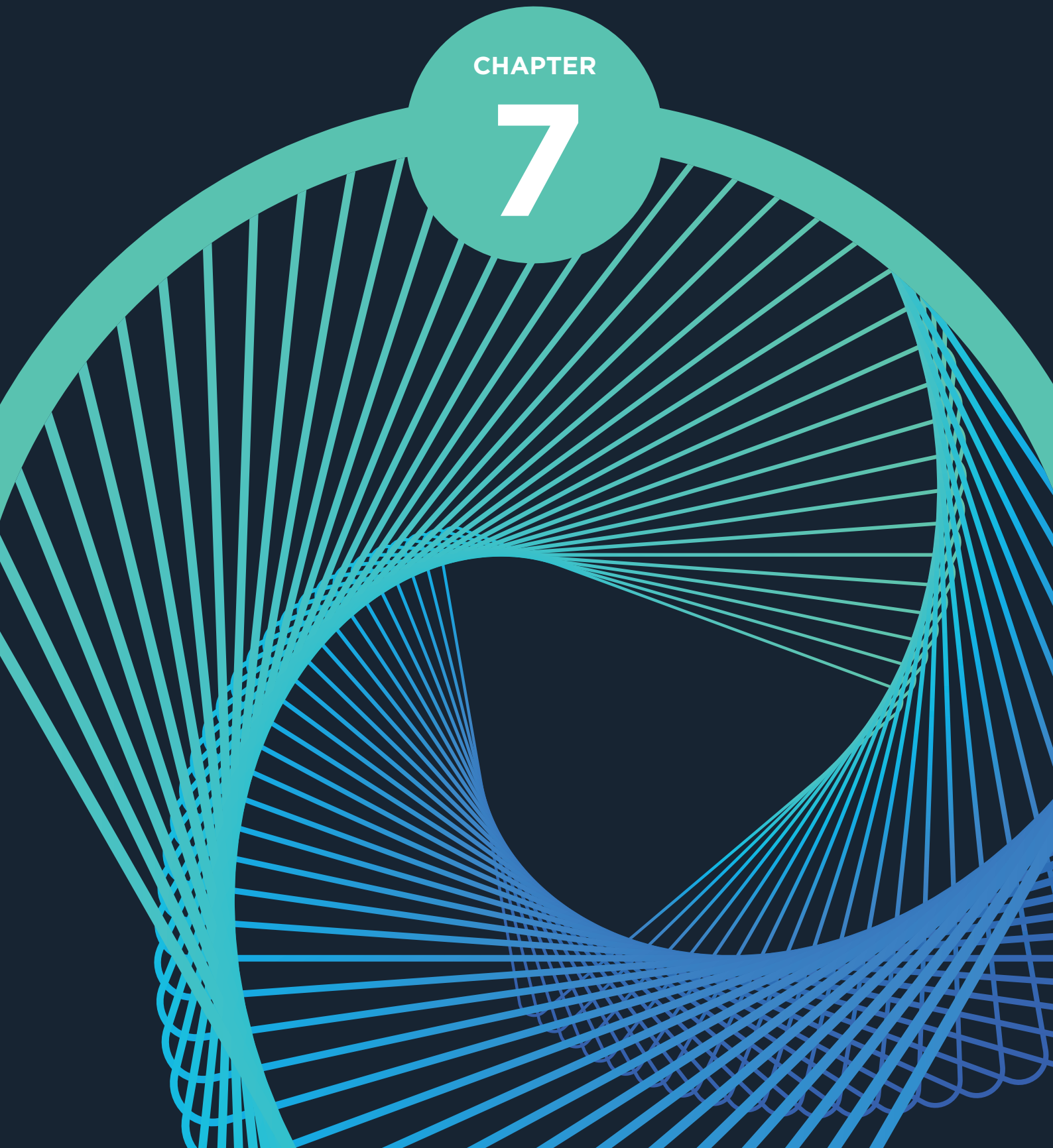
St Patrick's Mental Health Services also provide a Young Adult Service for young people aged 18 - 25. It consists of an inpatient and day patient programmes located at St Patrick's University Hospital and a community clinic located at the Dean Clinic Sandyford.

The Young Adult Team treat mental health conditions: depression, bipolar disorder, psychosis, schizophrenia, anxiety, substance dependence, personality disorders and eating disorders. A programme coordinator co-ordinates the day-to-day running of the programme

Transition to Adult Mental Health Services

CHAPTER

7



One of the failures of the mental health field so far is not to have appreciated that the timing and pattern of mental ill-health impacts so strongly on young people who, on the threshold of adult life, have the most to lose. Society as a whole also has much to lose, in reduced human capital or "mental wealth" and economic productivity. Further, a key paradox of the developed world is that while young people's material wellbeing and physical health have dramatically improved, the mental health of young people in transition from childhood to adulthood has been steadily declining over recent decades[109].

Not every young person attending CAMHS needs to transition to Adult Mental Health Services (AMHS) but there are some young people who require ongoing support and treatment as they reach adulthood. Good transition from CAMHS to AMHS should be a coordinated, planned and patient-centred process that ensures continuity of care and optimises mental health. It should start with preparing the young person to leave CAMHS and end when that person is received into, and properly engaged with, the AMHS Team. While young people with severe mental illness such as psychosis are more likely to transition to adult services, those with neurodevelopmental, emotional/neurotic and personality disorders are far less likely to cross the boundary and have more pronounced transition difficulties[110].

CAMHS has a culture and models of functioning, with emphasis on family involvement, which are very different from adult mental healthcare, and these pre-existing differences get accentuated at the transition boundary. Continuity of care is hampered by a multitude of issues, including

- differences between adult and child models of care;
- differing referral criteria;
- lack of a planned, purposeful and needs-based assessment of those who reach the boundary;
- communication and information transfer problems between services caused partly by different beliefs, attitudes, mutual misperceptions and lack of understanding of different service structures;
- lack of shared protocols/manuals for transition;
- lack of shared client planning between child and adult systems;
- young people's level of maturity and understanding; and
- adolescent and/or family resistance to transition[111].

In the UK, almost half of the service users reaching the transition boundary of their CAMHS do not go on to receive adult care[112]. The 'Transition from CAMHS to Adult Mental Health Services' (TRACK) study found that less than 5% of patients undergoing CAMHS-to-AMHS transition experience continuity of care[113]. Young people's experiences of moving from CAMHS and AMHS are influenced by concurrent life transitions and their individual preferences regarding autonomy and independence. They identified preparation, flexible transition timing, individualised transition plans, and informational continuity as positive factors during transition. Young people also valued joint working and relational continuity between CAMHS and AMHS[114].

[109] Patrick McGorry, Transition to Adulthood: The Critical Period for Pre-emptive, Disease-modifying Care for Schizophrenia and Related Disorders, *Schizophrenia Bulletin*, 37, Issue 3, May 2011, 524–530, https://doi.org/10.1093/schbul/sbr027

[110] Singh SP, Paul M, Ford T, et al. Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. *Br J Psychiatry*. 2010; 197: 305–312.

[111] Paul M, Street C, Wheeler N, et al. Transition to adult services for young people with mental health needs: A systematic review. *Clin Child Psychol Psychiatry* 2015; 20: 436–457.

[112] Singh SP, Paul M, Ford T, et al. Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): a study of protocols in Greater London. *BMC Health Serv Res* 2008; 8: 1–7.

[113] Singh SP, Paul M, Ford T, Kramer T, Weaver T. Transitions of care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK study): a study of protocols in Greater London. *BMC Health Serv Res*. 2008 Jun 23; 8: 135. doi: 10.1186/1472-6963-8-135. PMID: 18573214; PMCID: PMC2442433.

[114] Broad KL, Sandhu VK, Sunderji N, Charach A. Youth experiences of transition from child mental health services to adult mental health services: a qualitative thematic synthesis. *BMC Psychiatry*. 2017 Nov 28; 17(1): 380. doi: 10.1186/s12888-017-1538-1. PMID: 29183289; PMCID: PMC5706294.

Problems at the CAMHS–AMHS interface are compounded by the fact that young people are simultaneously negotiating developmental and situational transitions, such as changes in housing, education/employment, relationships and moving on to adult roles. Those who slip through the care net are likely to present to adult services at a subsequent time, with more severe and enduring mental health problems[115].

Disruption of care during transition adversely affects the health, wellbeing and potential of this vulnerable group, and negative transition experiences adversely impact the young person's future engagement with mental health services. Intervening at the level of transition represents one of the most important ways we can facilitate recovery, and mental health promotion and mental illness prevention in adulthood. Ensuring sustained treatment through the transitional period is very likely to be cost-effective since the presence of mental illness during childhood leads to 10 times higher costs during adulthood[116].

European research on transition from CAMHS to AMHS is sparse, with little information available on the quality of transition and transition experiences in different European Union countries in relation to long-term mental health outcomes. The organisation of CAMHS in the member states varies, including the age at which young people are transitioned to adult services, size and complexity, sources of funding, and service provision and care. The National Institute for Health and Care Excellence (NICE) review on transition from child to adult care across all specialties found that there was no robust evidence on models of transitional care[117].

McNamara et al.[118] found a lack of standardised practice nationwide regarding the service transition boundary, an absence of written transition policies and protocols, and minimal formal interaction between child and adult services. They suggest that there are critical gaps between current operational practice and best practice guidelines.

The TRACK study[119] explored the process and predictors of transition between CAMHS and AMHS in the Republic of Ireland. The study found that despite perceived ongoing mental health service need, many young people are not being referred or are refusing referral to the AMHS, with those with ADHD most affected. CAMHS continued to offer ongoing care past the transition boundary, which has resource implications.

Within *Sharing the Vision* **Recommendation 36** states:

> *Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS. The age of transition should be moved from 18 to 25, and future supports should reflect this. Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS.*

In 2020 the National Implementation Monitoring Committee (NIMC) Specialist Group on CAMHS was set up. The purpose of the NIMC Steering Committee is to drive reconfiguration, monitor progress against outcomes and deliver on the commitments set out in *Sharing the Vision*.

The particular focus of this specialist group is Recommendation 36:

[115] Singh SP, Tuomainen H. Transition from child to adult mental health services: needs, barriers, experiences and new models of care. *World Psychiatry.* 2015 Oct; 14(3): 358–361. doi: 10.1002/wps.20266. PMID: 26407794; PMCID: PMC4592661.

[116] Suhrcke M, Pillas D, Selai C. Economic aspects of mental health in children and adolescents. Social Cohesion for Mental Wellbeing among adolescents: WHO, 2008: 43–64.

[117] National Institute for Health and Care Excellence. *Transition from children's to adults' services for young people using health or social care services.* NICE guideline: Full version. London: NICE, 2016

[118] McNamara N, McNicholas F, Ford T, Paul M, Gavin B, Coyne I, Cullen W, O'Connor K, Ramperti N, Dooley B, Barry S, Singh SP. Transition from child and adolescent to adult mental health services in the Republic of Ireland: an investigation of process and operational practice. *Early Interv Psychiatry.* 2014 Aug; 8(3): 291–297. doi: 10.1111/eip.12073. Epub 2013 Jul 4. PMID: 23826636.

[119] McNicholas F, Adamson M, McNamara N, Gavin B, Paul M, Ford T, Barry S, Dooley B, Coyne I, Cullen W, Singh SP. Who is in the transition gap? Transition from CAMHS to AMHS in the Republic of Ireland. *Ir J Psychol Med.* 2015 Mar; 32(1): 61–69. doi: 10.1017/ipm.2015.2. PMID: 30185283.

The MILESTONE project is an EU-wide study of transition from CAMHS to AMHS to strengthen transitional care, including appropriate discharge from services, across different healthcare systems[120] by conducting a mapping exercise across all EU states to delineate current transition policies, practices and outcomes, where available, and develop and validate two clinically relevant transition-related measures. The aim is to transform services so that the current weakness in the CAMHS–AMHS care pathway is replaced by a clinically robust, cost-effective, high-quality accessible care pathway for vulnerable young people with mental disorders, ensuring that those who need ongoing care get it effectively.

The first phase of work (Workstream 1), to ensure that short-term additional supports a available for individuals who are currently making the transition from CAMHS to GAMHS at age 18, is the development of an enhanced transitions plan (including implementation plan) to support those transitioning from CAMHS to AMHS at 18 years. The HSE report that this work is now completed and Implementation plan with actions is also completed

A Children and Young Person Working group has been established to provide an age-appropriate specialist mental health service for those aged up to 25 years with consideration given to a pilot reconfiguration of services that could ascertain the specific mental health needs of the 0-25 cohort to inform staffing requirements going forward. This will involve development of a reconfiguration plan, including prioritised and phased recommended action.

Currently, a uniform process is not in place for the transition to Adult Mental Health Services and once again the process varies across the CHOs. The CAMHS Operational Guidelines recommend a six-month transition period before the child's 18th birthday but in most cases that we reviewed this does not happen. Some AMHS will not accept a referral until the child reaches their 18th birthday. Only very rarely do the recommended introductory meetings take place. Some children with ADHD are not accepted by AMHS as there is no expertise within AMHS to treat these young people. Therefore there is evidence that the services are not complying with their own guidelines.

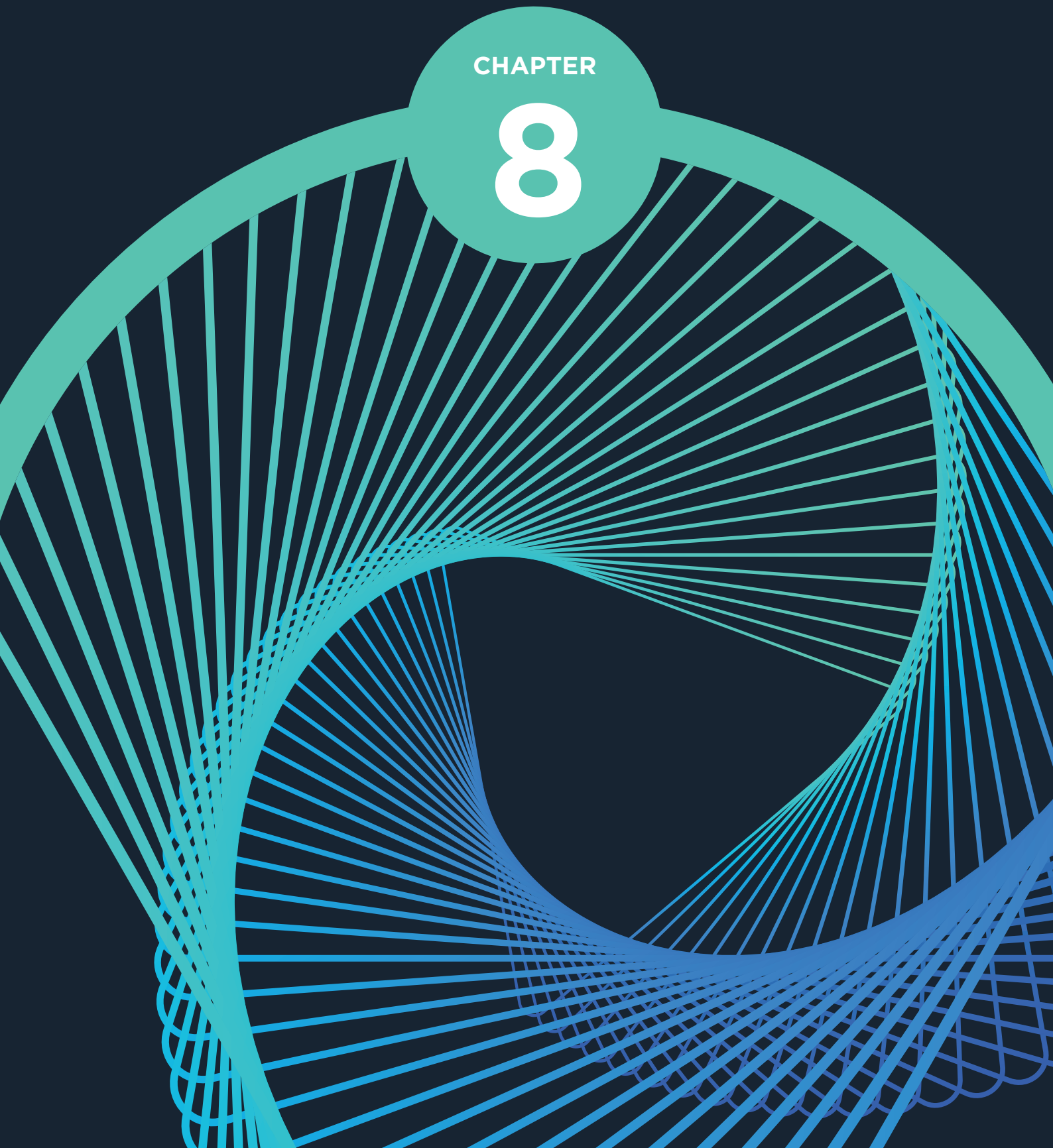
This clearly illustrates that meaningless boundaries and silos within the mental health services adversely affect patient care and wellbeing, despite a strong evidence base that such boundaries should not exist.

