CPSYCHI
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OF IRELAND

A Model of Governance and Management Structures for **Child and Adolescent Mental Health Services in Ireland**

Registered Charity No. 20204452

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Executive summary

"Trust is the fuel of good governance" (Burke, 2024).

Trust has been lost by the public in Child & Adolescent Mental Health Services (CAMHS) due to the adverse findings of the Maskey Report (Maskey, 2022) and the Mental Health Commission (MHC) report on CAMHS (Finnerty, 2023). In line with its values and mission to promote excellence in the practice of psychiatry, it is of critical importance to the College of Psychiatrists of Ireland (CPsychI) that new governance and management structures for CAMHS are introduced as a priority to ensure patients and their families can be provided with a high-quality service.

The scope of this paper is to propose a new governance and management structure for CAMHS in Ireland. The goal of the new structure is to facilitate a gold standard service for children and adolescents in Ireland, aged 0-17 years, who require specialist support and treatment for moderate to severe mental illness and disorders. This model of governance and management structures will restore trust that CAMHS is enabled to meet the needs of these children and their families in a timely, effective and efficient manner. It will also restore trust between clinicians in CAMHS working on the front line and health system leaders.

Developed by a Working Group of the Faculty of Child & Adolescent Psychiatry

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Summary of key recommendations

This paper proposes eight key areas of reform required to ensure high quality governance within CAMHS services. The recommendations are as follows:

1. Formal acknowledgement that management and clinical leadership are fundamental to the effective provision of a gold standard service from local to national level

In keeping with legislative and contractual requirements, the consultant holds ultimate responsibility for clinical case management and delivery of clinical care of the patients who attend the service. Child and adolescent specialists (consultants) are specifically qualified and registered with the Medical Council as specialist psychiatrists in the field of child and adolescent psychiatry. Specialist (consultant) child and adolescent psychiatrists must therefore lead the CAMHS team.

To fulfil the management functions of service review and development, the CAMHS specialist (consultant) psychiatrist must be placed and meaningfully involved in CAMHS organisation, governance and management structures (including the new Regional Health Authority (RHA) structures).

A nationwide network of clinical directors (CDs) for CAMHS with appropriately and proportionally funded backfill for each CD is required to successfully and effectively fulfil the clinical and managerial roles for teams and, vitally, facilitate two-way links with national management and planning. There must be a consistent national standard contract and job specification for CDs in CAMHS, and roles should be of a fixed term of duration.

2. The introduction of a new Clinical Service Manager role
A senior management & co-ordination business role at a team and regional level

This senior role will support and work alongside the consultant, with the ultimate aim of providing a gold-standard, fit-for-purpose service for patients and their loved ones. A CAMHS team Clinical Service Manager, who requires clinical experience of specialist CAMH services, is responsible for efficient management, coordination and administration of each team, and implementation of its developmental and strategic aims. Examples of key responsibilities include:

- Managing corporate governance and financial, physical and human resources.
- Representing CAMHS and liaising with senior management in other health industry agencies on mental health service planning and delivery.
- Participating in the development and delivery of a comprehensive, integrated child and adolescent mental health service across CAMHS.
- Co-ordination of team activity and operations alongside the specialist (consultant) child and adolescent psychiatrist.

3. Proposed new governance and management structure
CAMHS representation at the Area Mental Health Management Team and at national level

Both the CAMHS Clinical Director and representative of the directorate of CAMHS Clinical Service Managers must have membership of the Area Mental Health Management Team to represent CAMHS. They also must have clear links with the National Office for Child & Youth Mental Health.

4. Defined team roles and accountability

Health and social care professionals and psychiatric nurses must have clearly defined and collaborative roles and must report and be accountable to the specialist (consultant) child and adolescent psychiatrist leads regarding clinical case management.

5. Team core competencies and skills

Specialist CAMHS-specific training, to ensure requisite competencies and skills, must be available and mandatory for health and social care professionals and psychiatric nurses on CAMHS teams.

6. The introduction of appropriate digital infrastructure

An EU-compliant digital infrastructure tailored to the needs of child and adolescent mental health services must be developed and deployed nationally and conform to European Health Data Space regulations and the eHealth Digital Service Infrastructure (eHDSI) (European Commission, 2022a). Child and adolescent mental health services are the keystone specialist health services nationally crossing into hospital, community, social care, disability and youth mental health services. CAMHS should therefore be resourced and facilitated to lead on national digital health infrastructure developments into the future.

7. Financial requirements and investment

A dedicated, CAMHS-specific budget, including resourcing, is urgently required and must be maintained. It is imperative that tracking, measurements and accountability, as well as clear communication at all levels on funding and expenditure, are put in place. Regional Clinical Service Managers and CDs must have budgetary control and input to ongoing financial and budgetary developments for CAMHS.

8. Defined and improved links to community and primary care services

Enhanced primary care and NEPS services and more formal, meaningful links with CAMHS would help to ease current lengthy waiting lists and minimise referral issues to all services. it is critically important that this happens to ensure patients are seen by the right service.

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Part 1

Introduction

Psychiatry is the field of medicine that specialises in the assessment, diagnosis and treatment of mental illness. Psychiatrists work alongside allied mental health professionals, Health and Social Care Professionals (HSCPs) and Psychiatric Nurses, in delivering treatment and intervention for those with moderate to severe mental illness/ mental health disorders.

The College of Psychiatrists of Ireland (CPsychI) is the sole accredited professional and training body for psychiatry in Ireland, representing circa 1,300 professional psychiatrists (both specialists and trainees) across the country. The mission and main object of the College is to promote excellence in the practice of psychiatry which includes advocating for the highest standards required for our mental health services.

All children have the right to enjoy the highest attainable standard of physical and mental health under Article 24 of the United Nations Convention of the Rights of the Child (Convention on the Rights of the Child, 1989), which was ratified in Ireland in 1992. Childhood and adolescence are a critical stage of social, cognitive and physical development. Experiences of adversity, chronic illness or mental health problems in childhood and adolescence, have been shown to be associated with an increased risk of poorer quality of life, ill-health and reduced psychosocial functioning in adulthood (Copeland et al., 2015; Hughes et al., 2017; Maslow et al., 2011).

Mental health is defined as 'a state of mental wellbeing that enables people to cope with the stresses of life, realise their ability, learn well and work well, and contribute to their community' (World Health Organisation, 2022). Mental health is central to overall wellbeing and is recognised by the World Health Organisation (WHO) as a basic human right. Mental health exists on a continuum from optimal mental health and wellbeing to mild distress or difficulties through to the development of mental disorders and mental illness.

