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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

Interim Report

Promoting Quality, Safety and Human Rights in Mental Health

January 2023

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CHAPTER

1

Executive Summary

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 2022, I am reviewing the provision of Child and Adolescent Mental Health Services (CAMHS) in Ireland. During this review we are cognisant of the findings of the Maskey Review[1] and the public concerns about the provision of CAMHS.

The review of the provision of CAMHS in 5 out of 9 Community Healthcare Organisations (CHOs 3, 4, 5, 6 and 7) has been completed.

We would like to thank all the young people and their families, who spoke with us thus far in this review. We recognise that their openness to share their journey through CAMHS has sometimes been distressing for them, but that 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.

We would also like to thank stakeholders, individual teams, team members and area management teams who gave their time and knowledge to give us an understanding of the provision of CAMHS both nationally and in local areas. HSE CAMHS staff and senior managers have engaged fully with the review and we recognise that this review is seen by the HSE as a contribution to ongoing work to improve their services.

The HSE stated that it acknowledged that there are deficits in current service provision, including access, capacity and consistency in quality of services provided. In acknowledgement of deficits the HSE 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 digital platforms for accessing services.

I decided to issue an interim report because of the serious concerns and consequent risks for some patients that we have found across areas of 4 out of 5 Community Healthcare CAMHS. 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 felt 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 National Director, Head of Operations, Quality and Service Improvement in the Health Service Executive (HSE). So far in this review, we have made five escalations of risk to the HSE due to risks to the wellbeing and safety of children. The Mental Health Commission continues to monitor the actions taken on foot of these escalations but has no legal power to enforce any action.

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 lack of staff. We are aware that experience of good services with positive outcomes may get lost in the sometimes-heated discussions about CAMHS and we have found many teams where there was good quality clinical practice and one CHO where an independently provided CAMHS service provided excellent care.

Governance

We found that lack of governance in many areas is contributing to some inefficient and unsafe CAMHS services, through failure to manage risk, failure to fund and recruit key staff, to look at alternative models of providing services when recruitment becomes difficult, and failure to provide a standardised service across and within CHOs.

Budget for CAMHS

There is no ring-fenced funding for CAMHS, which must compete with other mental health services for resources. Requests for funding and business cases for particular posts are put forward to national HSE, but in looking at the profound variations in staffing levels

[1] Maskey S. Report On The Look-Back Review Into Child & Adolescent Mental Health Services County MHS Area A .14 January 2022

and availability of different disciplines across the CAMHS it is unclear how the decisions to provide a discipline in one area and not in others are made.

Integration of children's mental health services

Children need to move between primary care, disability services and specialist services such as CAMHS according to their changing needs and that care needs to be child centred. CAMHS is a specialist service for moderate to severe mental illness, other agencies provide other aspects of care for a child, whose needs are often 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.

Risk Management

There were no risks pertaining to CAMHS documented within the HSE Corporate Risk Register and therefore no documented actions to address the risks which were clearly present. In one CHO, where risks were escalated to and accepted by the HSE National Mental Health Operations Team, we made repeated requests for an action plan to address the risk. The plan, when finally received, did not assure us that there were sufficient actions to address the risks. Further engagement with the National Office of the HSE will take place during this review.

In some areas reviewed, risk management was poor, with lack of communication and lack of actions to mitigate risks. There was limited understanding in a number of teams as to what constituted a risk, how it was assessed and how it was escalated. In these areas, there was little or no feedback as to where the risk had been escalated, who was responsible for its management and what actions were taken. 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 resulted in a haphazard documenting of risks and minimalist generalised actions recorded on the CHO risk register.

Staffing of CAMHS

The new mental health policy, *Sharing the Vision*[2], does not recommend minimum staffing levels. In the absence of any other benchmarking for CAMHS staffing nationally; the requirement of appropriately qualified clinicians to achieve the outcomes outlined in *Sharing the Vision*; and the continued recruitment of staff in teams according to the previous mental health policy *A Vision for Change*[3] by the HSE, we used the recommended minimum staffing requirement in *A Vision for Change* to assess the staffing of each team.

All teams were significantly below the recommended staffing levels, according to *A Vision for Change*; some below 50% of recommended staffing. 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 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.

The CAMH service depends heavily on a model of care which places the onus on a single profession i.e., the consultant psychiatrist and all clinical responsibility rest with them. This is outdated in international practice which favours a more multi-disciplinary approach. It is also unsustainable with the current medical workforce.

Access to CAMHS

There was a large variation in both the number of children on waiting lists and the length of those waiting lists both across CHOs and internally within CHOs. Across our sample of clinical files, we found that 4% children were waiting for over 12 months for an assessment appointment and 28% were waiting for more than 3 months. Rates for acceptance of referrals varied between 38% and 81%. We are aware that many young people and their families are frustrated, distressed and are trying to cope with deteriorating mental health difficulties while waiting for lengthy periods

[2] 'Sharing the Vision - A Mental Health Policy for Everyone' June 2020

[3] A Vision for Change Mental Health Policy 2006 - 2020

on waiting lists for essential services. GPs told of frustrating attempts to get a child assessed and having to resort to sending a child to the Emergency Department in local hospitals to obtain a psychiatric assessment. Families and young people reported having to be referred on multiple occasions in order to get a service from CAMHS while being unable to get a timely service from other agencies.

There was unacceptable variability in which services were provided across CHOs or even within CHOs. Outside of Dublin, the range of services that were provided depended on where the child lived and therefore what team they attended. Individual teams did not have the necessary capacity and training to provide standardised therapy in many cases.

There was piecemeal Emergency provision of CAMHS, with CHOs outside the Dublin area particularly deficient in this area.

There were no CAMHS Liaison Teams in the three CHOs outside Dublin, resulting in long waiting times for psychiatric reviews of children in the general hospitals. A Liaison Service was in place in the CHI (Children's Hospital Ireland) in Crumlin. Eating Disorder teams were in place in three CHOs and an ADHD team was operating in one CHO with plans to set up a similar team in another CHO. There was a Forensic CAMHS team set up in the past 18 months with 1 WTE consultant, 0.2 WTE nursing and 0.2 WTE social worker. Recruitment is ongoing.

There were very few CAMHS-ID (intellectual disability CAMHS teams) across the CHOs. Two CHOs had no access to CAMHS-ID (intellectual disability) services. The CAMHS-ID model was launched in September 2022. There should be 16 teams across the country, but nationally there are only 4 teams. Staff capacity is now 23% of recommended levels.

