



PAEDIATRICS

**A NATIONAL MODEL
OF CARE FOR PAEDIATRIC
HEALTHCARE SERVICES
IN IRELAND
CHAPTER 13:
CAMHS**



Féidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Strategy and Programmes Division



**ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND**

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13.0 INTRODUCTION

It is well recognised that, in order to become healthy individuals, children need safety and security within their primary relationships, opportunities to play and learn, and the positive self-esteem that comes from knowing they are valued and cherished by families and friends (A Vision for Change, 2006). While most children do not experience mental health problems, at any one time, about 2% of children will require specialist mental health expertise. These children may have distressing emotional, behavioural or relationship problems that can hinder learning and social development. Relevant mental health risk factors in childhood include loss, separation, trauma, child abuse, and family breakdown.

Ireland acknowledges the importance of children's mental health and is a party to international commitments to provide health services for children. Article 24 of the United Nations Convention on the Rights of the Child (UNCRC, 1989), 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 to facilities for the treatment and rehabilitation of health, and shall strive to ensure that no child is deprived of his or her right of access to such health care services". The Mental Health Act, 2001 dealt with some of the demands of the UNCRC, including extending the age of childhood to 18 years and, in Section 25, addressed the specific issues associated with the involuntary admission and detention of a child for treatment of severe mental illness.

The Mental Health Commission is an independent body that was established in 2002. The Commission's main functions, as set out in the Mental Health Act, 2001, are to promote, encourage and foster high standards and good practices in the delivery of mental health services, and to protect the interests of patients, including children, who are involuntarily admitted.

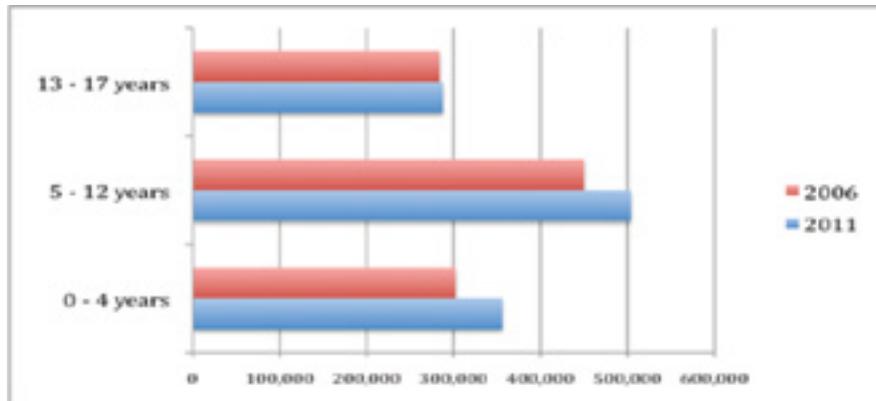
The National Children's Strategy: Our Children – Their Lives, reiterated the principle that 'children will be supported to enjoy the optimum physical, mental and emotional well-being'. Current policy on Child and Adolescent Mental Health Services (CAMHS) is outlined in A Vision for Change (AVFC) (2006), the national policy for mental health services. In addition, two reports from a working group appointed by the Department of Health and Children addressed the need for increased inpatient beds and for improved resources to care for 16-18 year-olds who may fall between child and adult services, and may not receive care appropriate to their particular needs.

This chapter outlines how services for children and young people with mental health difficulties are delivered in Ireland and provides recommendations on how these services should be developed in line with AVFC (2006).

Population

The total population aged under 18 years in the 2011 Census was 1,148,687 compared with 1,036,036 in 2006, i.e. an increase of 10.9%. Under-18s now account for 25.04% of the total population. Figure 13.1 shows that the increase in 2011 was largely in the 0-4 years and 5-12 years age groups.

Figure 13.1 (i) 2011 and 2006 Census by age



Source: Central Statistics Office

Table 13.1 (a) 2011 and 2006 Census by age

Age	Census 2011	Census 2006
0-4 years	356,329	302,252
5-12 years	504,267	450,074
13-17 years	288,091	283,708
0-17 years	1,148,687	1,036,034

Source: Central Statistics Office

Prevalence of Childhood Mental Illness

The majority of illness burden in childhood, and particularly adolescence, is caused by mental illness and the majority of adult mental illnesses have their onset in adolescence. The World Health Organization (2003) document *Caring for children and adolescents with mental disorders: Setting WHO directions* states that: “The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive.”

