



**CHILDREN'S
MENTAL
HEALTH
COALITION**

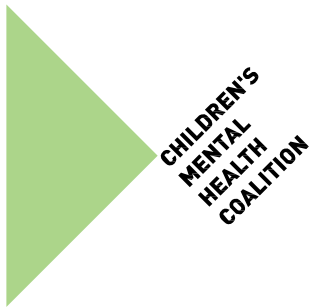


**Meeting the mental health support
needs of children and adolescents:**

a Children's Mental Health Coalition view

Table of Contents

Introduction	2
Gaps identified by the Children's Mental Health Coalition membership	9
Summary of a literature review of national and international good practice	12
Summary of the mapping survey of professionals	21
Recommendations of the Children's Mental Health Coalition	27
Conclusion	30
About the Children's Mental Health Coalition	32
Acknowledgements	33



Introduction

2

The Children's Mental Health Coalition (CMHC) consists of more than 70 members, including representatives from 53 organisations and a number of individual legal experts, practitioners, academics and researchers from a range of backgrounds and sectors, including children's rights, human rights, education and mental health services. Membership of the group is open to organisations and individuals interested in the mental health needs of children and young people.

The CMHC's vision is that Ireland should be one of the best places in the world to be a child, where every child's right to mental health is realised.

The CMHC has advocated for the development of child appropriate mental health services and an end to the inappropriate admission of children and adolescents to adult wards, as well as delivery of the full complement of child and adolescent community mental health teams promised under *A Vision for Change* so that no child is denied timely access to such teams.

As of December 2014 the number of clinical staff in post in community child and adolescent mental health services (CAMHS) was 521.5 whole time equivalents (WTEs). This represents 51.6% of the staffing level recommended in *A Vision for Change* and is a 40.7% increase on the number of clinical staff that were in post in community CAMHS as of September, 2011.

According to the HSE's Performance Assurance Report, at the end of December 2014 the child and adolescent mental health service waiting list had increased to 2,818 cases, an 8% increase on the same period last year. There are 405 children/adolescents, or 14% of the waiting list waiting more than 12 months.¹

By the end of December 2014, there had been 290 child and adolescent admissions, of which 31% (89) were to approved adult mental health inpatient units.²

As part of its 2013 and 2014 work plans, the CMHC has developed this position paper on child and adolescent mental health services (CAMHS) and primary care mental health services for children and adolescents in order to inform the review of *A Vision for Change* due in 2015 and any subsequent policy. As a complement to this process, a brief literature review on good practice in the delivery of children's and young people's specialist and primary mental health services was commissioned and a small-scale survey of professionals involved in children's and young people's mental health services and supports carried out. Together, this evidence base supports the recommendations of the Children's Mental Health Coalition for improving child and adolescent primary care and specialist mental health supports.

Structure of this report

This report is structured in six sections:

- Introduction
- Gaps identified by the Children's Mental Health Coalition membership
- Summary of a literature review of national and international good practice
- Summary of the mapping survey of professionals
- Recommendations of the Children's Mental Health Coalition
- Conclusion

The report is complemented by two appendices: a full version of the literature review and a detailed report of the mapping survey on relationships between existing child and adolescent services and supports in Ireland.

The appendices are available on www.childrensmentalhealth.ie.

Policy context

National policy

A Vision for Change details the government's comprehensive policy framework for improving the mental health of the population, with a timeframe from 2006 to 2016.³ The framework is conceptualised in terms of health promotion and early intervention, primary and community care services, and specialist mental health services for more complex difficulties. *A Vision for Change* is underpinned by a set of principles that apply to all mental health services. Of particular salience within current debates about CAMHS are the principles of coordination, effectiveness, early intervention, equity and quality.

Key principles in *A Vision for Change*

Coordination: Services must be coordinated and integrated to meet the full range of social, psychological and physical care needs of individuals with mental health problems. The structure and organisation of mental health services should facilitate and encourage continuity of care. Seamless mental health services should be available in a continuum stretching from the community at large to primary care and specialist mental health services.

Effectiveness: There must be an evidence-based approach to service development to ensure the highest standard of care and the optimum use of resources. It is important to take a broad definition of evidence and to be inclusive of all knowledge that may help improve mental health services.

Early intervention: The mental health system should be based on the principle of early intervention, through the provision of mental health promotion at all levels of the mental

health framework, and through a focus on early intervention with individuals in mental health services.

Equity: Within the mental health system, resources and services to the population should be provided on the basis of need, using the principle of proportionality ... Mental health resources must be distributed equitably across mental health services.

Quality: Mental health services and the treatment and care offered in them should be of the highest standard.

Chapter ten of *A Vision for Change* sets out recommendations for best practice in the provision of mental health promotion and prevention as well as the delivery of mental health services for children and adolescents.⁴ The recommendations include the following:

- The need to prioritise the full range of mental health services from primary to specialist mental health services
- CAMHS should provide mental health services to children and adolescents aged 0-18 years
- Service users, carers and their families should be given the opportunities to influence developments within mental health services based on their own experiences
- Mental health promotion and primary prevention should be targeted at child populations at risk
- Evidence based mental health promotion programmes should be implemented in primary and post primary schools
- The Social, Personal and Health Education (SPHE) programme should be extended to include the senior cycle, as well as the junior cycle in post primary schools
- The expansion of CAMHS community mental health teams
- Clear links should be developed between CAMHS and community and primary care services
- Development of four inpatient units in Cork, Limerick, Galway and Dublin, with the appointment of fully staffed multi-disciplinary teams

- Early intervention and assessment services for children with autism to include comprehensive multi-disciplinary paediatric assessment and mental health consultation where necessary

A Vision for Change also recommends the development of the following specialist services for children and adolescents:⁵

- An eating disorder team
- A high-secure unit
- 4 substance misuse and dependency teams
- 1 mental health of intellectual disability team per 300K population
- 2 forensic teams

The children's policy framework *Better Outcomes, Brighter Futures*, 2014 includes a commitment under its five national priorities to ensure that children and young people in Ireland achieve mental well-being.⁶ The framework includes specific commitments to:

- Implement *A Vision for Change* as it relates to children and young people, in particular to improve access to early intervention youth mental health services
- Coordinate service supports, with a focus on improving mental health literacy and reducing incidents of self-harm and suicide
- Achieve effective inter-agency workings in mental health service provision, including between TUSLA (the Child and Family Agency) and the HSE
- Strengthen the participation of children and young people in decision-making for health and well-being at community level
- Strengthen transitions between child and adolescent and adult services in the areas of physical and mental health services
- Promote timely assessment and equity of access to appropriate mental health supports, including for young people aged 16 and 17 years

- Achieve a cross-Governmental and multi-agency approach in line with the goals of Healthy Ireland, to seek to improve all aspects of health and wellbeing, and to reduce risk-taking behaviour in children, with a particular focus on promoting healthy behaviour and positive mental health

- Support integrated mental health services at community level
- Train and up-skill professionals across formal and non-formal education settings to be in a position to identify potential mental health difficulties
- Enable hard to reach groups to access mental health services, including a recognition of the high level of children and young people in the care and youth justice system with mental health needs

Prior to the publication of the national children's framework, the *National Children's Strategy 2000-2010* specified that "children will be supported to enjoy the optimum physical, mental and emotional well-being".⁷

The Taskforce on the development of a new Child & Family Support Agency (2012) made a number of recommendations for child and adolescent mental health services.⁸ Most notably, the Taskforce recommended that child and adolescent mental health services should be directly provided by and transferred into the new agency.

The rationale for this recommendation was that:

- There were "significant deficits in access to, and coordination between ... specialist mental health services and other services for vulnerable children and families"
- There is significant shared population between CAMHS and both child protection and youth justice systems
- Some children and adolescents have difficulty accessing the clinic-based services of CAMHS
- "Multidisciplinary working is vital for improving outcomes for children and young people ... Young people with emotional and behavioural difficulties sometimes fall

5 Ibid.

6 Minister for Children and Youth Affairs (2014) *Better Outcomes, Brighter Futures: The National Policy Framework for Children & Young People 2014-2020*, Dublin: Department of Children and Youth Affairs.

7 Department of Health and Children (2000) *National Children's Strategy – Our Children - Their Lives*. Dublin: The Stationery Office.

8 Minister for Children and Youth Affairs (2012) *Report of the Taskforce on the Child and Family Support Agency*, Dublin: Department of Children and Youth Affairs.

between services as they may not require the services of a psychiatrist but would benefit from other interventions offered by CAMHS teams”

- “Determining strict eligibility criteria is not helpful for children as many children with complex needs present with emotional and behavioural difficulties ... locating CAMHS within this broader professional environment would facilitate a more effective response and a better utilisation of the significant expertise in CAMHS”

It is clear both from the Taskforce report and from the more recent children’s policy framework that improving integration of services for vulnerable children and adolescents with mental health difficulties is a priority for government.

The Mental Health Commission’s *Quality Framework* aims to deliver high standards and good practices across all mental health services, incorporating the Mental Health Act Regulations 2001. The *Quality Framework* applies to all mental health services in the public, voluntary and independent sectors and includes mental health services for children and adolescents.⁹ It applies equally to all mental health services irrespective of whether they are being delivered within the service user’s home, community settings, both residential and non-residential, or within in-patient facilities.¹⁰ The Framework sets out standards on access to services and community based services; prevention, early detection, early intervention and mental health promotion; the provision of therapeutic services and programmes; the active involvement of service users through information; access of service users to peer support/advocacy; the provision of accessible mechanisms for participation of service users; a recovery focused approach to treatment and care; and the appointment of quality staff with appropriate skills.¹¹ All of the aforementioned standards apply to services for children and adolescents.