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 agency which also provided the CAMHS service. Another CHO in our review had a system that they had devised themselves that did allow generation of reports but did not provide electronic records.

The result of the lack of digital infrastructure was inefficiency to a large scale within the teams and this is preventing service development.

CAMHS Facilities

There are a number of CAMHS teams clinics and offices in what are mostly new Primary Care Centres or other well maintained buildings and have adequate clinical, office and waiting spaces and are bright and cheerful with appropriate furnishings and decorations. 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, lack of sound-proofing, inadequate and insecure spaces for storing clinical files, competition for clinical rooms with other services in the building and inadequate parking.

Clinical Governance

Consultant Psychiatrist Staffing

Some teams had no consultant psychiatrist and were covered by a number of different consultants, resulting in confusion and frustration among team members. In one CHO three consultant psychiatrists were not on the specialist register for CAMHS. This patchwork of cover increases the risk of poor care being delivered to young people and families. Telepsychiatry was used in a number of areas to mitigate the risk of lack of consultants. This allowed children to have psychiatric assessments and consultant-led case reviews, albeit remotely.

Care Plans

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 to be meaningless in many teams. High quality care planning does not require extra resources and it was hard to find a credible explanation as to why this was not taking place.

Medication

Antipsychotic medication (also called neuroleptic medication) can be used for mental illnesses other than psychosis. 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 escalated this to the Chief Officer (CO) of the CHO. This resulted in the relevant teams undertaking a review of the identified files and in one case an entire review of all open cases in that CHO CAMHS.

Children Lost to Follow-up

Of serious concern was that in some CAMHS teams children and young people with open cases, have been lost to follow-up. This means that children who should have had follow-up appointments including for review of prescriptions or monitoring of medication did not have an appointment, in some cases for up to 2 years. These included some who had reached their 18th birthday with no planning, discharge or transition to adult services or any advice about medication. For one team, there had been 140 "lost" cases. A very limited desk top review was carried out to identify these children. We identified another team that had open cases of children where there was no documented review for up to 2 years. This risk had not been identified by this CAMHS service. Another team were attempting to identify an unknown number of cases that had been lost to follow-up following a change in staffing. Other teams had commenced a 6-monthly review of their open cases following the Maskey Review.

Clinical Audits

Audits of clinical practice were rarely carried out by individual teams in three CHOs, which cited lack of staff as the reason for failure to do so. Where they are carried out, it has been in response to the Maskey report and consists mainly of reviewing caseloads and medication reviews. There were elements of good auditing practice in two CHOs. Outcome measuring is variable across the reviewed CHOs, although this a key component of *Sharing the Vision*, 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 do not measure the quality of the service provided.

Clinical Files

Four out of the five CHOs visited used paper based files, only one CHO used an online system to manage patient information. The paper based clinical files were 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. Practices such as filing the most recent notes at the back of a section of the file, or maintaining separate parts of the file per discipline meant that it was frequently difficult to follow the care and treatment pathway delivered by CAMHS to the young person.

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. In the CHOs that we have reviewed to date, 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 referred to above, the lack of emergency services and out of hours services, and absence of monitoring for children on medication all point to a breach of Article 24.

In light of our findings across five CHOs and the concerns that they have raised for the safety and wellbeing of children:

1. **There should be an immediate clinical review of all open cases in all CAMHS Teams, using the NICE Guidelines and the CAMHS Operational Guideline. 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 should also be a priority.**

Further recommendations will form part of the Final Report of this review.

This review is continuing with the remaining four CHO CAMHS (CHO 1, 2, 8 and 9) and further meetings with young people, parents and stakeholders. A final report will be issued in 2023.

Dr Susan Finnerty
Inspector of Mental Health Services

CHAPTER

2

Overview

Review Team	
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Marianne Griffiths	*Assistant Inspector*
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Sarah Jones	*Assistant Inspector*
Sarah Moynihan	*Assistant Inspector (until 21 August 2022)*
Amy Weinmann	*Research Assistant*
Stephen O'Rourke	*Business Manager and Project Manager for this Review.*
Ines Martelli	*Administrative Support*

Advisors	
Professor Tom Keane	Chair, *previous Director of the National Cancer Control Programme and past Chair of the Slaintecare 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*

2.1 What is CAMHS?

CAMHS stands for Child and Adolescent Mental Health Services, which provides assessment and treatment for young people up to 18 years of age who experience moderate or severe mental illness. CAMHS treat depression, problems with food and eating, self-harm, attention deficit hyperactivity disorder (ADHD), psychosis, bipolar disorder, schizophrenia and anxiety, among other difficulties.

While a broad range of services including Primary Care, 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 multi-disciplinary team.

Evidence shows that a substantial proportion of mental health problems in adults originate during childhood and adolescence[4]. Approximately two thirds of affected adults exhibit signs of a mental disorder earlier in life. This applies to most if not all disorders, including substance use disorders, psychosis and emotional disorders[5].

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[6]. 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[7]. Most mental disorders have their peak of incidence during the transition from childhood to young adulthood, with up to 1 in 5 people experiencing clinically relevant mental health problems before the age of 25; 50% of whom were already symptomatic by the age of 14[8]. For those under 25 years old, mental health problems, especially anxiety and mood disorders, account for 45% of the "global burden of disease"[9]. Of concern is that following symptom onset, people aged 0–25 experience the greatest delay to initial care and treatment.

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.

2.2 Background

This Review of CAMHS commenced in April 2022. As noted above, each year as part of my statutory duty under the 2001 Act, 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.[10] 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).

4 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

5 Rutter M, Kim-Cohen J, Maughan B. 2006. Continuities and discontinuities in psychopathology between childhood and adult life. J. Child Psychol. Psychiatry 47:276–95

6 WHO. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013.

7 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.

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

9 Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, et al. Global burden of disease in young people aged 10–24 years: a systematic analysis. Lancet. 2011;377(9783):2093–102.

10 Annual Report including Report of the Inspector of Mental Health Services Mental Health Commission 2017

The Maskey report was confined to South Kerry CAMHS and did not look at CAMH services 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 Mental Health Commission, as per the Terms of Reference at Appendix 1.

2.3 Method

The Terms of Reference can be found in Appendix 1.