[120] Tuomainen H, Schulze U, Warwick J, Paul M, Dieleman GC, Franić T, Madan J, Maras A, McNicholas F, Purper-Ouakil D, Santosh P, Signorini G, Street C, Tremmery S, Verhulst FC, Wolke D, Singh SP; MILESTONE consortium. Managing the link and strengthening transition from child to adult mental health Care in Europe (MILESTONE): background, rationale and methodology. BMC Psychiatry. 2018 Jun 4;18(1):167. doi: 10.1186/s12888-018-1758-z. Erratum in: BMC Psychiatry. 2018 Sep 14;18(1):295. PMID: 29866202; PMCID: PMC5987458.

CAMHS Inpatient Units

CHAPTER

8



CAMHS inpatient units are to be found in approved centres which are registered with the Mental Health Commission. As such they are regulated under the Mental Health Acts.

The difficulty in recruiting and retaining staff has had a devasting effect on the number of available CAMHS inpatient beds.

Table 15 *CAMHS inpatient units*

No.	CAMHS inpatient units	Location	Number of registered beds	Number of operational beds
1	Linn Dara	CHO 7, Cherry Orchard, Dublin	24	13
2	Adolescent Inpatient Unit, St Vincent's Hospital	CHO 9, Fairview Dublin	12	8
3	CAMHS Inpatient Unit	CHO 2, Merlin Park, Galway	20	14
4	Eist Linn	CHO 4 Bessborough Cork	16	16
	Total		72	51 (70% of registered beds)

The following graph below shows beds per 100,000 population under 18 in 2018 across 10 countries.

Ireland has 2 CAMHS beds per 100,000. This compares with 11 beds per 100,000 in England, 10 per 100,000 in Scotland and nine per 100,000 in Northern Ireland in 2020[121].

[121] Royal College of Paediatrics and Child Health (2020) State of Child Health. London: RCPCH. [Available at: stateofchildhealth.rcpch.ac.uk].

Linn Dara

Linn Dara Approved Centre is a 24-bed centre divided into three units: Rowan, Oak and Hazel. The approved centre has a sports hall and gym, an outdoor sports pitch, family therapy suites, enclosed garden areas and a family accommodation suite. There are ongoing improvements to the physical environment.

Rowan and Hazel both consist of 11 individual beds and Oak Unit has two beds which provide high dependency observation and care. Eight of these beds are specialist eating disorder beds (SEDBs) which cater for level four care and treatment (the most intensive treatment setting) for children and adolescents with severe and complex eating disorders. Nasogastric feeding can be provided in the approved centre. There have been no transfers back to medical hospital of young people with eating disorder once admitted to Linn Dara since 2018.

More than one-third of Linn Dara's bed occupancy is for eating disorders, with 20–25% of admissions to Linn Dara for treatment for an eating disorder.

Linn Dara Approved Centre has a primary catchment area of: Dublin South-West, Dublin South City, Dublin South-East, Dún Laoghaire, Kildare, Wicklow, Laois, Offaly, Longford, Westmeath; this is across CHO 6, CHO 7 and partially CHO 8. The approved centre also takes national referrals.

In 2022, Linn Dara reduced their bed capacity to 13, effectively closing one unit due to a shortage of nursing staff. HSE Linn Dara accounted for 35% of the total HSE CAMHS admissions. At the time of writing the beds have not been reopened.

CAMHS Inpatient Unit Merlin Park

Inpatient services are provided in an approved centre in Merlin Park, Galway University Hospital. The inpatient services cover a population 320,000 young people from Donegal, Sligo, Leitrim, Mayo, Galway, Roscommon, Clare, Limerick and North Tipperary. It currently has 14 operational beds. The centre provides an out-of-hours emergency bed and has two multidisciplinary teams.

Nasogastric feeding is provided in the unit for children/young people with eating disorders. It was reported to the Review Team that the procedure was very rarely used, and the staff employed psychological interventions to encourage adequate intake of calories.

The facility is a purpose-built inpatient facility for the Child and Adolescent Mental Health Service. The approved centre comprises two individual units: Woodsend and The Willows. There was a separate administration block that included the main dining facilities, a gym, therapy and activity rooms and staff offices. The approved centre also had a school and a parent accommodation flat. There was a central garden and the back of the centre was surrounded by a wooded area.

The Willows had a high-dependency suite with three bedrooms. A seclusion facility was also located in The Willows. Funding for a new seclusion room had been approved with a time-bound plan as to when this would be completed.

Adolescent In patient Unit (AIPU) St Vincent's Hospital

The Adolescent Inpatient Unit (AIPU) was located on the first floor of St Vincent's Hospital, Fairview. It provided services, including inpatient CAMHS, to the HSE under a Service-Level Agreement. The approved centre accepted admissions for the age group 15 to 17 years.

Admissions were accepted from the Dublin Northeast area, Dublin North City and County, Meath, Louth, Cavan and Monaghan. Admissions were also accepted from other areas depending on need and availability. All young people were under the care of one multidisciplinary team (MDT).

It currently operates as a 12-bed approved centre for 15–17-year-olds, accepts planned admissions only and does not provide an emergency service. It has an operational bed capacity of eight. In 2022, it accepted 46% (53) of referrals for admission. AIPU refused one-third of referrals for admission as they did not meet the age range, were out of the catchment area or did not meet the criteria for admission.

The AIPU is a converted unit on the first floor in St Vincent's Hospital, which is a mental health inpatient facility for adults with mental illness

in North Dublin City. It is a separate approved centre registered with the Mental Health Commission with its own dedicated staffing. At the time of writing, there are 8.5 vacancies in the AIPU multidisciplinary team.

There was an external garden and a basketball court. Indoor communal areas included a common room, an art room and a relaxation room. There was a designated school located within the grounds of St Vincent's Hospital, approximately 100m from the approved centre.

There was an Executive Management Team, which governed St Vincent's. This consisted of the CEO, the Clinical Director and Director of Nursing. There was one Clinical Director for both the CHO CAMHS and AIPU services but nursing management of the two services was separate. The occupational therapist, psychologist and social worker in AIPU were governed by St Vincent's Hospital, while the Community CAMHS psychologists, social workers and occupational therapists were governed by the HSE.

The AIPU struggled to keep nursing levels at the number for which the unit was registered. This was in common with all other areas of CAMHS and was due to retention and recruitment difficulties across all disciplines, including nursing.

The unit also has a national remit in line with all four public CAMHS inpatient units (Galway, Cork and Dublin). However, there are no emergency beds in the AIPU, which increases the risk of young people being admitted to adult inpatient units.

Community meetings with children and staff are held weekly and reported to management monthly (issues raised are reviewed by Management). YAP[122] attend weekly as advocates, and report to management quarterly.

AIPU's overall structure and design are not suitable as a modern CAMHS inpatient facility. The lines of sight in the unit are poor, which can result in difficulties in observation of young people. Capital funding has been granted to carry out a feasibility study at Connolly Hospital for a new inpatient unit. Feasibility plans are due to commence in Quarter 3 of 2023.

Eist Linn

Eist Linn Child and Adolescent Inpatient Unit is located on the grounds of the Bessborough Centre in Blackrock, Co. Cork and has two floors. It covers counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry and Cork.

The ground floor of the approved centre provided communal spaces and therapy rooms for the residents: staff offices, two visiting rooms, a library or assessment room, a television/sitting room, and a dining room with a servery kitchen. The residents also had access to a pool room and a small computer room on the ground floor. A parents' apartment with kitchenette, bed and bathroom facilities was also located on the ground floor.

A low-stimulus extra care area, called the Suaimhneas suite, was located on the first floor of the approved centre. This area included one en-suite bedroom, a de-escalation room, living and dining space and an enclosed outdoor space also on the first floor. On the first floor there was a sensory room that could be accessed both from the Suaimhneas suite and the main upstairs accommodation area. A sitting room/television room and a further 16 bedrooms with en suite were also located on the first floor.

There was a school with a classroom, an art room, an activity kitchen, and a large gym/hall. A smaller gym area was also available in the school building with a treadmill, cross-trainer and fixed bicycle. There was only one teacher in the school.

There has been a vacant Clinical Director post since February 2022, with the role being covered by the Executive Clinical Director. Efforts are ongoing to fill this post. During the review of Eist Linn in February 2023, there was an acute shortage of nursing staff due to retention and recruitment difficulties. At the time of writing it was operating 16 beds - but was currently 50% occupied.. If a child is in the Suaimhneas suite, they are nursed by two staff. This can leave insufficient nursing staff in the general part of the unit. While nurse management used overtime and agency when nursing shortages occurred, on occasion it has been necessary for the Area Director of Nursing to assist in nursing duties to maintain a safe service.

[122] Youth Advocacy Programmes.

There were two consultant-led multidisciplinary teams with health and social care disciplines, including occupational therapy, psychology, speech and language therapy, dietetics and social work.

CAMHS Teams in both CHO 4 and CHO 5 reported during our review difficulty is accessing a CAMHS inpatient bed in Eist Linn. However, the management team stated that there was no child on the waiting list who was suitable for an inpatient bed in either CHO4 or CHO5.

Eist Linn required urgent decoration and maintenance. It had dingy walls in bland colours, scuffed paint, marked floors and little to make it child friendly. Despite repeated requests from management in the unit to address this issue, nothing had been done and the unit management were unaware of any plans to address this.

Nasogastric Feeding

Two CAMHS units provide nasogastric (NG) feeding where this is indicated: the CAMHS Inpatient Unit Merlin Park and Linn Dara. The advantages include:

- Preventing the transfer of children abroad for treatment of eating disorders
- Maintaining the ability to respond to national demands (the increase in presentations)
- Alleviating pressure on acute medical/ paediatric settings by being able to admit more unwell children requiring NG feeding once medically stable
- Allowing for holistic care in one setting (psychiatric and medical)
- Improving outcomes for children and families
- Developing skills and expertise in Ireland
- Acquiring skills and expertise for the new National Children's Hospital.

The severe shortage of beds for young people makes it particularly difficult to access a bed, particularly in a crisis situation. The Mental Health Commission has determined that children under the age of 18 years should not be admitted to adult approved centres except in exceptional circumstances[123]. Community CAMHS Teams around the country spoke of the difficulty in accessing CAMHS inpatient beds, or having their referral of a young person to inpatient care rejected. The decision to admit rests with the consultant responsible for the inpatient care of the child.

Young people under 16 years with mental illness are often admitted to paediatric hospitals or wards as there are no available beds in CAMHS inpatient units. Access to emergency out-of-hours beds in CAMHS units is difficult. Where there is no CAMHS Liaison Team, the mental health needs are often not well met as the environment is unsuitable and the nursing and medical staff lack specialist knowledge in treating such children and adolescents, placing the young person at increased risk. Paediatric beds used for mental health treatment are not regulated by the Mental Health Commission.

Young people with mental illness may be admitted to Adult Mental Health Units if there is no bed in CAMHS available. Usually this is for short periods of time, until a bed in CAMHS becomes available or they are well enough to be discharged to Community CAMHS. However, there have been occasions where a young person has spent lengthy periods of time in an adult mental health unit.

The figure below shows the admission of under 18s to adult units from 2019 to 2022, and the CAMHS inpatient unit they were transferred to. There has been a substantial decrease in the number of young people admitted to Adult Mental Health Units since 2019.

Referral to CAMHS inpatient Units

The referral document and referral process are nationally agreed. Referrals are accepted from CAMHS consultant psychiatrists, on the basis that the consultant has assessed the young person within the 24 hours before referral. The consultant psychiatrist need only refer to a single inpatient unit, i.e. their regional inpatient unit. If the regional unit is at capacity, or there is a clinical reason why admission can't proceed at pace, the referrer is advised to forward the referral to the three other regional units. The inpatient consultant psychiatrist has a specified timeframe to respond to referrer, depending on the urgency of case. The referral form defines three levels of urgency: routine, urgent and emergency. A telephone call between community and inpatient consultant is required only when and if the case is a clinical emergency as defined on the referral form.

[123] Code of Practice Relating to Admission of Children under the Mental Health Act 2001 ADDENDUM 1st July 2009.

Restrictive Practices in CAMHS

Seclusion is used as a technique to manage confrontational situations that can include violence, aggression and behavioural disturbance in psychiatric services. Strategies to manage these circumstances through the use of seclusion need to balance the need to keep patients safe while respecting personal liberty and freedom. In this context seclusion is typically used as a short-term management strategy.

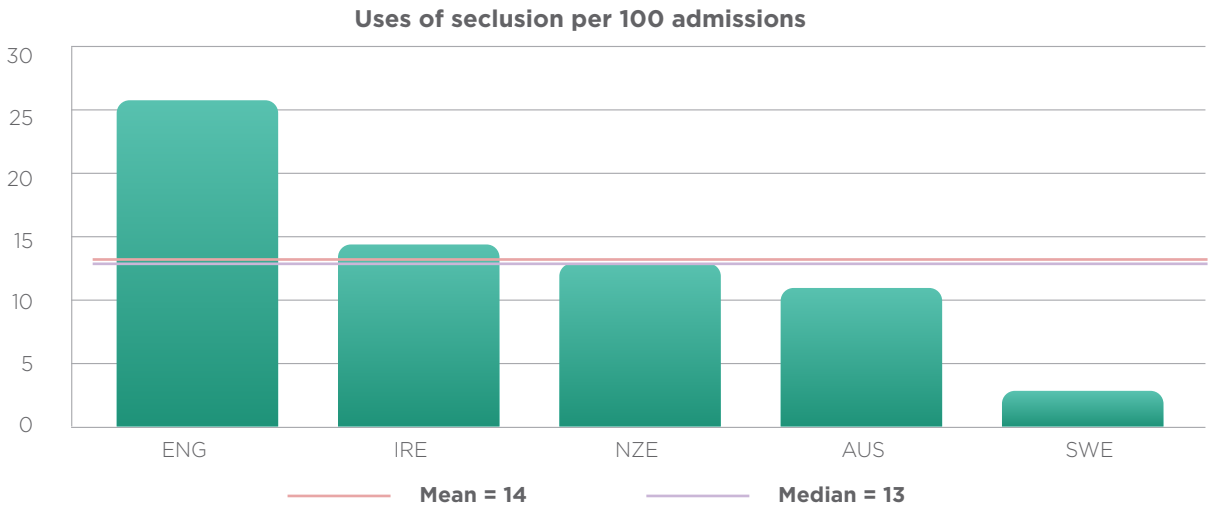
Three of the CAMHS inpatient units use seclusion (CAMHS Inpatient Unit Merlin Park, AIPU St Vincent's Hospital and Linn Dara Inpatient Unit) as a form of restrictive practice, while one independent approved centre (Ginesa Suite) transfers young people to an adult approved centre on the same campus to access seclusion facilities, although this only happens rarely. This, of course begs the question as to how we have a total of four inpatient units using seclusion while two do not even have facilities for seclusion. The units without seclusion facilities may have less capacity to take admissions with a history of violence, aggression or substance misuse issues citing that they do not have access to seclusion facilities. With regard to physical restraint, 248 episodes of physical restraint took place in three CAMHS in-patient units in 2021, down from 670 in 5 in-patient units in 2020.

In 2021 there were 36 episodes of seclusion across two approved centres, down from 98 episodes across three CAMHS inpatient units in 2020. In 2021, 1.9% of seclusion episodes were in the under-18 age group, down from 2.4% in 2020.

With regard to physical restraint, 248 episodes of physical restraint took place in three CAMHS inpatient units in 2021, down from 670 in five inpatient units in 2020[124].

On 1 January 2023, new *Rules Governing the Use of Mechanical Restraint* came into force. These prohibited the use of any form of mechanical restraint for young people under the age of 18. New *Rules Governing the Use of Seclusion*[125] and the *Code of Practice on the Use of Physical Restraint*[126] also came into force on 1 January 2023.

Figure 25 *Uses of seclusion per 100 admissions to CAMHS units*



Source: International Comparisons of Mental Health Services for Children and Young People summary report by the NHS Benchmarking Network 30 May 2018.

[124] The Use of Restrictive Practices in Approved Centres September 2022 Seclusion, Mechanical Restraint and Physical Restraint Activities Report 2021 Mental Health Commission.