The WHO defines a mental disorder as being *'characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning'* (World Health Organisation, 2022). Mental health disorders are defined as illness, with classification and diagnosis based on globally agreed standards, namely the International Classification of Diseases (ICD) (World Health Organisation, 2019), or the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM 5) (American Psychiatric Association, 2013). Mental health disorders/mental illnesses themselves can be differentiated as mild, moderate to severe, depending on the severity of the symptoms and degree of impact on functioning. Examples of mental health illness requiring specialist mental health treatment are:

- moderate to severe depression
- moderate to severe anxiety disorders
- moderate to severe attention deficit hyperactivity disorder (ADHD)
- moderate to severe eating disorders bipolar disorder and psychosis

Ireland has the youngest population in Europe, with nearly a quarter of the population being under 18 years of age, versus an EU average of 18.1% (Central Statistics Office, 2022). In 2006, Ireland's mental health policy, A Vision for Change (A Vision For Change: Report of The Expert Group on Mental Health Policy, 2006), estimated 2% of children and young people (CYP) would meet the criterion for 'moderate to severe mental health disorders' (Government of Ireland, 2006). However, recent studies of the prevalence of mental health have demonstrated far higher rates of mental health disorders among children and young people.

For example, a population survey in England (NHS England, 2017) estimated that:

- one in eight children and young people had at least one mental health disorder
- 5% met criteria for two or more mental health disorders
- approximately half of all long-term mental health disorders began by the age of 14 years

National surveys in Ireland have estimated that one in five of children and young people aged 10–15 and 15–19 years met criterion for a mental health disorder (Government of Ireland, 2023c). The rising prevalence of mental illness has been reflected in steadily increasing referral rates to specialist child and adolescent mental health services, with over 22,000 referrals in 2023 (Government of Ireland, 2024). Following the COVID pandemic, referral rates have continued to increase dramatically, with a further 33% increase in referral rates to specialist CAMHS between 2020 and 2021 alone (Finnerty, 2023).

Optimal mental health supports therefore require a holistic approach. Health promotion and health prevention should be provided for all through public health /social policy. Failure to support mental wellbeing, or lack of services to address stressors or underlying needs are known risk factors for triggering, maintaining risk factors or exacerbating mental health disorders. For those with psychological distress or mild mental health difficulties intervention should be provided by primary care services, including HSE primary care services, Tusla (the Child and Family Agency), Disability Network Teams, and community based voluntary care services such as Pieta House, Jigsaw and Family Resources Centres (Government of Ireland, 2006), (Government of Ireland, 2020). Specialist mental health services such as CAMHS provide multidisciplinary team intervention for those with moderate to severe mental illness.

High quality, consistent and equitable governance is essential to provide equitable, safe, effective and high-quality healthcare services. However, recent reviews in Ireland into specialist CAMHS have identified repeated and systemic failures in governance at both a local and national level (Finnerty, 2023). Furthermore, the reviews have clearly identified links between failures in governance to serious deficits in the standards of service provision, and have recommended urgent reform of governance structures for CAMHS at this time (Finnerty, 2023; Maskey, 2022).

In line with its values and mission to promote excellence in mental health services, it is of critical importance to the CPsychI that new governance and management structures for CAMHS are introduced as a priority. To support reform, the College has developed this position paper, to identify current challenges in governance and to present and outline proposals to improve governance within CAMHS, for the benefit of the children, young people and their families who need and deserve optimal services.

Part 2

Recommended governance structures of specialist CAMHS in Ireland

Evolution of CAMHS services

Corporate governance can be defined as 'the system by which organisations are directed and controlled'. Governance of publicly provided mental health services lies within the overall governance framework for the Health Service Executive (HSE).

CAMHS was established for children and adolescents in Ireland who have and require specialist intervention for moderate to severe mental illness and disorders. It was first developed in the 1950's as the "Child Guidance" model of service for children and adolescents, staffed by psychiatrist, social worker and psychologist as the core team. The composition of the team was broadened and described in A Vision for Change national policy to include other disciplines such as Nursing, Occupational Therapy, Speech and Language Therapy and Child Care / Social Care Workers.

The aim of this broad representation of different disciplines was to work together to give a richer, more holistic understanding of the child, their developmental stage and key relationships in the child's life such as with parents, siblings, extended family and their broader environment - friends, school etc. Each discipline has its own individual theoretical background that contributes to the assessment, formulation and diagnosis of each child's disorder and other factors that contribute to complexity of presentations ("No child is an island"). The team ideally formulates and agrees a treatment plan together and delivers specific interventions that are individually tailored to meet a child and family's needs. This usually requires a variety of therapeutic interventions which can, at any one time, require two or more team members to provide treatment for one child and family. The consultant, in addition to their own specialist psychiatric skills, as the team leader, is responsible to ensure delivery of the overall care of the "patient".

Following broad consultation and collaboration, a radical reform of national mental health policy for Ireland was launched with the publication of 'A Vision for Change' in 2006 (Government of Ireland, 2006). This policy recommended a holistic, needs-led view of mental illness outlining the need for a holistic, multidisciplinary approach to mental health provision for those with mental illness. The policy's overarching focus was detailing the government's plan for the development and provision of specialist mental health services in Ireland which, importantly, included governance structures. It provided detail on recommended service needs, team structure, staffing requirements and associated governance and management provisions to deliver high quality mental health services in Ireland.

'Sharing the Vision – A Mental Health Policy for Everyone' was published in 2020 (Government of Ireland, 2020). 'Sharing the Vision' (STV) complemented 'A Vision for Change' (AVFC), providing greater detail on prevention of mental illness and disorder and provision of mental health services at primary care level. It developed themes of inclusivity and holistic care, increasing service user experiences, and updates on emerging models of service organisation and delivery within specialist mental health services. STV did not amend or update the recommendations regarding the governance structure of specialist mental health services. It specifically treats AVFC as the reference regarding recommendations for core mental health team staffing and governance, and management structures of specialist mental health services. At this time, therefore, mental health policy in Ireland is based on both AVFC and STV, and both will be referenced as appropriate in this paper.

Over the last 20 years, mental health services that have operated within the Community Operations section of the HSE have been delivered by Community Healthcare Organisations (CHO), each under the management of a CHO Chief Officer.

Each CHO area has responsibility for the delivery of primary and community-based services within the national frameworks, which includes General Practitioner (GP) services, Primary Care, Social Care, Health and Wellbeing, and Mental Health Services (Health Service Executive, 2024a).