The methodology for the review is as follows -

1. Meetings with young people and/or their families either individually or in focus groups and collating relevant information.
2. Meeting with individual CAMHS teams (45/74 teams to date) and collating information.
3. Meeting with area management, Quality & Safety, and Executive teams (5/9 meetings taken place to date) and collating information.
4. Information gathering from the Assistant National Director, Head of Operations, Quality and Service Improvement following review of each CHO.

   Review of and data collection from a randomised sample of 10% of clinical files, open since January 2021, of each CAMHS team.

   The data collected included: diagnosis/ presenting symptoms; interval between referral and first assessment; number of re-referrals; therapeutic interventions provided; type of medication prescribed, and frequency of physical status monitoring.

5. Data collection from clinical files for children who were discharged and those transitioned to Adult Mental Health Services.
6. Individual meetings with stakeholders (See Appendix 2).
7. Correspondence with parties referred to above.

All identifying information was anonymised.

The standards used were the NICE Guidelines and the CAMHS Operational Guideline. The data was collected from January 2021 to current date.

CHAPTER

3

Findings to date

3.1 Governance

Corporate Governance is a framework that accounts for all the processes of governing organisations and businesses. It is a structure that holds boards and leaders accountable for continuously improving operations, clinical staff and processes, society and financial performance. Clinical and corporate governance systems are intrinsically linked, although each has its own objectives.

Clinical governance requires staff to deliver measurable and effective patient care that is also consistent and safe. Clinical governance must incorporate structures that help the organisation to continually assess and monitor clinical risks to achieve the best possible outcomes.

Good governance is key to providing good quality services.

Mental health services for children are provided by primary care for mild to moderate mental illness and by specialist mental health care (CAMHS) for children who have moderate to severe mental illness. Almost all of CAMHS is provided publicly by the HSE or through a service level agreement with an independent provider in one CHO. CAMHS is under the governance of the HSE Mental Health Services and is separate from all other children's services such as Primary Care psychology, speech and language therapy and occupational therapy, Tusla and the Community Disability Network Teams (CDNTs), which provide other mental health and disability services for children.

The Mental Health Operations team has responsibility for all mental health services including CAMHS. The Mental Health Operations team is led by the Assistant National Director, 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. Mental Health Services are organised by Community Healthcare Organisations, and include in-patient 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.

The HSE's Performance and Accountability Framework (2020) sets out the means by which accountable officers within the HSE are held to account for their performance, ensuring that the system has clear authority, responsibilities and accountability structures. Reporting to the National Director, Community Operations, the Chief Officer has overall accountability for mental health services provided within each CHO, and is supported in this role by a management team, including the Head of Service –Mental Health.

The Chief Officer in each CHO works in line with nationally agreed frameworks and reporting arrangements, has responsibility and accountability for the delivery of all primary, community, social and continuing care services, including mental health, within the CHO.

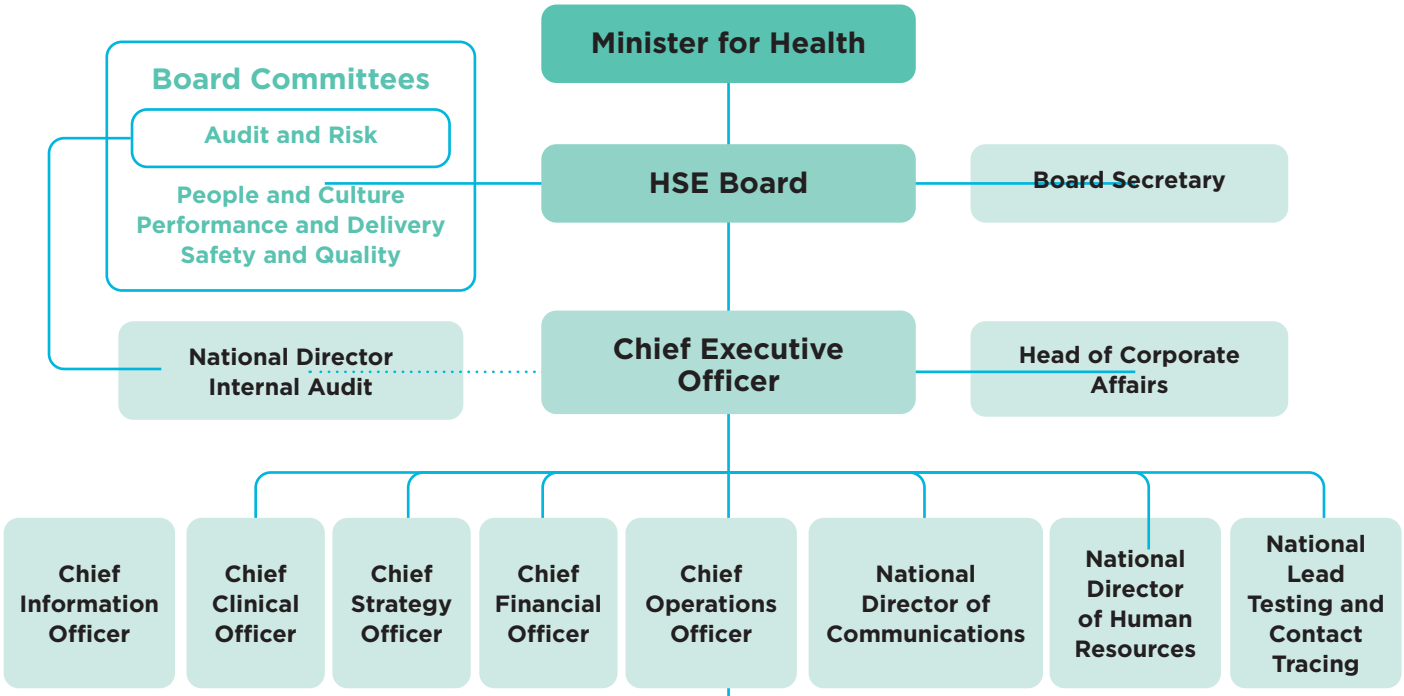
Sharing the Vision - A Mental Health Policy for Everyone' is Ireland's national mental health policy and was published in June 2020. This policy followed *A Vision for Change* which was published in 2006 and while it progressed a number of matters in relation to mental health a lot of the objectives were not met.