The Framework includes specific criteria for children, including:

- Individual care and treatment plans – Approved centres must adhere to regulation 17 of the Approved Centres Regulations 2006 that each “child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan”¹²
- Choice, rights and informed consent – In the absence of patient consent to treatment, the provisions of Section 61, administration of medicine to a child of the Mental Health Act 2001, must be complied with. “In the case of a child, informed consent is obtained from the parents (either of them), or the legal guardian, or the Courts”. The view of the child should also be taken into consideration¹³
- The Mental Health Commission’s Code of Practice relating to Admission of Children under the Mental Health Act 2001, pursuant to Section 33 (3) (e) of the Act, must be adhered to¹⁴ and
- Family/chosen advocate involvement and support – Specific outcome criteria for child services are as follows: “Parents/guardians are partners in the treatment process; Parents/guardians receive clear information about treatment processes; Follow-up and outreach services are available for parents”.¹⁵

Criticism of CAMHS by the Ombudsman for Children

In December 2007, the then Ombudsman for Children Emily Logan criticised the “continuing use of adult psychiatric wards for the treatment of children, and called for the implementation of the recommendations of A Vision for Change to proceed without further delay.”¹⁶ She explained that mental health issues had been raised with her office by many children and young people across the country. Many young people advised that “they want to have access to information and assistance



9 Mental Health Commission (2007). *Quality Framework for Mental Health Services in Ireland*. MHC, Dublin.

10 Ibid.

11 Ibid.

12 Ibid.

13 Ibid.

14 Ibid.

15 Ibid.

16 Ombudsman for Children’s Office, (2007). *Mental health services for children remain inadequate, stigma prevails*. Retrieved from <http://www.oco.ie/2007/12/mental-health-services-for-children-remain-inadequate-stigma-prevails/>

locally, and that in times of crisis they would like to have a place to go to that is welcoming and non-threatening.”¹⁷

In November 2013, the Ombudsman for Children’s Office once again highlighted the lack of adequate mental health programmes and services to address the mental health of children and their families, in accordance with the concluding observations of the UN Committee on Children in 2006.¹⁸ The report *Child-Friendly Healthcare*, commissioned by the OCO, identified that there is little statutory provision for children’s healthcare or governing healthcare decision-making in Ireland. Further ambiguity is added by the fact that mental health law defines children as those below 18 years of age. As a result, the law does not currently give clear guidance to healthcare professionals about consent for healthcare decisions for children and it provides little support for health professionals seeking to treat children as individual rights-holders.

Complementary national policy

Since 2006 there have been a number of policy developments that complement *A Vision for Change*. In January 2013, the Government’s Action Plan on Bullying: Report of the Anti-Bullying Working Group to the Minister for Education and Skills was published setting out 12 actions for confronting and preventing bullying in primary and post-primary schools.¹⁹ National Procedures on Anti Bullying were launched in September 2013 and are to be implemented in all schools.²⁰

In January 2013, the National Guidelines on Promoting Positive Mental Health and Suicide Prevention in Post-Primary Schools²¹ were published. The Guidelines were developed in response to Action 2.1 of Reach Out: National

Strategy for Action on Suicide Prevention 2005-2014²² and were funded through the National Office for Suicide Prevention (NOSP) and the Department of Education and Skills (DES). The National Guidelines on Promoting Positive Mental Health and Suicide Prevention in Primary Schools were published in January 2015.²³ The publication of the Guidelines was welcomed by the Children’s Mental Health Coalition. However, the Coalition has concerns over the lack of a clear implementation plan for ensuring the Guidelines translate into action. The Coalition has also noted that training and support for schools is needed in order to implement a whole school approach. In addition, the Department of Education needs to assign senior responsibility to ensure that the relationship and referral process between schools and other agencies is developed in a coherent manner.

International policy and law

Under the United Nations Convention on the Rights of the Child (UNCRC) Ireland has an obligation to ensure the mental health needs of all children and young people are adequately met. Article 24 of the United Nations Convention on the Rights of the Child (UNCRC), which was ratified by Ireland in 1992, states that “the State shall recognise the rights of a child to the enjoyment of the highest attainable standard of health and the facilities for the treatment and rehabilitation of health, shall strive to ensure that no child is deprived of his/her right of access to such health care services.”²⁴

The right to access information and material from a diversity of sources, especially those aimed at the promotion of a child’s spiritual and moral well-being and physical and mental health is specifically set out in Article 17 of the UN Convention on the Rights of the Child.²⁵

Furthermore, Article 12 of the UNCRC²⁶ and General Comment 12 on the Right of the Child to

17 Ibid.

18 Killkelly, U. and Savage, E. (2013) *Child-Friendly Healthcare*, Dublin: Ombudsman for Children.

19 Minister for Education and Skills, (2013) *Government’s Action Plan on Bullying: Report of the Anti-Bullying Working Group to the Minister for Education and Skills*, Dublin: Department of Education and Skills.

20 Department of Education and Skills (2013) *Anti-Bullying Procedures for Primary and Post-Primary Schools*, Dublin, Department of Education and Skills. Retrieved from <http://www.education.ie/en/Publications/Policy-Reports/Anti-Bullying-Procedures-for-Primary-and-Post-Primary-Schools.pdf>

21 Department of Education and Skills (2013) *New national Guidelines on promoting positive mental health and suicide prevention in post-primary schools*, Dublin: Department of Education and Skills. Retrieved from www.education.ie/en/Press-Events/Press-Releases/2013-Press-Releases/PR-%202013-%201-%202013.html#sthash.AYibOsfS.dpuf

22 HSE (2005) *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014*. Dublin: HSE.

23 Department of Education and Skills (2015) *New national Guidelines on promoting positive mental health and suicide prevention in primary schools*, Dublin: Department of Education and Skills. Retrieved from <http://www.education.ie/en/Publications/Education-Reports/Well-Being-in-Primary-Schools-Guidelines-for-Mental-Health-Promotion.pdf>

24 United Nations (1989) *Convention on the Rights of the Child*, Geneva: United Nations. Retrieved from <http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>

25 Ibid.

26 Ibid.

be Heard²⁷ guarantees a child's right to express his/her opinions and for such opinions to be taken into account. This explicitly guarantees children's and adolescent's right to participate fully as service users in mental health service provision.

The voice of children on decisions that affect them is further supported in Irish legislation, primarily through the Ombudsman for Children's Act, 2002. Under section 7 of the Act, "the Ombudsman for Children shall establish structures to consult regularly with groups of children that he or she considers to be representative of children"²⁸ for the purposes of promoting the rights and welfare of children. "In consultations under this subsection, the views of a child shall be given due weight in accordance with the age and understanding of the child."²⁹ This will be supported by the first National Strategy on Children and Young People's Participation in Decision-Making, a constituent Strategy of the recently published *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (2014–2020)*. The participation strategy is guided by Article 12 of the UNCRC and builds on the foundations of the National Children's Strategy. The primary goal of the participation strategy is to ensure that children and young people have a voice in their individual and collective everyday lives. This strategy is currently being developed by the Department of Children and Youth Affairs.

The World Health Organisation has published a *Mental Health Action Plan 2013–2020* which promotes evidence-based, culturally appropriate and human rights-oriented mental health services for children and young people.³⁰ The *Action Plan* identifies that children and adolescents with mental difficulties should be provided with early intervention through evidence-based psychosocial and other non-medical interventions based in the community. The *Action Plan* follows the WHO's mental health policy and service guidance

package, 2005³¹ which provides guidance on the development and implementation of a national child and adolescent mental health policy and plan.

On 13th June 2008 an EU mental health conference launched the *European Pact for Mental Health and Well-Being*. The Pact included five priority areas for improving mental health and well-being among EU member states, including mental health in youth and education. Member states are encouraged to take action in the following areas:³²

- Ensure schemes for early intervention throughout the educational system
- Provide programmes to promote parenting skills
- Promote training of professionals involved in the health, education, youth and other relevant sectors in mental health and well-being
- Promote the integration of socio-emotional learning into the curricular and extracurricular activities and the cultures of pre-schools and schools
- Programmes to prevent abuse, bullying, violence against young people and their exposure to social exclusion
- Promote the participation of young people in education, culture, sport and employment

Concluding observations of the UN Committee Against Torture and the UN Committee on Children

In its concluding observations on Ireland in 2006, the UN Committee on Children identified that "children with mental health difficulties still do not access existing mental health programmes and services for fear of stigmatization, and that some children up to 18 years of age are treated with adults in psychiatric facilities."³³ The Committee recommended that Ireland implement

27 UN Committee on the Rights of the Child, (2009) *The Right of the Child to be Heard*, CRC/C/GC/12 (1st July 2009). Retrieved from <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf>

28 Government of Ireland, *Ombudsman for Children Act, 2002*, Dublin: Government of Ireland. Retrieved from <http://www.irishstatutebook.ie/pdf/2002/en.act.2002.0022.pdf>

29 Ibid.

30 World Health Organisation (2013). *Mental Health Action Plan 2013-2020*. WHO, Geneva. Retrieved from http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

31 World Health Organisation. (2005). *Mental Health Policy and Service Guidance Package: CAMH policies and plans*. WHO, Geneva.

32 EU, (2008) *European Pact for Mental Health and Well-Being*, Brussels: EU.

33 Committee on the Rights of the Child, *Consideration of Reports Submitted by States Parties under Article 44 of the Convention Concluding Observations: Ireland, CRC/C/IRL/CO/2* (29 September 2006). Retrieved from http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fIRL%2fCO%2f2&Lang=en

the recommendations in A Vision for Change, undertake awareness-raising and sensitization campaigns to prevent stigmatization, ensure that focus is given to early intervention programmes, and continue its efforts to ensure that children with mental health difficulties benefit from specific services designed for children under 18 years of age.³⁴

In 2011, the UN Committee Against Torture recommended that Ireland review its Mental Health Act of 2001 in order to ensure that it complies with international standards. The Committee raised concerns about the detention of individuals, including children and adolescents under the current mental health legislation.³⁵

34 Ibid.

35 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Consideration of reports submitted by States parties under article 19 of the Convention Concluding observations of the Committee against Torture: Ireland*, CAT/C/IRL/CO/1 (17th June 2011). Retrieved from <http://humanrights.ie/children-and-the-law/un-committee-against-torture-considers-ireland/>

Gaps identified by the Children's Mental Health Coalition membership

Issues arising from the Children's Mental Health Coalition Mental Health Services Subgroup

The Mental Health Services Subgroup of the Children's Mental Health Coalition met three times between August 2013 and November 2013. These meetings focussed on identifying issues and gaps in existing children's and young people's mental health services and supports and their configuration. The subgroup felt that it was important that their focus went beyond the specialist child and adolescent mental health services (CAMHS) to cover the wider range of mental health supports from primary care and community supports through to intensive, specialist mental health services. This chapter describes the issues and gaps in current mental health services and supports for children and young people in Ireland articulated by the subgroup.

Integration of services

Subgroup members acknowledged that seamless service delivery is essential to best meet the mental health needs of children and young people. They noted that a key challenge to providing high quality, accessible mental health services and supports is inadequate interagency communication and collaboration. This challenge exists within services and between mental health and primary care services as well as between health and TUSLA services. In particular, concern was expressed that CAMHS is not under the remit of the Child and Family Agency and that there are negative implications of this in terms of communication and collaboration.

Members said that there is a lack of clarity around the future configuration of primary care and mental health services and around the interface between the two. Anecdotally it appears that there is variable access to mental health services through primary

care. Some CAMHS only accept referrals through a medical professional while others do not require a medical referral. In addition, it appears that some children who could be managed in primary care are ending up in CAMHS due to a shortage of primary care psychologists.