As outlined in the 2014 Health Service Executive (HSE) Fifth Annual Report of Child and Adolescent Mental Health Services (CAMHS) 2012–2013:

- One in 10 children and adolescents suffer from mental illness that is associated with “considerable distress and substantial interference with personal functions” such as family and social relationships, their capacity to cope with day-to-day stresses and life challenges, and their learning.
- An examination of the prevalence rates of mental illness, suicidal ideation and intent, and parasuicide in the population of Irish adolescents aged 12-15 years in a defined geographical area found that 15.6% of the total population met the criteria for a current mental illness, including 2.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with Attention Deficit Hyperactivity Disorder (ADHD). Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide.
- The prevalence of mental illness in young people is increasing over time.

- 74% of 26-year-olds with mental illness were found to have experienced mental illness prior to the age of 18 years and 50% of this group had experienced it prior to the age of 15 years in a large birth cohort study.
- A range of efficacious psychosocial and pharmacological treatments exists for many mental illnesses in children and adolescents.
- The long-term consequences of untreated childhood mental illness are costly, in both human and fiscal terms (Mental Health: Report of the US Surgeon General, 1999).

13.1 CURRENT SERVICE PROVISION

The response to children's mental health needs requires consideration of a variety of services at different levels. These range from early intervention and health promotion programmes to primary and community care services and specialist mental health services for the treatment of more serious mental illness. Each will now be outlined briefly, with more detail provided about the specialist services available at secondary care level.

Health Promotion/Early Intervention

There is much evidence to demonstrate that early identification of behavioural difficulties and early implementation of family support programmes leads to better mental health outcomes for children, particularly those at risk of mental health problems. AVFC recommends that programmes addressing risk and protective factors early in life should be targeted at child populations at risk, e.g. being in a family with low income, low education levels and living in disadvantaged areas.

For children aged 5-12 years, school should be the focus for the promotion of positive mental health. A school-based approach to mental health promotion, which encompasses the whole school environment including the curriculum, school ethos, physical environment, and links with parents and community, leads to positive mental health in schoolgoers. The capacity building and personal development elements of the Social Personal and Health Education (SPHE) curriculum provide mental health promotion opportunities for school-age children. Bullying prevention is a key element of mental health promotion activity within the school setting, and bullying policies have been developed across the primary school sector.

Adolescence is a pivotal stage of psychological development, one in which children require an understanding of the life challenges they face and need in order to develop basic skills to cope with difficult emotions. It is a time of increased risk of poor mental health with anxiety, depression, psychosis, eating disorders, and substance misuse becoming more prevalent, as well as an increasing risk of deliberate self-harm and suicidal behaviour. The Mental Health Matters programme, developed by Mental Health Ireland, provides a useful resource for secondary schools, both in conjunction with the wider SPHE curriculum and as a standalone teaching unit. Published in 2015, *Connecting for Life – Ireland's National Strategy to Reduce Suicide (2015-2020)* places responsibility on the Department of Education to develop positive mental health initiatives within the school system.

Child and Adolescent Mental Health Services Delivery Structure

Current mental health services for children are delivered in Ireland in the following multi-layered model as shown in Figure 13.2, with guidelines for referral shown in Figure 13.3.

