30.

The following is a submission to the Seanad Public Consultation Committee in relation to Children's mental health Services in Ireland. This submission has been prepared on behalf of Ms Anne O'Connor, National Director, Mental Health Division.

1.0 Introduction

1.1 A broad range of services support the mental health of children and adolescents. The term CAMHS or Child and Adolescent Mental Health Services to give it its full title, is applied very specifically to services that provide **specialist** mental health treatment and care to young people up to 18 years of age through a multidisciplinary team approach. It is the function of CAMHS to provide a specialist mental health service to those young people who have moderate to severe mental health disorder. The mental health disorder is severe enough that is causes substantial distress to the young person, their family or others, and has a significant impact on various aspects of the young person's life within the domains of development, family relationships, school, peers, and leisure activities.

1.2 CAMHS is part of a whole system approach to the health and wellbeing of young people. Like any 'whole system' CAMHS is reliant on other parts of the system to work in order for it to function properly. Where CAMHS fits into this system is best conceptualised in a tiered model as shown in Appendix I.

1.3 The provision of any healthcare model is similar to the model depicted in appendix I. The broadest range of services are those provided at the base of the triangle and are accessible by all of the community. These are for the most part delivered by NGO's who provide the services on behalf of the statutory bodies, such as the HSE. The funding for these services is largely provided by the HSE and other State entities and will consist of early interventions, information, signposting to services and health promotion as their main themes.

1.4 PRIMARY CARE SERVICES (Tier 1): As a young person's needs become more clinical in nature, Primary Care services are usually the first point of contact for a young person when mental health problems arise and they provide a first line of response. These services include:

- Community Psychology services
- Speech and Language Therapists
- Community Occupational Therapists
- Public Health Nurses
- Primary Care Social Workers
- Public Health Doctors
- Specialist early intervention and school age services for children with developmental delay. This includes Autism Spectrum Disorder.

Young people with **mild to moderate** difficulties are seen by the relevant primary care services listed above. They and their parents/careers receive information, advice and specific interventions based on their clinical needs. An important role of Primary Care services is also to identify when a young person needs more specialist mental health care and to initiate such a referral often through the young person's General Practitioner, Assessment of Needs Officer or other health care professional as detailed in the CAMHS SOP. It is important that there are clear links between Primary Care and

Mental Health services to coordinate appropriate service provision for young people who are at risk of mental health problems.

1.5 SECONDARY CARE SERVICES (Tier 2): This is the first line of specialist mental health services which is accessed by a referral from a Tier 1 service. Within the context of CAMHS, a Community CAMHS team provides assessment and clinical interventions to determine the nature, severity and complexity of the presenting mental health problem(s) in collaboration with the young person and their family. To work effectively, a range of disciplines, skills and perspectives are required, so that the young person is offered a care and treatment package which addresses their individual clinical needs. A multi-disciplinary composition to the team is therefore required that incorporates the range of skills necessary to address the clinical management of the varied and complex clinical problems presented. Community CAMHS teams will also work closely with other agencies present in the young person's life, such as with Tusla (if they are involved), the National Educational Psychology Services (NEPS) and the young person's GP to name but a few.

1.6 TERTIARY SERVICES (Tier 3): This is the second line of specialist mental health services for young people. These consist of intensive community based care and in-patient interventions which are provided by specialist mental health teams. Young people who require such services will have very complex and severe mental health problems and may be at high risk of harm to themselves. The types of services provided under Tier 3 will include CAMHS day hospitals, specialist out-reach teams, and generic CAMHS in-patient units. Despite significant increases in in-patient bed capacity over the past 10 years, the provision of beds within the four regional generic in-patient units falls short of the recommended number suggested by *A Vision for Change* (2006). The provision of Day Hospital Services are also limited to only three such services located in the Dublin and Galway areas, which is again is much lower than the Vision for Change (2006) recommendations.