Overall, members described a lack of clarity among stakeholders around the specific roles and functions of key services such as Child and Adolescent Mental Health Services (CAMHS) and the National Educational Psychological Service (NEPS) and the relationships between them. Members agreed that better communication and integration working is necessary and noted that this will require leadership. While the appointment of the National Directors for Mental Health and Child and Family Services was welcomed, the need for clarity around interagency working and associated protocols was emphasised. A suggestion was made to explore effective models for facilitating relationship-building between agencies, such as the Advanced Nurse Practitioner role in West Cork Mental Health Services. The potential of the Children's Services Committees for promoting interagency communication and cooperation was also noted. Clarification of the role of Children's Services Committees in this respect and of Committee membership was considered necessary by subgroup members.

Additional barriers to service integration were identified as the non-alignment of HSE catchment areas, Local Authority catchment areas and Child and Family Support areas. In addition, it was noted that services may be reluctant to work together due to competition for scarce resources. CAMHS resources, for example, are allocated on the basis of face-to-face contacts; liaison work with schools is therefore not reflected in its performance monitoring.

Particular challenges for CAMHS

Particular challenges identified for CAMHS centred on waiting times, the availability of secondary and tertiary mental health supports and staff shortages.

Members said that young people in distress need immediate care and therefore waiting lists to access CAMHS are a significant barrier to young people receiving appropriate and timely care. Subgroup members noted that case prioritisation occurs as a result of staff shortages in CAMHS. This means that non-acute cases can be required to wait untreated for lengthy periods, as long as two years in some areas. Subgroup members noted the uneven provision of community support services across the country, which means there can be few lower level support options to which CAMHS can refer. A challenge also exists in that there is no one person or agency responsible for caring for young people while they are on a waiting list.

Members noted that long waiting lists to access CAMHS can dissuade young people from accessing the service and can also mean increased rates of “did not attend” (DNAs), further straining CAMHS. Stigma around accessing CAMHS was also noted as a potential barrier for young people. The need for CAMHS to be more child and adolescent friendly was therefore suggested.

The need for accessible, lower-level family support

The lack of lower-level community supports for children, young people and their families represents another issue identified by the subgroup. Many children, young people and their families require low-level on-going support, but this is in short supply and proves difficult to find and access nationally. There is therefore a need for clarity around family support networks and pathways.

Counselling services for children and adolescents

The subgroup members noted that there is no national counselling service for children and adolescents. In addition, community counselling services are unevenly distributed and difficult to identify. The former Family Support Agency (now the Child and Family Agency) funds some counselling services but these tend to be located in more urban areas with rural areas being neglected. Crisis counselling and youth-friendly counselling are particularly sparse. It was further noted that it

can be difficult to get adolescents to approach their GPs in the first instance to access counselling; when they do, it can be difficult to get them to commit to weekly sessions. Members noted the potential of digital technologies to provide help and support, but that this area requires standards and regulation.

Members pointed to the value of low-level early interventions, such as crisis counselling at The Base Youth Centre. The Jigsaw model was noted as having good outcomes where implemented, but it is unclear whether the model would be replicable in all areas of the country.

Members were of the opinion that children and adolescents should be able to access an educational psychologist through NEPS if referred by the school. Members thought that teachers are not always sure about an appropriate course of action when a difficulty is identified for a particular student. The issue of training in this area and practical, solution-focussed advice for teachers was raised. The need for consultation models between specialist services and schools and voluntary groups was further noted. Some schools are providing counselling to students from their own funds.

The subgroup members said that it is essential that any national counselling service would be open to referrals for young people with a dual diagnosis of a mental health issue and substance misuse.

Mental health issues among children under 13 years of age

Some members said that teachers have been noticing an increase in depression among eight to ten year-olds, making children’s mental health a larger issue for primary schools than it had been. It is often teachers and parents who must initially respond to complex difficulties, but schools may have limited ability to respond given that teachers and principals cannot refer directly to CAMHS. There is a reported lack of psychologists in schools. Numbers of Special Needs Assistants have also been reduced. Training for teachers is required in how to respond where they perceive that a child has a mental health difficulty. It was also noted that mental health policy should address supporting teachers and schools in responding to mental health difficulties among children. It was suggested that principals be given the authority to refer children directly to CAMHS.

Children must have a diagnosis and be active in the mental health services in order to access support services such as Special Needs Assistants. The subgroup queried whether or not mental health issues should be considered a special need. In addition, the necessity of a diagnosis was identified as problematic as it places children within a medical model of treatment which is not recovery-oriented. These requirements are also exclusionary to children who may require access to specialist resources but do not have a diagnosis of a mental health issue or intellectual disability, leaving these children and their families without appropriate support.

The subgroup identified the need for clear guidelines from government for schools on promoting mental health along with training to enable those working in schools to identify children with potential mental health issues and equip them with practical, solution-focused advice.

It was also noted that early intervention teams are in place in some schools and are effective.

Dual diagnosis (mental health and substance misuse)

Members highlighted how, in their experience, many mental health services will not accept referral or treat young people with a dual diagnosis of a mental health issue and substance misuse, yet community services such as The Base Youth Centre are seeing numerous such presentations. Typically mental health and substance misuse issues are being treated separately by different services. This means that underlying issues may not be addressed. Young people presenting to The Base Youth Centre with such issues tend to be in the 15 to 22 years age range, some of whom are outside the remit of CAMHS. When these young people are not accepted by mental health services, the burden of providing support can fall on youth workers who may not have the necessary skills to deal with these issues and to “hold” the young person.

Members also noted that existing addiction services are not well-equipped to deal with the misuse of substances other than heroin. This is problematic as national prevalence rates show that young people tend to present with cannabis use more frequently than with heroin use. Specialist services that exist to deal with substance abuse, including cannabis, namely SASSY (Substance Abuse Service Specific to Youth) and YoDA (Youth Drug

and Alcohol service), tend to be located in Dublin. These services do work closely with CAMHS. Anecdotally it appears that these services accept referrals from outside of Dublin. However, there is a gap in information about dual diagnosis services for young people outside of Dublin and whether or not provision is consistent throughout the country.

Children and adolescents from ethnic minority groups

The subgroup members noted that the aforementioned barriers to services and supports can be more challenging for some children and young people in specific circumstances, and that children and young people from different ethnic backgrounds are one such group. Accessing services is very difficult for young people going through the asylum-seeking process. These young people can experience high levels of Post-Traumatic Stress Disorder and specialist services are scarce, with SPIRASI in Dublin being a noted exception.

The subgroup noted that mainstream services are not ready to deal with children from different ethnic minority groups.

Conclusion

Key issues identified by subgroup members have been outlined above. In particular, issues around communication and collaboration between agencies and services have emerged as barriers to the provision of seamless mental health services and supports for children and young people. The lack of lower-level, community-based supports was identified as leading to greater pressure being put on CAMHS. Specific issues were also identified for particular services and for particular vulnerable groups of children and young people, including those with dual diagnosis of mental health and substance misuse difficulties, those from ethnic minority communities and those who do not meet the current diagnostic criteria for treatment in CAMHS.

Summary of a literature review of national and international good practice

Background to the literature review

A brief literature review was commissioned by Mental Health Reform (MHR) to provide the Children's Mental Health Coalition (CMHC) in Ireland with an overview of some of the findings from recent national and international research on good practice in the delivery of child and adolescent mental health services, including primary care.

Lorna Kerin³⁶ was contracted as an independent research consultant to conduct the literature review, synthesise the findings and write a report. The purpose of the literature review was to inform the CMHC's development of recommendations for improving the mental health system for children and adolescents.

Structure of the literature review

The literature review is divided into three sections which cover the three main tiers of CAMH services in Ireland. Each section contains an executive summary and a detailed discussion of key messages identified in the literature. The report has a total of twenty-four key messages.

Section 1 contains eight key messages synthesised from the literature reviewed about good practice in the integration of child and adolescent mental health services into primary care, or Tier 1 CAMH services.

Section 2 contains eight key messages synthesised from the literature reviewed about good practice in the delivery of community-based, multidisciplinary services, known as Tier 2 CAMH services.

Section 3 contains eight key messages synthesised from the literature reviewed about the delivery of specialist services including inpatient care for children and young people with complex, acute mental health needs, known as Tier 3 CAMH services.

An overview of current Child and Adolescent Mental Health Services in Ireland is given here, along with the Executive Summary findings from the three sections mentioned above, and a summary of the twenty-four key messages on good practice in the delivery of CAMHS.

Research Methodology

The methodology chosen for this review was a 'quick scoping review' which is a relatively new but increasingly common approach for mapping broad topics in short timeframes³⁷. The benefit of a quick scoping review³⁸ is that a rapid overview of research can be undertaken to provide a summary of what the evidence indicates. However inherent limitations of this methodology are that scoping reviews are not systematic due to time constraints, search sources are limited to a couple of journal databases, and research is mapped providing only simple description with limited analysis³⁹.

Current Child and Adolescent Mental Health Services (CAMHS) in Ireland – Staffing, Service, Need & Structure

The term 'CAMHS' in Ireland refers specifically to the HSE Child and Adolescent Mental Health

36 Lorna Kerin (BA, H.Dip Psych., MCAT) is a qualified Social Researcher since 1995 and a member of SRA, IEN and CRNINI. Lorna specialises in evidence-informed interventions to develop child and youth wellbeing. See ie.linkedin.com/in/lornakerin

37 Alexandra Collins, James Miller, Deborah Coughlin and Stuart Kirk. (2014). *The Production of Quick Scoping Reviews and Rapid Evidence Assessments: A How to Guide*. The Joint Water Evidence Group (Beta Version 2), DEFRA.

38 Miler, J. (2012.) *Guidance document for the production of quick scoping reviews and rapid evidence assessments* (Beta Version 8), DEFRA.

39 Ibid.

Services that work to provide specialist mental health treatment and care to children and young people *“with the most severe and complex problems and with other services engaged with children and young people experiencing mental health problems.”*

Mental health services are offered either as an outpatient community mental health service or through inpatient services. The CAMHS Community Mental Health Teams (CMHTs) are staffed by multi-disciplinary professionals, led by a consultant psychiatrist. In 2013 CAMHS in Ireland consisted of 60 community teams, 3 day hospital teams and 3 paediatric hospital liaison teams staffed by 531 whole-time staff working with 17,116 children and adolescents.

There is increasing demand for CAMHS in Ireland with 2,541 children and adolescents waiting to be seen at the end of September 2013, which represented an increase of 24% from the total number waiting at the end of September 2012 (2,056).