[125] Rules | Mental Health Commission (mhcirl.ie)

[126] Codes of Practice | Mental Health Commission (mhcirl.ie)

Vulnerable Groups

CHAPTER

9

Young Travellers and Roma

According to the 2016 Census, there are were 30,987 Travellers in Ireland, accounting for approximately 0.7% of the population. The number of usually resident Irish Travellers increased by 6% to 32,949 in 2022 census. The Traveller Community have a proportionally higher young population. According to the 2016 Census, the proportion of children under 15 is 39.7% while in the general population it was 21.4%. These figures reflect a count of ascertained Travellers only and are considered a conservative estimate, as the All-Ireland Traveller Health Study (AITHS 2010) establishes the Traveller population at 36,224, with 42% of Travellers were under 15 years compared with 21% in the general population and 63% of Travellers were under 25 years compared with 35% in the general population.

Young Travellers and Roma remain largely invisible in mental health policy and service delivery, including the current Statement of Practice, despite robust evidence indicating disproportionate levels of poorer mental health and suicide for Travellers, who have the highest rate of suicide of any group in the country. Findings from the All-Ireland Traveller Health Study are well-established both nationally and internationally as they quantify the extent of the Traveller mental health crisis, identifying Travellers as a 'high-risk' group in relation to suicide and poor mental health (including frequent mental distress). The need to tackle the complex issue of mental health among Travellers is further compounded by the fact that almost 40% of Travellers are under the age of 15, underscoring the urgency of ensuring access to CAMH Services.

There are health inequalities for Travellers due to structural inequalities and failure to address the social determinants of health, including poor accommodation conditions, poverty, illiteracy and discrimination. Mortality rates are higher than for the general population at all ages and for all causes of death due to the impact of discrimination. This is reflected in Travellers' overall demographic profile, which is similar to that in developing countries, with a high birth rate and a young population[127].

National Traveller and Roma Inclusion Strategy (Insert gootnote 130) was developed by the HSE for 2017 – 2021. This is a cross-departmental initiative to improve the lives of the Traveller and Roma communities in Ireland.

The Health Themes and Objectives in the Strategy are as follows:

- Travellers and Roma should have improved access, opportunities, participation rates and outcomes in the health care system
- Travellers and Roma should have improved access, opportunities, participation rates and outcomes in the health care system.
- Health inequalities experienced by Travellers inequalities experienced by Travellers and Roma should be reduced
- Health services should be delivered and developed in a way that is culturally appropriate
- The rate of suicide and mental health problems within the Traveller and Roma communities should be reduced and positive mental health initiatives should be put in place.

The rate of suicide and mental health problems within the Traveller and Roma communities should be reduced and positive mental health initiatives should be put in place

The National Traveller Health Action Plan (NTHAP) outlines significant Traveller health inequalities that must be addressed during the 5-year period of 2022-2027. Goal 2 is to improve Traveller's equality of access, participation and outcomes in mainstream health services through a human-rights based approach.

CAMHS is one of the few statutory agencies collecting and publishing disaggregated data on the basis of ethnicity (with the inclusion of a Roma category) but it is not clear how data are being proactively used to benchmark and/or inform the allocation of resources and/or service delivery on the ground for young Travellers and Roma. The National Traveller Health Action Plan (2022–2027) *Working together to improve the health experiences and outcomes for Travellers* aims for the implementation of a standardised ethnic identifier across all health administrative systems to monitor access, participation and outcomes of all groups, including Travellers, and to inform the development of evidence-based policies and services.

Young Travellers and Roma face many inequalities. Traveller mental health has been identified as one of the most pressing issues for Traveller advocacy groups across Ireland. The

[127] Pavee Point Submission to Review of the Child and Adolescent Mental Health Services (CAMHS) Standard Operating Procedure February 2018.

All-Ireland Traveller Health Study *indicated that suicide was the cause of 11% of all Traveller deaths in 2010 and the crisis is even more acute when it comes to the mental health of young Travellers, many who have faced fresh challenges presented by the COVID-19 pandemic and its implications for their future.* The suicide rate for Traveller women is six times higher than that for settled women and seven times higher for Traveller men than for settled men. Suicide is most common in young Traveller men aged 15–25[128].

The report and associated animation *Measuring the Impact of Discrimination on Traveller Youth Mental Health*[129] highlighted a number of concerns raised by young Travellers including the discrimination they face in shops, education settings and the workplace and the negative portrayal of Travellers in the media. This makes young people question their self-worth and has a negative impact on their mental health and self-esteem.

The authors made a number of recommendations which focused on making youth services friendly, open and respectful places. There are barriers for Travellers and Roma engaging with CAMHS and accessing the services they provide. This was clearly outlined in the All-Ireland Traveller Health Study[130], which reported that while mental health services were available to Travellers, services were perceived as inadequate and substandard, resulting in low engagement. Findings from AITHS indicate various institutional, cultural, social and structural barriers that restrict Travellers accessing and engaging with mental health services, including discrimination and racism (both at individual and institutional levels), lack of trust in healthcare providers, inappropriate service provision and lack of engagement from service providers with Travellers and Traveller organisations[131]. AITHS identified Travellers as a 'high-risk' group in relation to suicide and poor mental health (including frequent mental distress). As 40% of Travellers are under the age of 15 there is urgent need to improve access to CAMH Services.

There are currently Traveller Mental Health Coordinators employed in CHO 1,5,6,7 and 9. There are nine funded posts and 4 vacancies at present. The Mental Health Service Co-ordinator for Travellers in the CHO areas are responsible for driving, managing and supporting the implementation of agreed improvement programmes and projects for Travellers within CHOs and in collaboration with Community Operations – Mental Health.

An information booklet *Supporting Traveller Families' Mental Health, Understanding the Stages of Support Services to Access for Children and Adolescents* is an initiative developed by representatives of HSE Mental Health Services and the HSE Traveller Health Unit (THU) Cork/Kerry Community Healthcare, in collaboration with Traveller organisations across the Cork and Kerry region.

The Traveller Mental Health Initiative (TMHI) programme was funded by the Health Service Executive via the Dormant Accounts Fund and was developed to:

- Improve mental health outcomes for Travellers and reduce suicide;
- Maintain and promote positive mental health and wellbeing;
- Improve Traveller access to mainstream health services.

Evaluation of the project showed that the involvement of Travellers in the design and delivery of projects is critical to success, with high levels of participation and engagement at a local level in this project.

There is also the National Traveller Mental Health Service funded by the HSE, which offers direct mental health support by phone, in person or online. The service provides psychotherapy, cognitive behavioural therapy, assessment and management of suicidal thoughts and feelings, and peer support and mentorship.

Improving mental health services for Travellers requires an acceptance that equity is based not just on equality of access but on equality of participation and outcome and that the particular needs of Travellers and Roma require innovative approaches which can be achieved by working in partnership with Travellers, Roma and representative organisations.

However, in their submission to the review of the Child and Adolescent Mental Health Services Standard Operating Procedure,

[128] All Ireland Traveller Health Study Summary of Findings September 2010. School of Public Health, Physiotherapy and Population Science, University College Dublin.

[129] Measuring the Impact of Discrimination on Traveller Youth Mental Health (TVG, 2022) Report final - Google Drive

[130] All-Ireland Traveller Health Study: Our Geels. Department of Health 2010.Updated 2020 gov.ie - All-Ireland Traveller Health Study (www.gov.ie)

[131] All-Ireland Traveller Health Study: Our Geels. Department of Health 2010.Updated 2020 gov.ie - All-Ireland Traveller Health Study (www.gov.ie)

Pavee Point recommended prioritisation of the development of Traveller Inclusion Leads in each CHO to complement existing Traveller health infrastructure, including Traveller Primary Health Care Projects and Mental Health Service Coordinators for Travellers. CAMHS Traveller Inclusion Leads would be responsible for driving, managing and supporting the implementation of agreed improvement programmes and projects for young Travellers within CHOs, in addition to participating within THU structures in each region[132].

Children in Care

Tusla, the Child and Family Agency, has a statutory responsibility to provide Alternative Care Services under the provisions the Child Care Act, 1991, the Children Act, 2001 and the Child Care (Amendment) Act, 2007. Children who require admission to care are accommodated through placement in foster care, placement with relatives, or residential care. The Agency also has a responsibility to provide aftercare services. In addition, services are provided for children who are homeless or separated children seeking asylum. The policy is to place children in a family-based setting, and over 92% of children are in foster care placements.

Children in care may have experienced childhood trauma, such as abuse or neglect within their family, extreme family dysfunction, or parental substance abuse. In fact, the care system can compound that trauma by repeatedly moving these children around between placements.

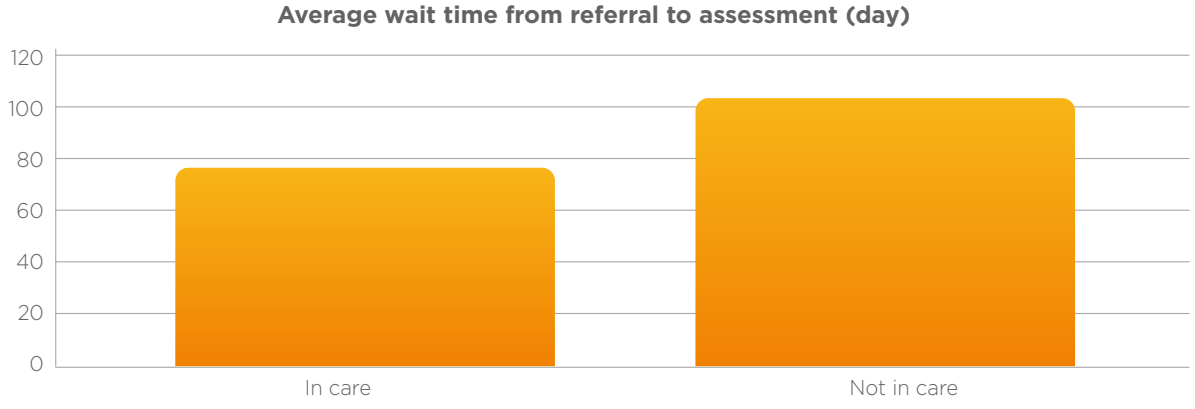
The Assessment Consultation Service (ACTS) is a small national specialised clinical service that provides multidisciplinary consultation, assessment and focused interventions to young people who have high-risk behaviours associated with complex clinical needs. ACTS also supports other professionals in their ongoing work with young people and their families. This not a replacement for CAMHS, and children and young people requiring treatment for moderate-to-severe mental illness are referred to CAMHS. Tusla reported to us that the waiting times for CAMHS for children in care were too long and that the children and young people in care should be prioritised for CAMHS due to their complex situations.

We looked at 1,178 clinical files during our review. In our sample, 5% of the children/young people are in care while 92% are not in care. It was not reported in 3% of the clinical files whether the child/young person was in care. Figure 27 shows the average wait time from referral to assessment of children in care and children not in care.

From Figure 26, it can be seen that children/young people in care in our sample, wait on average two months from referral to assessment while children/young people not in care wait on average three months from referral to assessment. Note that only 5% of children/young people in CAMHS were in care, and this may affect the above analysis due to the small numbers.

As children in care can often move between placements, sometimes with little notice and sometimes repeatedly, this can cause difficulties where a child or young person is receiving CAMH services. Irish mental health services tend to be rigidly provided in catchment areas related to where a service user lives. If the child or young person remains with their original treating team, this may involve long journeys from their new placement resulting in missed school. If they move to CAMHS in their new catchment area, it means "starting all over again" with new therapists. This can cause disruption

Figure 26 *Average wait time from referral to assessment for children in care*



[132] Pavee Point Submission to Review of the Child and Adolescent Mental Health Services (CAMHS) Standard Operating Procedure February 2018.

of treatment, fractured therapeutic relationships and uncertainty for the child/young person. There is some flexibility in the HSE as to where the child/young person chooses to receive treatment from CAMHS but moving remains disruptive and potentially causes further trauma for the child/young person.

Asylum Seekers, Refugees and Migrants

Forced migration is seen as a global threat to mental health and refugee children are considered particularly vulnerable, as the context of displacement will affect all parts of their life and happens at crucial times of their physical, emotional, social and cognitive development[133]. Refugee children are uprooted from home, friends and family, many have taken long and hazardous journeys, and may have spent long periods in transit or camps. Many families have been displaced by war, atrocities, persecution and severe poverty, and refugee and asylum-seeker children have high rates of post-traumatic stress disorder, depression and anxiety.

The use of Direct Provision in Ireland since 1999 has meant a significant number of people living in poor accommodation and among strangers, with their ability to self-care left to atrophy[134].

Since Russia's invasion of Ukraine in February 2022, over 85,000 people have arrived in Ireland from Ukraine, and approximately one-third of the arrivals were minors under the age of 18.

The table from International Protection Accommodation Services below shows the number of asylum seekers, regugees and migrant children in different types of provided accommodation at the end of June 2023. In total, 21% of those in provided accommodation are children.[135]

Accomodation type	No of Centres	Total Occupancy	Of whom children
IPAS Acom-modation Centres	49	7007	2083
Emergency Accomodation Centres	158	13518	2460
National Re-ception Centre	1	413	48
City West Transit Hub	1	486**	0
Temporary Tented Acco-modation	2	149	0
Totals	211	21.573	4,591

In addition to the adverse events that caused the migration and journey to Ireland, some children may have had pre-existing mental health problems that will now need to be cared for by a culturally different mental healthcare system, in a different language and without the benefit of their own clinical records in most cases.

It is not acceptable to consider access to CAMHS and other mental health services as equitable simply because such children can potentially access the same services. They need assistance in ensuring appropriate access and they face numerous barriers to obtaining appropriate care[136].

Without serious commitment by health and resettlement services to provide early support to promote mental health, research suggests that a high proportion of refugee children are at risk for educational disadvantage and poor social integration in host communities, potentially affecting their life course[137].

[133] Dangmann C., Dybdahl R., Solberg O. Mental health in refugee children, Current Opinion in Psychology, Volume 48, 2022, 101460, https://doi.org/10.1016/j.copsyc.2022.101460.

[134] Blackmore R, Gray K., Boyle J. et al. Systematic Review and Meta-analysis: The Prevalence of Mental Illness in Child and Adolescent Refugees and Asylum Seekers, Journal of the American Academy of Child & Adolescent Psychiatry, Volume 59, Issue 6,2020,Pages 705–714, ISSN 0890-8567,https://doi.org/10.1016/j.jaac.2019.11.011.

[135] gov.ie - June 2023 (www.gov.ie)

[136] The Mental Health Service Requirements in Ireland for Asylum Seekers, Refugees and Migrants from Conflict Zones. College of Psychiatrists in Ireland Position Paper EAP/01/17 approved by Council March 2017.

[137] Blackmore R, Gray K., Boyle J. et al. Systematic Review and Meta-analysis: The Prevalence of Mental Illness in Child and Adolescent Refugees and Asylum Seekers, Journal of the American Academy of Child & Adolescent Psychiatry, Volume 59, Issue 6,2020,Pages 705–714. ISSN 0890-8567,https://doi.org/10.1016/j.jaac.2019.11.011.

However, refugee children are not a homogenous group and the effects of events leading to migration, during migration and following migration are not consistent across all groups. In fact, recent reviews describe a wide range of prevalence rates for different types of mental distress such as post-traumatic stress disorder (PTSD), depression and anxiety that vary with age, gender, measurement type, country of origin and settlement. In line with this, a recent study conducted by a research group in Sweden, showed a PTSD prevalence nearly twice as high (56%) for minors from Afghanistan compared to rates found in minors from Syria (34%)[138].

Without national clinical leadership in mental health of asylum seekers, refugees and migrants, including those under 18 years, there is a risk that in the already stretched CAMH Service, young people will not receive the most appropriate care and treatment.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Young People[139]

Members of the LGBTI community have been shown by national and international research to have increased risk of suicidal behaviour and have been identified as a priority group within Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015–2024.

The LGBTIreland report, a national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland highlighted particular vulnerability among young LGBTI people, and reported rates of self-harm as two times higher, and attempted suicide as three times higher, compared to their non-LGBTI peers. The data revealed that anti-LGBTI bullying in schools can have a devastating impact on LGBTI teenagers' mental health, increasing the likelihood of reporting stress, depression, anxiety, self-harm and attempted suicide. The authors found that 46.8% (n=872) had scores indicating some level of depression. Approximately one in ten (11%; n=204) participants had scores within the mild depression category and a further 15.9% (n=296) scored within the moderate depression category. Just over 20% of the scores fell within the categories of either severe (7.1%; n=132) or extremely severe (12.9%; n=240) depression.