In the UK and other jurisdictions such as Canada, Australia and New Zealand, there is an additional level of Tier 4 CAMHS services. Tier 4 services consist of highly specialised in-patient facilities with a specific remit to cater for complex difficulties that lie outside the scope of a generic CAMHS in-patient services. Examples of such services include Treatment Resistant Eating Disorders Services, Medium and High Secure Forensic CAMHS and specialised in-patient units for young people with Intellectual Disability. Such specialist Tier 4 services do not currently exist in the Republic of Ireland resulting in many young people requiring alternative makeshift arrangements both in Ireland and on occasions being sent overseas. There are plans to build a new 10 bedded Forensic CAMHS unit in Portrane as part of the new Forensic Mental Health campus which is due for completion in 2020. In addition, as part of the new Childrens Hospital, an 8 bedded specialist CAMHS Eating Disorder unit will be built as part of a 20 bedded CAMHS unit.

2.0 INTERNATIONAL COMPARRISON - Ireland's Two Tiered System & Challenges within CAMHS

2.1 There is an urgent need to build mental health capacity within the Primary Care sector in order to respond effectively to young people who are at risk of mental health problems. The Primary Care landscape varies significantly from local area to local area with a range of different primary care supports in different areas of the country. The presence of a Community Psychology Service, an Educational Psychological Service or an Early Intervention Team for developmental

screening is variable across different geographic locations leading to an inconsistent profile of services across the country.

2.2 The development and publication of the CAMHS Standard Operating Procedure in 2015 went a significant way in identifying clear pathways of referral to Tier 2 & 3 CAMHS as well as clearly outlining what the role and function of CAMHS is at these levels. A side effect of the CAMHS SOP was that no similar service description policy document existed for other services that have a mandated role and responsibility in the mental health wellbeing of young people. This in turn highlighted significant deficits in other clinical areas such as a lack of primary care psychology to deliver early interventions, a lack of NEPS across schools to pick up issues/concerns, total absence of both community and in-patient services for young people with an Intellectual Disability as well as the need to develop joint working protocols, both within the HSE Divisions (Primary Care, Social Care and Mental Health) and with external agencies such as with Tusla, in how complex cases are managed. Joint Working Protocol policies are now in final draft form and are due to be published shortly, while a HSE/Tusla protocol is now in operation.

2.3 In reviewing the comparison of Irish CAMHS to other international models, especially the UK, Irish CAMHS works off a two tiered model as opposed to the internationally recommended 4 tiered model.

2.4 Largely CAMHS in Ireland consists of out-patient specialist community CAMHS teams (of which there are only 46% of what has been recommended by A Vision for Change 2006) and a collection of generic CAMHS in-patient units (again far less than what is recommended for a population of this size).

2.5 In reviewing the comparison of other international services these two fundamental service design deficits would seem to be crucial to the problems encountered in establishing uniformity in national service delivery.

2.6 It can be inferred from the literature (UK CAMHS Review, 2008) that the absence of Primary Care Mental Health workers would lead to a potential problem of targeting appropriate referrals to CAMHS. Without an informed 'Single Point of Entry' system, cases of childhood behavioural problems may be referred to CAMHS as a first port of call as opposed to a targeted intervention that requires specialist help. This lack of a signposting service means that there is an overwhelming burden on GP's and other primary care services to know where to access specialist help (Keirns 2014). This also means that the important distinctions between health, education and social services become blurred and fudged with each service lacking a clear identity and often overlapping and duplicating their efforts with families with mixed presentations (Goodman 1997). It is reasonable to assume that the absence of mental health clinicians in the Irish primary care system could mean that Irish CAMHS teams are being asked to carry out interventions that ordinarily would be addressed by primary care clinicians in other comparable countries. Therefore Irish CAMHS teams become unable to offer services to those families who are on the waiting list trying to access services who may be presenting with what is deemed to be more 'appropriate' or 'core business' CAMHS presentations.

2.7 The lack of a mental health presence in Primary Care also means that there is no means of returning families to a less intensive service when specific CAMHS specialist interventions are no

longer required. This may mean that families stay in specialist CAMHS longer than is required due to a lack of primary care service to refer them back to.

2.8 The other obvious gap in Irish CAMHS is the complete absence of Specialist Tier 4 services. In most other international CAMHS whole service designs, there are a selection of Tier 4 in-patient and specialist services which are available to treat the differing presentations that occur in that sector. For example the variations in secure levels of treatment available throughout the UK offer a collection of services including low secure, medium secure in-patient treatment centres, alongside Children's (under 12s) units and specialist eating disorders services.