This demand for child and adolescent mental health services, along with the need for youth specific mental health services aged 14-24, can reasonably be expected to increase, as evidenced by the latest findings from the first report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group Dublin at the Royal College of Surgeons in Ireland⁴⁰:

By the age of 13 years, 1 in 3 young people in Ireland is likely to have experienced some type of mental disorder. By the age of 24 years, that rate will have increased to over 1 in 2.

The experience of mental ill-health during adolescence is a risk factor for future mental ill-health and substance misuse in young adulthood, and is associated with an increased risk of unemployment during early adult years.

High numbers of young Irish adults aged 19-24 years are engaged in the misuse of alcohol and other substances, with over 1 in 5 meeting criteria for a diagnosable substance use disorder over the course of their lives.

Significant numbers of young people are deliberately harming themselves and by the age of 24 years, up to 1 in 5 young people will have experienced suicidal ideation. Many of the recommendations of *A Vision for Change* concerning inpatient services, mental health intellectual disability teams, substance misuse, eating disorder and forensic services for young people remain yet to be implemented.

CAMHS Delivery Structure

Current CAMHS delivery in Ireland is best conceptualized in the following three tiered model.

Tier 1 Services (CAMHs in Universal and Primary Care Services)

Tier 1 child and adolescent mental health services (CAMHs) are community based services that provide a first line of response if children or young people start to show mild mental health difficulties that cause minimal or occasional distress, without significant risk of harm. Resources such as information, advice, general support and simple medical or psychosocial interventions are offered to the child, young person, family, carers and wider community.

Tier 1 CAMHs include teachers, school counselling, school attendance, social work, childcare, residential care, child protection, speech & language therapy, community occupational therapy, educational psychology, clinical psychology, community psychology, area medical officers and public health nursing, and early intervention services for children with developmental delay.

According to the draft iCAMHS guidelines, it is the role of Tier 1 services to *“identify when a child or young person needs more specialist mental health care, and to make the appropriate referrals or ask for specialist advice or support.”*⁴¹

40 Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I (2013). *The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL)*. Royal College of Surgeons in Ireland, Dublin.

41 CAMHS Specialist Child and Adolescent Mental Health Service Advisory Group (2013). *Irish Child & Adolescent Mental Health Service (iCAMHS) National Quality Guidelines Document*. Unpublished draft pending HSE approval and progression since October 2013.

Referrals to CAMHS in Ireland must be made through General Practitioners (GPs) who are currently the interfacing primary care service between Tier 1 services and specialist Tier 2 CAMHS. According to the draft iCAMHS guidelines it is the role of GPs *“to recognize risk factors for mental health disorders, to provide treatment or advice where appropriate, and to refer to more appropriate community care personnel or specialist services when this is indicated”*.

A central finding of this literature review is that there is an **urgent need to build capacity of the primary care sector** to respond effectively to children and adolescents at risk of mental health problems. Additionally **clear pathways of collaboration and referral** need to develop between mental health services (Tier 2 and Tier 3 CAMHS) and primary care/community resources (Tier 1 CAMHS) to coordinate appropriate service provision for children and adolescents at risk of mental health problems. These and other findings are more fully discussed in Section 1 of the full report.

Tier 2 Services (Community or Outpatient Specialist CAMHS)

This is the first line of specialist services for children and young people with mental health problems in Ireland. Children/young people are assessed by a multidisciplinary Community Child and Adolescent Mental Health team, under the clinical direction of a consultant child and adolescent psychiatrist. This community CAMHS should be multidisciplinary to ensure that children and adolescents are offered care and treatment for complex problems that require a range of disciplines, skills and perspectives. The multidisciplinary team should include junior medical staff, two psychologists, two social workers, two nurses, a speech and language therapist, an occupational therapist and a child care worker. According to the draft iCAMHS guidelines *“the assessment and intervention provided by such a team is determined by the severity and complexity of the presenting problem(s)”*.⁴²

A central finding of this literature review is that families find it **difficult to access community CAMHS in Ireland** due to a lack of information,

restrictive referral criteria and pathway, lengthy waiting periods and a lack of out of hours/crisis service. There also appears to be a lack of **standardized outcome monitoring** and a **lack of published, service quality guidelines**. These and other findings along with recommended good practice to increase equitable access to **evidence-informed** CAMHS is identified and discussed in more detail in Section 2 of the full report.

Tier 3 Services (Inpatient CAMHS)

This is the second line of specialist services for children and young people with mental health problems in Ireland. This comprises of intensive community based care and inpatient care through specialist mental health inpatient services. Tier 3 services provide specialist mental health services for those children and adolescents who have complex and severe mental health problems, and/or who are at high risk of harm.

A central finding of this literature review is that there is a **lack of service user and outcomes based research** on the experiences of children and young people attending Tier 3 services. One study documents concerns about **lack of local services, the long waiting list, the stigma of attending psychiatric wards, and the distress and isolation** experienced by young people placed on adult or paediatric wards.⁴³ Section 3 of the full report details this research and discusses the **good practice need** to provide timely referral, assessment and access procedures to safe, developmentally appropriate care in a supportive environment, and to incorporate young people’s and their families’ views into service planning and delivery.

Tier 4 Services (UK & Northern Ireland)

There are four tiers to CAMHS in the UK and Northern Ireland. The extra capacity appears to be at Tier 2 which consists of individual practitioners offering interventions for mental health problems at early intervention stage and supporting universal and primary care services to respond to the mental health needs of children and young people in their care.

42 CAMHS Specialist Child and Adolescent Mental Health Service Advisory Group, (2013), *Irish Child & Adolescent Mental Health Service (iCAMHS) National Quality Guidelines Document*. Unpublished draft pending HSE approval since October 2013.

43 Buckley, S et al (2012). *Mental health services: the way forward. The perspectives of young people and parents*. St Patrick’s University Hospital, Dublin.

The difference between CAMHs and CAMHS

A wide range of statutory, community and voluntary services also support the mental health of children and adolescents so for the purposes of this literature review, the term ‘child and adolescent mental health services’ or ‘CAMHs’ will refer to the provision of these community-based and primary care services and the term ‘CAMHS’ will refer to the HSE specialist services.

Executive Summary Findings on CAMHs in Primary care, Community CAMHS & Inpatient CAMHS

The literature review is divided into three sections to reflect the three tiers of Child and Adolescent Mental Health services (CAMHs) currently delivered in Ireland through primary care settings (Tier 1), specialist CAMHS services in the community (Tier 2) and inpatient CAMHS (Tier 3) for complex/acute mental health needs. This Executive Summary condenses the findings contained in the report as per section.

Executive Summary of Section 1: CAMHs in Primary Care

Section 1 of this report reviews the national and international literature on good practice in the delivery of **CAMHs (Tier 1) in primary care settings**. The overall recommendation is to build capacity in primary care services to effectively prevent, detect and appropriately treat child and adolescent mental health difficulties and disorders. Key messages include the following: The delivery of child and adolescent mental health services in primary care settings is **internationally acknowledged best practice**⁴⁴. Along with the family home and the school, primary care provides an accessible, non-stigmatising community setting to prevent, detect, treat and support child and adolescent mental health issues. The psychiatric literature evidences the ‘primary care advantage’ of a trusting, longitudinal relationship between the service provider and family as a therapeutic alliance that predicts both engagement and *“favourable care outcome over and above any specific treatment including medications.”*⁴⁵

44 The World Health Organisation. (2008). *Integrating Mental Health into Primary Care: A Global Perspective*. WHO, Geneva.

45 Meschan, J. (2010). *Enhancing Pediatric Mental Health Care: Algorithms for Primary Care*. American Academy of Pediatrics Task Force on Mental Health.

Internationally, there is a problem of **high prevalence rates yet low rates of detection and treatment** of mental health disorders among children and young people in primary care services. Findings from the most recent epidemiological study⁴⁶ in Ireland is that young Irish adolescents in the 11-13 year age range have higher current rates of disorder (15.4%) than similarly-aged young adolescents in both the USA (11.2%) and the UK (9.6%). However there appears to be a significant **lack of data and research** on child mental health presentations in primary care settings in Ireland, which is problematic for responsive service planning, workforce training, effective delivery and rigorous evaluation.

Adequate **financial and human resource investment** is one of the key ‘non-negotiable’ conditions critical to ensure successful integration of first line mental health services into primary care. Primary care clinicians must be reimbursed for the investment of their time on restructuring services to encompass child mental health, as well as their time spent in the development of collaborative clinical relationships with mental health specialists⁴⁷. The **lack of reimbursement** of GPs in Ireland for their participation in the current Irish shared care system⁴⁸ is identified in the literature as a fundamental barrier, among others, to the efficacy of an accessible, collaborative model that could improve child and adolescent mental health services in primary care⁴⁹.

The literature highlights the need for **collaborative engagement** with key stakeholders to build primary care service capacity to respond effectively to child and adolescent mental health needs. Good practice service examples identified in Ireland include ‘Ready, Steady, Grow’, an area-based infant mental health strategy in Ballymun, Dublin and ‘Jigsaw’, a national youth mental health systems-change initiative with service delivery in ten communities to date. International good practice service examples

46 Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I. (2013). *The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group*. Dublin: Royal College of Surgeons in Ireland.

47 American Academy of Pediatrics, Task Force on Mental Health. (2007). *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit*. Elk Grove Village, IL: American Academy of Pediatrics.

48 The Irish College of General Practitioners. (2011) *Primary Care Teams - A GP Perspective*. ICGP, Dublin.

49 American Academy of Pediatrics Task Force on Mental Health. (2009). *Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration*. Pediatrics. 2009;123(6):1611.

identified include the regional initiative in Ontario, Canada where over 200 'Family Health Teams' have embedded an inter-professional, collaborative team approach to primary care, and a local initiative in the urban area of Macul, Chile where existing resources were leveraged to establish a multidisciplinary family health clinic with a particular focus on child and adolescent mental health.

It is a critical necessity to **support primary care providers through access to specialist mental health staff**. Structures to enable this include facilitating primary care access to specialised mental health consultation, co-location of mental health staff in primary care settings, the creation of 'Tier 2' primary mental health care workers and appropriate training programmes for primary care providers in child and adolescent mental health.

Finally, international evidence-informed **good practice guidelines** on the assessment, diagnosis and treatment of children and young people in mental health distress are available from the World Health Organisation, the American Academy of Pediatrics Task Force on Mental Health, and the National Institute for Clinical Excellence in the UK. Irish guidelines for GPs on the diagnosis and referral of child and adolescent mental health in primary care settings have also been issued by the Irish College of Practitioners (ICGP).