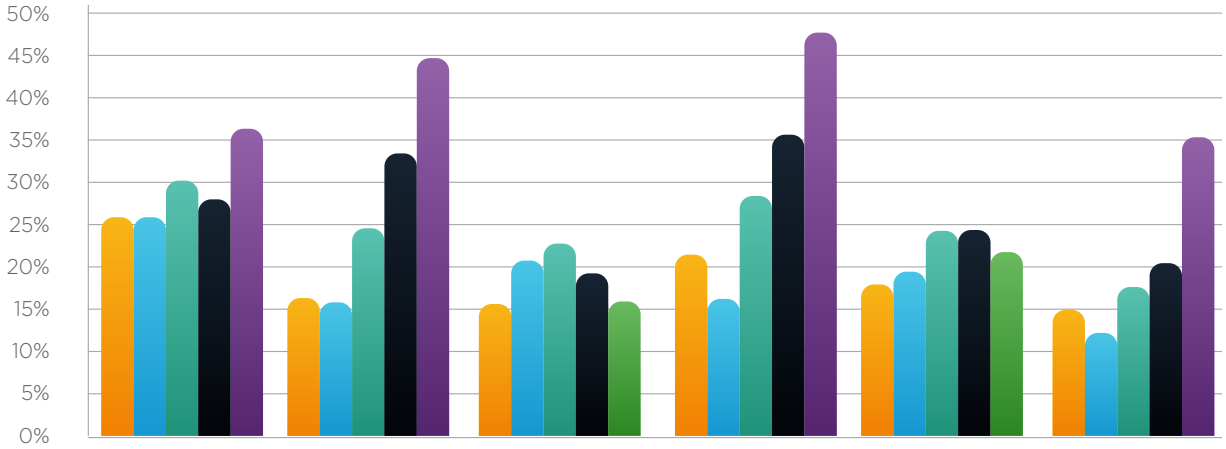
A further 10.5% (n=198) and 8.7% (n=163) had scores in the mild and moderate anxiety categories respectively. Over 20% had scores that were within either the severe (7%; n=131) or extremely severe (15.6%; n=294) anxiety categories.

The vast majority of staff on teams do not have adequate training in LGBTI. BelongTo, the support agency for young people who are LGBTI, report young people arriving to their service where CAMHS do not have the knowledge or confidence to treat a young LGBTI person's mental illness. There has been some training completed in the Linn Dara CAMHS and in the Paediatric Liaison Services in CHI Crumlin in this area.

[138] Dangmann C., Dybdahl R., Solberg O. Mental health in refugee children, Current Opinion in Psychology, Volume 48,2022,101460,https://doi.org/10.1016/j.copsyc.2022.101460.

[139] The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland ISBN: 978-0-9561023-8-6.

Figure 27 *Proportion of LGBTI participants with mild/moderate or severe/extremely severe Depression, Anxiety, and Stress Scale (DASS-21) scores by LGBTI group*[140]



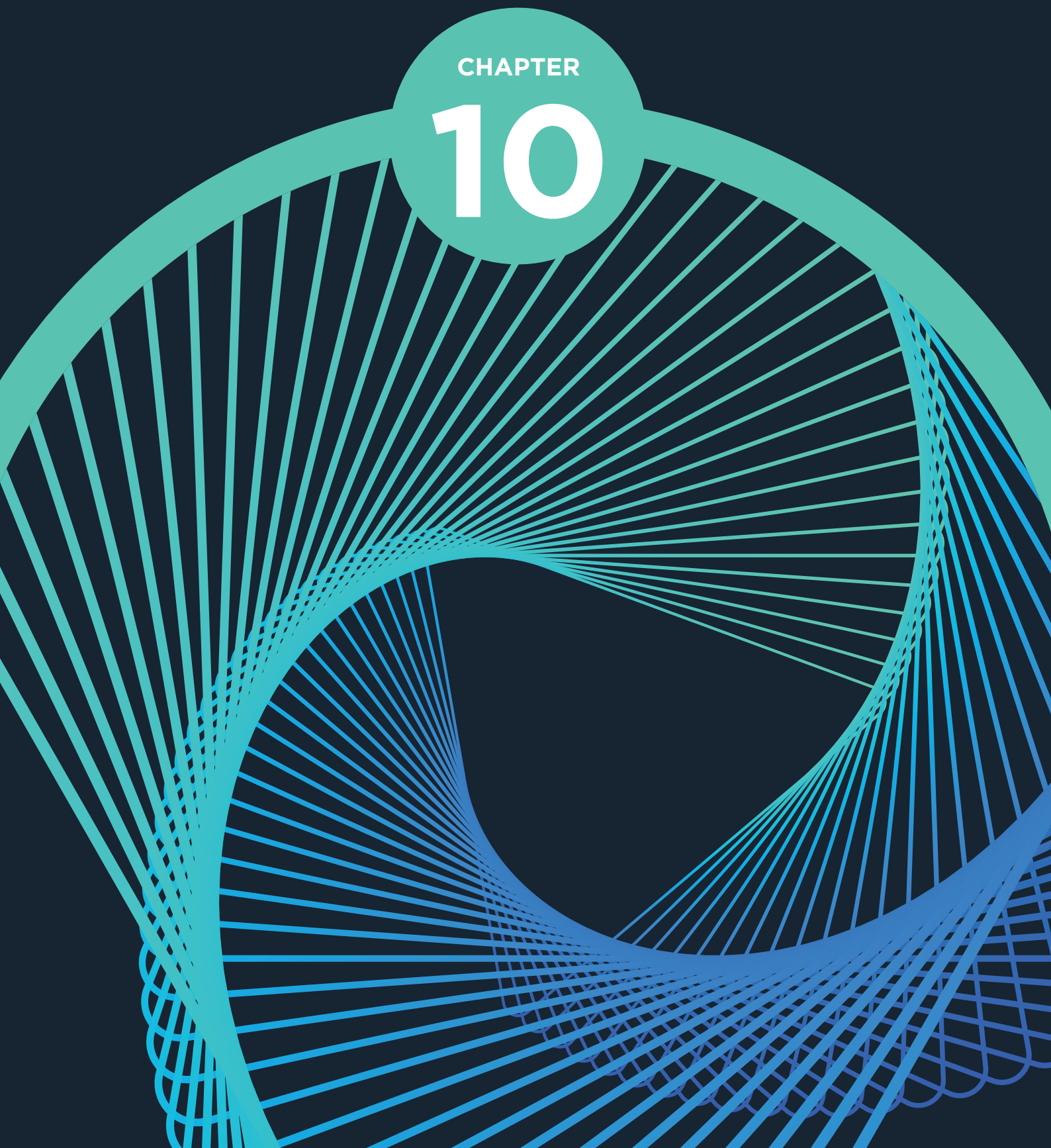
	Mild/Moderate	Severe/ Extremely Severe	Mild/Moderate	Severe/ Extremely Severe	Mild/Moderate	Severe/ Extremely Severe
	Depression		Anxiety		Stress	
Lesbian/gay female	25.7%	16.2%	15.5%	21.3%	17.8%	14.8%
Gay male	25.7%	15.7%	20.6%	16.1%	19.3%	12.1%
Bisexual	30.1%	24.4%	22.6%	28.2%	24.1%	17.5%
Transgender	27.8%	33.2%	19.1%	35.4%	24.2%	20.3%
Intersex	36.1%	44.4%	15.8%	47.4%	21.6%	35.1%

[140] The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland ISBN: 978-0-9561023-8-6.

Adherence to Guidelines

CHAPTER

10



Adherence to CAMHS Operational Guidelines

The majority of children (97%) in the sample had an initial assessment completed and documented at their first appointments.

Consent

The functional approach to the assessment of capacity to consent to an intervention outlined in the National Consent Policy[141] applies to a young person aged 16 and 17 years in the same way as to an adult, except where the Mental Health Act 2001 applies in the admission of children to approved centre inpatient units. If a young person is found to lack the capacity to consent on the basis of the functional test, his or her parents may give consent on his or her behalf until the young person reaches the age of 18 years. The Irish courts have not provided a definitive ruling on consent by children under 16 years. This means that as a general rule, the consent of a parent(s) or legal guardian(s) should be obtained before providing treatment to a child. In a non-emergency situation, all reasonable effort should be made to involve the young person and to reach a consensus as regards the appropriate intervention.

Table 17 displays the percentage of clinical files in our sample containing documented consent of a child/young person to an initial assessment.

Table 17 *Percentage of clinical files containing documented consent to an initial assessment.*

Child/young person's documented consent	Percentage of children/ adolescents under 16	Percentage of children/ adolescents 16 and over
Yes	9%	12%
No	88%	86%
Unknown	2%	2%

In our sample, 78% of parents/carers provided written consent for an initial assessment to be carried out on the child/young person while 20% of parents/carers did not provide written consent for an initial assessment to be carried out. For 1% of children/young people it is unknown whether the parents/carers provided consent to an initial assessment.

Overall, 59% of children/adolescents have been prescribed medication by CAMHS. Of the children/adolescents on medication, 76% had documented consent to medication, provided by either the child/adolescent themselves or the parent/carer, while 21% did not have consent to medication documented. For 2% of children/ adolescents it is unknown whether consent to medication was provided and for another 1% providing consent was not applicable.

The HSE states that it is the practice of the CAMHS clinician to explain the nature and purpose of the assessment with a child and their parents/guardians. A child agrees to participate in the assessment process. HSE Consent policy refers to consent for an intervention and when a child refuses consent. Parents have given consent for the referral for assessment as part of the referral process.

Multidisciplinary Reviews

Multidisciplinary reviews took place weekly in all teams, and we found that there was strong multidisciplinary working in nearly all teams, despite the low number of staff.

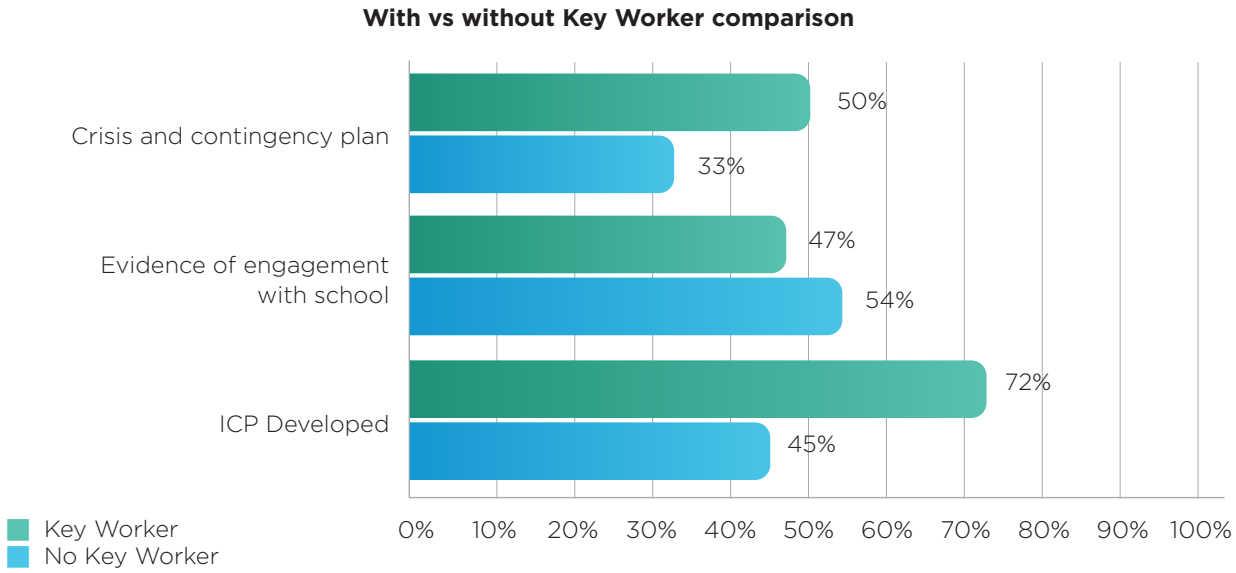
Key Workers

A key worker coordinates the care for the individual child and so is essential for case management and support for the child and their family. Overall, 62% of children/young people in our sample had been assigned a key worker and 36% of children/young people had not been assigned a key worker. For 1% of children/young people it is unknown whether the children/young people were assigned a key worker.

Figure 28 compares the CAMHS profile of children/young people with key workers against the profile of children/young people without key workers.

[141] hse-national-consent-policy.pdf - hyperlink - https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/consent/hse-national-consent-policy.pdf

Figure 28 *CAMHS profile of children/young people with and without key workers*

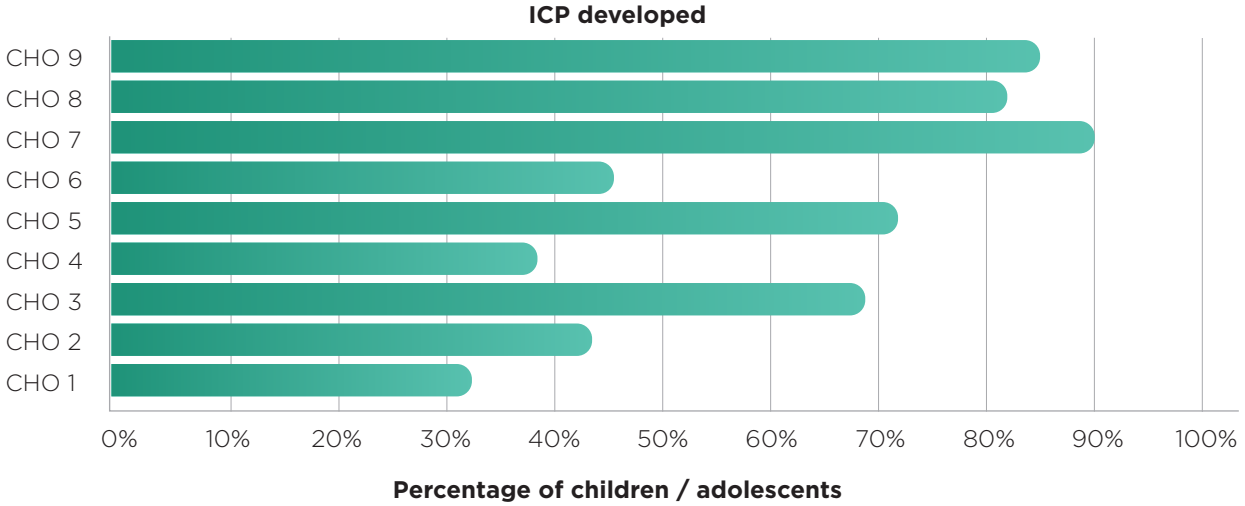


Individual Care Plans

Overall, 62% of children/adolescents had an individual care plan (ICP) developed and 38% did not have an ICP developed. Of the children/adolescents that had an ICP developed, none satisfied 100% of the CAMHS Operational Guidelines, and only 6% satisfied five out of six of the COG requirements. To satisfy the COG, the ICP must have all of the following criteria.

Ref	COG Requirement
1	A clinical formulation.
2	A diagnosis if available.
3	Agreed goals between CAMHS Team, the child or adolescent and the parent(s).
4	A list of other agencies involved with the child or adolescent.
5	An individual risk and safety management plan.
6	A discharge/transition plan which includes a provisional discharge date.

Figure 29 *Percentage of children/adolescents that had an ICP developed in each of the CHOs in CAMHS.*



It can be seen from Figure 29 that CHO 7 has the highest percentage of children/adolescents that have an ICP developed and CHO 1 has the lowest percentage of children/adolescents that have an ICP developed.