Tier 4 Services in the UK as of January 2014.

- Eating Disorder Units - 13
- High Dependency Units - 2
- Low Secure Units - 6
- Medium Secure Units - 5
- Deaf Services - 1
- Learning Disability Services - 4
- Children's Services – 6

2.9 It therefore stands to reason that the presentations of young people across a diverse age group and presenting with a diverse collection of needs will need stream lined services during this acute phase. It is a significant oversight to expect that Irish in-patient units are equipped or able to manage all of these diverse needs 'under one roof' within a context of not having any access to these other specialist services. The reality is that generic Irish in-patient services cannot manage this range of diversity under one roof. This may explain the strict culture of 'Gate-Keeping' that is often criticised, but absolutely necessary to protect these services from being expected to manage inappropriately placed young people on generic units who compromise the safety of young people and staff on these units. A more appropriate placement would undoubtedly be a highly specialist Tier 4 service. It is the case in most adult services that there are a series of environments in place to deal with different levels of acuity. It therefore seems unusual that in CAMHS that they are expected to function without this consideration. In the interim, funding has been secured and the recruitment of both an Eating Disorders Community Team and a Community Forensic CAMHS team is currently taking place until in-patient beds within these specificities become available.

2.10 This links neatly to the concept of 'Multi-Agency Working'. Almost all of the literature that has been written in the last 10 years suggests that this is the most successful model of treatment. Within such a concept of Multi-Agency working, the social, educational, justice and health systems work together to provide a treatment model for the young person and their family. We do not have Multi-Agency working at present in Ireland, and the development of Joint working protocols is attempting to address this. There remains a problematic culture of ownership that gets played out in terms of linear treatment models as opposed to integrated treatment systems. Currently there is a culture that a young person must only attend one system of intervention at a time. Where there is a case of dual diagnosis or multiple problems, the young person and their family are expected to only attend one service at a time until each difficulty is resolved independently. These silos of treatment mean that young people do not access comprehensive systems of treatment but rather get pigeon-holed into one service. Much of the time this will be into a Community CAMHS team.

In the incidence of self-harm or risk, there can be an issue of accountability that stems from these separate models of treatment and so, allied services are reluctant to get involved and CAMHS are reluctant to hand over. Not all self-harm is as a result of a mental health problem and sometimes the educational or social services are far better placed to address this difficulty than the health service. We need to move toward a Universal, Targeted and Specialist model of treatment if we are to integrate CAMHS into an effective health system for children and their families.

2.11 One of the biggest factors that is currently impacting on CAMHS nationally is the recruitment of specialist staff, especially within the nursing and medical professions. Attracting CAMHS Consultants is especially challenging with many citing pay and conditions as a reason for seeking employment in other speciality areas or jurisdictions. Currently, staffing within CAMHS community teams is about 50% of that as recommended in A Vision for Change. This is despite significant investment in CAMHS over the last number of years (see appendix IV).

2.12 On a positive note, there have been significant developments within CAMHS in recent years following the establishment of the HSE Mental Health Division in 2014. A CAMHS service improvement project team was established in 2014 that developed and published the CAMHS SOP in 2015. This HSE policy clearly articulates for the first time what the role and function of CAMHS is and attempts to introduce a degree of consistency in how CAMHS is delivered across the country.

2.13 In-patient beds have increased over the past number of years though there continues to be challenges in keeping these open due to ongoing medical manpower issues (see appendix II).

2.14 Joint Working Protocols between CAMHS providers in the HSE and other external agencies such as Tusla have been completed.

2.15 Through the Mental Health Division, there is a dedicated senior manager responsible for providing national oversight of CAMHS and its activities on behalf of the Division. This includes monitoring and reporting of all admissions of young people to adult approved centres and taking direct action with local areas to facilitate a timely transfer to an age appropriate CAMHS unit where this is clinically indicated. In 2015 there were 503 admissions of children under the age of 18 years. This represents an increase of 41% (149) when compared with 364 admissions in 2007. In 2016 there were 312 admissions to HSE child and Adolescent units, a four-fold increase when compared to the total of 78 admissions in 2007. The number of admissions to Adult units in 2016 fell by 29% (28) when compared with 96 such admissions in 2015. The length of stay of children admitted to adult units also decreased in 2016, with 62% of children being discharged within 3 days of admission. Less than 3% of child in-patient days were spent in adult units. In 2015 41% of children were discharged within 3 days of admission.