Executive Summary of Section 2: Community CAMHS

Section 2 of the report reviews the national and international literature on good practice in the delivery of **specialist CAMHS (Tier 2) in community settings**. The overall recommendation is to ensure accessible, community based, evidence-informed and outcomes-monitored child and adolescent mental health services. Key messages include the following:

There is a clear social, economic and rights based **imperative to provide fully accessible CAMH services** to children and adolescents. A key standard of the Mental Health Commission's Quality Framework for Mental Health Services in Ireland is that *"mental health services must be accessible in the community"* and that *"quality service is dependent on access to that service"*.⁵⁰

However **many factors predict successful service access and engagement**⁵¹ and these present challenges at policy, service and provider level.⁵²

It appears that **accessing CAMHS (Tier 2) is challenging for families in Ireland** due to a *'knowledge deficit, a lack of information and a limited availability of specialist services'*.⁵³ Concern is expressed about the restrictive referral criteria to access community based CAMHS, the lengthy waiting period, and the lack of information about what to do during the waiting period. *"A total of 2,541 children and adolescents were waiting to be seen at the end of September 2013. This represented an increase of 485 (24%) from the total number waiting at the end of September 2012 (2,056)."*⁵⁴

International and national **good practice guidelines advise** on how to remove barriers to timely access, to inform and support service users through the referral and waiting list process and how to enable equitable service access. This includes the provision of clear and easily accessible service information.

Irish research evidence indicates that digital media could be a particularly effective communication channel to disseminate service information.⁵⁵

Equitable access to CAMHS is facilitated by a range of **local service referral pathways** for needs based assessment and possible CAMH service. The current **restrictive referral criteria in Ireland** where only a medical doctor can refer a child or young person to CAMHS is flagged as highly problematic in terms of equity of access. Recent Irish research indicates that *"many young people experiencing mental health problems do*

-
- 51 Garland, A. et al (2013). *Improving Community-Based Mental Health Care for Children: Translating Knowledge into Action*. *Adm Policy Ment Health*. 40(1): 6–22.
- 52 World Health Organisation. (2005). *Mental Health Policy and Service Guidance Package: CAMH policies and plans*. WHO, Geneva.
- 53 Coyne, I. et al (2014). *Adolescents and parents' experiences of attending child and adolescent mental health services (CAMHS) in Ireland: The report*. TCD, Dublin.
- 54 Health Services Executive (2014). *Fifth Annual Child and Adolescent Mental Health Service Report*. HSE, Dublin.
- 55 Millward-Browne, L (2009). *Young People and Mental Health: A National Survey*. Dublin. National Office for Suicide Prevention.

*not consult with their GP*⁵⁶ and that young people in Ireland may be “*least likely to seek help from a GP*”.⁵⁷ The Choice and Partnership Approach in the UK and Australia is cited as a good practice example CAMH service model that is needs based and that enables early access through referral relationships between CAMHS and other child and family service agencies.

Clear, accessible routes to ‘**out of hours**’ and ‘**crisis**’ CAMHS is also described in Irish and international guidance as essential to facilitating access to CAMHS. However Irish guidance for GPs on referrals to CAMHS⁵⁸ along with the documented views of service users and family members⁵⁹ indicate that the lack of ‘out of hours’ crisis CAMHS services, lack of standardized services, and lack of clarity about what age to refer adolescents to paediatric versus adult services is affecting both the equity and accessibility of mental health services for children and young people in Ireland. **Good practice guidelines** on the provision of ‘crisis’ CAMHS have been developed by the Quality Network for Community CAMHS Standards (2011, UK)⁶⁰ and are offered here as sample good practice.

Facilitating **children’s, young people’s and their families’ participation** in service design, care plan delivery and service evaluation is also detailed as critical to good practice in the literature, as is the need to ensure **vulnerable children and young people** at higher risk of mental health difficulties are targeted and included in CAMHS service provision. Evidence informed guides and examples of good practice from the UK are cited in the full review, including good practice in-service provision for children and young people with learning disabilities.

The importance of the provision of **evidence-informed CAMH services** to ensure children and young people can access quality CAMHS is

discussed. Good practice guidelines and findings from the newly developing field of implementation science include fostering CAMHS organisations that are conducive to change through leadership, addressing the inevitable organisational resistance to change and supporting practitioners to access the evidence base and to engage in reflective practice.

A **quality improvement process** is essential good practice for CAMHS to measure whether “*services increase desired mental health outcomes and whether they are consistent with current evidence based practice*”. There is promising international evidence that “**outcome monitoring systems**” demonstrate a positive impact on treatment effectiveness and efficiency for child/family mental health services.

However it appears that the **effectiveness of CAMHS treatment or intervention is not being routinely measured** in Ireland. Although the specialist, multidisciplinary CAMHS advisory group developed operational guidelines based on the Mental Health Commission’s Quality Framework, these draft guidelines were sent to the HSE for approval and progression over a year ago in October 2013 and have not yet been progressed. This **lack of documented quality guidelines for CAMHS** in Ireland is not aligned with good practice in the provision of CAMHS as advised by the World Health Organisation⁶¹.

Executive Summary of Section 3: Inpatient CAMHS

Section 3 of the full report recommends that children and young people with complex or acute mental health difficulties need accessible, developmentally appropriate specialist inpatient services, along with local, evidence-informed, alternative services that meet their complex needs.

Children and young people have a right to access levels of healthcare that are appropriate to their needs.⁶² In Ireland ‘Tier 3’ CAMHS provide intensive community based care and specialist mental health inpatient services for children and adolescents who have complex and severe mental health problems,

56 Buckley, S et al (2012). *Mental health services: the way forward. The perspectives of young people and parents*. St Patrick’s University Hospital, Dublin.

57 Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I (2013). *The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group* Dublin: Royal College of Surgeons in Ireland.

58 O’Keefe et al (2013). *Child and Adolescent Mental Health Diagnosis and Management*. CAMHS Quality in Practice Committee, Irish College of General Practitioners (ICGP), Dublin.

59 Buckley, S et al (2012). *Ibid*.

60 Barrett et al (2011). *Quality Network for Community CAMHS Service Standards*, 3rd Ed. 2011. QINMAC. The Royal College of Psychiatry, London.

61 World Health Organisation (2005). *Mental Health Policy and Service Guidance Package*: CAMH policies and plans. WHO, Geneva.

62 Mental Health Commission (2007). *Quality Framework for Mental Health Services in Ireland*. MHC, Dublin.

and/or who are at high risk of harm.⁶³

There is a **stark lack of service user and outcomes based research** on the experiences of these children and young people attending Tier 3 services in Ireland and whether their needs are being met. Buckley et al (2012) report young service users' and some parents' concerns about the lack of local services, the long waiting list, the stigma of attending psychiatric wards and the distress and isolation that has been experienced.⁶⁴ The report recommends the need to provide accessible, appropriate, de-stigmatised care in a supportive environment, and to incorporate young people's views into service planning and delivery.

Good practice in CAMHS inpatient care identified⁶⁵ includes **timely referral, assessment and access procedures to inpatient services**. Inpatient bed provision should be based on a needs assessment and gaps should be identified through monitoring referral outcomes. Children and young people should not be placed inappropriately in adult or paediatric wards as this may expose them to safety and health risks and care may not be effective in meeting their needs. If emergency beds are not available, there must be clear service protocols for community CAMHS to follow and children who are initially placed in adult wards must be swiftly transferred to appropriate services.

However the literature notes that inpatient services are not necessarily the most effective environment for managing children and young people with complex mental health needs.⁶⁶ Good outcomes result when there is better access to inpatient services along with the delivery of more **locally-based services, with multi-agency collaboration**. Additional and/or **alternative CAMH services** are also essential to meet children's and young people's complex mental

health needs and there is significant evidence from the UK and the USA for the efficacy of a number of approaches.

Relationship building with the child or young person with complex needs is associated⁶⁷ with the effectiveness of service delivery. This has service implications in terms of ensuring adequate time, staff support, supervision, flexibility and interagency collaboration to develop recovery-focused relationships that meet the complex mental health needs of children/young people at their changing developmental stages.

Specific CAMH care pathways need to be developed for vulnerable groups of children and young people who have complex needs, such as children and young people with **learning disabilities**, who have far higher rates of mental health problems. However *"there is currently no recognised, fully staffed team forchildren with mental illness and learning disability"*⁶⁸ in Ireland despite the clear recommendations in *A Vision for Change*. An evidence-informed good practice guide from the CAMHS Evidence Based Unit in the UK on **developing a care pathway** is described.

Good practice on **managing the transition from CAMHS to adult mental health care** is recommended however the literature notes that the current cut off of a young person from the CAMH service based on age is highly problematic⁶⁹. National epidemiological research evidences the public health crisis of acute youth mental ill-health and recommends a **youth-specific specialist mental health service** which could better target care for young people aged 12 -25. McGorry recommends including *"access to integrated mental health care, substance use and vocational-recovery services"*.⁷⁰ Purcell et al note this is *"an urgent and achievable goal if we are to deliver appropriate, acceptable, and effective care in the*

63 In 2012 there were 438 admissions of children and adolescents up to the age of 18 years to inpatient units in Ireland, according to the HSE 2013-2014 CAMHS service report.

64 Buckley, S et al (2012). *Mental health services: the way forward. The perspectives of young people and parents*. St Patrick's University Hospital, Dublin.

65 Quality Improvement Network for Multi-Agency CAMHS (QINMAC) & Quality Network for Inpatient CAMHS (QNIC). *Improving access to inpatient CAMHS and appropriate alternatives* (2010). The Royal College of Psychiatrists, London.

66 Green J, Worrall-Davies A (2008). *Provision of Intensive Treatment: inpatient Units, Day Units and Intensive Outreach*. Pp. 1126- 1142 In: Rutter's Child and Adolescent Psychiatry, 5th edition. Edited by Rutter M. et al. Blackwell Publishing.

67 Kurtz, Z (2009). *The Evidence Base to Guide Development of Tier 4*. National CAMHS Support Service, Dept. of Health, UK.

68 Irish College of Psychiatrists. (2013). *Pre Budget 2014 Submission Re Mental Health Services*. ICP, Dublin.

69 Singh et al. (2010). *Process, Outcome and Experience of Transition from Child to Adult Mental Healthcare: A Multiperspective Study*. British Journal of Psychiatry.

70 McGorry, P.D. (2007) *The specialist youth mental health model: Strengthening the weakest link in the public mental health system*. Medical Journal of Australia, 187(Suppl. 7), 53-56.

*twenty-first century.*⁷¹ The Orygen Youth Project (OYP) in Australia is cited as a good practice service example.