Figure 30 displays the percentage of children/adolescents with an ICP that contains each requirement of the COG. Please note that a child/adolescent could be counted in more than one of the below percentages if their ICP satisfies more than one of the COG requirements:

Figure 30 *Percentage of children/adolescents with an ICP that satisfies each requirement of the COG*

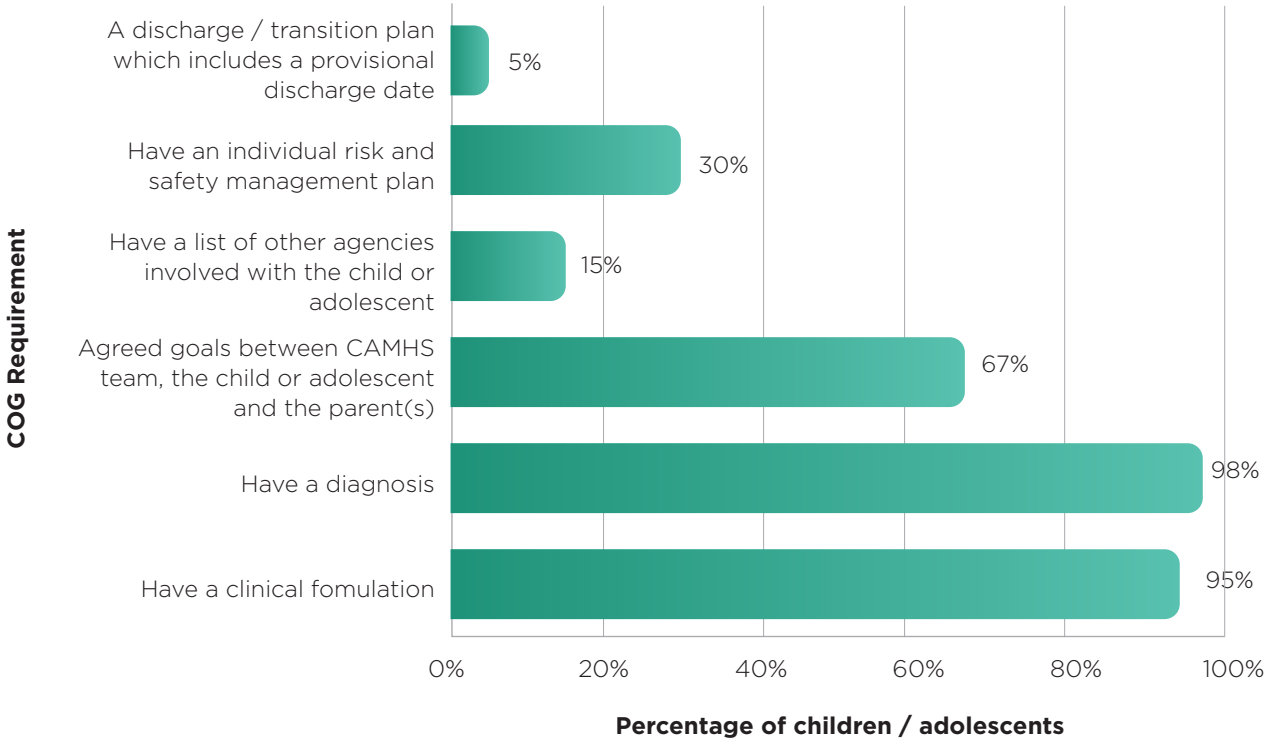
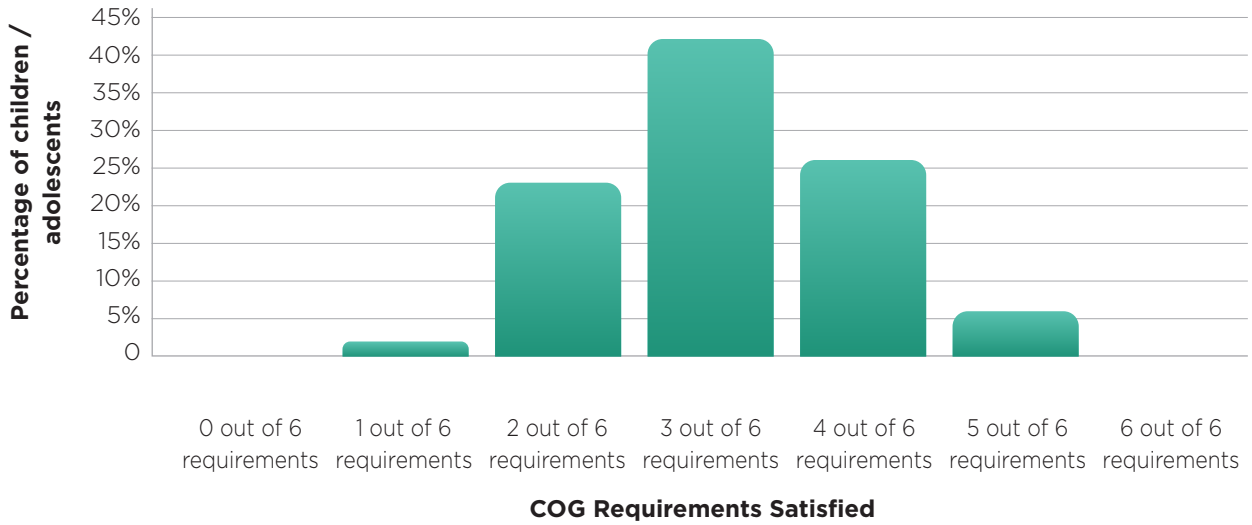


Figure 31 displays the percentage of children/adolescent ICPs that satisfy different numbers of the COG requirements.

Figure 31 *Number of COG requirements that children/adolescents' ICPs satisfy*



From Figure 31, it can be seen that 42% of ICPs satisfy three out of six of the COG requirements with 0% satisfying 100% of requirements and 6% satisfying five out of six.

Some ICPs were of such poor quality as to be meaningless. This contrasted sharply with some teams where care planning was at the heart of the treatment in CAMHS and the patient was at the centre of the care planning process. High-quality care planning is resource neutral and it was hard to find a credible explanation as to why care planning was not taking place. The HSE state that, in fact it is not resource neutral as "high quality care planning depends on being assigned a key worker". It is therefore incumbent on the HSE to provide key workers. It is not good enough to say that a child can't have a high quality ICP because there is no keyworker. The CAMHS Operational Guidelines state that each child should have a care plan and lists what such a care plan should contain. Good care planning is essential for communicating to staff, parents and where appropriate the child, what the treatment plan is for the child. Such communication is vital in the light of the current high turnover of staff.

A full audit of adherence to the CAMHS Operating Guidelines has commenced and is due for completion by the end of 2023.

Adherence to NICE Guidelines

Clinical guidelines are evidence-informed recommendations intended to optimise patient care. Clinical guidelines have the potential to improve quality of care by assessing the benefits and harms of alternative care options and reducing unwarranted practice variations. The National Institute for Health and Care Excellence (NICE) is an independent organisation that develops clinical guidelines[142].

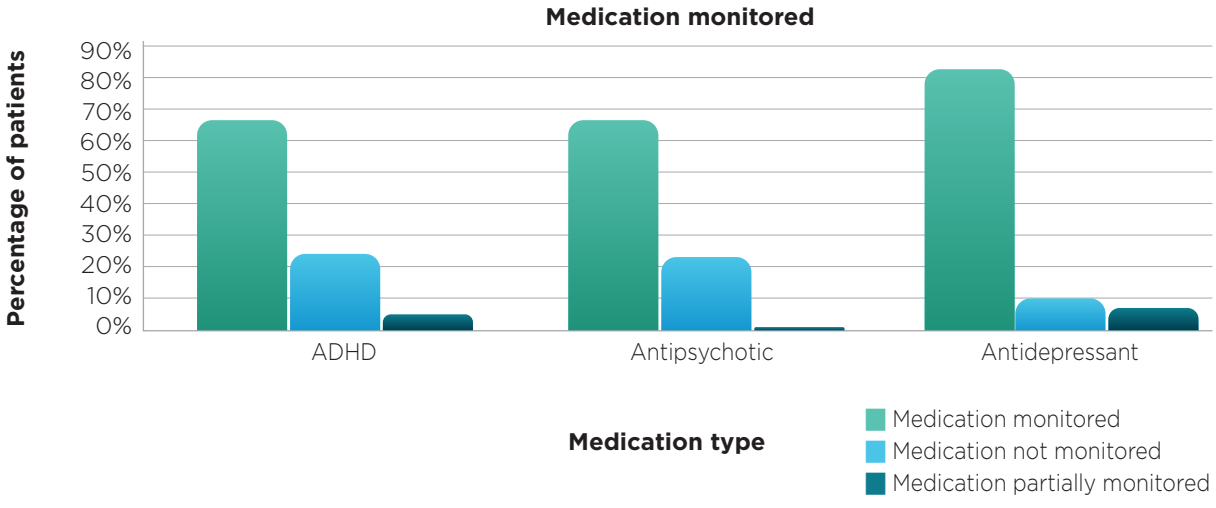
We audited stratified randomised sample of 10% of clinical files opened since January 2021 across all CAMHS Team. The sample was stratified to include:

- Young people who have a diagnosis of ADHD
- Young people who have a diagnosis of an Eating Disorder
- Young people who have a diagnosis of a Mood Disorder
- Young people prescribed anti-psychotic medication

Stratified random sampling is a method of sampling that involves the division of a population into smaller subgroups known as strata. In stratified random sampling, or stratification, the strata are formed based on members' shared attributes or characteristics, such as different diagnosis, or different prescribed medication, as in our sample. Random samples are then selected from each stratum.

In our stratified samples, 30% of children/adolescents were on ADHD stimulant medication, 25% on antipsychotic medication and 56% on antidepressant medication. Please note that a child/adolescent could be on more than one type of medication.

Figure 32 *Percentage of children/adolescents on each type of medication who have their medication monitored*



[142] 1 (nice.org.uk)

ADHD

NICE Guidelines recommend the following for children on stimulant medication for ADHD:

- Measure height every six months in children and young people.
- Measure weight every three months in children 10 years and under.
- Measure weight at three and six months after starting treatment in children over 10 years and young people, and every six months thereafter, or more often if concerns arise.
- Plot height and weight of children and young people on a growth chart and ensure review by the healthcare professional responsible for treatment.
- Monitor heart rate and blood pressure and compare with the normal range for age before and after each dose change and every six months.

Source: Attention deficit hyperactivity disorder: diagnosis and management NICE guideline [NG87]. Published: 14 March 2018. Last updated: 13 September 2019.

Overall, 66% of children/adolescents on ADHD medication had their medication monitored, 24% did not have their medication monitored and 5% had their medication partially monitored. Five percent were not at the medication-monitoring stage at the time of the audit.

Figure 33 displays the percentage of children/adolescents on ADHD medication who had each of the premedication checks at the appropriate interval.

Figure 33 *Percentage of children who had premedication checks for stimulant ADHD medication*

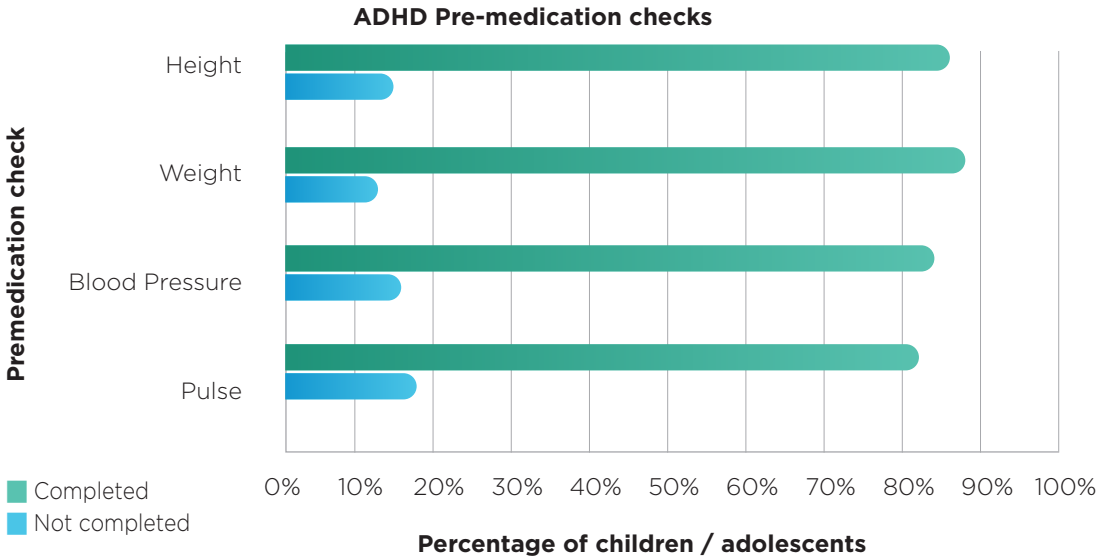
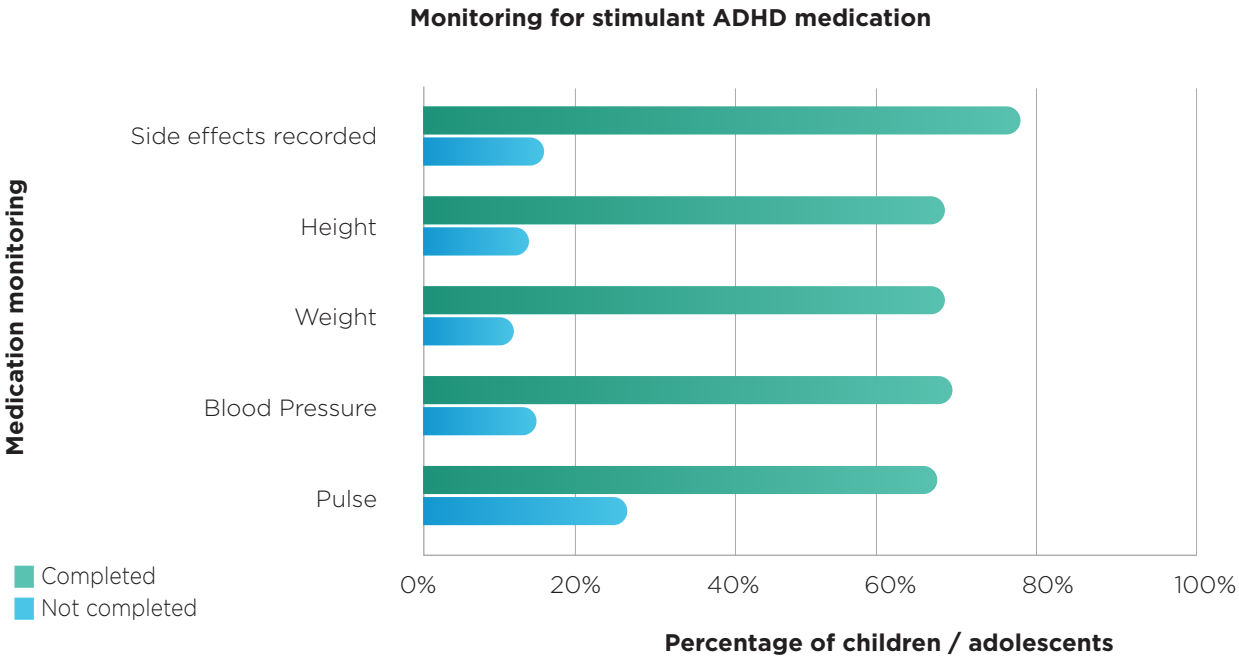


Figure 34 *Percentage of children who had medication-monitoring checks for stimulant ADHD medication*



Antipsychotic Medication

Antipsychotic medication is used for the treatment of psychosis but also in other mental illnesses in children. In the absence of Irish guidelines in medication management for children and young people on antipsychotic medication, the NICE Guidelines[143] are known and accepted by consultant psychiatrists in CAMHS as an appropriate standard of care. The Guidelines lay out clearly what monitoring is required for these medications and the frequency of that monitoring. This applies whether or not the child has a psychosis or is taking the medication for another reason. While some teams were meticulous in that monitoring, we found other teams which did not carry out monitoring to an acceptable standard. This has safety repercussions for the children on these medications as some antipsychotic drugs carry side effects that can, in some cases, be detrimental to a child or young person's physical health. Side effects of antipsychotic medication can include sleepiness, dulled feelings, slowed thinking, serious weight gain, increased blood pressure, galactorrhoea (production of breast milk) and distress. In some cases, we found that prescriptions were renewed without a documented review of the patient for up to two years. These cases were escalated to the Chief Officer of the relevant CHO and this was immediately addressed by the CHO. In CHOs where children in our sample of 10% of cases were not monitored sufficiently for antipsychotic/neuroleptic medication, the HSE provided comprehensive reports regarding the actions they would take. The HSE also reported there is no evidence that any child was harmed or suffered side effects from their medication. The Mental Health Commission continues to monitor the implementation of their actions.

NICE Guidelines recommend that it is necessary to monitor and record the following for children and young people on antipsychotic medication:

- Efficacy, including changes in symptoms and behaviour.
- Side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia (for example, the overlap between akathisia and agitation or anxiety).
- The emergence of movement disorders.
- Weight, weekly for the first six weeks, then at 12 weeks and then every six months (plotted on a growth chart).
- Height every six months (plotted on a growth chart).
- Waist circumference every six months (plotted on a percentile chart).
- Pulse and blood pressure (plotted on a percentile chart) at 12 weeks and then every six months.
- Fasting blood glucose or HbA1c, and blood lipid and prolactin levels at 12 weeks and then every six months.
- Adherence.
- Physical health.