2.16 A number of factors contribute to the admission of young people to adult units including increased referrals to CAMHS, community CAMHS capacity, change in clinical need/complexity of cases, emergency and out of hours presentations, availability of out of hours CAMH services, capacity of social care services, and geographical considerations at time of emergency presentation.

3.0 CONCLUSION

3.1 The HSE is committed to the further reduction in the number of admission of children to adult units, while acknowledging that, in **exceptional circumstances**, it will continue to be necessary, where there is a clear clinical imperative, to admit a small number of children to adult units, for the shortest time possible. Safeguards are always put in place in the event that a young person is admitted to an adult approved centre and these are governed under the Code of Practice Relating to Admission of Children under the Mental Health Act 2001.

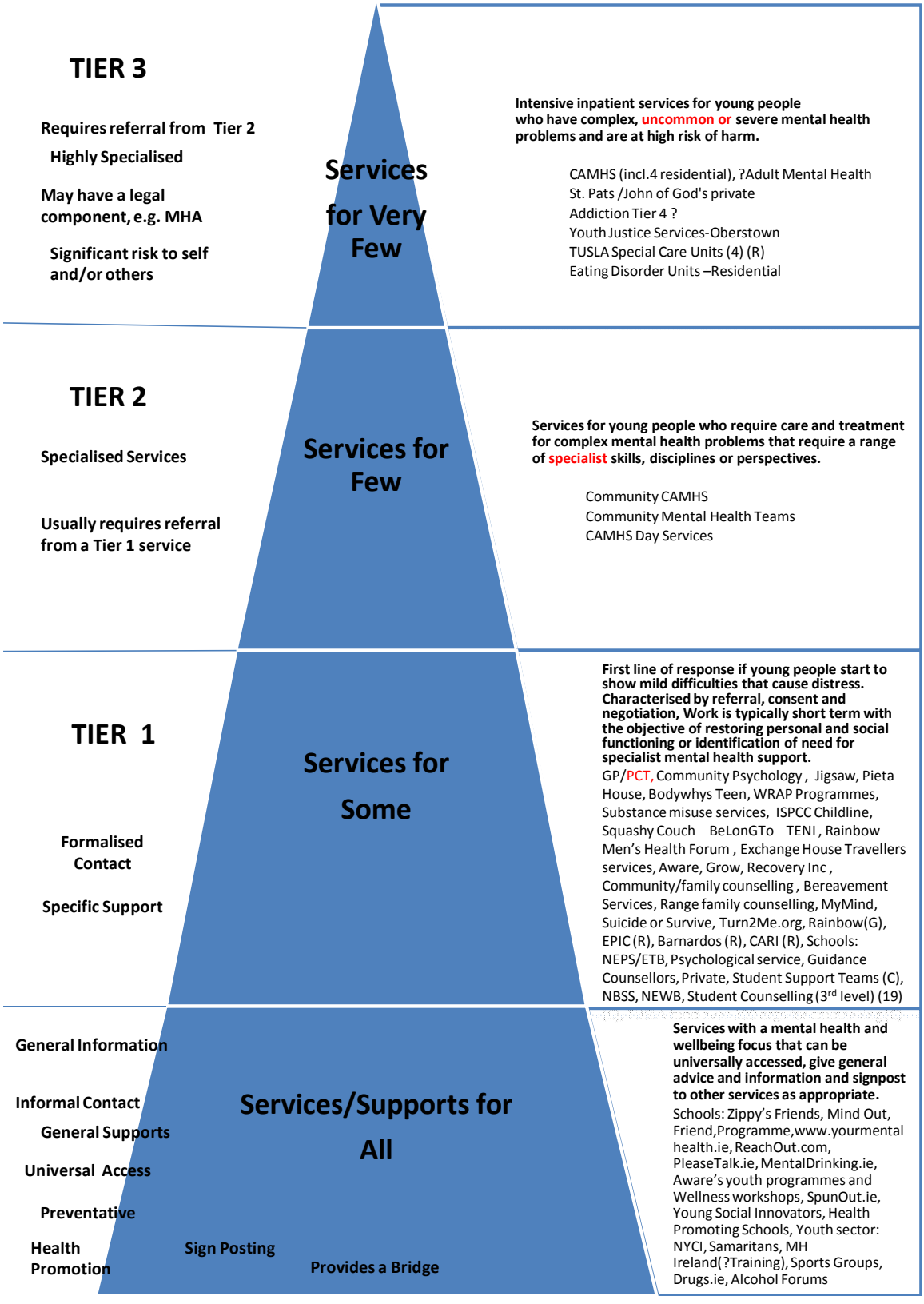
3.2 Within the current context of available services, any 'ban' on admitting a young person who is in a suspected mental health crisis to an adult approved centre is not practical or safe. This is especially true in the absence of a 'whole system' approach to mental health which remains a challenge at the various levels within the tiered model.