Figure 13.2 Model of Child and Adolescent Mental Health Services

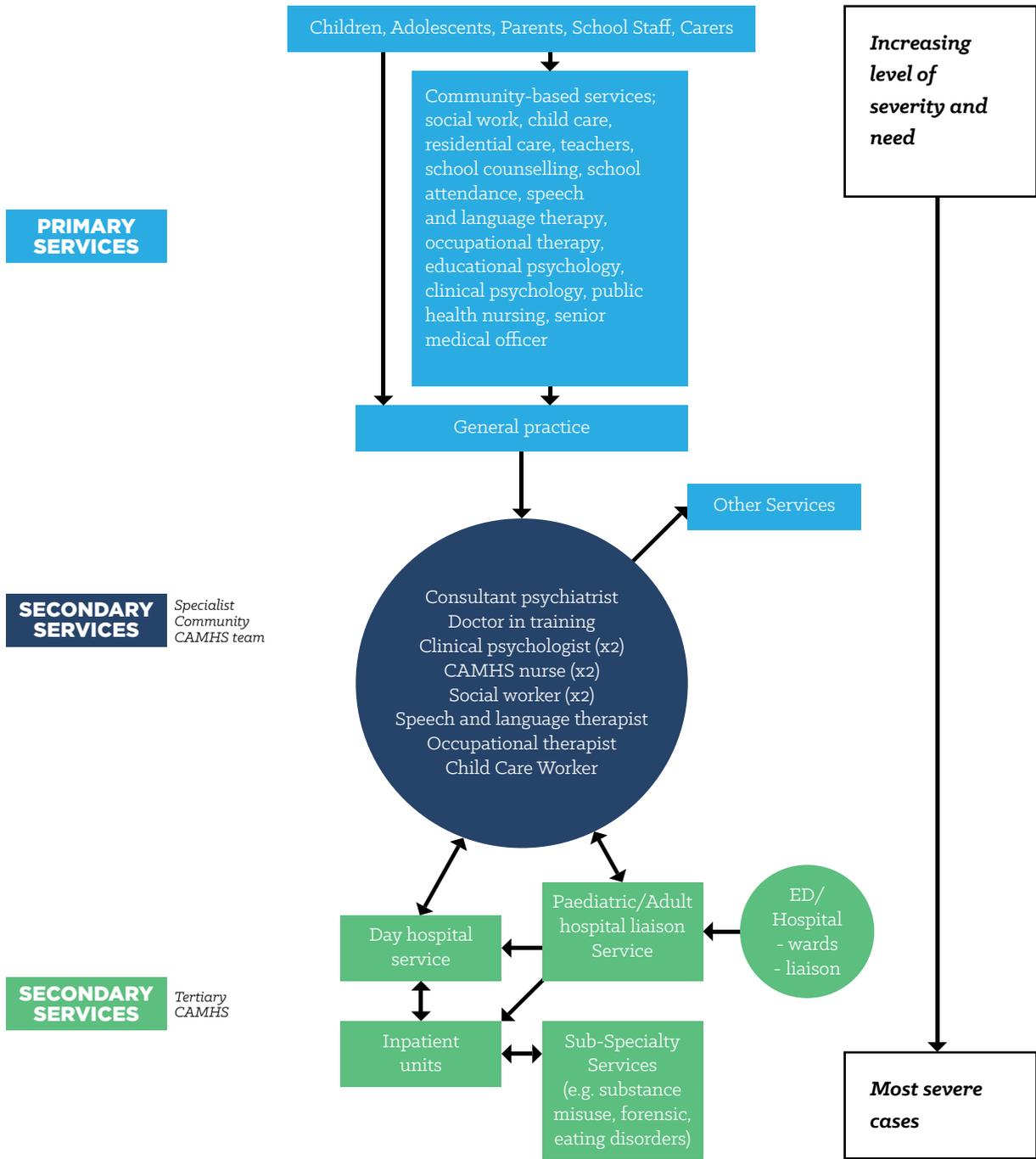
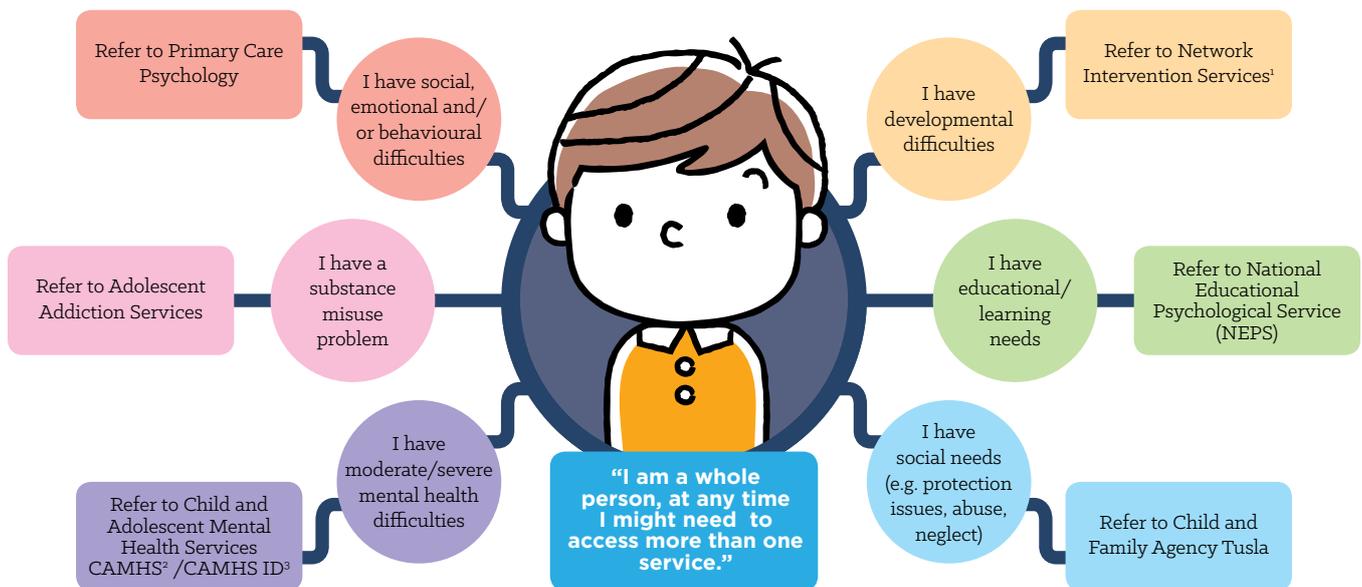