Reform and reorganisation of these services is currently underway in line with 'Sláintecare' (Government of Ireland, 2018), the current health policy in Ireland. This involves a reorganisation of community health services into new regional health area (RHA's), which will managed by integrated service areas (ISA). These integrated service areas will have management and governance responsibility for both acute hospital services and community health care services.

Governance recommendations for CAMHS

Within specialist mental health services, governance structures at a local, regional and national level have been based on the recommendations of AVFC (Government of Ireland, 2006). These recommended governance structures are summarised diagrammatically in AVFC. Key aspects of the recommendations pertaining to CAMHS are:

- The Consultant Psychiatrist was identified as the clinical lead of the Community Mental Health Teams in AVFC and tasked to "articulate the collective vision of the team and ensure clinical probity" (Government of Ireland, 2006). The role of the Consultant Psychiatrist as Clinical Lead was affirmed in STV (Government of Ireland, 2020).
- At a local level, AVFC recommended an integrated, multidisciplinary team approach to care, known as a Community Mental Health Team (CMHT), identifying and acknowledging that no one discipline can meet the complex needs of every presenting child or adolescent.
- According to AVFC, there should be one local CMHT CAMHS team per 50,000 population, including a Team Leader (the specialist consultant), a Team Coordinator and Practice Manager.
- Detailed recommendations for provision of subspecialist services (e.g. paediatric liaison services, intellectual disability, addiction services etc.) were provided, as well as need for CAMHS inpatient services.
- Governance and management of all CMHTs in a region was to be provided by regional management structures, covering a population of circa 300,000. These were referenced as Mental Health Catchment Area Management Teams (AMTs). A Vision for Change recommended that these should include managers of two to three local health offices, Medical Director, Nursing Director and Heads of Disciplines of Health and Social Care Professionals.
- At a national level, mental health services would be managed and governed through a National Mental Health Service Directorate.

Specialist (consultant) psychiatrists are medical doctors who are specialists in the field of psychiatry. In Ireland, to become a specialist (consultant) psychiatrist a person must hold a recognised degree in medicine and have completed several years (typically 7 or more) of additional postgraduate training in the field of psychiatry. Qualifications and competency in psychiatry requires validation and approval by a recognised professional training body, (in Ireland the CPsychI), and requires registration with the Medical Council of Ireland as a medical specialist. Registration must be renewed annually and requires submission of evidence of ongoing professional learning and good standing to the Medical Council annually throughout a career as a specialist psychiatrist.

Legal and contractual obligations require the specialist (consultant) child and adolescent psychiatrist (the 'consultant') to be the clinical lead of the specialist CAMHS team. The Mental Health Act 2001 is a central piece of legislation which incorporates legal obligations pertaining to the delivery of specialist mental health services in Ireland. This act defines mental health services as: *"'Mental health services' means services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist."* (Mental Health Act, 2001)

Roles and responsibilities of specialist (consultant) psychiatrists operating within the Health Service Executive (HSE) are clearly stipulated. The HSE's consultant contract from 2008 stipulates that consultants have responsibility for the management of their team as well as clinical responsibility for all patients attending that team. The 2023 consultants' contract likewise describes the consultant as retaining overall clinical responsibility for the delivery of care to patients who attend their team (Consultant Contract, 2023).

Part 3

Implementation of recommended governance structures to date

According to AVFC there should be one local team per 50,000 population, including a Team Leader (the consultant), Team Coordinator and Practice Manager. These teams exist, however despite the recommendations, no formal agreement or job description exists confirming the consultant as 'Team Leader'. Team co-ordinators have not been funded or appointed in the vast majority of teams.

Areas with higher population size, e.g. Dublin, Cork and Galway, have historically benefitted and continue to benefit from a role of Clinical Director (CD) for CAMHS. CDs in CAMHS are psychiatry specialists (consultants) who are appointed by the HSE to oversee a group of specialist CAMHS teams in a region, with a role to promote regional CAMHS service planning and delivery. Areas with a CD in CAMHS typically developed local management structures with Nursing and allied Heads of Disciplines in line with structures suggested for Catchment Area Management Teams. Clinical directors in CAMHS have a reporting responsibility to the Executive Clinical Director (ECD), who is the psychiatry representative on the area management team (see below). Areas without a CD for CAMHS are managed directly from the Catchment Area Mental Health Team / Executive Management Teams.

Mental Health Catchment Area Management Teams (AMT) were formed in each CHO area. This team has the responsibility for planning and management for all specialist mental health services in the area (General Adult, Old Age, Intellectual Disability and Child & Adolescent Mental Health Services).

The role of the Medical Director is provided by a specialist (consultant) psychiatrist recruited as an Executive Clinical Director (ECD). The ECD is the chair of the AMT and represents all specialist mental health services (including CAMHS), for their designated area, on this team. All members of the AMT have equal voting rights and status. However, the ECD may be the only specialist psychiatrist member of the AMT. Additional membership of the AMT includes Area Managers, the heads of each of the Health and Social Care Professional (HSCP) disciplines, and the regional Director of Nursing.

The National Mental Health Service Directorate as proposed has not been developed. At the time of writing, the ECD of Psychiatry reports to the Chief Officer for the CHO area, who in turn has a reporting responsibility to the Community Operations Office and the Chief Operations Officer, as well as briefing the Chief Clinical Officer of the HSE.

The Chief Clinical Officer role in the HSE was created to provide leadership and management for the delivery of clinical innovation and design within the HSE. Within this office, a National Lead for Integrated Care is in place, with a remit to support the design and delivery of National Clinical Programmes. The National Clinical Programmes provide model of cares for the development and delivery of services for areas of identified clinical need, involving both community health care services and acute hospital services. This process is supported by National Clinical Advisor and Group Leads (NCAGLs) for identified areas within the Health Service.

A National Clinical Advisor and Group Lead for Mental Health is in post and in 2024 five national clinical programmes in mental health are operational. These cover domains of Eating Disorders, Self-Harm, Early Intervention in Psychosis (these aim to provide an approach involving CAMHS and AMHS), Dual Diagnosis and Adult ADHD.

In 2023, a new HSE National Office for Child and Youth Mental Health was formed to *'improve leadership, provide operational oversight and management of all service delivery and improvements'* (Government of Ireland, 2023a). A National Clinical Lead (NCL) and an Assistant National Director (AND) for Child and Youth Mental Health were appointed to this office, with a reporting relationship to the NCAGL in Mental Health.