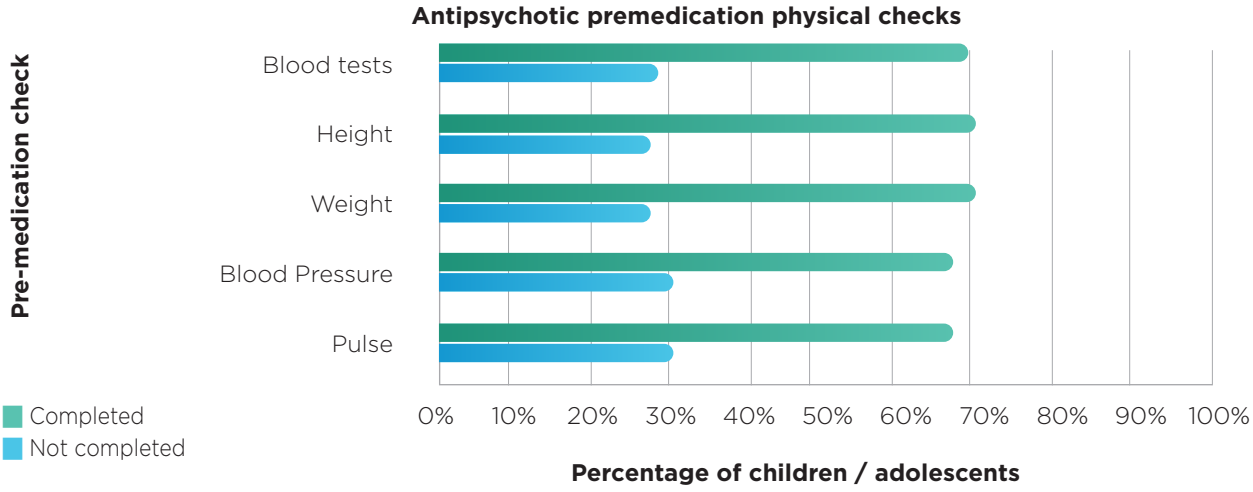
For children and young people with first-episode psychosis the following should be offered:

- Oral antipsychotic medication, in conjunction with psychological interventions and family intervention with individual Cognitive Behavioural Therapy.

Source: Psychosis and schizophrenia in children and young people: recognition and management Clinical Guideline [CG155]. Published: 23 January 2013. Last updated: 26 October 2016.

[143] Psychosis and schizophrenia in children and young people: recognition and management Clinical guideline Published: 23 January 2013 (updated 2016) www.nice.org.uk/guidance/cg155

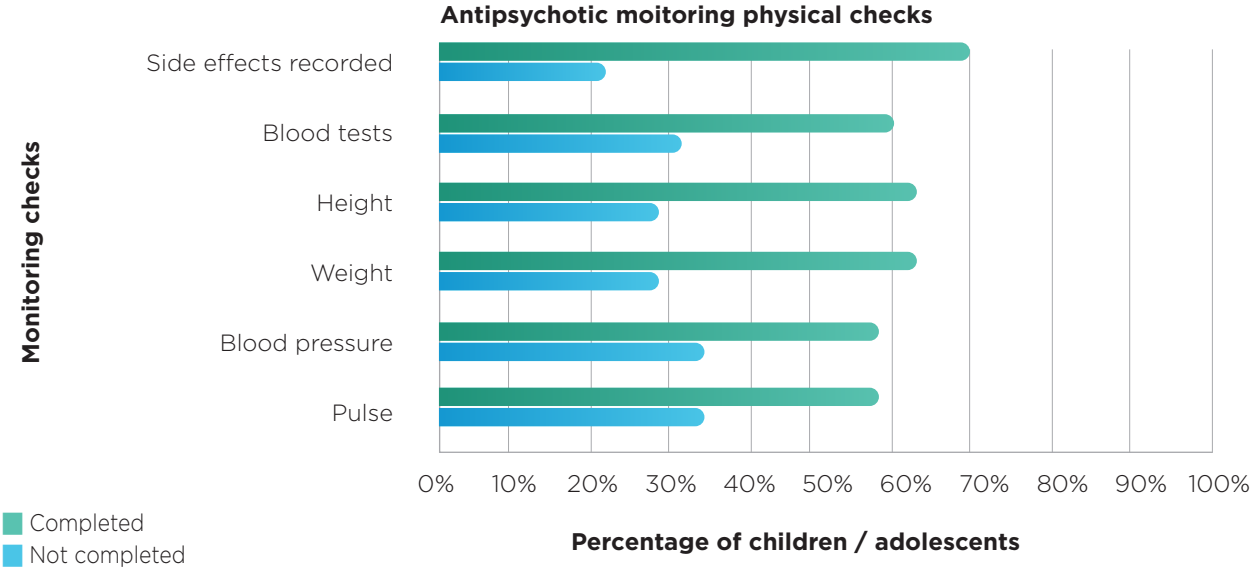
Figure 35 *Percentage of children who had antipsychotic premedication physical checks*



From Figure 36, it can be seen that 71% of children/adolescents on antipsychotic medication had their height and weight checked, 70% had their bloods completed, 68% had their blood pressure checked and 68% had their pulse checked.

Figure 36 analyses the monitoring that is performed while a child/adolescent is on antipsychotic medication.

Figure 36 *Percentage of children who had physical check monitoring while on antipsychotic medication*



From Figure 36, it can be seen that 70% of children/adolescents on antipsychotic medication had the medication's side effects recorded at the recommended intervals, 63% had their height and weight taken and 60% had their bloods completed.

It should be noted that some children may not tolerate the physical and blood tests during their illness, and medication may be continued after weighing up benefits over the risk of continuing the medication in the absence of these checks.

Antidepressant Medication

For five-to 11-year-olds with moderate-to-severe depression, NICE recommends considering the following options adapted to developmental level as needed:

- Family-based therapy (FBT)
- Family therapy (family-focused treatment for childhood depression and systems integrative family therapy)
- Psychodynamic psychotherapy
- Individual cognitive behavioural therapy.

For 12–18-year-olds with moderate-to-severe depression, offer individual CBT for at least three months.

If individual CBT would not meet the clinical needs of a 12–18-year-old with moderate-to-severe depression or is unsuitable for their circumstances, consider the following options:

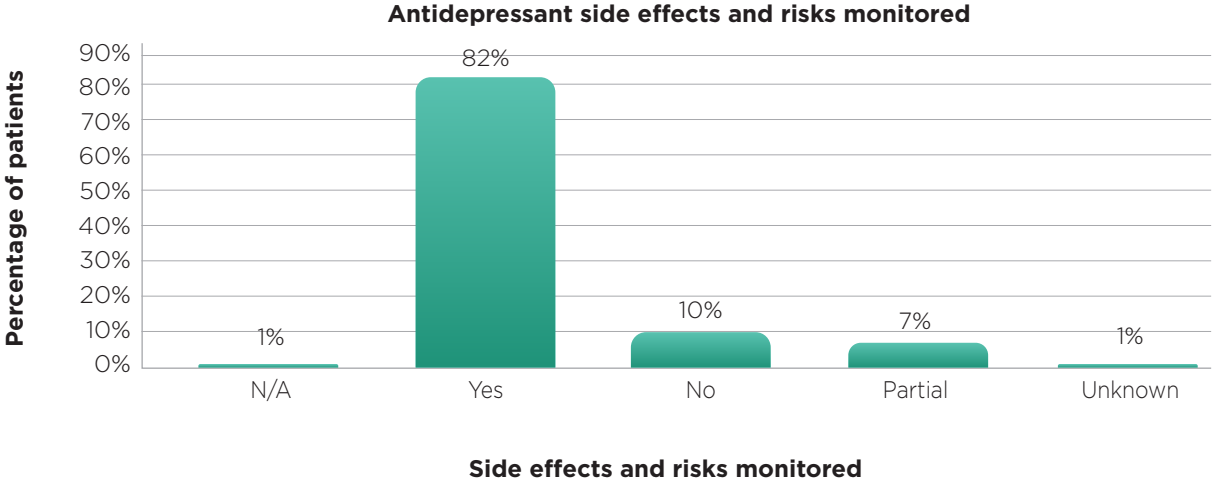
- Interpersonal psychotherapy for adolescents (IPT-A)
- Family therapy (attachment-based or systemic)
- Brief psychosocial intervention
- Psychodynamic psychotherapy.

Do not offer antidepressant medication to a child or young person with moderate-to-severe depression except in combination with a concurrent psychological therapy.

NICE Guidelines recommend that a child or young person prescribed an antidepressant should be closely monitored for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment, by the prescribing doctor and the healthcare professional delivering the psychological therapy. Unless it is felt that medication needs to be started immediately, symptoms that might be subsequently interpreted as side effects should be monitored for seven days before prescribing. Once medication is started the patient and their parents or carers should be informed that if there is any sign of new symptoms of these kinds, urgent contact should be made with the prescribing doctor.

Source: Depression in children and young people: identification and management NICE guideline [NG134]. Published: 25 June 2019.

Figure 37 *Percentage of children/adolescents on antidepressant medication who have had the medication side effects and risks monitored*



From Figure 37, it can be seen that 82% of children/adolescents on antidepressant medication have the medication's side effects and risks monitored, 10% do not have either their side effects or risks monitored, and 7% only have one of side effects or risks monitored. Whether a child/adolescent's antidepressant medication side effects or risks were monitored was unknown for 1% of children/adolescents and whether a child/adolescent's side effects and risks were monitored was not applicable for 1% of children/adolescents.

According to the NICE Guidelines, a child/adolescent on antidepressant medication should also receive CBT support and/or psychological intervention. Table 18 displays the percentage of children/adolescents on antidepressant medication that receive either CBT and/or psychological intervention.

Table 17 *Percentage of children/adolescents on antidepressant medication who receive either CBT and/or psychological intervention*

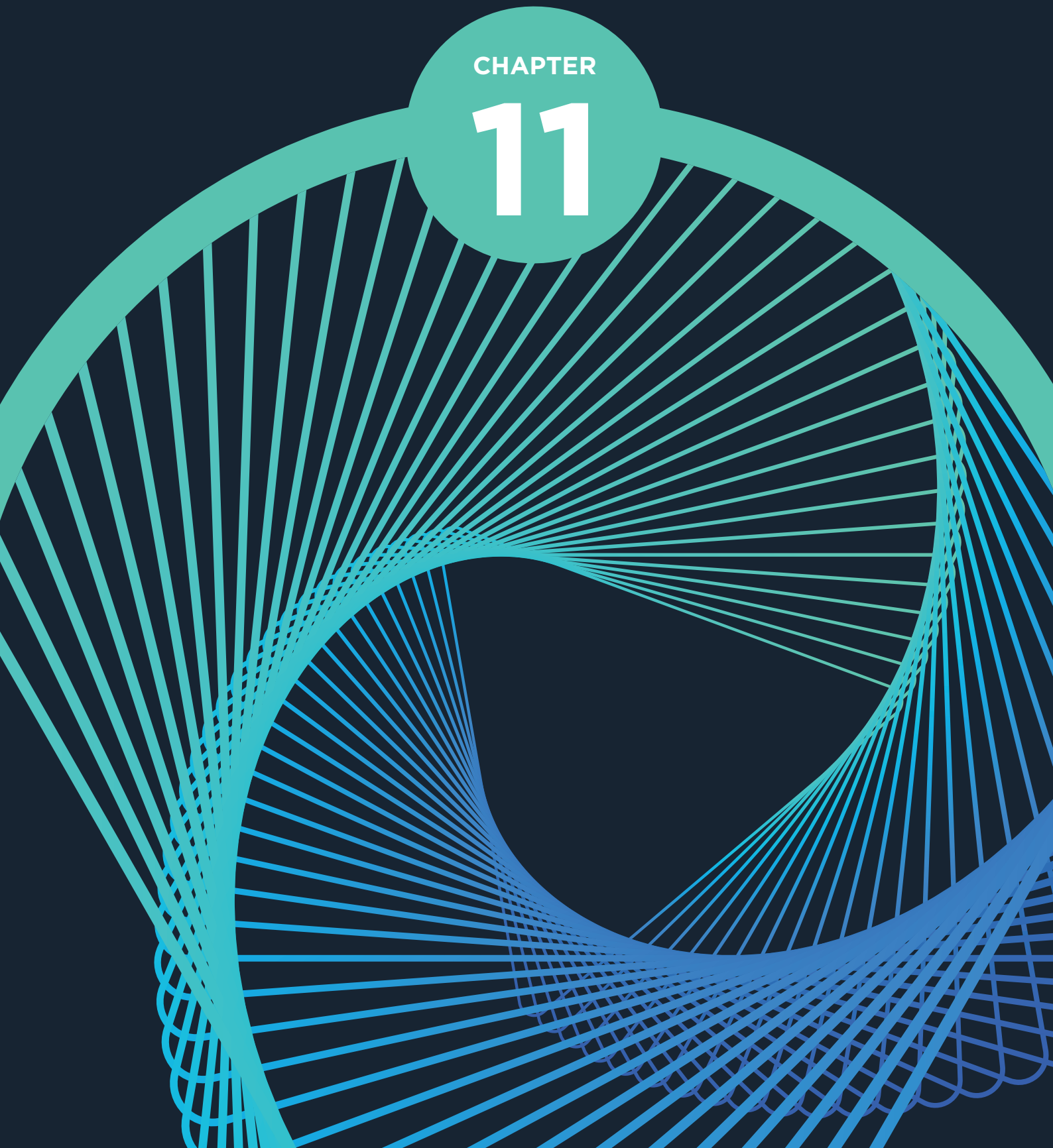
Psychological intervention or CBT	Percentage of children/adolescents
Yes	51%
No	48%
Unknown	2%
N/A	0%

The table above shows that 51% of children/adolescents are receiving psychological intervention and/or CBT and 48% of children/adolescents are not receiving psychological intervention or CBT.

Integrated Person-centred Care of Children and Young People With Mental Health Difficulties

CHAPTER

11



Integrated Care is defined by the HSE as all services working together centred on the needs of the person. Therefore CAMHS cannot be reviewed in isolation. Health services, including mental health services for children, should be integrated and should put the child's needs at the centre of any package of care, thus providing child-centred care.

As noted above, CAMHS assess and treat children and young people under 18 years of age with moderate-to-severe mental illness. Other services for children, such as Primary Care services, which assess and treat mild-to-moderate mental health difficulties, and the Community Disability Network Teams are equally important. Mental illness may only be one component of a presentation that could also include autism, learning disability, mobility difficulties, social difficulties or child safety concerns. The importance of inter-agency working is therefore paramount.

The HSE disability teams have recently reconfigured services for children with intellectual disability and other disabilities nationally into Children's Disability Network Teams (CDNTs) through a HSE national programme called 'Progressing Disability Services for Children and Young People'[144]. The CDNTs provide services to children with complex needs who have a wide range of disabilities including intellectual disability, physical disability, sensory disability and autism. They do not include mental health services and are separate and distinct from the CAMHS-ID services. When reconfiguration is fully complete, every child with complex needs in the country is supposed to have access to an interdisciplinary disability team based on the geographical location of where they live.

Under the National Policy on Access to Services for Children & Young People with Disability & Developmental Delay[145], Primary Care Services are providers of services to children with non-complex difficulties in functional skills and/or applied skill sets required for activities of daily living, learning new skills and social interactions.

The HSE states that it takes a coordinated approach to waiting list initiatives, focusing on children and young people who have waited longer than nine months, aiming for a stepped-care service model. There has been investment in 'upstream' youth mental health services, including Jigsaw and other funded agencies in the community and voluntary sector, which are providing enhanced services for children and young people with mild-to-moderate mental health difficulties who do not need to access specialist mental health services such as CAMHS. However, this is not enough and waiting times for HSE Primary Care remain, in many areas, up to two to three years.

Jigsaw

Jigsaw provide brief early-intervention mental health supports for young people aged between 12 and 25 in different areas around Ireland. The majority of its funding comes from the HSE. Waiting times for Jigsaw services have lengthened in some areas, as the demand for mental health services increases. Jigsaw plays a vital role in providing Primary Care services for young people as there are difficulties in accessing HSE Primary Care in many areas around the country due to staff shortages. Jigsaw professionals were sometimes trying to manage young people who they deem at risk or mentally unwell but the referrals to CAMHS were refused as they did not meet the criteria of moderate-to-severe mental illness.

Jigsaw carried out the My World Surveys, in conjunction with the Department of Psychology in UCD, into youth mental health in Ireland in 2012 and 2019[146]. The survey of 90,000 young people in 2019 found that:

- rates of anxiety and depression in young people have increased in recent years,
- having the support of One Good Adult and talking about problems is important for young people's mental health and good sleep hygiene and physical activity are related to better mental health.

These surveys have provided valuable insight into youth mental health and wellbeing in Ireland.