Figure 13.3 Guidelines for GPs and primary care teams referring children and adolescents with social/emotional/behavioural/developmental difficulties

The initial referral should be to the agency best suited to respond to the predominant difficulty. Children may need to access more than one of these services at any one time, e.g. Tusla, National Educational Psychological Service (NEPS) and CAMHS simultaneously. The primary agency involved should refer to other relevant agencies as required



Explanatory notes on certain services in Figure 13.3 are given below:

1. Network Intervention Services

The implementation of the Progressing Disability Strategy in each community health organisation (CHO) means that there is a network team which responds to children with complex developmental, emotional and/or behavioural problems that contribute to a range of functional skills deficits, which lead to moderate/severe restrictions on participation in normal daily activities and interactions. The network team is multidisciplinary, which enables it to identify and advise on developmental, behavioural or psychological issues, where appropriate. The team has responsibility for:

- specific development delay in children, e.g. language, developmental coordination disorder (dyspraxia)
- behavioural problems
- diagnosis and management of autism and Asperger's syndrome
- children with moderate/severe intellectual disability (ID) (directly or indirectly through Section 38-funded voluntary organisations)

Children with non-complex needs, i.e. one or more impairments giving rise to milder functional difficulties, are seen by primary care teams.

2. CAMHS services

CAMHS services see children and adolescents with:

- suspected/actual moderate to severe mental illness
- mild ID, those with autism who have a normal IQ, or those with mild ID who have comorbid mental illness.
- ADHD, for assessment and treatment.

3. CAMHS ID

Where a child has moderate to severe ID and a suspected/actual moderate to severe mental illness, the child should be referred to the CAMHS - ID Service.

Primary and Social Care Services

General practitioners (GPs) are usually the first point of contact for families who seek help for various problems, and they provide the first line of response. GPs are ideally placed to recognise risk factors for mental health problems, to provide advice and treatment, and to refer to primary care services or specialist services when this is indicated.

Primary care services are community-based services that provide a first line of response to children and adolescents with mild to moderate mental health difficulties. They provide assessment, interventions, monitoring and support services for children with mental health difficulties as well as those with developmental delay, autism spectrum disorder (ASD) or in need of care and protection. These community-based services are particularly important for children or young people with mild to moderate mental health difficulties.

They include:

- Community care psychology services
- Tusla (The Child and Family Agency)

Services include:

- family support
- child welfare
- child abuse investigations and post-abuse counselling services
- speech and language therapy
- occupational therapy
- physiotherapy
- public health nursing
- senior medical officer services
- disability network teams for children with developmental delay and ASD, which include:
- early intervention services
- school-age intervention services
- national Educational Psychological Service (NEPS)
- primary care social work
- Assessment of Need Officers (Disability Act, 2005)

The availability of these services to respond to children with mild to moderate mental health problems is crucial in minimising the progression to more severe problems. Likewise, the provision of services for children with developmental delay (dyslexia, dyspraxia and speech delay) and ASD minimises the risk of developing comorbid mental health problems such as anxiety or depression. It also reduces the likelihood of behavioural problems developing.

While most of these services are provided by both the Primary Care and Social Care Divisions of the HSE, others such as NEPS and Tusla are provided through service level agreements with the HSE.

Specialist Mental Health Services for Young People

These are commonly known as Child and Adolescent Mental Health Services (CAMHS). When Planning for the Future was adopted as policy in 1984, there were only 18 Child Guidance Teams and three inpatient units in Ireland, based in Dublin, Galway and Cork, respectively. Following the implementation of the recommendations in Planning for the Future, CAMHS services were developed further and there were 43 teams in place by 2006. Current policy and development is based on AVFC (2006), which sets out recommendations for a comprehensive mental health service for young people up to the age of 18 years, on a community, regional and national basis, mirroring the provision for other age groups.

Recommendations in A Vision for Change (AVFC):

Catchment Area Provision

AVFC recommends the following CAMHS services per 300,000 total population:

- a total of seven multidisciplinary community mental health teams (MHTs)
- two teams per 100,000 population (1/50,000)
- one additional team to provide a hospital liaison service per 300,000 population
- one day hospital service per 300,000 population
- each multidisciplinary team (MDT), under the clinical direction of a consultant child psychiatrist, to have 11 whole-time equivalent (WTE) clinical staff and two WTE administrative staff.