Part 4

Identified deficits in recommended and current governance of CAMHS

A HSE-commissioned 'Report on the Look Back Review into Child and Adolescent Mental Health Services County MHS Area A', authored by Dr Sean Maskey was published in 2022 (Maskey, 2022). Referred to as 'The Maskey Report' it focussed on areas of identified concern in South Kerry CAMHS. This report revealed serious deficits in regional governance and national governance which directly impacted clinical governance at a local team level. These deficits in governance were identified as directly contributing to deficits in the standards of delivery of care. It identified failures in team leadership; failures in team functioning through the system of line governance; a lack of identification and response to identified risk; and lack of clarity as to whom responsibility for action lay between local, regional and national governance structures.

In 2022 and 2023, the Office of the Mental Health Commission (MHC) conducted a detailed review of CAMHS nationally. The 'Independent Review of the provision of Child and Adolescent Mental Health Services (CAMHS) in the State by the Inspector of Mental Health Services' (frequently referred to as 'The Mental Health Commission Report') was published in 2023 (Finnerty, 2023). It stated in its summary of findings, '*... that ineffective 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 MHC report details failures in corporate governance at a national and regional level, including insufficient funding and resourcing of CAMHS; deficits in the structures to obtain and monitor funding of CAMHS; failures to record, recognise or respond to identified risks in CAMHS at a HSE corporate level; serious deficits in digital infrastructure; and chronic and ongoing understaffing of CAMHS.

It demonstrates, clearly, the impact of these failures on clinical governance at team level, negative impacts on service provision and, ultimately, the negative impacts on service user/patient experiences of care. Both HSE and MHC reports provided detailed recommendations to improve CAMHS and for urgent reform of governance, staffing, resourcing and funding structures for CAMHS. Many similar themes were identified in both reports including:

- An absence of many of the pre-requisites needed by consultants to fulfil their contractual obligations as clinical leads and managers of the specialist, multi-disciplinary CAMHS team.
- A lack of staffing and essential skillsets on specialist CAMHS teams, and ongoing failures in recruitment and retention of staff.
- Insufficient training and induction for new staff members to ensure the provision of a high-quality service.
- A lack of staff accountability due to existing reporting and management structures.

The College undertook a survey of child and adolescent specialist psychiatrist members into experiences of governance of CAMHS (College of Psychiatrists of Ireland, 2022). The results reflected the findings of the Maskey Report and the Mental Health Commission Report. The membership reported that deficits in governance for CAMHS have contributed to less-than-optimal effects on both the patients and families/guardians who rely on the services, and on the practitioners tasked to provide those services. The survey demonstrated that satisfactory management structures for CAMHS cannot be assumed, and when they do occur their success is largely dependent on the individual and local arrangements of managers and medical practitioners in any particular area.

Examples of identified challenges from the findings included:

- Lack of CAMHS service planning at a broader area level, with only half of respondents working in an area with a CAMHS specific management team.
- Lack of equitable representation for CAMHS at Area Management Teams - only one out of 15 ECDs was a CAMHS consultant, and the vast majority of representatives from nursing and other disciplines at area management were not working in CAMHS.
- Deficits in communication and access within management structures with the majority of CAMHS Consultants reporting that they never had direct scheduled contact with ECD/Area Manager/Head of Service; the majority did not receive minutes from monthly management team meetings; only a quarter reported having a Directorate Service Plan for their post; and nearly all (85%) reported having no information on the budget for their individual CAMHS post.
- Lack of transparency and clarity regarding governance arrangements for implementing the Clinical Operational Guidelines (COGs) for CAMHS and deficits in training for staff on COGs.
- Although specialist (consultant) psychiatrists are the designated leader of the team, nearly all respondents identified that they do not hold managerial authority for the other disciplines on the team. However, consultants identified still holding high levels of responsibility for monitoring activity levels of the team.
- Of significant concern, despite the consultant holding clinical responsibility for all patients attending the service, a lack of awareness of the clinical reporting responsibility of multidisciplinary team members to the consultant was reported, with rates ranging from 41% to 64% for various disciplines as always being aware of this responsibility.

The Consultant as Clinical Lead /Team Leader

As described above, the consultant is the clinical lead of specialist mental health team as defined by the Mental Health Act 2001, and as stipulated in government national mental health policy (AVFC and STV), and through the HSE Consultant Contracts 2008 and 2023. The HSE consultant contracts stipulate that consultants have responsibility for the management of their team as well as clinical responsibility (Consultant Contract, 2008; Consultant Contract, 2023).

The Maskey Report occurred in the context of a review of a CAMHS team that had been without a specialist (consultant) child and adolescent psychiatrist in post for approximately five years. This report summarised the impacts of the lack of a consultant as a team leader as follows:

> *'The Consultant is the clinical lead as defined by A Vision for Change and legislation and the absence of a clinical lead means that there is no-one, in the words of A Vision for Change, to "articulate the collective vision of the team and ensure clinical probity" (AVfC, 9.3). This is a complex role, encompassing clinical and managerial leadership and advocacy for the service and service users, teaching, training and supervision generally and specifically for junior medical staff, and consultancy, that is the provision of specialist thinking and advice to others in the team and outside it. As the clinical lead the consultant carries and is seen to hold, the ultimate responsibility for the clinical care of the patient within the team. As the senior manager within the team, the consultant has a significant role in setting and maintaining standards of professional, clinical and corporate practice.... In the absence of leadership, a team becomes a group of individuals, with different objectives and interests.'*

The Maskey report identified the challenges of a team being managed without a team leader with responsibility and authority over the team, with the multidisciplinary team being managed through multiple independent disciplinary specific line managers disconnected from front line services.

> *'The CAMHS Governance Group did not have a clear coherent view of Team A presented to them and did not seem to integrate their line management and team governance roles. This disconnect is exemplified by the planning of leave and working patterns; each discipline submits their annual and leave requests to their line managers, and they are agreed within that formal relationship. There has been no consideration or discussion of leave planning at the CAMHS Governance Group and the availability of staff from other disciplines was not considered when agreeing leave. Similarly in relation to caseloads, the managers were concerned that their staff were not subject to excessive workloads, but there has been no effective consideration of the capacity of the team and how overall workload and clinical risk is balanced.'*

Despite the legal and contractual responsibility of the consultant to be the clinical lead and hold clinical responsibility for all patients attending the service, consultants currently have no direct management authority over multidisciplinary team members. A description of Team Leader as identified in AVFC has not been developed. Health and Social Care Professionals (HSCPs) in CAMHS report solely to their respective profession line managers and clinical responsibility to the consultant is not specified in the organisational structures. As highlighted in the Maskey Report and the CPsychI survey, many HSCPs do not recognise the consultant as clinical leader of the team and may seek to work independently which can, and does, lead to fragmented working. Line managers for CAMHS HSCPs often work outside of the CAMHS team, may not have any experience in CAMHS and, therefore, may themselves have limited or no knowledge of the needs of the CAMHS team or indeed a CAMHS service and its patients.