Summary of 24 Key Messages on Good practice in the Delivery of CAMHS

The following key messages have been extracted from the national and international literature on good practice in the delivery of Child and Adolescent Mental Health Services with regard to the provision of CAMHS in primary care, specialist community CAMHS and specialist inpatient CAMHS for complex mental health needs. Each of these 24 key messages is discussed with reference to the supporting literature in the body of the full report.

Section 1: Build capacity in primary care services to effectively prevent, detect and appropriately treat child and adolescent mental health difficulties and disorders.

Key Messages in Section 1:

1. There is a high prevalence but a low detection rate of child and adolescent mental health difficulties and disorders in primary care settings
2. The delivery of CAMHS in primary health care is internationally recommended as good practice
3. There are national and international good practice examples of integrated mental health services into primary care for children and young people
4. Financial and human resources are critical enablers of the integration process
5. Capacity needs to be built to collaboratively embed mental health services in primary care
6. Primary care providers must be supported with access to specialist CAMHS consultation
7. The capacity of primary care workers to deliver child and adolescent mental health

services must be developed through training, supervision and support

8. Existing good practice guidelines should be considered in the assessment, diagnosis and treatment of children's and adolescent's mental health in Primary Care

Section 2: Ensure accessible, community based, evidence-informed and outcomes-monitored child and adolescent mental health services.

Key Messages in Section 2:

9. Service information about CAMHS should be clear and accessible prior to & during service use
10. Access to CAMHS should be needs-based, timely and facilitated by a range of local service referral pathways
11. Appointments should be provided in accessible, confidential environments with consistent staff
12. Clear, accessible routes to 'out of hours' and 'crisis' CAMHS should be provided
13. Children, young people and their families should be involved at all stages of service & care plan development, delivery and evaluation as key stakeholders
14. CAMHS information, referral criteria and access pathways should consider how to reach vulnerable children, young people and families who are at higher risk of mental health difficulties
15. Evidence informed practice should be embedded in the delivery of CAMHS to ensure high quality service provision
16. Incorporate accountability for CAMHS outcome monitoring at policy, funding and organisational level

Section 3: Develop accessible, inclusive, developmentally appropriate specialist inpatient care for children and young people with complex mental health needs, along with local, evidence-informed services

Key Messages in Section 3:

17. Inpatient care has advantages and disadvantages but is not effective for some mental health disorders

71 Purcell, R. et al. (2011) *Toward a Twenty-First Century Approach to Youth Mental Health Care: Some Australian Initiatives*. International Journal of Mental Health, vol. 40, no. 2, Summer 2011, pp. 72–87.

18. Prompt assessment and timely access to inpatient CAMHS is crucial for children and young people in need of care
19. Children and young people should not be placed inappropriately in adult or paediatric wards
20. Additional and/or alternative CAMH services to inpatient care are essential
21. Evidence informed alternative approaches to inpatient care for children and young people with complex mental health needs
22. Relationship building with service users & support for staff are central to effective CAMH service provision
23. Specific CAMH care pathways should be developed for children and young people with intellectual and learning disabilities
24. The transition from child to adult mental health services should be effectively managed but a fundamental system change is urgently required to meet the needs of youth mental health care

Summary of the mapping survey of professionals

The mapping survey aimed to describe the current relationships between Tier 1, Tier 2 and Tier 3 mental health services and supports for young people in Ireland using two geographical areas as case studies, North Dublin and Portlaoise. It sought to identify obstacles to service cohesion with a particular emphasis on interagency/service communication.

The mapping survey involved an online questionnaire focussed on communication and referral pathways between agencies involved in supporting children's mental health. The questionnaire was based on a social network analysis method described by Blanchet and James (2012).⁷² Questions focussed on:

- Information received
- Information supplied
- Type of information (e.g., advice and guidance; referral)
- Frequency of contact

In addition, an open-ended question allowed participants to raise issues and concerns relating to the configuration of children's and young people's mental health services and supports and their perceptions of how well the system is working. The data was analysed by the Work Research Centre.

A total of 29 individual respondents working in public health, social protection, educational or NGO services for children completed the survey. After validation the final sample size was 24. The most common service/organisation that respondents worked in was CAMHS. Respondents also worked in primary care and other health services, NEPS, TUSLA, the community and voluntary sector,

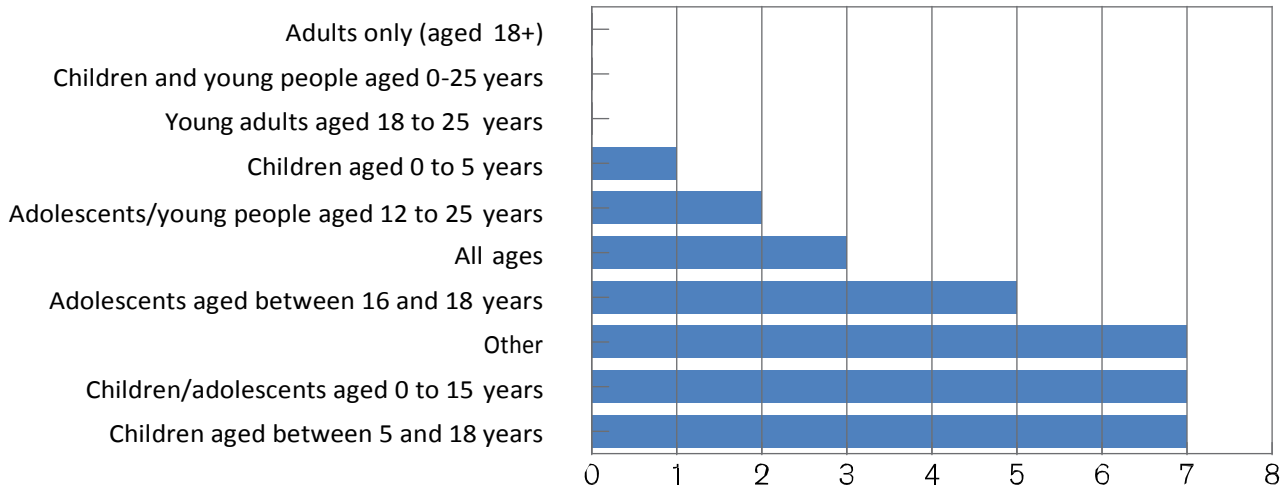
and one school. The most common specialism/profession of respondents was Social Work (5 respondents), followed by Education Psychologists (2), Clinical Psychologists (2), Counsellor/Psychotherapists (2), GPs (2), Occupational Therapists (2), and Educational Welfare Officer/Senior Educational Welfare Officer (2). One psychiatrist and one school principal participated. The services within which they worked were mostly based and provided in HSE Dublin North-East or HSE Dublin Mid Leinster areas, with six national services included.

72 Blanchet, K. & James, P. (2012). How to do (or not to do) ... a social network analysis in health systems research. *Health Policy and Planning*, 27, 438-446.

Key findings from the mapping survey are described here.

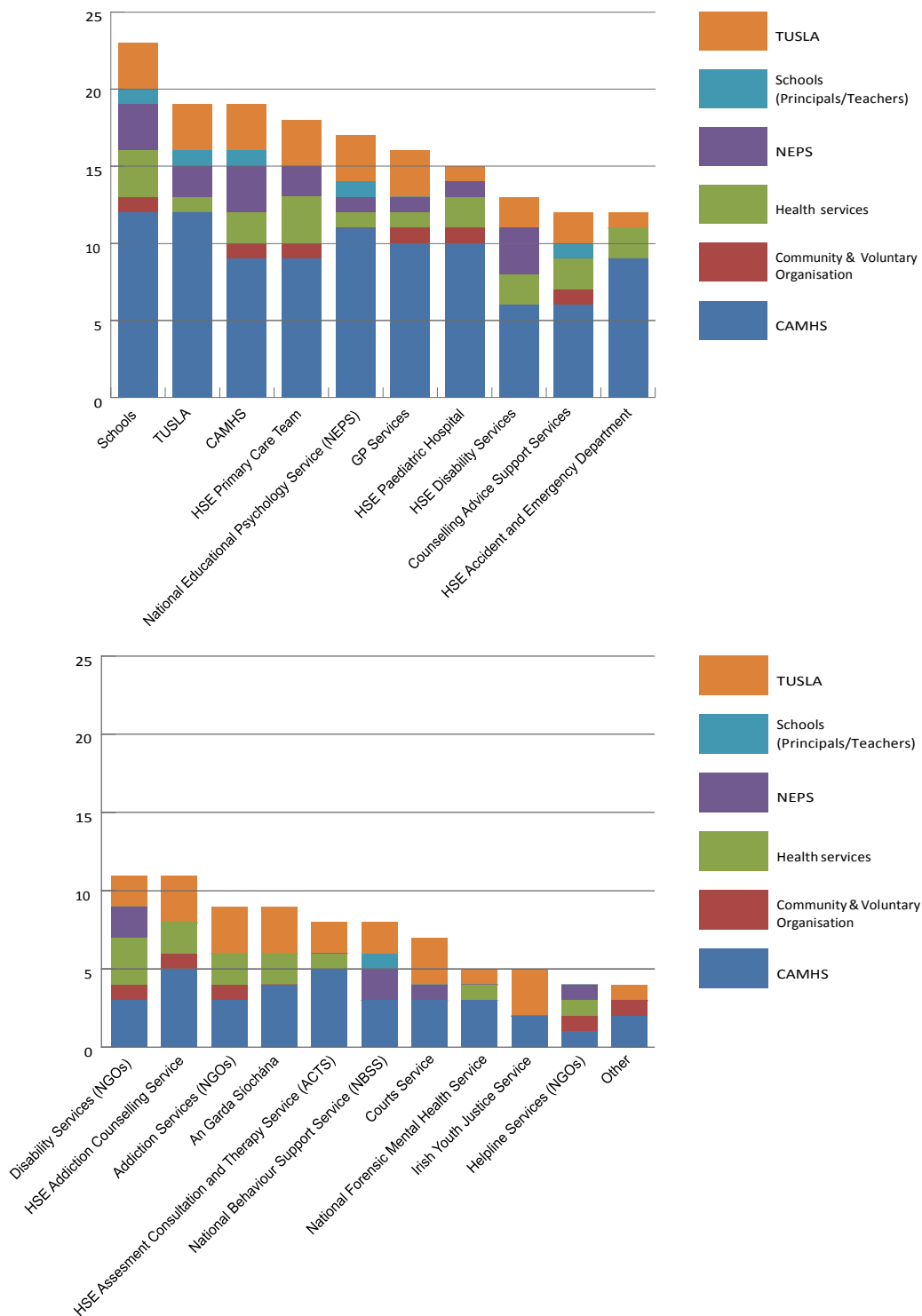
The age range covered by services varied and included: 0-5; 12-25; all ages; 16-18; 0-15; 5-18 and other age ranges.