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[11]

[11] Sharing the Vision - A Mental Health Policy for Everyone - HSE.ie Accessed 23/10/2022

HSE Organisational Structure



Hospital Group CEOs
RCSI Hospitals Group
Dublin Midlands Hospital Group
University of Limerick Hospital Group
South/South West Hospital Group
Saolta University Health Care Group
Ireland East Hospital Group
Children's Health Ireland

Community Healthcare Organisations Chief Officers	
Area 1	Cavan, Donegal, Leitrim, Monaghan and Sligo
Area 2	Community Healthcare West
Area 3	Mid West Community Healthcare
Area 4	Cork, Kerry, Community Healthcare
Area 5	South East Community Healthcare
Area 6	Community Healthcare East
Area 7	Dublin South, Kildare and West Wicklow Community Healthcare
Area 8	Midlands Louth Community Healthcare
Area 9	Dublin North City and County Community Healthcare

All of the above intended outcomes in *Sharing the Vision* are relevant to the provision of mental health services for children. We found in our review to date that progress on all of the above intended outcomes has been slow in CAMHS.

Risk Management

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 CAMH services. An outline of the risk management structure within the HSE can be found in Appendix 3.

Operational risks in the first instance are raised with the mental health area management team with further escalation through the Head of Service to the Chief Officer. Mitigation of operational risks that require a national response are generally considered as part of the structured monthly engagements between CHOs and HSE Community Operations that form part of the performance management process.

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 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 National Office that the National Risk Register contained no risks about CAMHS. We have repeatedly sought clarification about this from the Mental Health Operations Office. Further inquiries into this are ongoing by the review team.

The risks identified by the review team were serious risks to the safety and wellbeing of children with mental illness across the majority of the CHOs, which have been reviewed to date. There was only limited identification of some of these risks 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 was taking place at national or local level.

While Kerry CAMHS is being reviewed and remodelled by the HSE, there are serious deficits across other teams and CHOs and the review found evidence of the following:

- lack of staff with high turnover,
- lack of capacity to provide needs-based therapeutic programmes,
- poor monitoring of medication,
- lack of clinical governance, and
- long waiting lists all leading to risk to the safety and wellbeing of children.

All of 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. There is no evidence that a national coordinated approach is being taken. Instead, we have consultant psychiatrists from different areas seeing children over weekends or on-line; 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 only auditing when a crisis occurs and not routinely as a safety and quality improvement.

Budget

Funding for CAMHS accounts for approximately 10.8% of the overall mental health budget on an ongoing basis. Between 2017 and 2022, a total of €22.56m in development funding was allocated specifically to service developments in CAMHS. 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 and there was no means of differentiating between the budget for mental health for adults or children. It was possible, however, to see how CAMHS was funded at the end of each year through accounting.

Because of this centralised budgeting, the CHOs could not plan for the services they needed for CAMHS, based on a CAMHS budget, and there was unavoidable competition between projects for adult and children's mental health services when looking for funding. Approval for staff was done by the HSE centrally and not locally, again making it difficult, based on priorities, to get funding for specific posts. This left continuing

skill gaps in teams and clinicians in posts that have not been prioritised. This led to the CHOs having a lack of control as to the services they provided, and the feeling that they were "lucky" to get any post approved, even if it was one that was not prioritised.

The review team found great variations in staffing levels and availability of different disciplines across CAMHS, it is unclear how the 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.

Access to CAMHS

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

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

There are additional community CAMHS teams that have been established over the past 2-3 years under the 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)

Access to CAMH services varies across the CHOs reviewed. In many areas there are long waiting times and large numbers of children on waiting lists. In other areas waiting times are a matter of months. The re-referral rates for CAMHS are high with some children and young people being referred two or three times for the same difficulties. 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.

Eating Disorder Teams

There are two fully operational specialist eating disorder teams in CAMHS (CHO 4 and CHO 7) with recruitment underway for a third team in CHO 2.

CAMHS-ID Services

The CAMHS ID Model of Service (CAMH services for children with intellectual disability) was launched September 2022. Over the last 18 months there has been a significant recruitment drive in MHID/CAMHS-ID services nationally. A total of 31 multi-disciplinary staff have been employed and there is a recruitment process in place for another 23 posts.

Further to *A Vision for Change* recommendations, there should be 16 children's teams nationally. There are, however, some localities where difficulties in staff recruitment have contributed to areas not developing CAMHS-ID teams. In those areas local arrangements exits where other CAMHS teams or Consultant Psychiatrists provide a consultative service.

Children's services (CAMHS ID teams) have increased their staff capacity from 14 to 21% over the last 18 months, with adult teams better resourced. Despite the recruitment, services are some way short of reaching full capacity.

Recruitment issues, especially for Consultant Psychiatrists in CAMHS-ID, are a significant challenge. The reasons for this are more complex

than what can be addressed by the MHID Service Improvement Programme[12] (a framework for providing specialist mental health services for people with an intellectual disability), and there are multi-agency efforts to address this.

CAMHS -ID Teams.

	CAMHS-ID
A Vision for Change (AVfC)	1 team per 300,000
Recommended Teams per AVfC based on population of Ireland	16
Teams in Place currently	4 (25%)
Total Recommended staff nationally	176
Staff in Place (2022)	37.5

Forensic CAMHS

There is a Forensic CAMHS Team established in the National Forensic Mental Health Service (NFMHS). This provides a national consultation service and is led by a forensic CAMHS consultant psychiatrist. According to the HSE, this service will be expanded to include two Forensic CAMHS teams along with 10 Forensic CAMHS in-patients beds located in the new unit in Portrane. No dates are available as to when these developments will take place.

Waiting Lists

Number on waiting lists in all 9 CHOs	Total
September 2022	3,800
April 2022	4,003
November 2021	3,357
April 2021	2,919
September 2019	2074
September 2018	2,453

Provided by HSE Business Unit

Referrals to CAMHS have increased in the last 2 years and the severity and complexity of cases have also risen. Between 2020 and 2021, referral rates into CAMHS have increased by 33%, while the number of new cases seen has increased by 21% in that same period. It is likely that these changes have happened partly as a result of COVID-19 and enforced lockdowns but the full reasons for this are not known. This has put pressure on already understaffed teams, resulting in more children on waiting lists for longer. There have been various waiting list initiatives, which has resulted in the reduction of 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.

Young People and their families views of access to CAMHS

Families spoke of their child deteriorating on waiting lists, 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 spoke of a lack of contact and reviews with CAMHS, of being discharged to no service because they did not want their child to have ADHD medication, and of early discharge before they thought their child was ready, so that another child could be taken off the waiting list. 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.

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 SOP was published and circulated to all CAMHS teams and CAMHS stakeholders. This was subsequently reviewed and updated in 2019 (CAMHS Operational Guideline) and again disseminated to all teams and external

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

stakeholders. It was printed and circulated as well as being available online. The CAMHS Operational Guideline contains detailed referral criteria and pathways into 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.