The role of practice managers to support the Consultant in discharging his/her management responsibilities has not been developed nationally. Team coordinators have not been funded or recruited for the vast majority of CAMHS teams, and where recruitment has occurred it is often only in part time roles.

This reduces the ability of a team to review and co-ordinate team activity and contributes to the high responsibility on consultants to assess and manage team activity, as well as holding clinical responsibility for all cases.

With a lack of clarity regarding team leadership, team accountability and reporting structures, accountability is formally lacking in CAMHS teams. This impacts the ability of consultants to address areas of underperforming practice, and, conversely, consultants also have difficulty rewarding or incentivising valuable and productive activity. The ability for the consultant to coordinate clinical inputs based on demand and need or to address resourcing and service development requirements is heavily compromised with team members often working in 'silos'. This results in inconsistent and fragmented delivery of treatment and support programmes nationwide and can stymie innovative and evidenced based advancement and improvement of services.

Skills and training

Central to the delivery of CAMHS is the multidisciplinary team. Multidisciplinary colleagues (HSCPs) enable the service to provide a holistic approach to understanding a child or adolescent's presentation. They provide additional specialist skills in area of assessment, psychotherapy and interventions for children and adolescents and their families, who are presenting with mental health disorders.

*Every service and programme **must have** the medical profession and HSCPs with the requisite experience, training and skills to support and treat the patient, including basic risk assessment.* At this time, the CAP consultant and psychiatry trainees are the only practitioners on the team who must receive dedicated child and adolescent psychiatry training. The consultant is the only team member whose qualification is specifically within child and adolescent psychiatry, or who has to complete continual professional development standards on an annual basis.

At this time, there are no eligibility requirements for HSCP appointments to CAMHS to have specific expertise or experience in child and adolescent psychiatry or mental health. National standard job descriptions specific to CAMHS do not exist for HSCPs working in CAMHS. There is currently no specific induction process for HSCPs in specialist CAMHS teams, or continual professional development standards or requirements on an ongoing basis for HSCPs.

Management structures for CAMHS at local, regional and national level

An Executive Clinical Director (ECD) represents psychiatry on the regional Mental Health Catchment Area Management Team (AMT). However, while the ECD chairs the team, each member of the AMT has equal standing and voting rights. Although under 18's account for approximately one in four of Ireland's population, at the time of writing, only one of 15 practising ECDs is a Child and Adolescent Psychiatrist. This lack of equitable representation of child and adolescent consultants at a senior management level means many ECDs who have responsibility to represent and advocate for CAMHS do not have sufficient understanding of the specialist service itself.

The vast majority of CAMHS teams are isolated from existing regional management structures. Despite their contractual responsibilities for service management, most consultants have no meaningful involvement in senior management, service planning, or budgetary allocations. Up until 2023, no national lead for child and adolescent mental health existed to advocate for national planning or the development of specialist CAMHS services. The lack of representation of CAMHS at senior management level has resulted in a national child and adolescent mental health service which has developed without structured planning or oversight and has prevented the service from being developed in a meaningful way based on demand. This has resulted in significant variations in resourcing, funding and service provision for CAMHS across the country.

The aforementioned CPsychI survey of specialist child and adolescent psychiatrist members demonstrated that satisfactory management structures for CAMHS cannot be assumed and, when they do occur, their success is largely dependent on the individual and local arrangements of managers and medical practitioners in any particular area.

Deficits in the stepped care approach to mental health services

Accessibility to the 'right service at the right time from the right providers' is a core tenet of Irish mental health policy (Government of Ireland, 2020), and the government identified the need for a 'stepped care approach'. However, services to address underlying needs are significantly under-resourced.

According to STV, two percent of all children and adolescents will develop the most severe disorders which require care and a need to attend CAMHS for assessment, diagnosis, and multidisciplinary treatment.

As described earlier, rates of mental health disorders in children and young people have significantly increased since that time, as well as significant increases in population. At the time of writing, there are approximately 22,000 children receiving a service from CAMHS with over 4,000 children and adolescents on waiting lists.

However, the lack of psychosocial supports and early intervention options within primary and community care leads to patient referrals to CAMHS for those who should be treated and supported more appropriately in a different service. Subsequently, there can be widespread rejections of referrals as "inappropriate" or "not meeting criteria for CAMHS", and increased demand for CAMHS in the context of prolonged lack of intervention or a lack of other service provision.

Developmental needs

Children with underlying developmental needs require timely access to assessment, diagnosis and intervention. However, currently in Ireland:

- The 2023 HSE National Service Plan identified approximately 7,500 referrals for Assessment of Need in 2023, but estimated only 15.9% of assessments were completed within the timelines as provided for in the regulations (Health Service Executive, 2024b)
- Greater than 73,000 children with developmental needs are reported to be on wait lists for primary care services, which include speech and language therapy, physiotherapy, occupational therapy and primary care psychology (Irish Mirror, 2023).
- Network disability teams provide services for children and young people with complex needs, i.e. needs in two or more domains. Long delays in access to these services exist nationally, with some services having wait lists of up to five years in duration (Finnerty, 2023).
- National Educational Psychology Services (NEPS), run by the Department of Education, provides educational psychological support to all primary, post primary and special schools. In 2023 this service had a 20% vacancy rate (Government of Ireland, 2023b). With approximately one million children enrolled in primary and secondary school in 2022-2023 (Central Statistics Office, 2022) this equates to less than 2.5 NEPS staff per 10,000 students. Many families can therefore only access assessment through private providers, at significant cost.

For children and young people where mental health difficulties are being triggered by underlying stressors or unmet needs, providing mental health interventions without identifying or addressing underlying needs may limit or negate the impact and effect of mental health interventions. Of serious concern, it may indeed expose children and young people to unnecessary risk of harm through misattributing symptoms of unmet needs as mental health disorders, or reliance on medication, rather than receipt of required therapeutic intervention via disability or educational psychology services. Furthermore, it has been demonstrated that referral to mental health services may result in other services withdrawing or reducing required service provision, referred to in the Mental Health Commission report as 'silos of service provision' (Finnerty, 2023).