Figure 2.5 Age groups of children/young people to whom the service is offered



Respondents said that they communicated with a wide variety of agencies on a routine basis concerning children’s mental health, with a total of 21 different agencies/services named. The service, organisation, agency or group cited by most respondents was ‘Schools’ (23) followed by TUSLA (19), CAMHS (19), HSE Primary Care Team (18) and NEPS (17). Amongst respondents from CAMHS, most communicated with Schools (12), TUSLA (12) and NEPS (11), followed by GP Services (10) and the HSE Paediatric Hospital (10).

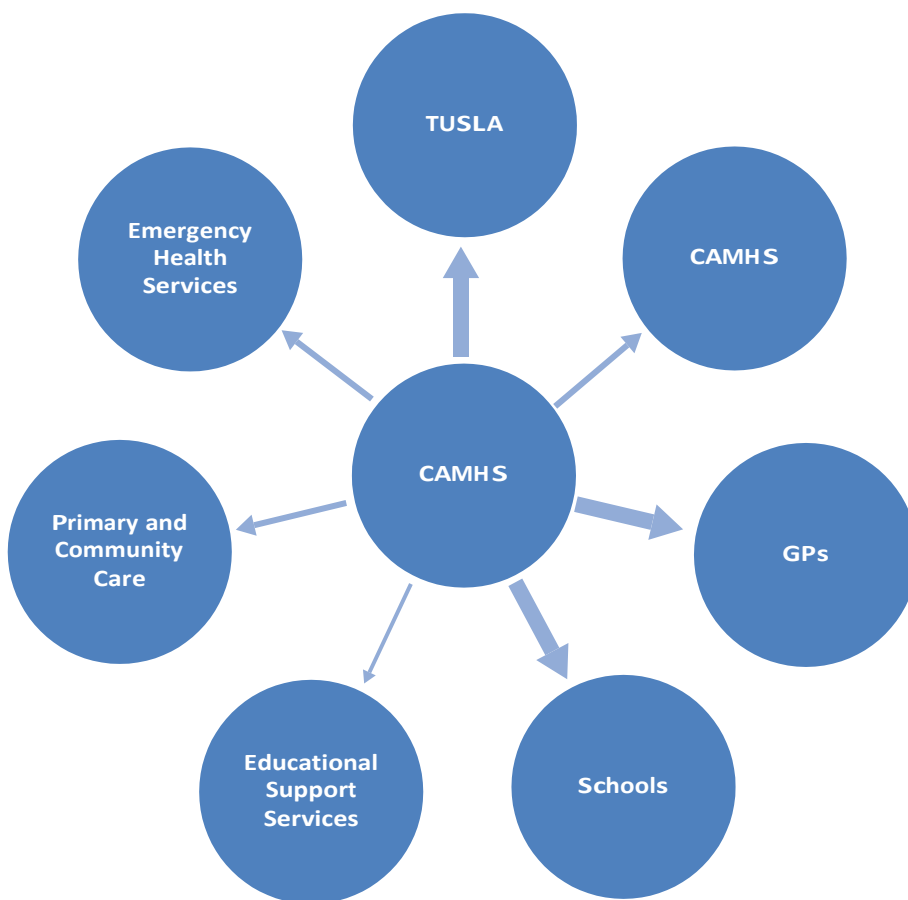
Figures 3.1 and 3.2 Services, organisations, agencies or groups communicated with by respondents, broken down by respondent organisation



Respondents were asked to rate how frequently they communicated with each organisation they identified on a scale from daily, a few times per week, weekly, monthly, to less than monthly.

For each of the organisations communicated with most frequently, weighted arrows indicate the strength of the relationship. The size of the arrow is based on the number of respondents who rated a certain point on the scale, multiplied by the relevant point on the scale.

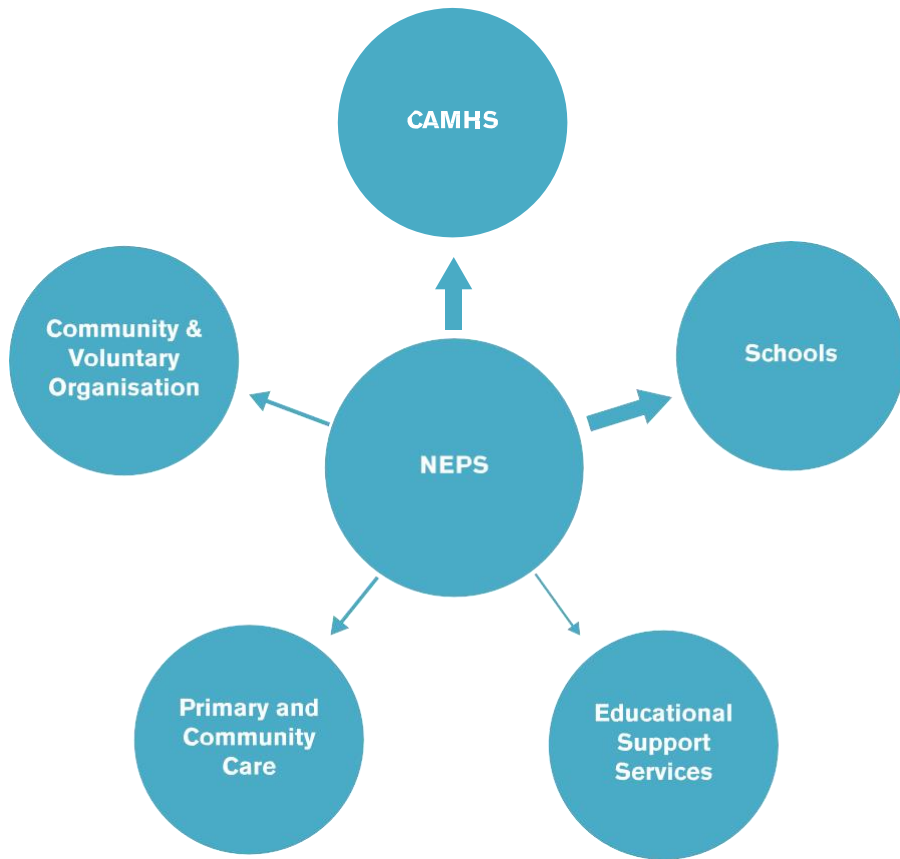
Figure 3.4 Frequency of communication – CAMHS



Communication was most frequent between respondents from CAMHS and Schools, TUSLA and GPs. It should be noted that as these responses were self-generated, some respondents referred to 'primary care' without specifying which professional, and therefore, these responses could have included GPs or other primary care professionals such as psychologists.

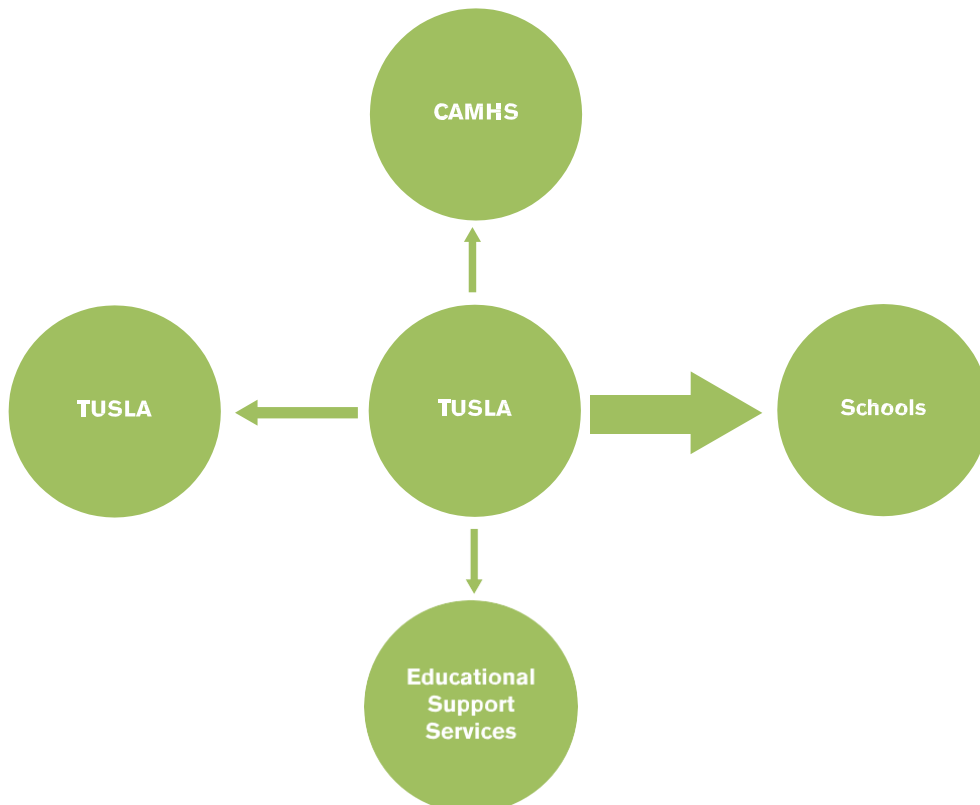
Some respondents said they communicated with social work; however it was not specified whether this referred to social workers in CAMHS or TUSLA. Social work is therefore not included in the analysis.

Figure 3.13 Frequency of communication – NEPS



Respondents from NEPS communicated most frequently with Schools, CAMHS and Primary and Community Care.

Figure 3.22 Frequency of communication – TUSLA



Respondents from TUSLA communicated most frequently with Schools

Respondents were also asked to rate how well they thought the current mental health service system for children and young people performs in the following activities:

1. Using a common system for tracking services to children and young people across service providers
2. Developing mechanisms to share clear and up-to-date information on what kinds of assistance agencies offer
3. Creating opportunities for joint planning between mental health, education, child welfare, and juvenile justice agencies
4. Preventing children and young people and their families from 'falling through the cracks' between agencies
5. Fostering a 'big picture' understanding of service systems and roles and responsibilities of agencies that constitute that system
6. Ensuring that all agencies have timely access to client records in ways that do not violate client confidentiality/rights
7. Developing agreements among agencies at the direct service delivery level to avoid needless duplication of effort
8. Ensuring meaningful discharge planning between inpatient psychiatric centres and community-based mental health agencies
9. Developing computerised client record/information systems that link hospitals, other mental health providers, and psychosocial support services
10. Co-ordinating services across agencies to meet the individual needs of children and young people with mental health issues and their families
11. Expanding service capacity to meet growing needs of children and young people with mental health issues and their families
12. Making mental health services available to all children and young people with mental health issues and their families who need them
13. Avoiding excess waiting lists or long delays in scheduling
14. Keeping 'red tape' to a minimum in

enrolling children and young people with mental health issues into services

15. Providing transportation to service/events when needed
16. Placing services in accessible locations
17. Offering services during evening and weekend hours
18. Providing services for children and young people with mental health issues and their families
19. Encouraging options for treatment of children and young people in community settings

The majority of the activities were rated as 'fairly poor' or 'very poor' by most respondents.