Transition to Adult Mental Health Services

The National Implementation Monitoring Committee (NIMC) Specialist Group on CAMHS has been set up. The particular focus of this Specialist Group is recommendation 36 of Sharing the Vision:

> *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. The age of transition should be moved from 18 to 25, and future supports should reflect this.*

Currently, a uniform process is not in place for the transition to adult mental health services (AMHS) process is not in place and once again the process varies across the CHOs. The CAMHS Operational Guidelines recommend that there is 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, which is another example of the lack of integration in services referred to above. 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. It is expected that this will improve as the ADHD in Adult National Clinical Programme Model of Care[13] is rolled out.

Integrated care of children with mental health difficulties

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 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. This is where the teams' skill, expertise and resourcing lie. Other services for children, such as primary care services or the Community Disability Network Teams are equally important, to assess and treat mild to moderate mental health difficulties. 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. We found little evidence of this in our review to date. There has been investment in 'upstream' youth mental health services, including Jigsaw and other funded agencies in the community and voluntary sector who 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 lists for primary care remains, in many areas up to 2-3 years in length.

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, 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 and lost out due to internal squabbles. 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 serious 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

[13] adhd-in-adults-ncp-model-of-care.pdf (hse.ie)

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 which has serious implications for their safety and wellbeing. Many families and young people told of the lengthy times on waiting lists, trying to be referred to other services when refused by CAMHS. There is little sense of the child and their family being the centre of holistic mental health care 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 heated 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 evidence by the research referred to in the introduction to this report. We found in our review 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[14] 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 to date. We were told by the HSE that a survey of stakeholder's views has been commissioned and will commence shortly.

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.

Variations in care and treatment

There are unacceptable variations in care that is being delivered. Some services can offer, for example, treatment for eating disorders, with family-based therapy, dietetics and cognitive and 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.

3.2 Clinical Governance

Clinical governance is the system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish. 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 HSE principles of clinical governance can be found in Appendix 4.

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, so far in this review, we have made five escalations of risk to the HSE due to risks to the wellbeing and safety of children.

A number of CHOs had resorted to telepsychiatry[15] as an effective tool to overcome the physical barrier between patients and

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

[15] Telepsychiatry, which encompasses teleconsultation, teletherapy, telepsychology, telepsychotherapy, or telemental health through videoconferencing, phone discussions, and real-time chat (Beidas and Wiltsey Stirman, 2021, Di Carlo et al., 2021), is the name given to these modalities when applied to mental health.

healthcare providers to give mental healthcare during COVID-19. Telepsychiatry is described as the use of technology through audio and video telecommunications to offer healthcare across long distances, to enable information sharing between healthcare practitioners, or to provide healthcare when face-to-face contact is not feasible[16].

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 provision during the working week. Some clinicians said that they felt less able to examine vital forms of non-verbal communication during telepsychiatry sessions, which were considered instrumental in assessing and engaging people experiencing difficulties. Other clinicians felt that it was more difficult to engage with the child or maintain their attention during a telepsychiatry session. Telepsychiatry is in its early stage in Ireland and assessment of safety and effectiveness needs to assessed.

Risk management

Risk management in healthcare can be defined as an organised effort to identify, assess, and reduce, where appropriate, risk to patients, visitors, staff and organisational assets.

We were concerned about risk management in some areas, as risk management was poorly understood. Services were recording risks locally and trying to escalate these where they could not be managed within the team. There was concern among team members that escalated risks "fell into a black hole" as they had received no information about what actions had been taken or even whether the risk had been accepted. This led to frustration, lack of assessment of risk and not completing the paperwork to escalate the risk. 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. 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. The HSE Integrated Risk Policy[17] is clear that the outcome of any considerations in the management of risk must be communicated back to the service that notified the risk.

Staff in most areas had received training about risk management but this was not 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 multi-disciplinary process and clinical lead. This could result in the same risk being escalated twice through different pathways.

Some CAMHS teams had their own local risk register which was discussed at the multi-disciplinary teams while other teams did not. Some staff members were not familiar with how a risk register operated or how to rate risks.

Consultant Psychiatrist Staffing

Due to the difficulty in recruiting and retaining CAMHS consultant psychiatrists, there were difficulties in filling permanent consultant posts. Some were covered by locums which had implications for the continuity of care. In one CHO, no consultant worked full-time, but 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.

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 two CHOs other consultants from outside the CHO provided clinics at weekends or in the evenings. In one team a Consultant Psychiatrist

[16] 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.*

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

covers 23.5 hours a week by tele-psychiatry from the Middle East. 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.

Medication Management

Antipsychotic medication is used for the treatment of psychosis but is also used 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[18] 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 persons' physical health. Some 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 2 years. These cases were escalated to the Chief Officer of the relevant CHO. In one CHO where 11 children in our sample of 10% of cases were not monitored sufficiently for antipsychotic/neuroleptic medication, the HSE states that there is no evidence that any child was harmed or suffered side-effects from their medication.

We were pleased to note that, in the majority of the sample of files reviewed, the physical monitoring was completed for children and young people with ADHD on stimulant medication.

The HSE have commenced a prescribing audit which is due for completion by end of 2022.

Children lost to follow-up

We are concerned that in some CAMHS teams that children and young people with open cases have 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 team has already started process of a 'desk top review' of these cases (i.e. reviewing their files) before our review had commenced. These cases had been identified through a Healthcare Record Review,. At the time of the inspection we found that actions taken were minimal, did not involve face to face assessments of the child and it was unclear at what stage these children would be re-assessed. Further information supplied subsequently to our review from the HSE stated that a resulting Healthcare Record Review Report is currently being compiled and will be examined by the Serious Incident Management Team (SIMT) in line with the HSEs Incident Management Framework. The SIMT will identify if any further review is required.