Mild mental health needs

The vast majority of children or young people who experience mental health distress will experience milder difficulties. Early intervention is critical, however HSE Primary Care Mental Health Services, which should be available to children with milder mental health disorders, are underdeveloped and sometimes absent. As a result, waiting lists are lengthy:

- In 2024 more than 18,500 children and young people are on wait lists for primary care psychology; waiting lists for primary care psychology have doubled in the last 4 years (Mark Ward TD, 2024).
- More than 7,500 children waiting more than a year for an appointment with primary care psychology.
- Wait lists in multiple CHO's have been shown to extend into years, with wait lists up 7 years in some areas.
- Other mental health services such as family therapy, play therapy, youth counselling are provided by a variety of voluntary care /non-governmental operations / charitable and community services e.g. Jigsaw, Pieta House, family resource centres and so forth. This has resulted in a broad variation of available service provision, a lack of coordination in available treatment options for early intervention, and multiple services operating independently, creating a patchwork of service provision. Many services operating in this sector are also reporting increasing delays in access to services due to increasing demand (Irish Examiner, 2023).

Early intervention at points of difficulty e.g. schools / disability/ primary care services is not being provided due to the lack of resourcing and wait lists extending into years for many of these services. This frequently results in inappropriate referrals to specialist mental health services for cases that do not reach criterion of moderate to severe mental health disorders, while children and families struggle to access primary care services. This can result in untreated and prolonged milder mental health difficulties, or children and young people then progressing over time to develop moderate to severe mental health disorders.

Funding

There is no dedicated funding for CAMHS within the national mental health budget (€1.2 billion). The mental health budget is an estimated 5.6% of the overall national health budget, less than half that recommended by the World Health Organisation or of levels of funding provided in similar jurisdictions. It should be minimum €2 billion. Of this allocation towards mental health, it is estimated that specialist CAMHS secures approximately only 12% of the mental health budget even though under 18-year-olds account for 25% of the population.

IT deficits

Most specialist child and adolescent mental health services have no access to or adequate electronic patient records or fit for purpose ICT patient administrative systems to chart patient records, appointments or data. This has been associated with governance failings, including patients being 'lost to follow up', loss of clinical records, and reductions in the quality of patient records. It also significantly increases workload on clinical staff performing administrative duties, further reducing the already under-resourced clinical capacity with specialist CAMHS teams and hinders development and enhancement of services.

Part 5

Key recommendations

1. Formal acknowledgement that management and clinical leadership are fundamental to the effective provision of a gold standard service from local to national level

In keeping with legislative and contractual requirements the consultant holds ultimate responsibility for clinical case management and delivery of clinical care of the patients who attend the service. Consultants must therefore formally lead the specialist CAMHS team. If there is more than one consultant on the team, one assumes a lead role locally known as Head of Service.

To fulfil the management functions of service review and development, the consultant must be placed and meaningfully involved in CAMHS organisation, governance and management structures (including imminent RHA structures to be confirmed).

A nationwide network of clinical directors (CDs) for CAMHS with appropriately and proportionally funded backfill for each CD is required to successfully and effectively fulfil the clinical and managerial roles for teams to establish and maintain two-way links with national management and planning. There must be a consistent national standard contract and job specification for CDs in CAMHS as the lead specialist consultant for a defined number of teams. CDs must have budgetary control in a region.

The roles of CD and ECD are distinct and should not be held by the same person concurrently, given CDs will focus exclusively on CAMHS and ECDs serve as line manager for consultants in all psychiatry specialties. The position of CD should be for a fixed term, and recruited by interview process, in line with recruitment processes for ECDs.

All subspeciality CAMHS teams such as intellectual disability, substance abuse, liaison services and forensics should follow the same governance structures, with access to a specialist child and adolescent CD and, by extension, the regional Mental Health Catchment Area Management Team (AMT).

2. The introduction of a new Clinical Service Manager role

It is imperative that all members of specialist CAMHS teams are given the opportunity to work together in a seamless and inclusive fashion in order to minimise accessibility issues and prioritise the holistic working model as proposed in 'A Vision for Change'. As clinical lead, the specialist consultant psychiatrist (the Consultant) should therefore be able to discharge management functions as needed. This will necessitate the introduction of a Clinical Service Manager, who will report to the Consultant.

This part-time senior management role at a team and regional level helps develop and deliver a comprehensive, integrated child and adolescent mental health service across CAMHS. The Clinical Service Manager is responsible for efficient management, coordination and administration of each specialist team, and the implementation of its developmental and strategic aims.

The Clinical Service Manager supports the Consultant with the management of the specialist team. Their remit includes identifying and recommending the composition of the specialist CAMHS team, organising rotas and annual leave, caseload management, data management, KPI monitoring, ongoing risk assessment, staffing reports, recruitment, budget reports, and the management of key administrative functions.

The role should be defined by a set of management and organisational functions and skills required to carry out the tasks and will not be defined by discipline. Clinical experience of specialist CAMHS is a pre-requisite of the role, and the Clinical Service Manager will have the option to carry a clinical caseload. This senior role will support and work alongside the Consultant, with the aim of providing a gold standard, fit-for-purpose service for patients and their loved ones. Examples of key responsibilities include:

- Managing team corporate governance structures e.g. risk, organisational policies, strategy, organisational governance, and financial, physical and human resources.
- Representing CAMHS and liaising with senior management in other health-related agencies on mental health service planning and delivery.
- Co-ordination of team activity and operations alongside the Consultant.
- Overseeing and coordinating training of all specialist CAMHS team members, including AHPs.
- Chairing one monthly CAMHS specialist team business session, separate from the specialist team's clinical meeting, at which any administrative or logistical concerns or requests can be discussed.

Similar 'dual team management' approaches are used and have been long established in other jurisdictions. West Australian CAMHS and other parts of Australia use a dual model which consists of a Specialist Consultant Psychiatrist referred to as "Head of Service" (lead consultant where there may be more than one on a team) and a Service Manager.