3.3 There needs to be a greater understanding and awareness, particularly amongst policy makers, on how services for young people are constructed and delivered. The HSE funds a considerable level of activity in the early/ low level intervention phase which is mostly delivered through the NGO network of service providers. This is an appropriate way of funding and delivering such services with more serious complex presentations being managed by statutory agencies.

3.4 The single biggest challenge currently in CAMHS is that of recruitment, specifically the filling of medical posts. Under A Vision for Change, every young person who accesses secondary and tertiary CAMHS is required to have a named Consultant. In the absence of a Consultant, a community CAMHS team ceases to operate at its optimum capacity and is prevented from accepting new referrals. The HSE , on a daily basis, faces significant challenges in recruiting Consultant and NCHD staff for CAMHS.

3.5 The development of resources and capacity to meet the needs of young people in both primary care and in social care and disabilities must be seen as a priority. Mental Health has funded an initiative to recruit 120 Assistant Psychology posts into primary care. This has just received Department of Public Expenditure approval and the recruitment process will now begin. These posts will assist by ensuring that young people whose clinical needs are at primary care level are not inappropriately ending up on secondary care waiting lists due to lack of appropriate assessment and resources.

Appendix I: Tiered Model of Service Delivery



Appendix II: HSE in-patient services and bed capacity (2006 to 2015):

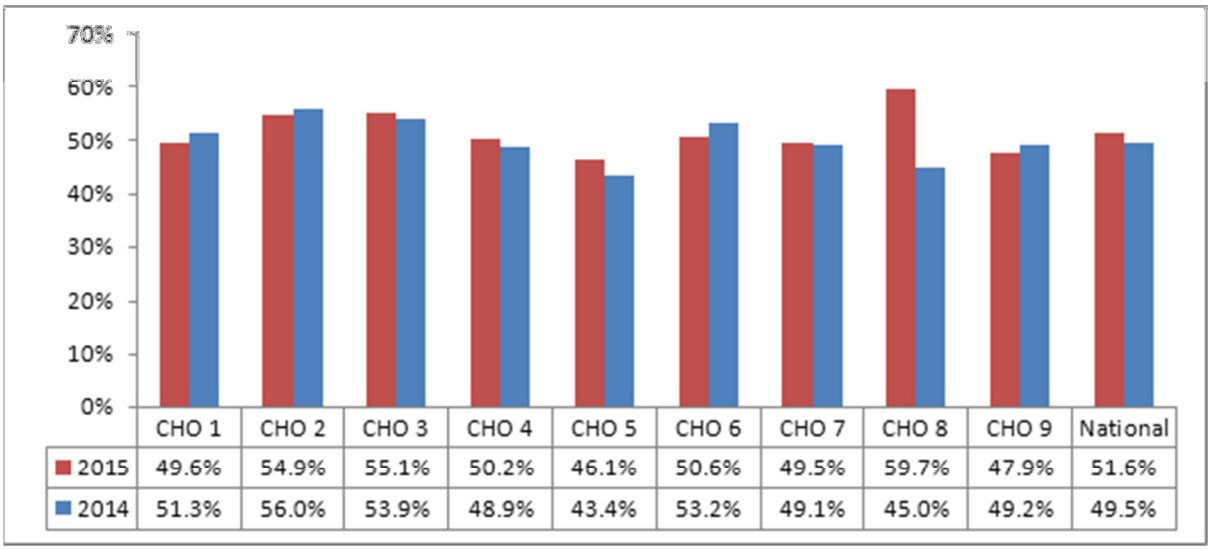
Child & Adolescent In-Patient Units	2006	2009	2011	2013	2014	2015
St. Anne's Inpatient Unit, Galway	6	10				
New Unit, Merlin Park Hospital, Galway			20	20	20	20
Warrenstown Inpatient Unit, Dublin	6	6	6			
Interim Linn Dara Adolescent Unit, Dublin				8	14	
Linn Dara Adolescent Unit, Dublin						24
St. Vincent's Hospital, Fairview, Dublin		6	6	12	12	12
Interim Eist Linn Unit, Cork		8				
Eist Linn Unit, Bessboro, Cork			20	20	20	20
Total No. of Beds	**12**	**30**	**42**	**60**	**66**	**76**