[144] Progressing Disability Services for Children and Young People HSE About PDS - HSE.ie

[145] National Policy on Access to Services for Children & Young People with Disability & Developmental Delay HSE 2019

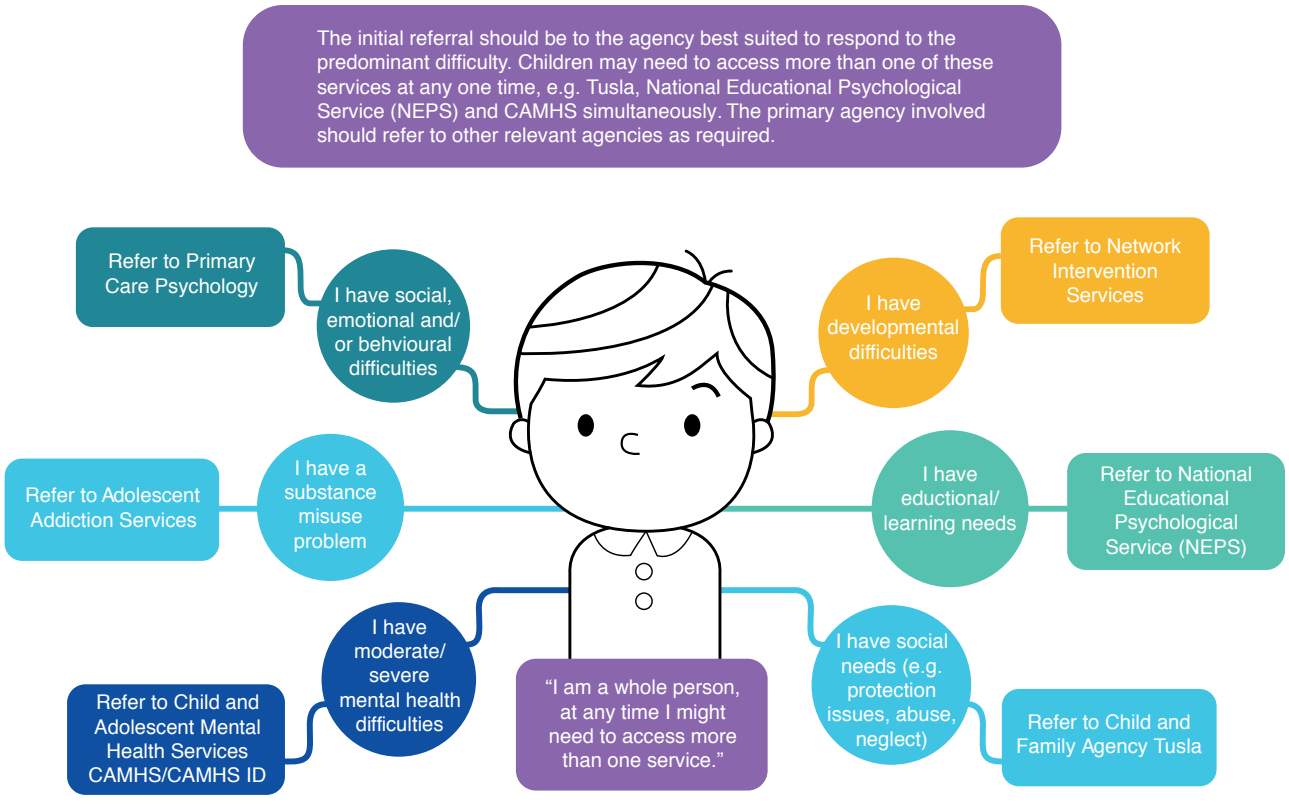
[146] Dooley B., O'Connor C., Fitzgerald A., O'Reilly A. MyWorldSurvey 2019.University College Dublin School of Psychology & Jigsaw, the National Centre for Youth Mental Health My_World_Survey_2.pdf (myworldsurvey.ie)

In 2017 the HSE issued the Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services[147]. Its aim was to produce an agreed operational protocol for children whose may need input from these different services at the same time. The Joint Working Protocol outlines service provision, roles and responsibilities for Primary Care, Disability Services and CAMHS. It also details the referral process, joint working, consultation and communication.

The Protocol set up the Integrated Children's Services Forum (ICSF) which provides a formal, regular mechanism for services to meet and discuss individual children whose needs are not clear or who require some level of joint assessment or intervention and for whom direct consultation between the relevant services has not led to a decision on the best arrangement for the child. This forum is empowered to call for inter-agency conferences and a joint plan for the child. Geographic area and frequency of meetings for the ICSF are decided by the Chief Officer, taking into account density of population and distances to travel to meetings.

A initial national meeting with the the HSE Chief Operating Officer, Chief Officers , National Director for Community Operations and Assistant Directors for Primary Care, Disability Services and Mental Health took place in Quarter 2 of 2023, with another meeting planned.

The following diagram demonstrates that the mental healthcare of children and young people should be person-centred with seamless access to whatever the child/young person needs at any particular time. In other words the **right** service delivered by the **right** people at the **right** time.



Source: National Clinical Programme for Self-Harm and Suicide-related Ideation Update[148].

[147] Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services HSE 2017 Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services

[148] National Clinical Programme for Self-Harm and Suicide-related Ideation Update Updating the National Clinical Programme for the Assessment and Management of Patients presenting to the Emergency Department following Self-Harm (Irish College of General Practitioners, College of Psychiatrists of Ireland, HSE) NCPSH Model of Care by Chapters - HSE.ie

Enormous gaps exist in how children and young people can access support across health services when required. There are children and adolescents with complex clinical issues who do not fit neatly into one specific diagnostic criterion but have multiple needs which need to be addressed by different children's services. The Protocol describes the proposed Integrated Children's Services Forum as a way to ensure a coordinated and flexible approach to the delivery of services to children and their families based on need. We saw evidence that these forums were taking place. However, reports from CAMHS Teams indicated that these did not always function in the way they were intended, with disputes about who took responsibility for providing services for the child. In other areas they seem to be working well, with increased joint working and case discussion, benefitting both child and family.

Due to the complex nature of the needs of many of the children/young people attending CAMHS with neurodevelopmental issues and comorbid mental disorder, they benefit from the involvement of agencies such as CDNT/Primary Care in addition to specialist CAMHS. However, lengthy waiting lists on the local CDNT often result in young people not receiving timely multi-agency interventions, which can significantly impact on their wellbeing and mental health. Lack of resources and long waiting lists in Primary Care and Disability Services contribute to crisis presentations to CAMHS.

The HSE report that

- There has been an increase in referral for all children's services post COVID particularly psychology , speech and language therapy and occupational therapy.
- Recruitment and retention of these professionals is challenging. In psychology provision of permanent development posts and increased sponsorship of psychology trainees is required.
- The expectations of Primary Care and CDNTs has been changing. This has occurred within the same resources; e.g. requirements to participate in new multidisciplinary team structures/meetings/pathways at Community Healthcare Networks level and requirements to work as part of a multidisciplinary team for new complex work such as ASD assessments.

A lack of integration of care and treatment with consequent disagreements over which organisation/service should provide assessment and treatment for a distressed child was evident in many services. At our meetings with CAMHS Teams, people spoke of a "blame game" over which organisation was allowing access to treatment, or who was not communicating with whom. Consequently the child (and their family) were not at the centre of a treatment plan. The result of this is the understandable frustration of parents and GPs, who then refer to CAMHS, although those children do not meet the moderate-to-severe mental illness criterium of CAMHS. Sometimes they are then referred back to the Primary Care or Disability Services to wait once again on a long waiting list. Once a child is on a CAMHS waiting list, they are dropped from all other waiting lists and so receive no treatment in the interim. The risk is that during this untreated period, mental health difficulties can progress to moderate and severe mental illness, then requiring the input of the CAMHS Teams. This is a vicious circle of poor service for children and young people with little sense that the child and their family are at the centre of holistic mental healthcare provision.

Therefore, while integrated care is the policy for our health service, this is not working in mental health services for children and young people and requires urgent attention by the HSE. Failure to do so will result in mental health services for children and younger people continuing to function in silos, with discussions about whose case it is, lack of joint working, lack of child-centred care and deterioration in children's mental health with its consequent risk of mental health difficulties and mental illness continuing into adult life, as evidenced by the research referred to in the introduction to this report. We found in our review that where joint working and regular inter-agency meetings were held, the outcomes for children were better, with shorter waiting lists for essential treatment and more case discussion.

The Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services states that the Primary Care, Children's Disability and Child and Adolescent Mental Health Services[149] will aim to make the referral process as seamless and timely as possible by collaborating to provide comprehensive information to families and other referrers and by communicating with all relevant parties effectively and efficiently. Unfortunately this is not the case in many areas of the CHOs reviewed. We were told by the HSE that a survey of stakeholders' views has been commissioned and will commence shortly.

[149] Joint Working Protocol Primary Care, Disability and Child and Adolescent Mental Health Services

No single "best practice" model of integrated care for children exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of children and young people especially where this care should be given by a number of different professionals and organisations.

The remit of the CAMH Services is to deliver care to those children with moderate-to-severe mental illness. Children with mild mental illness or distress should be referred to Primary Care services such as psychology, occupational therapy and speech and language therapy. The long waiting times in these other services has meant that there had been inappropriate referrals to some CAMHS Teams as parents become desperate for a service for their child and GPs become frustrated at the lack of available services for their patients. There can be deterioration of a child's mental state while waiting for an appointment in Primary Care thus necessitating an avoidable re-referral to CAMHS or a crisis presentation to the Emergency Department.

In our sample:

- 4% of children/young people in CAMHS presented in the ED while on a waiting list. CHO 8 had the highest percentage of children/young people presenting in the ED while on a waiting list (8%).
- 6% of children/young people who were referred to CAMHS more than once presented in the ED while on a waiting list. CHO 4 had the highest percentage of children/adolescents who were referred to CAMHS more than once and presented in the ED while on a waiting list (13%).

Triaging these cases and signposting to other services eats into the time that CAMHS Teams had to assess and treat those who had moderate-to-severe mental illness and contributes to long waiting lists. Many staff told the inspectors of their discomfort in rejecting inappropriate referrals, knowing that those children may go on long waiting lists for other services which could be up to two years, despite the fact they had waited for considerable time on the CAMHS waiting list. While efforts had been made to engage with other children's services, it was clear that services for children overall were not integrated or not child centred, and left children and their families moving from one waiting list to another.

Draft Overarching National Standards for the Care and Support of Children Using Health and Social Care Services

The *Draft Overarching National Standards for the Care and Support of Children Using Health and Social Care Services* developed by HIQA and the Mental Health Commission cover all health and social care services working with children including hospital services, disability services, mental health services, children's social services, and GP and Primary Care services. These standards set out the outcomes a child should expect and what a service provider needs to do to achieve these outcomes.

By providing a common framework for all health and social care services working with children, the overarching standards aim to promote clarity, consistency and continuity within and between services to ensure that no matter what health or social care services a child is using, there is a consistent and coordinated response to their needs, and that services will work in an integrated way to improve the experience and outcomes of children using these services. These standards recognise that children may use multiple health and social care services at any one time. In the absence of an integrated model of care they provide a valuable resource for all health and social care professionals working with children. However, at the time of writing, despite the standards being finalised by MHC and HIQA in July 2022, they have not received final ministerial approval.

The draft national standards are underpinned by four principles:

- A children's rights-based approach
- Safety and wellbeing
- Responsiveness
- Accountability.

It is envisioned that these overarching standards will also act as a framework for the development of more specific standards or guidance that describe in more detail how services can care for and support children in a particular context, if required in the future.

The *Draft Overarching National Standards for the Care and Support of Children Using Health and Social Care Services* should be finalised at ministerial level and implemented in all health and social care services for children.

Children and Young People with Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is a complex neurodevelopmental condition, characterised by difficulties in the social use of verbal and non-verbal communication which result in functional limitations in social participation and educational/occupational performance.

Progressing Disability Services for Children and Young People (2010) recommends equitable access to services for all children with a disability through local Children's Disability Network Teams.

Children and young people with autism are only accepted to CAMHS if they have a moderate-to-severe mental illness. If they do not have a moderate-to-severe mental illness they are signposted to other services, usually the Community Disability Network Teams, which can have waiting lists up to five years. However, CDNTs will only accept them for assessment and intervention if they have complex autism. Otherwise, they are signposted again to Primary Care services which usually also have long waiting lists. Thus, a child may move through three (usually) long waiting lists to try to obtain assessment and intervention. Referring children with ASD/autism without a moderate-to-severe mental illness falsely raises expectations for parents that CAMHS will assess and provide interventions for their children.

We found in our sample of clinical files that 6% of children/young people in CAMHS had ASD or query ASD as one of their reasons for referral. Of the children/young people referred with ASD or query ASD, 72% of these children/young people were accepted by CAMHS on first referral while 26% were refused once before being accepted by CAMHS.

Table 19 *Percentage of children/adolescents who were referred to CAMHS who had ASD or query ASD and the percentage who were accepted to CAMHS on first referral*

CHO	Percentage of children/ adolescents referred by GP with ASD or query ASD	Percentage of children/adolescents with ASD or query ASD accepted to CAMHS on first referral
CHO 1	1%	100%
CHO 2	4%	80%
CHO 3	4%	100%
CHO 4	7%	47%
CHO 5	6%	83%
CHO 6	4%	80%
CHO 7	10%	76%
CHO 8	9%	73%
CHO 9	1%	100%
Total	6%	72%

Meanwhile, children on the various waiting lists may be out of education, have worsening behaviour due to stress, have increasing levels of untreated anxiety, lose out on socialisation interventions and put strain on family relationships.

That children and parents have to go through these unacceptably lengthy processes, with possibly no service after years of waiting, can be traumatic of both children and their parents and is a possible breach of human rights.

The *Report of the Review of the Irish Health Services for Individuals with Autism Spectrum Disorders*[150] recommends stepped care services. 'Stepped care' is a term that has been used to describe how a presenting degree of symptom severity is a key factor in determining the level of required intervention. This typically involves processing referrals in a tiered manner so they are first screened for complexity by Primary Care services, with cases progressing through to secondary care services such as Disability Services, or alternatively with specialised care being incorporated into Primary Care as required based on needs. For such a 'stepped care' model of service delivery to function, liaison between primary and secondary care services is imperative. International best practice ASD guidelines have provided support and evidence for the efficacy of such a stepped-care model. The report states that there is a

[150] Report of the Review of the Irish Health Services for Individuals with Autism Spectrum Disorders HSE 33f312f0421443bc967f4a5f7554b0dd.pdf (assets.gov.ie)

need for effective and timely communication between HSE-funded and other services so that individuals with ASD can transition between services and interact with them fluidly[151]. However, although movement to this model has been initiated, there is insufficient resourcing of Primary Care services to accept children with autism, who are then left without any service. The risk is whether their challenges may increase to the extent that they are re-referred to CAMHS as they have deteriorated to what is now a moderate-to-severe mental illness and/or the child can no longer attend school, thus depriving them of essential educational inputs.

This lack of provision of a child-centred service is wholly unacceptable and has serious repercussions for the child's mental health and education. Parents and support agencies spoke of the distress of both parents and children at this lack of access to services and the frustration they felt as they were bounced from one waiting list to another, sometimes ending up with no service.

[151] Report of the Review of the Irish Health Services for Individuals with Autism Spectrum Disorders. Health Service Executive 33f312f0421443bc967f4a5f7554b0dd.pdf (assets.gov.ie) Accessed 10 March 2023.

Conclusion

CHAPTER

12

We published an Interim Report in January 2023 due to serious concerns we had identified in four out of five CHOs, which included lack of staffing and governance, including clinical governance.

We made two recommendations:

1. **There should be an immediate clinical review of all open cases in all CAMHS Teams, using the NICE Guidelines and the CAMHS Operational Guidelines. Particular focus should be given to identifying and assessing open cases of children who have been lost to follow-up, and physical health monitoring of those on medication.**

2. **Immediate regulation of CAMHS under the Mental Health Act 2001 should also be a priority.**

We saw some evidence of clinical audits of all open cases as we reviewed the remaining four CHOs. The findings in the Interim Report and the Maskey report should not be the catalyst for prompting teams to audit their own caseloads; this should be done as a matter of routine in all teams and used in service planning and management.

The recommendation that the CAMH Services be immediately regulated has not been met and there has been no progress on this to date.

This final report covers the findings from all nine CHOs.

There are obvious gaps in governance, both at corporate and clinical level. There has been poor risk identification and management, with serious risks unidentified and poor response when they are identified. There is a wide variation in what CAMHS can provide, differing from team to team, resulting in a postcode lottery for parents and young people. This is evident from the individual CHO reports, which we have published separately. We found that the lack of a digital infrastructure is seriously hampering the efficiency of CAMHS. There is lack of clinical leadership at CHO and national level with each team doing what they think is best and not according to standards and guidelines, and the absence of clinical directors in some CHOs has contributed to this. There is no National Clinical Director post in mental health in the HSE. A National Clinical Lead for CAMHS is being recruited but no appointment has been made to date.