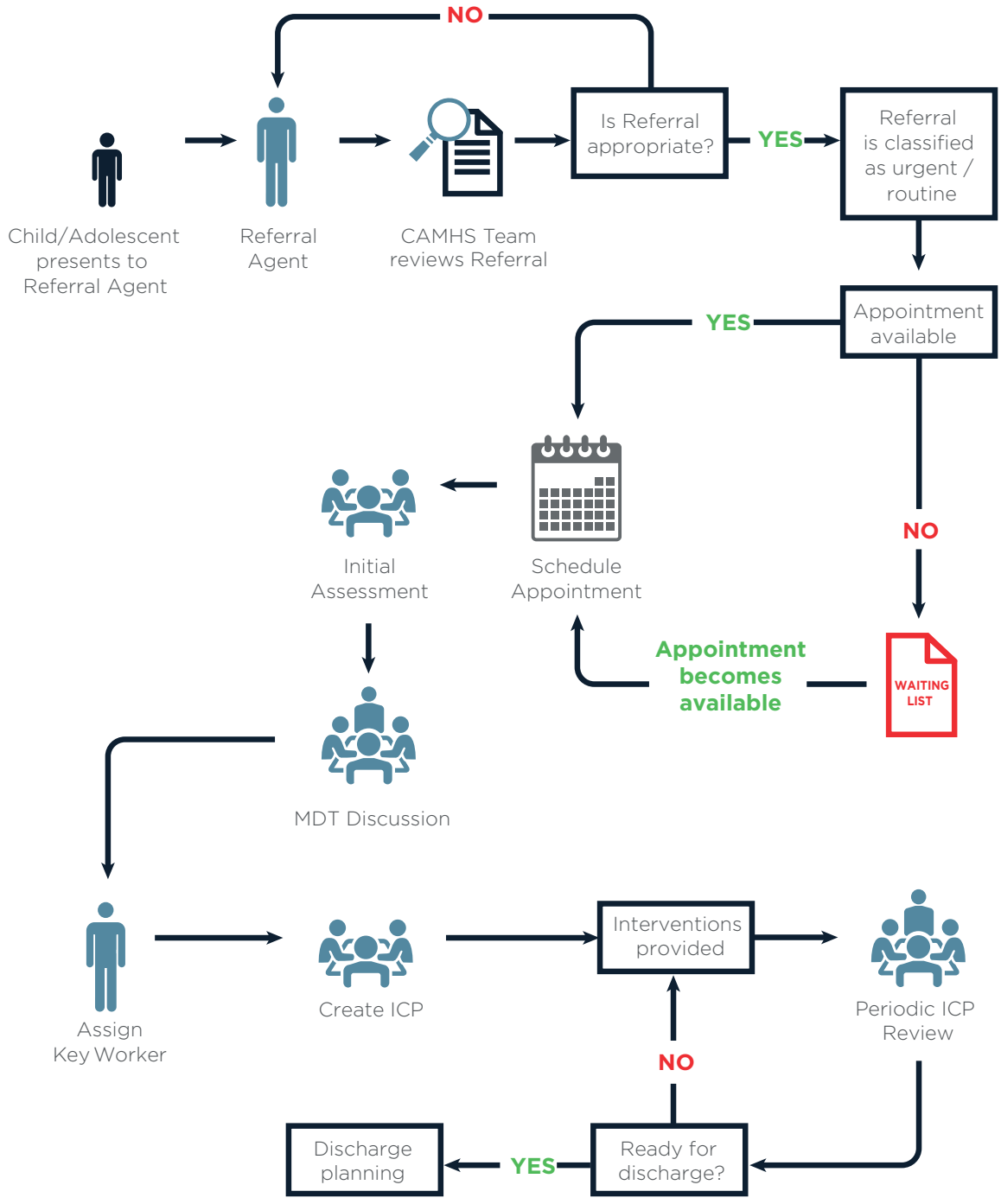
In another team the previous consultant psychiatrist had left without re-allocating their case load and the team were trying to identify which of these children required follow-up. another team did not follow-up their patients for up to two years despite these children being on continuing medication.

No reasonable explanations were provided for the lack of follow, which could result in serious risks to the mental and physical health of these children. These risks were escalated to the Chief Officer of the relevant CHOs and the Assistant National Director, Head of Operations, Quality and Service Improvement.

[18] 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

3.3 Journey through CAMHS

The patient pathway through the child and adolescent mental health care system as set out in the CAMHS Operational Guideline 2019 :



Note: Continue to assess at every stage whether CAMHS is the right service for the child or adolescent.

The referral acceptance by CAMHS in the five CHOs reviewed to date ranged from 38% to 81%, 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 that others, being more likely to accept children with autism and intellectual disabilities. One team rarely accepted children with ADHD, which usually accounts for 25-30% of all referrals to CAMHS. Another team looked for IQ assessment 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 following data was gathered from an audit of 680 files reviewed.

Referral Classification

Emergency	Urgent	Routine	Not classified
12%	25%	26%	36%

<7days	**10%**
7 -31 days	23%
1-2m	19%
2-3m	13%
3-4m	8%
4-5m	6%
5-6m	6%
6-9m	5%
9-12m	3%
1yr +	4%
Not documented	5%

Time from referral by GP to acceptance for initial assessment by CAMHS in sample

The majority of children (92%) in the sample had an initial assessment completed and documented at their first appointments.

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

In 40% of clinical files there was no documented key worker. 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.

In 45% of files, we found that care planning was absent. Others were of such poor quality to be meaningless. This contrasted sharply with some teams where care-planning was at the heart of the treatment in CAMHS and put the patient 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 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 in 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.

3.4 Quality Improvements

There were examples of innovative quality improvements within different teams, but mostly these were not generalised across the CHO when they had been found to be effective. The result was that teams had different ways of providing a service, depending on choice rather than in a standardised way.

Audits of clinical practice are rarely carried out by individual teams, which cite lack of staff as the reason for failure to do so. Where they are carried out, it has been in response to the Maskey report and consists mainly of reviewing clinical files and medication reviews. There were elements of good auditing practice noted in one CHO.

Outcome measuring was variable across the reviewed CHOs, although this a key policy in Sharing the Vision. Emphasis within the HSE is placed on Key Performance Indicators (KPIs),

which measure waiting lists and the number of patients seen but does not measure the quality of the service provided.

3.5 Resources

Staffing

The staffing resources of CAMHS teams is inadequate and in some areas, it is below what would be considered to provide a safe service. *Sharing the Vision* 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 policy *A Vision for Change* as needed to achieve the outcomes outlined in *Sharing the Vision*.

Irish CAMHS teams are seriously understaffed, some operating at below 50% of what they should be. There are no Practice Managers and only four clinical (Team) Coordinators in the CHOs reviewed, where there should be one Practice Manager and one Team Coordinator in each CAMHS team. While there are serious difficulties in retention and recruitment, many posts that should be funded in order to provide a basic service are not approved nor funded. We found team members working beyond their contracted hours, often without compensation, to continue to provide a service and we found evidence of stress and burnout in a significant number of team members. This has a potential impact upon job satisfaction and morale with staff expressing concerns about the quality of the service delivered to young people.