Each CAMHS team should comprise:

- one consultant psychiatrist
- one doctor in training
- two psychiatric nurses
- two clinical psychologists
- two social workers
- one occupational therapist
- one speech and language therapist
- one childcare worker
- two administrative staff

While AVFC recommends one team/50,000 total population, it is more appropriate to relate this to the number of the population aged under 18 years. Thus, it is now agreed that there should be one team per 12,500 children aged under 18 years. The number of teams in place has increased from 43 in 2006 to 63 in 2015.

Recommended CAMHS Services Organised on a Regional/National Basis:

- one national specialist eating disorder MDT team linked with the provision of eight inpatient beds to be based in the new children's hospital
- four child and adolescent mental health substance misuse teams
- two forensic MHTs, linked with the secure inpatient facility
- 15 child and adolescent mental health of intellectual disability teams (CAMHS MHID) for children with moderate or greater degrees of intellectual disability.

Table 13.2 A Vision for Change Recommendations (2011 Census data)

Child and Adolescent Mental Health Services	Recommended
Community Child and Adolescent MHTs	77
Adolescent Day Hospital Teams	15
Hospital Liaison MHTs	15
National Eating Disorder MHT	1
National Forensic MHTs	2
Substance Misuse MHTs	4
Intellectual Disability MHTs	15
Total	129

Recommended Inpatient Child and Adolescent Mental Health Services:

- The building of four new 20-bed inpatient facilities
- 10% of the bed complement to be provided as a secure/forensic facility
- A 6/8-bed eating disorder unit in the new children's hospital

Table 13.3 A Vision for Change Recommendations – inpatient services

Inpatient Services (Beds)	Recommended
General	90
Forensic/secure	10
Eating disorder	6/8
Total	106/8

13.2 CURRENT CAMHS PROVISION IN IRELAND

Community CAMHS Teams

Table 13.4 lists the community and acute hospital CAMHS teams together with day hospitals.

Table 13.4 A Vision for Change recommendations versus 2015 position

Mental Health Services	A Vision for Change (2006)	Number of recommended teams	Teams in place
Community MHTs	1: 50,000	77	63
Adolescent Day Services		15	4
Hospital Liaison MHTs	1:300,000	15	3

Inpatient Provision

Current inpatient provision is shown in Table 13.5 below.

Inpatient units	Beds planned	Beds open	Catchment area
St Vincent's, Dublin 3	12	12	North Dublin, Louth/Meath, Cavan/Monaghan
Linn Dara, Dublin 8	22	14 ¹	South/West Dublin, Kildare/Wicklow, Midlands
Merlin Park, Galway	20	20	Galway/Roscommon, Mayo, Sligo, Donegal, Limerick/Clare, North Tipperary
Aishlinn, Cork	20	12 ²	Cork, Kerry, Waterford/Wexford, Carlow/Kilkenny, South Tipperary
Forensic Unit	10	0	National
New children's hospital	12	0	Greater Dublin/new children's hospital
New children's hospital – eating disorders	8	0	National
Total	104	58	

The annual inpatient Child and Adolescent Mental Health Services performance reports provide a detailed annual analysis of the actual infrastructure provision, staffing provision and performance of the inpatient units. Currently, there remain a number of key challenges within the infrastructural provision. These include:

- current maximum bed capacity of 58 beds within the four units (May 2015)
- impact on operational capacity of units due to severe difficulties in consultant² and nursing recruitment
- impact on operational capacity of units due to environmental limitations¹
- current lack of a secure/forensic facility or specialist eating disorder unit

13.3 MODEL OF CARE FOR SPECIALIST MENTAL HEALTH SERVICES FOR CHILDREN

Psychiatry/mental health is unique among medical specialties in that it has a national policy, AVFC (2006), which describes in detail how secondary care mental health services should be staffed and delivered. Implementing AVFC for children's services required a move from a child guidance model to a secondary care model, with the focus on moderate to severe mental illness and the inclusion of 16- and 17-year-olds in line with the Child Care Act, 1991 and the Mental Health Act, 2001. The current services are described in the sections that follow; areas requiring improvement are identified, coupled with discussion on how these are being, or should be, addressed.

CAMHS is the specialist service for children and young people with mental health problems in Ireland. Children/young people are assessed by a MDT, under the clinical direction of a consultant child and adolescent psychiatrist. The multidisciplinary nature of the team is designed to ensure that children and adolescents are offered care and treatment for moderate to severe, and often complex, mental illness that requires a range of disciplines, skills and perspectives. The model of care is holistic and is based on a recovery approach. CAMHS services are delivered at secondary and tertiary care level.