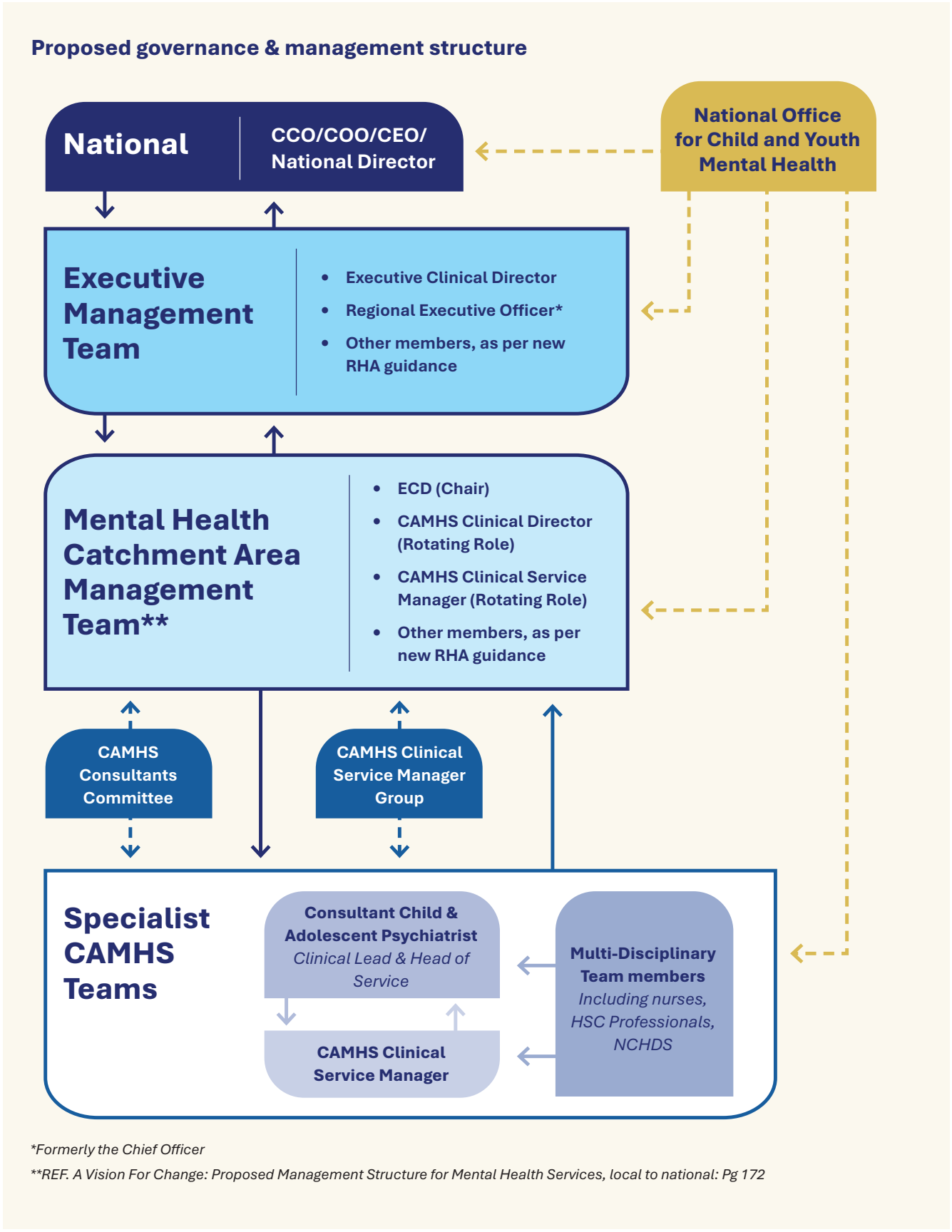
3. Proposed new governance and management structure

A clear management and governance structure is essential to the provision of high-quality services. Clarity regarding governance from front line services to national offices is required. The CPsychI propose a structure as follows:

- Clinical Leadership and management at a team level will be provided by the Specialist Consultant as Team Leader and supported by the Clinical Service Manager.
- All CAMHS services should be organised within CAMHS Clinical Directorates, supported by a nationwide network of clinical directors (CDs) (a specialist consultant) for CAMHS with appropriately and proportionally funded backfill for each CD.
- CDs should be a rotating role for a fixed term, appointed by interview, with consistent job descriptions, roles and responsibilities nationally, with reporting relationships to the ECD in the area and access to the new National Office for Child & Youth Mental Health.
- A specialist consultants' committee meeting – comprising all the child and adolescent psychiatrists in the clinical directorate - should be held monthly. The recommendations, requests and concerns arising from this meeting will be presented to the CD who will, in turn, raise these at a monthly meeting of the Area Management Team (AMT). A parallel meeting of Clinical Service Managers should also occur monthly, and a rotating Clinical Service Manager (CSM) representative should be nominated to represent CSMs at the monthly Area Management Team meetings.
- The role of the Area Mental Health Management Team (AMHMT) is to manage all specialist mental health services within a specified region. The CD and Clinical Service Manager representative (rotating roles both representing a number of specialist CAMHS teams) must have membership of the AMT to represent CAMHS, reporting to the ECD.
- The ECD will report at the Executive Management Teams at the new Regional Level, in line with the new RHA structures.
- The National Mental Health Directorate would cover all mental health specialties in Ireland, and as such would be represented by a national lead for child and adolescent psychiatry (as per recent role (2023) of Clinical Lead for Youth Mental Health). The Directorate would have a specific protected (ring-fenced) annual budget which would be divided among specialties based on demand. This demand would be analysed through the introduction of an electronic data system.

See Figure 1: New Governance & Management Structure.

Figure 1: Proposed Governance & Management Structure



*Formerly the Chief Officer

**REF. A Vision For Change: Proposed Management Structure for Mental Health Services, local to national: Pg 172

4. Defined team roles and accountability

It is imperative the structures are put in place for consultants to fulfil their obligations as clinical leads and managers of the multi-disciplinary team of HSCPs as set out in the HSE's 2008 and 2023 Consultant contracts. HSCPs and psychiatric nurses must have clearly defined and collaborative roles and must report and be accountable to the Consultant regarding clinical case management. Examples of job occupations and skills are available from ESCO (European Skills Competencies and Occupations) (European Commission, 2020).

Each discipline of CAMHS must have a job description acknowledging the Consultant's role as clinical lead of the team, the Consultant's ability to deliver patient care directly, and crucially, the Consultant's ability to delegate care to another HSCP on the team.

It is critically important that the Consultant can seamlessly work with and access resources from non-medical resources e.g. nurse, social worker, psychologist, to provide optimal care on a needs-led basis. This way of working will foster the holistic, integrated, team-centred approach recommended in 'A Vision for Change'. This process will be supported by the Clinical Services Manager to support oversight of operational and management function within the team.