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 many different models of CAMHS provision internationally, where other countries must also deal with recruitment difficulties. It is essential that alternative ways of delivering CAMHS are researched and considered.

While there is strong evidence of good multi-disciplinary 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 multi-disciplinary approach. As this model places the onus on a single profession, the level of increased responsibility disempowers other professions in the multi-disciplinary team and may reduce the attractiveness of consultant CAMHS posts to potential international recruits. It is also unsustainable with the current medical workforce.

Facilities

There are a number of CAMHS clinics and offices in what are mostly new Primary Care Centres or other well-maintained buildings and have adequate clinical, office and waiting spaces and are bright and cheerful with appropriate furnishings and decorations. 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. Therefore, some of the facilities that provided care and treatment to young people with mental health issues and intellectual disabilities are not designed, furnished or developed with the specific needs of these young people in mind.

Digital Infrastructure

In three CHOs, the digital infrastructure was mostly absent apart from the use of Excel® spreadsheets and Word® documents. Computers and other digital infrastructure are out of date and need up dating. It is hard to believe but most of the services do not have an IT system that manage 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. This is a basic requirement for all health services, and it is difficult to see how improvements in the quality of the CAMHS can occur without such a system.

- One CHO in our review had a system that they had devised themselves which allowed generation of reports but did not provide electronic records.
- Only one CHO had electronic records; this system was provided through an independent agency which also provided the CAMHS service.
- A small number of teams had independently tried to set up basic information systems within their own teams, through their own

knowledge of information technology, to increase efficiency and monitor patient files and outcomes. But time spent on such matters takes away from time on patient care and national system would be the most efficient and effective manner of dealing with this.

- In three CHOs reviewed, there was no way of obtaining comprehensive reports on activity, or scheduling appointments and booking rooms in an efficient manner.
- Only one CHO had electronic files and this system was available through the independent provider that provided CAMHS.
- There was minimal use of Healthlink[19]. Nationally only two CAMHS teams were set up to receive referrals via Healthlink. Both sites receive their referrals electronically on the attached national general referral form. Nationally, only approximately seven CAMHS teams are set up to receive their lab reports electronically via Healthlink. Setting up Healthlink is straightforward and should be rolled out to all CAMHS teams, which would greatly improve efficiency within the teams.

The result of the lack of digital infrastructure was inefficiency to a large scale within the teams and preventing service development. A Patient Management System which includes electronic clinical files should be set up across the country that would allow for better tracking of patients and improve standardisation and reporting and result in service improvements. Setting up such a system should be a priority for the HSE. The HSE informed us that implementation of an Integrated Community Case Management System (ICCMS) now underway will provide the required infrastructure. To date we have not seen such a system in place.

3.6 Clinical Files

Four out of the five CHOs visited used paper-based files, only one CHO used an online system to manage patient information. The paper based clinical files were frequently disordered, with little logic to the filing of documents within them. Some contained loose pages. Clinical notes were frequently illegible and at times were incomplete. Practices such as filing the most recent notes at the back of a section of the file, or maintaining separate parts of the file per discipline meant that is was frequently difficult to follow the care and treatment pathway delivered by CAMHS to the young person. At times, we were unable to locate required information within the clinical file, which had either not been documented or was stored elsewhere. The use of paper files is potentially limiting for team members meeting young people or conducting assessments outside of the clinic (such as school observations). In these cases, team members must choose to conduct assessments without access to the young person's full file, or to transport the clinical file with them (with all of the issues associated with same such an urgent requirement to access a file, data protection and so forth). Internal processes pertaining to the transportation of clinical files outside of the clinical setting were inconsistent across the CHOs. Electronic records would allow for better communication between health care service such as general hospitals and CAMHS and allow for better communication between health care services such as general hospitals and CAMHS.

3.7 Rights of the Child

All children have a right to enjoy the highest attainable standard of physical and mental health under Article 24 of the UN Convention on the Rights of the Child, which was ratified by Ireland in 1992.

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 health care 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 health care to all children with emphasis on the development of primary health care

[19] Healthlink 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.

In the CHOs that we have reviewed to date, it is 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[20]. In 2016, the UN Committee expressed its concern about access to mental health treatment in Ireland, highlighting the inadequate availability of age-appropriate mental health units, long waiting lists to access mental health supports and the lack of out-of-hours services.[21] In this review, to date, we have found that access to mental health services for children at all levels of severity is severely restricted.

[20] 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

[21] UNCRC, 'Concluding Observations: Ireland' (2016) UN Doc CRC/C/IRL/CO/3-4, para 53 (b)

CHAPTER

4

Conclusion

Our review of CAMHS to date has highlighted serious concerns about the provision of child centred integrated mental healthcare in Ireland. It demonstrates a lack of central planning to provide child centred care despite having a policy for integrated care. This is borne out by the numerous concerns raised by all involved: young people, families, CAMHS teams and stakeholders.

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 cannot be overstated. They were eloquent in their descriptions of long waiting lists, the refusal of the referral of their child to CAMHS, the long wating 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 how their child deteriorated while waiting for an assessment. This is of grave concern, as there is a small window of opportunity to provide early treatment of mental illness or distress to prevent long term difficulties and illness progressing into adulthood. GPs echoed the families concerns and spoke of difficulties in referring children to CAMHS with "unreasonable" demands for paperwork and tests.

Serious concerns have arisen with regard to clinical governance during this part of the review. In some teams there is a lack of consultant psychiatrist cover, the reliance on psychiatrists not registered as specialist CAMHS consultants, the lack of acceptable monitoring of medication (and the fact that this was not detected by the services), the "lost" open cases of children, a significant number of whom were on medication and required regular follow-up, all point to an unacceptable risk to children in many CAMHS community teams. To provide assurance that each child is receiving the appropriate care, treatment and follow-up and to reduce risk to any child, each team should urgently review all open cases and review any children where indicated. This will, of course add to the burden on the already overworked staff who are trying to deal with long waiting lists and continuing therapeutic interventions but essential to reduce the risk to children's safety and well-being.

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 on children of staff shortages. 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, where there is no motivation to stay in a service that is poorly staffed, overworked and often lacks promotional posts. Staff wellbeing also needs to be considered.