13.3.1 Secondary Care CAMHS Service

This is delivered through community CAMHS teams, each of which provides:

- assessment of emergency, urgent and routine referrals from primary care services
- treatment of more severe and complex mental health problems
- outreach to identify severe or complex mental health needs, especially where families are reluctant to engage with mental health services
- assessment of young people who require referral to inpatient, or day services
- training and consultation to other professionals and services
- participation in research, service evaluation and development

13.3.2 Referrals to Community CAMHS Teams

The detailed referral and exclusion criteria are set out in the Child and Adolescent Mental Health Services: Standard Operating Procedure (HSE, 2015).

The acceptance criteria are outlined briefly below:

- age up to 18 years
- The severity and complexity of the presenting mental health disorder is such that treatment at primary care service level has been unsuccessful
- Community CAMHS teams accept referrals for the assessment and treatment of disorders such as:
 - moderate to severe depression
 - mood disorders
 - psychosis
 - anxiety disorders
 - attention deficit hyperactivity disorder (ADHD/ADD)
 - moderate/severe eating disorders
 - suicidal behaviours and ideation where intent is present

Community CAMHS teams do not accept referrals in the following circumstances:

- children with a moderate or severe intellectual disability
- children whose presentation is a developmental disorder, unless there are comorbid mental health disorders present
- assessments or interventions that pertain to educational needs specifically
- where there are custody/access or legal proceedings pertaining to family breakdown in progress without evidence of a severe or complex mental health disorder
- child-abuse assessments and investigations

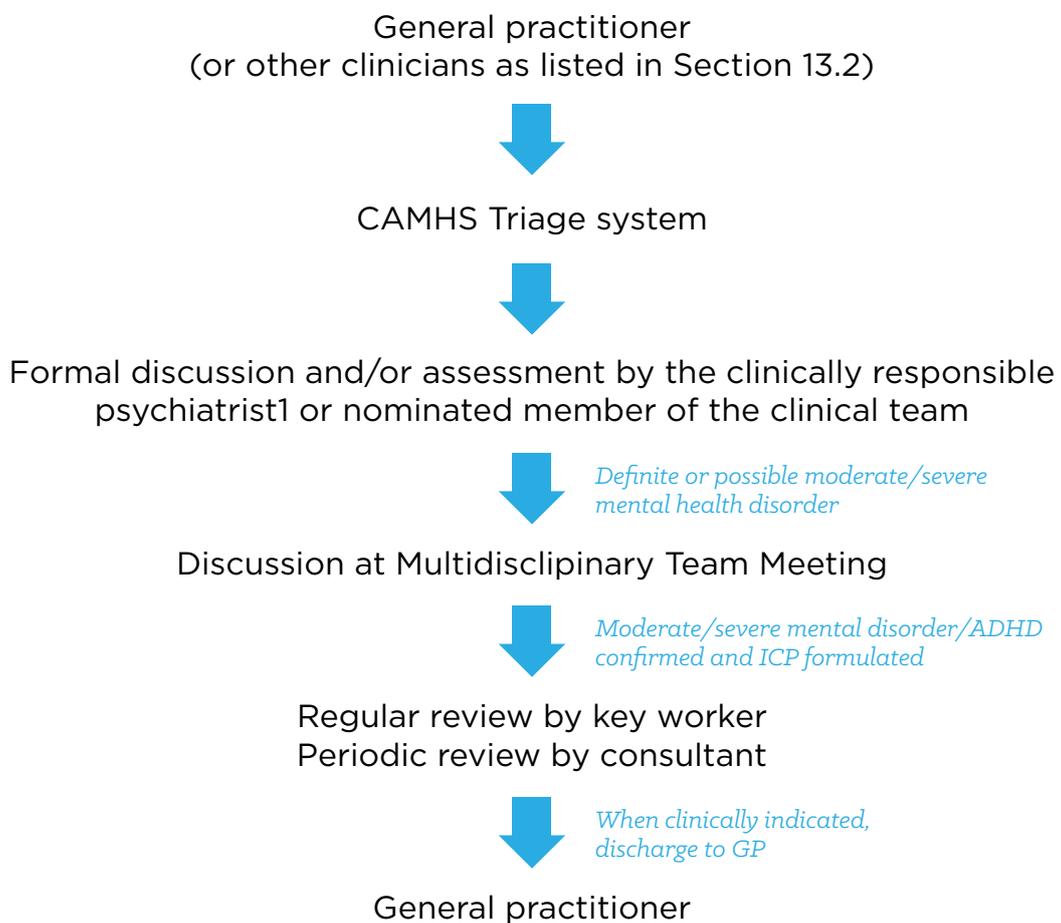
The referral agents are:

- General practitioners: As GPs are usually the first point of contact for families who seek help for various problems they are ideally placed to recognise risk factors for mental health disorders and to refer to more appropriate community care personnel or specialist services such as CAMHS, where this is indicated.
- Paediatricians (informing the child's GP)
- Consultant liaison psychiatrist (informing the GP)
- General adult psychiatrists (informing the GP)
- National Educational Psychological Service (NEPS) (in collaboration* with the child's GP)
- Community-based clinicians at senior/team-leader level or above (in collaboration* with the child's GP)

- Tusla – Child and family agency, team-leader level or above (in collaboration* with the child's GP)
- Jigsaw – Senior clinician (in collaboration* with the child's GP)
- Assessment of Need Officers (Disability Act, 2005) (in collaboration with the child's GP)

* Collaboration means that referral must be discussed with, and agreed by, the child's GP.
The referral process is shown in Figure 13.4.

Figure 13.4 Referral Process: Referral and clinical pathway for children and adolescents with moderate/severe mental disorder.



¹ May be Psychiatric Registrar or Senior Registrar formally supervised by Consultant Psychiatrist.

13.3.3 Mental Health Assessment and Care Planning for Children

Each child attending a specialist CAMHS will receive a multidisciplinary assessment and diagnosis which informs the development of an individual care plan (ICP). It is recognised that an ICP is an evolving document, reflective of the needs of the child/young person and the nature of the therapeutic process.

An ICP includes the following elements:

- a clinical formulation
- a diagnosis
- input from the child/young person, parent/carer and other relevant people, as appropriate
- agreed goals between the CAMHS team, child/young person and parent/carer
- liaison arrangements with other relevant agencies
- timely and collaborative development, implementation and review
- a discharge/transition plan, as appropriate

The ICP must be clear, and it must also be:

- collaborative
- strengths-based
- goal-oriented
- based on a recovery model
- regularly reviewed
- stored on the child/young person's file and a copy offered (where appropriate) to the child/young person and/or the parent/carer.

An ICP is informed by evidence-based practice, clinical experience and the individual child's needs and preferences in the context of their characteristics and culture. The ICP is the basis on which all interventions will be provided. While this is included on community CAMHS teams, it applies equally to all other CAMHS teams, e.g. in the day hospital, inpatient and paediatric liaison services.

13.3.4 Multidisciplinary interventions

To deliver an effective community CAMHS service, the team should provide multidisciplinary home-based treatment and assertive outreach, and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families (AVFC, 2006). As stated previously, each CAMHS team should include the core skills of psychiatry, social work, clinical psychology, nursing, occupational therapy, speech and language therapy and a childcare worker. The composition and skill mix of each team should meet the needs and social circumstances of its sector population (AVFC, 2006).

13.3.4.1 Disciplines and their respective contributions

Child Psychiatry

The clinical role of the child psychiatrist comprises assessment and diagnosis of the child's mental state, and treatment planning. This discipline prescribes medication and can assess the physical contribution to mental illness presentations, in order to ensure that these are addressed. At consultant level the child psychiatrist is the clinical lead for the team. Only child psychiatrists who are registered on the Medical Council's Specialty Register for Child and Adolescent Psychiatry are permitted to practise as consultants in Ireland. The eligibility criteria for inclusion on this Register are three years of satisfactory postgraduate training at higher level, in addition to basic training in psychiatry.

Clinical Psychology

Psychology aims to reduce psychological distress and to enhance and promote psychological well-being through the systematic application of knowledge derived from psychological theory and research data. Psychologists in CAMHS are involved in psychological assessment and psychological interventions and therapy to help address mental health difficulties. They are trained professionals with an in-depth knowledge of a broad range of psychological theory (including biological and social psychology), life-span development, abnormal psychology, and a flexible and general knowledge and application of psychology.

The psychology service in CAMHS aims to enable individual young people to have the necessary skills and abilities to cope with their emotional needs and daily lives in order to maximise psychological and physical well-being; to develop and use their capacity to make informed choices in order to enhance and maximise independence and autonomy; to have a sense of self-understanding, self-respect and self-worth; to be able to enjoy good social and personal relationships; and to share commonly valued social and environmental facilities.

Psychologists are viewed as core members within a multidisciplinary CAMHS team. An essential part of their work involves liaison and consultation with other disciplines and services in order to ensure the provision of a coordinated and effective service. This frequently involves joint working with other colleagues or members of the MDT.

Mental Health Nursing

Nurses work in all areas of CAMHS, and their expertise and experience vary. Their roles range from newly graduated nurses beginning their career in a CAMHS inpatient unit to registered advanced nurse practitioners in the community CAMHS Teams. The core responsibilities of the nursing discipline in CAMHS are to assess, plan, implement and evaluate the care of young people, and their families, who present to services with mental health needs. These responsibilities include a range of activities which include providing therapeutic support to young people and families, running groups, coordinating ADHD clinics and monitoring physical observations. Many nurses also pursue specialist qualifications in child and adolescent mental health, which enables them to expand their role into specialist family work, individual therapy and/or tailored group programmes.