5. Team core competencies and skills

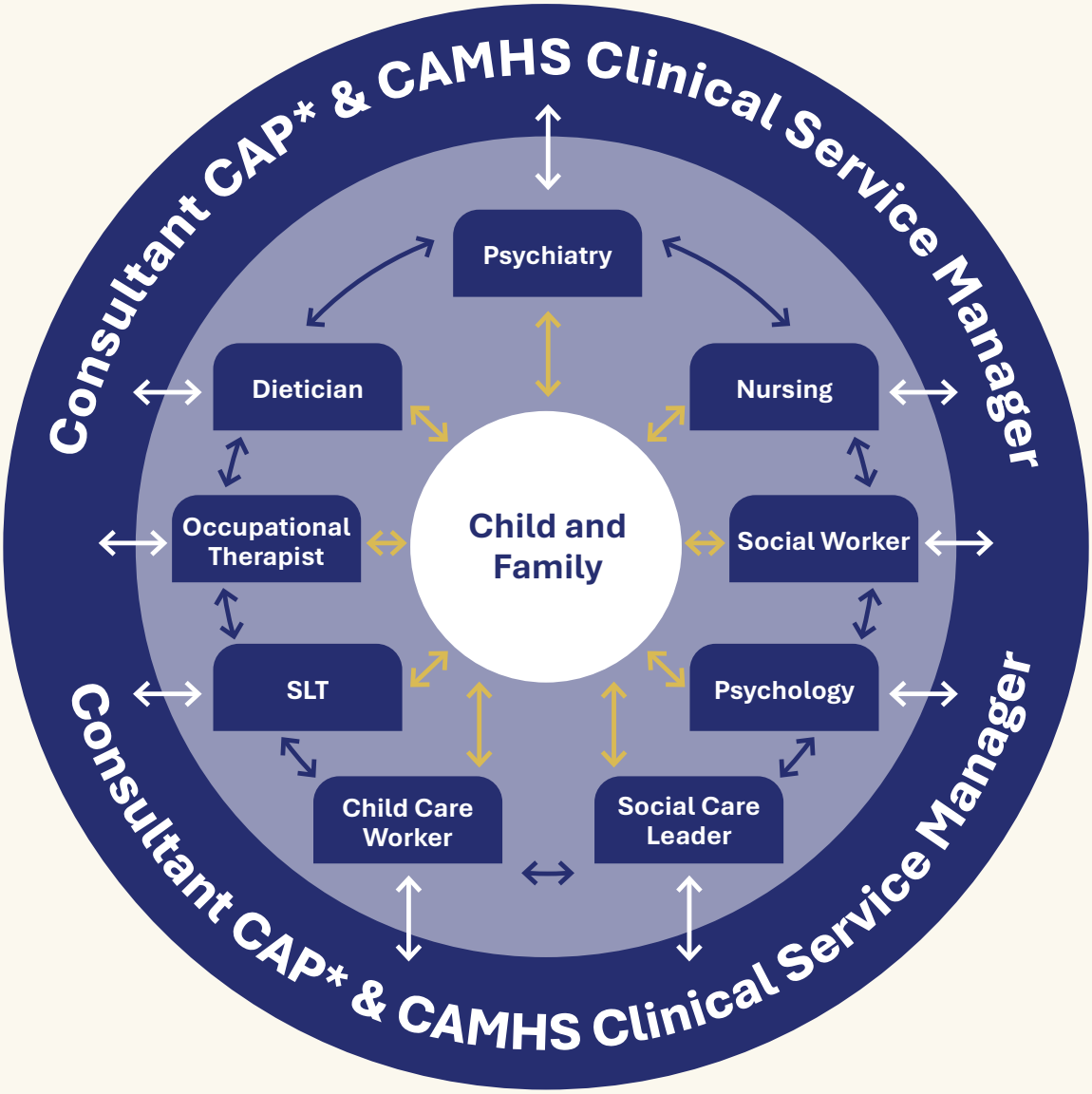
Specialist CAMHS-specific training, to ensure requisite competencies and skills, must be mandatory and made available for all staff, such as HSCPs and psychiatric nurses on specialist CAMHS teams, regardless of experience, to support the development of basic competencies for the job. At a minimum, this training should cover:

- Mental state assessment
- Risk assessment
- Best practice for reporting to and collaborating with the specialist team clinical lead
- Basic knowledge of disorders and known risk factors at primary care level

As the accredited education and training authority, in partnership with the relevant body in the HSE, CPsychI could support and /or lead the development and delivery of training, alongside the Consultant as clinical lead.

See Figure 2: Specialist Consultant CAP & CAMHS Clinical Service Manager.

Figure 2: Specialist Consultant CAP & CAMHS Clinical Service Manager



It is critically important that the consultant can seamlessly work with and access resources from non-medical resources e.g. nurse, social worker, psychologist, to provide optimal care on a needs- led basis.

This way of working will foster the holistic, integrated, team-centred approach recommended in A Vision for Change.

** Child and Adolescent Psychiatrist. All specialist (consultant) psychiatrists are on the specialist register of the Irish Medical Council.*

6. The introduction of appropriate digital infrastructure

CAMHS is a national specialist health service liaising with hospital, community, social care, disability and youth mental health services. CAMHS should therefore be resourced and facilitated to lead on national digital health infrastructure developments.

It is essential that an EU-compliant, digital infrastructure tailored to the needs of CAMHS and conforming to European Health Data Space regulations and the eHealth Digital Service Infrastructure (eHDSI) is urgently developed and integrated into the digital health services infrastructure (European Commission, 2022b).

7. Financial requirements and investment

A dedicated, CAMHS-specific budget, including resourcing, is urgently required and must be maintained. It is imperative that tracking, measurements and accountability, as well as clear communication at all levels on funding and expenditure, are put in place. Regional Clinical Service Managers and CDs must have budgetary control and input to ongoing financial and budgetary developments for CAMHS.

8. Defined and improved links to community and primary care services

At the time of writing, CAMHS does not have any formal links to community-based non-government organisations or voluntary and community sector primary care services such as Jigsaw or Pieta House. Nor is there any clear formal link to other specialist paediatric medical services. Enhanced primary care and NEPS services and more formal, meaningful links with CAMHS would help to ease current lengthy waiting lists and minimise referral issues to all services. Staff resourcing and lengthy waiting lists are key issues for specialist CAMHS teams. It is beyond the remit of this paper to identify the optimal way to improve links with primary care, yet it is critically important that this happens to ensure patients are seen by the right service and, consequently, that demand for CAMHS moderates accordingly.

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