Three CHO CAMHS reviewed have not implemented many of the recommendations of the CAMHS Standard Operating Procedure 2015 or the subsequent CAMHS Operational Guideline 2019. Care plans are either absent or poor in many teams; there are no practice managers and in general, teams are operating at about 50% of their recommended administrative staff. This impacts the amount of clinical time as clinicians try to cover administrative and clerical duties. There are team co-ordinators in only four teams out of the 45 teams reviewed to date, despite this being a recommendation of A Vision for Change in 2006 (with no proposals on this in Sharing the Vision). The lack of a digital infrastructure is seriously hampering the efficiency of CAMHS.

In issuing an interim report of our review into CAMHS, we wish to highlight that there are concerns that, to a greater or lesser extent, are applicable across four of the CHOs reviewed to date and that will require an urgent national response, which we considered could not wait until the final report in 2023. We also wish to highlight that there were areas of excellent practice across different teams in the CHOs reviewed where, as well as operating safe practices, also showed innovation and creativity.

We will continue our review into the national Child and Adolescent Mental Health Services, encompassing the remaining CHOs, and will set out all of our recommendation in the final report to be issued in 2023.

CHAPTER

5

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 Guideline. 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 insert 2001 should be a priority.**

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 to date

Meetings with other stakeholders continue to take place during the review.

List of Stakeholder Meetings
Families and carers whose child has experienced CAMHS
Young people who have experienced CAMHS
Autism Ireland
Barnardos
Children's Rights Alliance
ADHD Ireland
Primary Care Psychology
Irish College of General Practitioners
Irish College of Psychiatrists
Irish Foster Care Association
Irish Medical Organisation
Irish Primary Principals' Network
Jigsaw
Mental Health Ireland
Mental Health Reform
National Association of Principals and Deputies
National Youth Council of Ireland
National Parent's Council Primary (NPC) and St Patricks Mental Health Services
Ombudsman for Children's Office
Pavee Point
Probation Service
SpunOut
Stuart Lynch, Quality and Safeguarding Lead – NHS Mental Health Support Team
The National Parents Council Primary & St. Patrick's MHS
The Probation Service
Tusla
Wexford ICGP Faculty
YAP Ireland

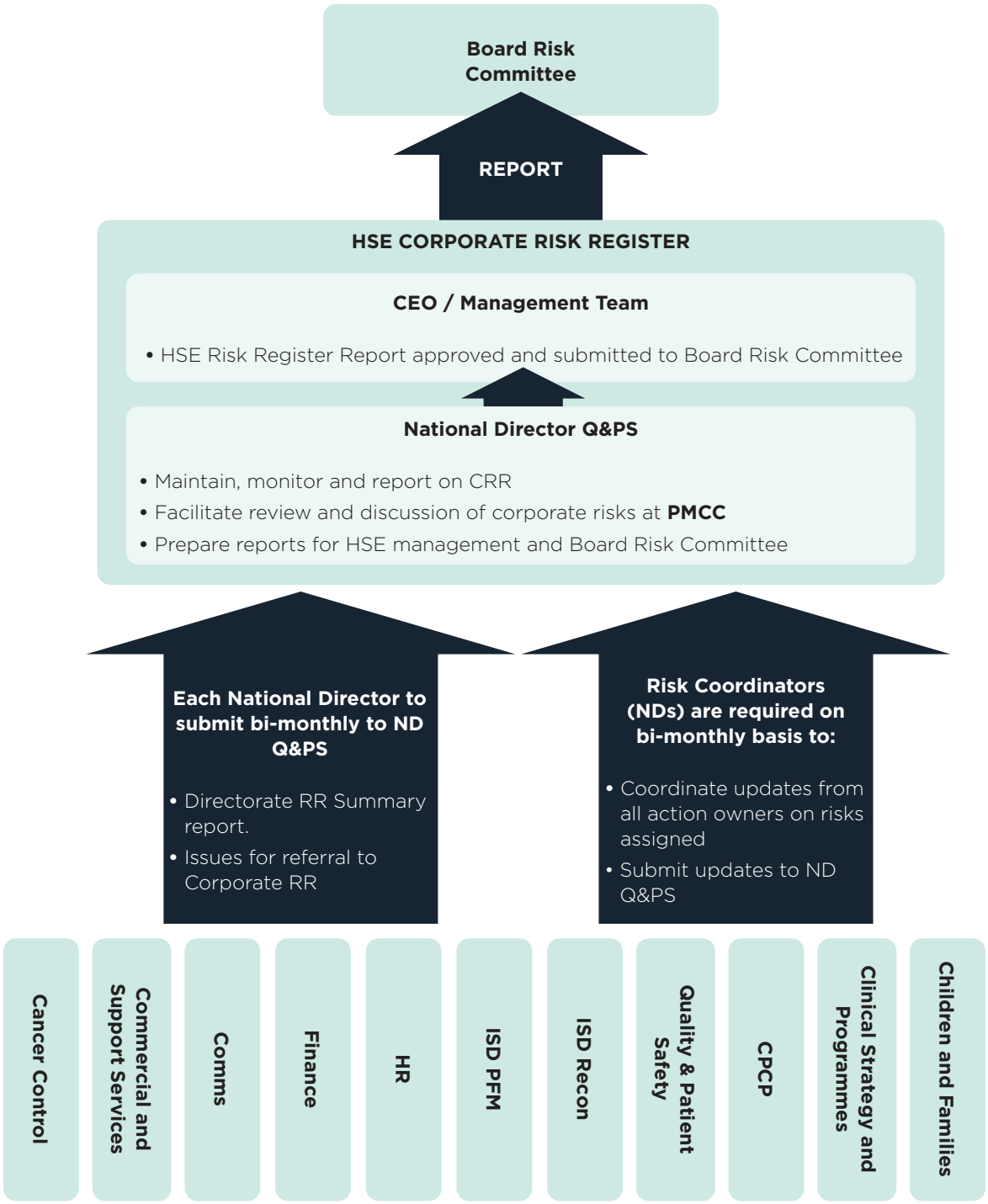
Appendix

3

HSE Corporate Risk Management

Diagram 1

Process for Maintaining the HSE Corporate Risk Register & Reporting to HSE Board Risk Committee



Appendix

4

Clinical Governance

HSE Clinical Governance Leaflet 2012 223415 Clinical Gov 4pp V3 (No ICGP (hse.ie)
Accessed 21 October 2022

PRINCIPLE	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 required in 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 manger.
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 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 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 the patients and staff experience being 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.

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