Appendix III: Growth in Community CAMHS Teams Staffing by Profession - 2011 to 2015 (Clinical and Non-Clinical)

	2011	2012	2013	2014	2015	Change +/-
Consultant Psychiatrist	57.69	60.44	60.37	65.39	64.15	6.46
Senior Registrar	19.8	20.6	10.4	13.30	10.70	-9.10
Registrar/SHO	43.49	45.2	47.03	48.58	59.52	16.03
Social Worker	68.01	67.29	72.09	76.47	77.60	9.59
Clinical Psychologist	57.78	57.78	55.75	61.61	66.54	8.76
Nurse	61.33	59.64	68.77	88.37	98.27	36.94
Occupational Therapist	26.7	25.72	50.53	47.99	52.19	25.49
Speech & Language Therapist	29.22	29.72	46.14	51.61	42.61	13.39
Child/Social Care Worker	15.74	12.74	33.54	41.35	41.13	25.39
Other Therapist	9	6.45	6.6	5.70	8.70	-0.30
Administrative Support Staff	75.48	76.36	80.54	79.83	82.54	7.06

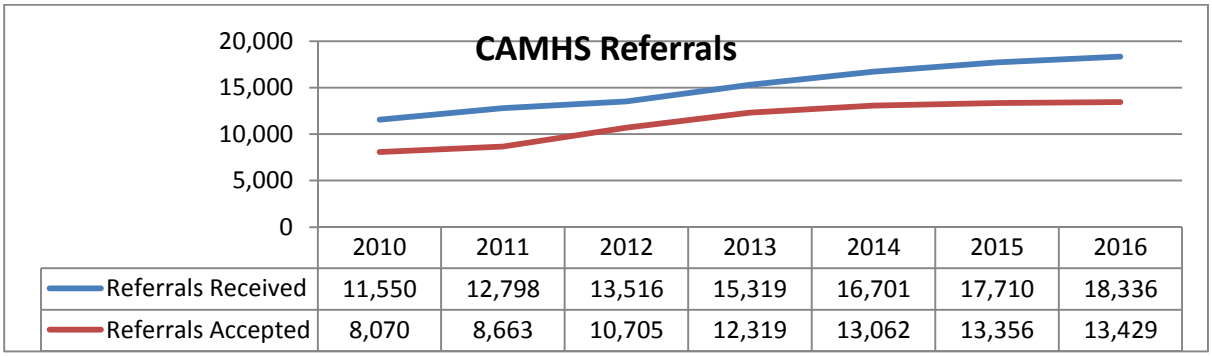
	464.24	461.94	531.76	580.20	603.95	139.71

Appendix IV: Community CAMHS Teams Staffing vs. VFC recommendations in 2014 – 2015 (as a %)



	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9	National
2015	49.6%	54.9%	55.1%	50.2%	46.1%	50.6%	49.5%	59.7%	47.9%	51.6%
2014	51.3%	56.0%	53.9%	48.9%	43.4%	53.2%	49.1%	45.0%	49.2%	49.5%

Appendix V: Referrals to CAMHS (2010 – 2016)



	2010	2011	2012	2013	2014	2015	2016
Referrals Received	11,550	12,798	13,516	15,319	16,701	17,710	18,336
Referrals Accepted	8,070	8,663	10,705	12,319	13,062	13,356	13,429