The distress and frustration of families that we spoke with, who are trying to access a CAMHS service or any mental health service for their child, was profound. They described long waiting lists, the refusal of the referral of their child to CAMHS, the long waiting lists for Primary Care or CDNTs, the re-referrals to CAMHS, the lack of service for their child with ADHD if they do not consent to medication. They expressed concern at how their child deteriorated while waiting for an assessment. Parents did not know where they can get help and information about services for their child and felt that a crisis needed to be reached before appropriate services are offered to them or that they have to battle with services before help is provided.

CAMHS asset is the excellent and skilled staff who provide CAMH services. We met many staff who worked hard to try to provide quality services. We found staff did not feel supported, and took the brunt of verbal abuse from frustrated parents for difficulties not of their making.

Staffing of teams is difficult due to retention and recruitment difficulties and it is unlikely that this will change unless incentives are used to entice professionals to work in CAMHS. Currently the average staffing of teams is 58% of *AVfC* recommended levels. As well as increasing salaries, other incentives can include improved accessibility to training, career progression, supportive management, adequate numbers in teams, a manageable workload, being able to evaluate and report on their work in a non-threatening environment, research opportunities and opportunities to meet with other teams through case discussions and other academic meetings. The absence of these incentives were all stated to the Review Team by individual CAMHS Teams. Consulting and listening to staff on the ground about what they need to remain in the service and then acting on that information would be a major step in increasing retention.

A large percentage of children presenting with moderate-to-severe mental illness to CAMHS have significant case complexity and multiple diagnoses. Mental illness may only be one component of a presentation that could also include autism, learning disability, mobility difficulties, social difficulties or child safety concerns. The importance of inter-agency

working is therefore paramount. Our review of CAMHS has highlighted serious concerns about the provision of child-centred integrated mental healthcare in Ireland for children. It demonstrates a lack of central planning to provide child-centred care even though there is a policy for integrated care. It was evident that despite policies, services providing Disability Services, Primary Care interventions and CAMHS were all operating in silos, with little integrated care for the young person. Some of this was due to staff shortages in all providers but much was due to a culture of silo mentality, which can result in the creation of barriers to communication and the development of disjointed work processes with negative consequences for service users, professionals and the HSE. Integrated provision of these services would be an important enabler in improving mental healthcare for children and young people.

The remit of the CAMHS is to deliver care to those children who have moderate-to-severe mental illness. In order to provide a full range of community CAMHS and specialist CAMHS interventions, teams must be developed and staffed adequately. We found that almost all teams were not staffed in accordance with recommended levels and that specialist teams such as ADHD Teams, CAMHS Liaison Teams and Forensic CAMHS Teams were not adequately provided. Some progress had been made in developing such teams, especially Eating Disorder Teams, which were moving to the provision outlined in the Model of Care for Eating Disorders.

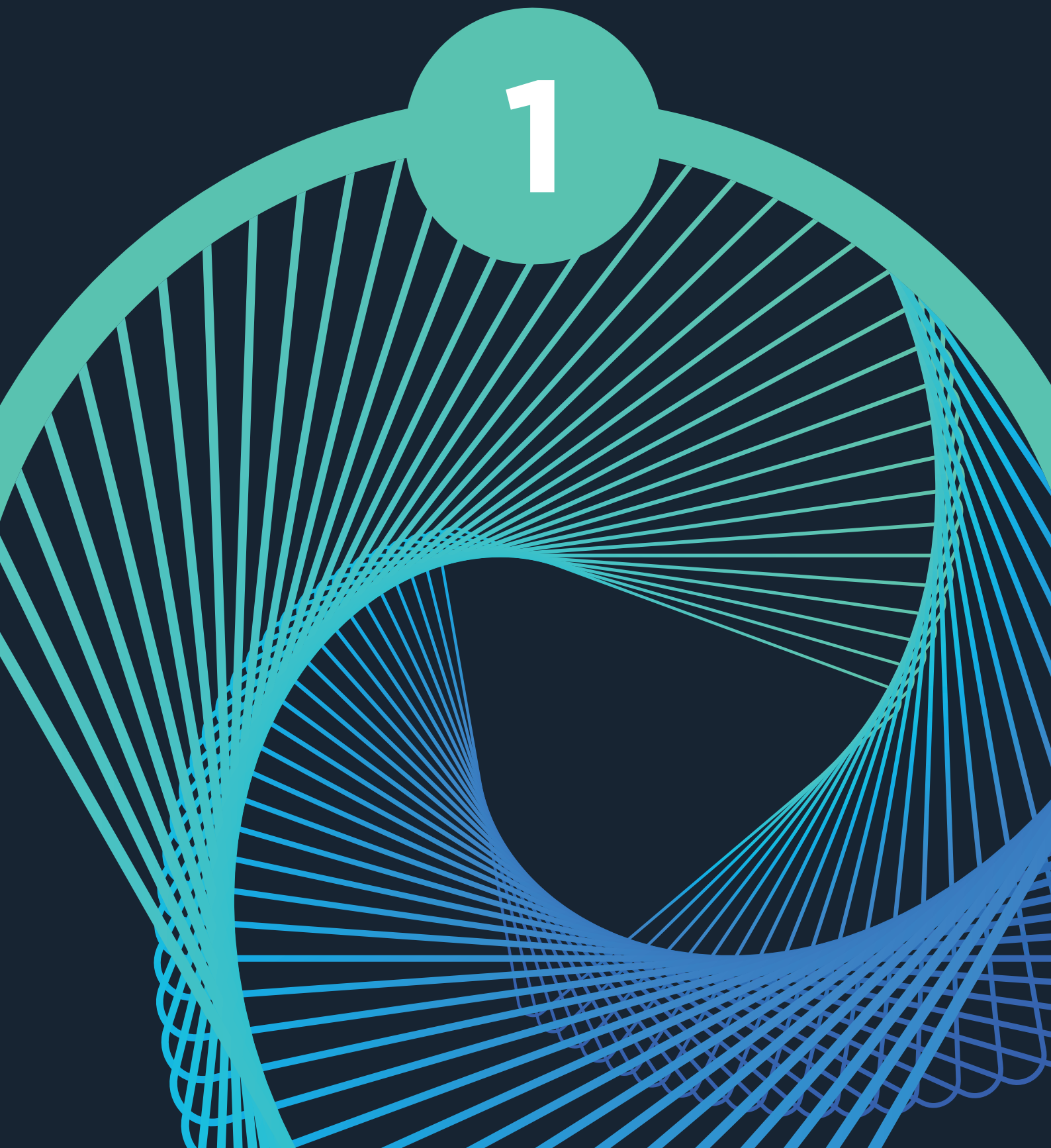
The HSE is clinging to old models of service provision that do not adequately meet the needs of young people and are different to models in other similar countries. It is obvious that staff shortages will continue and that it will be impossible to safely staff many teams, yet there is little consideration given to looking at alternative models of service provision that would lessen the impact of staff shortages on children and young people. These services are propped up by injecting boluses of money when crises occur, working staff to the point of burnout, blaming retention and recruitment difficulties, reacting to crises rather than trying to prevent them by good governance. The HSE rigidly maintain staffing models that are 16 years old and workforce planning that makes no sense in modern CAMHS, and stick to siloed provision of mental health services for children. The same service structure remains in place even though it is creaking at the seams, with increasing risk to children for whom the service is provided. What must be factored into this is staff burnout and continued attrition of staff – there is no motivation to stay in a service that is poorly staffed, where staff are overworked, and where there is often a lack of promotional opportunities.

The HSE should be looking at how CAMHS works internationally in countries with similar restrictions and evaluating those. It should be reviewing our CAMHS service provision models, improving governance structures and processes, implementing workforce planning that is informed by need, having clear and accountable budgeting for all children's services, looking at five-year plans and even 10-year plans. An **increased focus on outcomes data and the experience of those who use CAMHS** is needed rather than just key performance indicators on mental healthcare activity. As a nation we need to start aiming for a state-of-the-art service for our young people in a planned coherent way in conjunction with other services. The Interim Report and the Maskey report have resulted in reactive activity by clinical teams in audit and risk management, but the questions of sustainability and motivation remain in the absence of team coordinators and a Clinical Director in each CHO CAMHS.

This report gives an overview of national CAMHS, from corporate and clinical governance levels to the treatment and experience of individual young people and their families within or waiting for a CAMH service. I have spoken to many stakeholders, individual CAMHS teams, governance and management teams and most importantly young people and their families. I have made Recommendations based on our findings. I have recommended the immediate and independent regulation of CAMHS by the Mental Health Commission to ensure the State and the HSE act swiftly to implement the governance and clinical reforms to help guarantee that all children have access to evidence-based and safe services, regardless of geographical location or ability to pay. Now the Government and the HSE must act to provide a comprehensive, sustainable, integrated and evidenced based CAMH services that meets the needs of all children with moderate to severe mental illness.

Appendix

1



Terms of Reference

Terms of Reference: Independent Review of the provision of Child and Adolescent Mental Health Services (CAMHS) in the State by the Inspector of Mental Health Services in 2022.

1. Introduction

Under section 51(1) (b) of the Mental Health Acts 2001–2018 (the Act), the Inspector of Mental Health Services will conduct a review of the Child and Adolescent Mental Health Services (CAMHS) in the State. This review will be cognisant of the report on the findings of the Look-Back Review into Child & Adolescent Mental Health Services in Co. Kerry by Dr Sean Maskey (2022).

2. Scope

The scope of this review will include the number and resourcing of teams, training and expertise, facilities, governance structures and processes, good practice initiatives, young people and their families' involvement and experience of CAMHS, young people's rights and any other matters deemed relevant. This review shall cover all CAMHS Services in the State and will review matters during the period 1 January 2021 to 31 October 2022.

3. Purpose

The purpose of the review is to:

1. To assess how local, regional, and national clinical and corporate governance arrangements within the HSE operate and ensure the safety and quality of CAMHS Services in Ireland.
2. To identify whether risks to young people receiving CAMHS are identified, assessed and mitigated.
3. To assess whether the provision and delivery of CAMHS is in line with best practice.

NOTE If, during the course of the review, it becomes apparent that there are reasonable grounds to believe that there are serious risks to the health or welfare of any person or persons receiving services, the Inspector will inform the Department of Health and the HSE, and this may also result in further action being taken the Mental Health Commission as appropriate.

4. Process

The Inspector will carry out the review and may exercise such powers as she has, pursuant to section 51(2) of the Act, including but not limited to the right to inspect premises, clinical files, records, documents and conduct interviews with any person who has relevant information to the review.

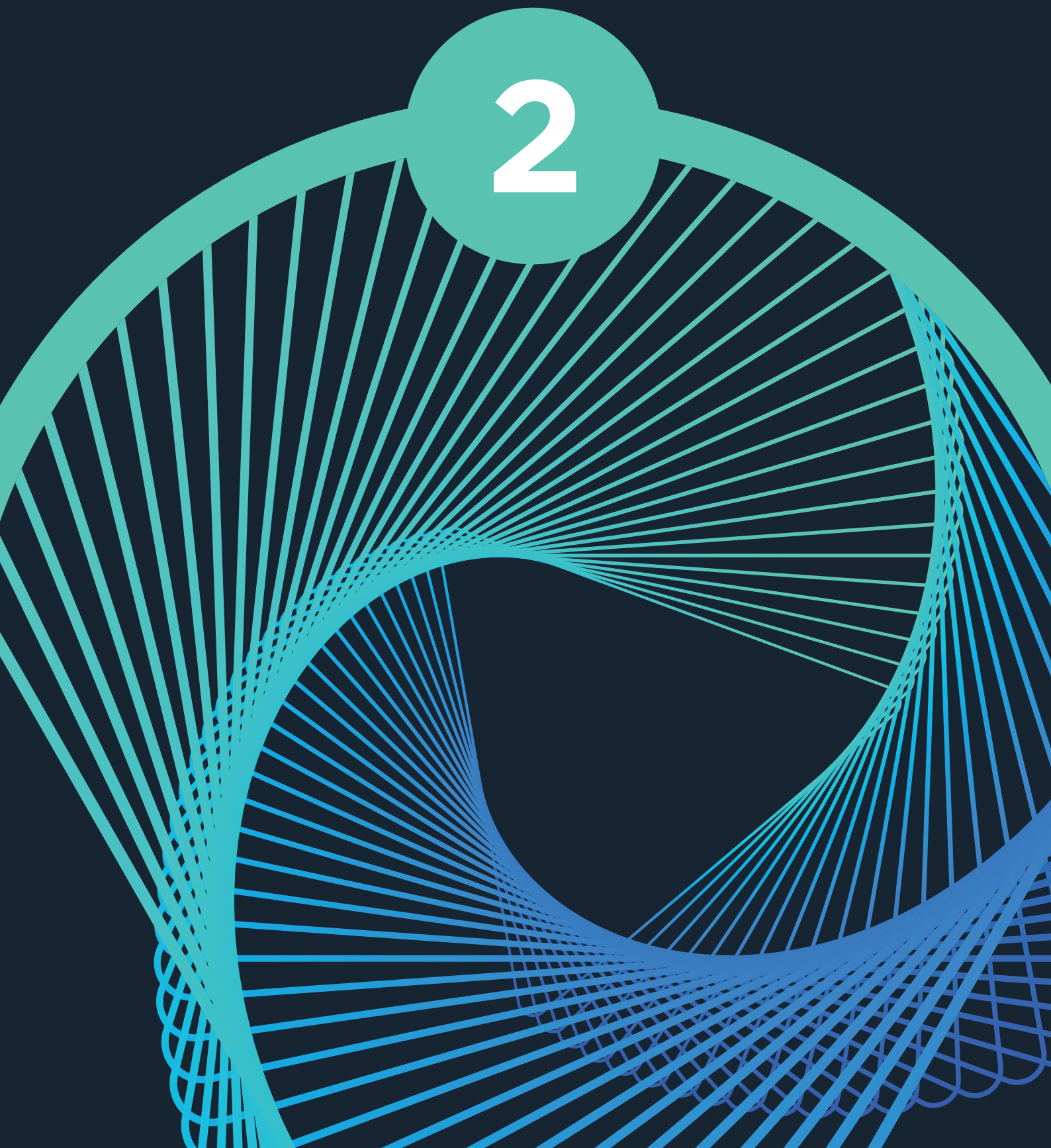
The Inspector will meet with relevant stakeholders, request documents, and conduct an inspection of the provision of services and meet with personnel in a sample of CAMHS Teams.

The Inspector may engage such external independent advisers as she considers necessary in the undertaking of this review. She will also engage all relevant legal and administrative supports required.

The Inspector will prepare a report of the findings of the review, in accordance with section 51(1)(b) of the Mental Health Act and make local and national recommendations as to the safety, quality and standards of Child and Adolescent Mental Health Services provided by the HSE. The report will be submitted to the Board of Mental Health Commission. This report will be published to promote safety and quality in the provision Child and Adolescent Mental Health Services.

Appendix

2



Stakeholder meetings

List of Stakeholder Meetings
Families and carers whose child has experienced CAMHS
Young people who have experienced CAMHS
ADHD Ireland
Jigsaw
Spunout
Mental Health Ireland
Mental Health Reform
National Youth Council of Ireland
Barnardos
YAP Ireland
Children's Rights Alliance
National Association of Principals and Deputies
Irish Primary Principals' Network
Irish College of General Practitioners
Tusla
College of Psychiatrists of Ireland
The Probation Service
National Parents Council Primary (NPC)
BeLonG To
Pavee Point
LGBT Rep Group
National Review Board
Irish Foster Care Association
Disability Federation of Ireland
Irish Medical Organisation
Primary Care Psychologist
Stuart Lynch, Quality and Safeguarding Lead – NHS Mental Health Support Team
Wexford ICGP Faculty
Autism Ireland
Children's Disability Network Teams
Disability Federation of Ireland

List of Stakeholder Meetings
The National Review Panel
The Pharmaceutical Society of Ireland (PSI)
Pieta House
AsIAm
NEPS
St Patrick's Mental Health Services
St John of God Mental Health Services
Association of Occupational Therapists of Ireland (AOTI)
Irish Association of Speech and Language Therapists (IASLT)
Irish Association of Social Workers (IASW)
Psychological Society of Ireland (PSI)
Adolescent Addiction Service

Mental Health Commission
Coimisiún Meabhair-Shláinte
Waterloo Exchange
Waterloo Road
Dublin 4

Telephone: 01 636 2400
Fax: 01 636 2440
Email: info@mhcirl.ie
Web: www.mhcirl.ie

Facebook: Decision Support Service
Twitter: @DSS_Ireland
Twitter: @MHCIreland
Instagram: decisionsupportserviceire
LinkedIn: Mental Health Commission
YouTube Channel: Mental Health Commission - YouTube