These findings illustrate both the frequency of communication between a wide variety of services involved in children's mental health and the frustration currently experienced by professionals trying to work together effectively to support children with mental health difficulties. The full report of the mapping survey is available at www.childrensmentalhealth.ie.

Recommendations of the Children's Mental Health Coalition

All of the recommendations set out below are interdependent and must be addressed collectively to ensure the effective realisation of each recommendation. All recommendations should be delivered in line with the recovery approach, as outlined in the national mental health policy *A Vision for Change* to support the recovery of children and adolescents with mental health difficulties.

Recommendation 1

Enhance mental health promotion to increase protective factors and decrease risk factors for developing mental health difficulties. This may be achieved through the delivery of evidence informed programmes and interventions from perinatal care and infant mental health to child and adolescent mental health. Public mental health promotion programmes that have proven to improve the mental well-being of the whole population should be prioritised. Protocols for effective inter-departmental and inter-agency collaboration on the promotion of mental health should be developed and adhered to at a national level in order to achieve good mental health and wellbeing among all children and adolescents, including specific vulnerable groups.

Recommendation 2

Build the capacity of the primary care sector to provide comprehensive mental health services to children and adolescents, including early intervention, detection and appropriate interventions for child and adolescent mental health difficulties and conditions.

This may be achieved through:

- Adequate resourcing of mental health services in primary care
- The development and implementation of a clear framework for collaboration and referral between mental health services – voluntary, community, primary care and specialist CAMHS services
- The provision of effective consultation and advice by specialist child and adolescent mental health services to the primary care sector and other specialist services
- The primary care sector needs to be resourced to provide child and adolescent mental health services, including the appointment of primary care mental health workers and the reimbursement of GPs for their time on child and adolescent mental health
- The delivery of appropriate training, supervision and support in child and adolescent mental health for GPs and other primary care professionals across the country
- The collection of data on children and adolescents presenting with mental health difficulties to identify the needs and research the prevalence of mental health difficulties

Recommendation 3

Develop specific quality standards and guidelines for CAMHS.

This should be supported by a quality and outcome monitoring system within the HSE to measure the extent to which services are achieving identified outcomes/key performance indicators and whether they are consistent with current evidence-informed practice. Key performance indicators should be rewritten to include the experience and outcomes

of the service user instead of focusing solely on the number of children and adolescents which are seen through CAMHS. This may include implementation of the quality improvement process in collaboration with service user, family and carer involvement.

Language about mental health used within CAMHS should promote the social inclusion and recovery of individuals experiencing mental health difficulties.

Recommendation 4

Increase accessibility of child and adolescent mental health services.

This may be achieved through:

- Increasing the staffing levels within child and adolescent mental health services in accordance with evidenced need
- Increasing coordination between mental health and disability services
- Clear and easily accessible service information for young people and their parents
- Equitable, timely and needs based access to CAMHS by enabling a range of local service referral pathways
- Greater integration of and access to specialist mental health services
- The provision of appropriate training for all CAMHS staff, including the assessment and treatment of a range of mental health disorders
- Ensuring all CAMHS provide a specialist out of hours and crisis service that is well publicised, fully staffed and resourced to provide a rapid response
- Extension of all CAMHS to provide a service to young people up to 18 years of age with the allocation of adequate resources for this extension
- Implementation of standardised approach to managing referrals and waiting lists

Recommendation 5

Develop local alternatives to inpatient services such as assertive outreach, early intervention in psychosis and other community-based intensive supports, in addition to family centred supports.

The HSE needs to develop community-based alternatives to inpatient services.

Recommendation 6

Ensure accessible, developmentally appropriate, and evidence informed specialist inpatient services for children and adolescents with complex or acute mental health difficulties, including children or adolescents with a dual diagnosis of mental health and substance misuse and children with both learning and mental health difficulties.

The implementation of specific measures is necessary, including a commitment to timely referral, strengths-based pre-admission assessments, access procedures to inpatient services and the availability of emergency beds. Children and adolescents should be involved in the design and continued review of individual care plans and should be provided with an appropriate exit plan. All children up to the age of 18 years admitted to an inpatient unit should be admitted to a child and adolescent mental health inpatient unit, except in exceptional circumstances.

Recommendation 7

Develop and implement a national framework to support children and adolescents to effectively transition from CAMHS to adult mental health services. The framework should include clearly documented steps to facilitate the process of transition and should take account of the overall health needs of the individual young person.

This may be supported by the establishment of a youth-specific specialist mental health service or through the development and delivery of new collaboration and referral processes between child and adolescent and adult mental health services. The appointment of key workers for young people

throughout this transition period (between the ages 16-25 years) is needed.

Recommendation 8

Effective and meaningful participatory structures should be resourced, mandated and evaluated to facilitate children's, young people's and their families' involvement in child and adolescent mental health service design, care planning, service delivery and service evaluation. Participatory structures should promote evidence of dialogue and evidence of change within child and adolescent mental health services. CAMHS should recognise the evolving capacity of the child/ adolescent to inform decision making processes.

A dedicated advocacy service should be established to ensure the advocacy needs of children and adolescents with mental health difficulties are being met.

The United Nations Convention on the Rights of the Child, Article 12 and General Comment 12 on the Right of the Child to be Heard guarantees a child's right to express his/her opinions and for such opinions to be taken into account.

At a national level, the right of children and young people to a voice in decisions that affect their lives is supported in government policy with the publication of the National Children's Strategy: *Our Children – Their Lives*. This policy is further supported in *A Vision for Change* and the national children's framework, *Better Outcomes, Brighter Futures*.

Conclusion

This report has sought to identify the current challenges for providing good quality mental health support to children and young people in Ireland and propose solutions based on international and national guidance.

In 2006, children's mental health services were starting from a very low base. *A Vision for Change* acknowledged that CAMH community teams were resourced well below international norms and that resources were inequitably distributed across the country. Inpatient and day hospital services were insufficient, services for adolescents were 'virtually non-existent', paediatric liaison services were not available in the majority of hospitals and there was no dedicated forensic team for children and adolescents.

Sadly, by the end of 2014, most of these shortages still existed. CAMHS community teams had significantly less staffing than recommended. According to the HSE Performance Assurance Report 2014, by the end of December 2014, just 48 out of the recommended 108 inpatient beds were in place, while a third of children and adolescents under age 18 were admitted to adult wards in that year. There is still no dedicated forensic mental health inpatient service for children and adolescents, nor for under-18s with mental health difficulties alongside intellectual disability..

Of equal concern are the inadequacies in primary care mental health supports and barriers between Tier 1 and Tier 2 services. Inadequate interagency communication and collaboration is hindering children's access to the specialist mental health supports they need. This is profoundly illustrated by the results of the Coalition's small-scale survey which shows the bewildering number of agencies involved in children's mental health care and documents their mutual frustration at poor communication and coordination between them. The lack of capacity in primary care also means that opportunities for early detection and intervention are being missed, putting increased pressure on

CAMHS. For some CAMHS teams, the answer has been to narrow the pathway into services with a GP-only referral policy. However, this approach goes against international and national good practice guidance which suggests that greater, rather than lesser accessibility to CAMHS is the way forward to ensure the best possible health outcomes for children. As the Taskforce on the development of the new child and family agency pointed out in 2012: "Determining strict eligibility criteria is not helpful for children as many children with complex needs present with emotional and behavioural difficulties."

A Vision for Change was published in 2006 and there have been significant developments in the field of child and adolescent mental health support in the intervening nine years. The WHO has made it a priority to promote mental health service provision within primary care, pointing to its advantages in facilitating accessibility to care and thus early intervention that results in better lifetime outcomes for children. Adequate investment in mental health resources within primary care, including mental health workers (psychologists, in particular) have been identified as a critical success factor for the entire mental health system. However, equally important are effective processes for ensuring ease of access from primary to specialist mental health care where required, including consultation/liaison mechanisms, co-location of CAMHS within primary care settings, and training for primary care staff.

Specialist child and adolescent mental health services should be accessible within the community, as stated by the Mental Health Commission in its *Quality Framework*. Accessibility can be improved through better information provision and local service pathways for parents and other professionals involved with children. Accessibility to CAMHS also means providing services when children and young people need them most, outside of normal working hours, so that age-appropriate services can be accessed in a crisis.

For those children who require intensive residential care, their right to age-appropriate support in the least restrictive environment should be fulfilled. The literature review for this report has identified that alternatives to inpatient care are possible even for children with the most intensive care needs. These alternatives should be explored in an Irish context so that the pressure on inpatient CAMHS can be reduced.

The CMHC has sought to make practical recommendations to address existing gaps. The CMHC now calls on the Ministers for Primary and Social Care, Children and Youth Affairs, Education & Skills and Justice and Equality and their Departments and agencies, including the HSE and TUSLA, to work together to implement these recommendations so that children and young people can get the effective, coordinated mental health care that is their right.

About the Children's Mental Health Coalition

32 The Children's Mental Health Coalition (CMHC) consists of more than 70 members, including representatives from 53 organisations and a number of individual legal experts, practitioners, academics and researchers from a range of backgrounds and sectors, including children's rights, human rights, education and mental health services. Membership of the group is open to organisations and individuals interested in the mental health needs of children and young people.

Mental Health Reform is the current chair of the Children's Mental Health Coalition.

The CMHC's vision is that Ireland should be one of the best places in the world to be a child, where every child's right to mental health is realised.

Acknowledgements

Acknowledgements

The Children's Mental Health Coalition is part-funded by the Statutory Scheme for National Organisations.

The Children's Mental Health Coalition gratefully acknowledges the following members who kindly provided donations in order that this work could be completed:

ASTI

Amnesty International Ireland

Barnardos

Focus Ireland

INTO

National Association of Principals and Deputy Principals

Peter McVerry Trust

St. John of God Hospital

St. Patrick's Mental Health Services

Youth Advocate Programmes Ireland

Children's Mental Health Coalition

c/o Mental Health Reform
Coleraine House
Coleraine Street
Dublin 7
Ireland

Tel: +353 1 8749468
Email: info@mentalhealthreform.ie
Web: www.mentalhealthreform.ie
www.childrensmentalhealth.ie

March 2015

CHILDREN'S
MENTAL
HEALTH
COALITION