Occupational Therapy

Occupational therapists in CAMHS work with children and their families to increase their independence in, and satisfaction with, the everyday occupations and roles that give meaning to their lives, for example, school attendance and leisure facilities. Occupational therapists are skilled at comprehensive assessment of, and intervention in, functional abilities, for example self-care, taking part in school, home and community activities. They consider the person, the occupation and the environment as part of this process and identify factors that are impacting on the person's occupational performance. Occupational therapists treat each person as being unique and believe that each child/young person has many occupations that are essential to their health, well-being and recovery. They help children/young people and their families to identify personal goals, taking into account what is important for their mental health, quality of life and recovery. They then support the child/young person, using their strengths, to achieve these goals. Occupational therapists may work with children/young people individually and/or in groups, using a range of therapeutic approaches. They often work in collaboration with other members of the MDT and also liaise with external services as needed (e.g. schools, and other community agencies).

Social Work

Social workers in CAMHS work in partnership with the child/young person, their family, colleagues on the multidisciplinary teams and professionals in other services (e.g. schools, and the HSE) to carry out both assessments and interventions in a CAMHS context. As part of the assessment, social workers explore an individual and family history and identify significant stresses for the individual and family, including relationships, supports, resources, strengths, resilience and social networks. During this process they usually conduct an analysis of needs. Social workers focus on repeated patterns of behaviours and relationships, with particular emphasis on assessing attachment-related difficulties. They analyse the information they gather and examine past and current strategies being used to resolve the presenting problems. From this assessment work they will formulate an agreed understanding of the issues with the client and use this to develop an agreed ICP. The guiding principle is one of recovery and empowerment in the promotion and maintenance of the client's positive mental health. The ability to work in, and with, the whole context or situation is an important distinguishing characteristic of social work practice. This work may include facilitating both therapeutic and psychoeducational individual/family sessions or groups for children, adolescents and parents. Alongside this, the social workers respond to requests from schools, residential childcare units and child protection social workers for support and consultation in the management of mental health issues.

Speech and Language Therapy

Speech and language therapists (SLTs) in CAMHS work with children and young people who experience communication difficulties as part of their mental health difficulties. Communication difficulties may be related to the child/young person's understanding of language, to self-expression, or to social communication difficulties when interacting with others. Communication difficulties are very common in children and young people with mental health difficulties and can represent a significant barrier to mental health interventions and to the young person's quality of life. SLTs work with the young person in the context of his/her environment at home, at school and in the community, to enhance their communication skills and help them to access the social, emotional and therapeutic supports that they need.

Childcare Work/Social Care Work

In CAMHS, childcare workers operate with the ethos of providing a child-centred approach to the needs of the young people and their families who attend the service. The social care worker works at the young person's pace and level of understanding to help them deal with both their presenting and dormant issues. Childcare workers believe that their work with individuals should be process-oriented rather than task-oriented. The role of childcare workers in CAMHS is that of empowerment and enablement. Its aim is to provide the individual with adequate skills, power, means, opportunity or authority to make changes in order to enhance their lives.

Dietetics

While dietitians are not referred to in AVFC, access to this service is important for young people, particularly for those with eating disorders. Dietitians have an important role to play in advising and supporting the multidisciplinary teams who are working with these young people.

Administrator

The administrator in each CAMHS team is a core member of the multidisciplinary team and is crucial to the smooth running of the service. Specifically, the role includes:

- being consistently at the team base and hence the point of contact for the team at all times
- triaging of phone calls from children and their families to ensure that their needs are met in a timely fashion

- receiving phone referrals from GPs and all other relevant agencies and triaging them to ensure a timely response
- alerting the relevant member of the multidisciplinary team in response to clinical situations.

The administrator is the first point of contact for the CAMHS service and the public impression of the service is determined by how this role is performed. It is essential, particularly in mental health services, that an administrator is available to patients and their families at the team base to respond to urgent phone calls. People with mental health difficulties are less likely to leave messages on an answering machine, and unanswered calls lead to increased clinical risk.

The administrator's role also includes crucial functions to ensure the smooth and safe running of the service.

These include:

- office management
- typing clinical reports for referring doctors/agencies, in order to ensure timely communication of the child's needs

13.3.4.2 Interventions

There should be an appropriate mix of skills in each CAMHS team to ensure the provision of a range of best-practice, therapeutic interventions. These interventions should be recovery-focused, using the appropriate expertise on each team according to the needs of service users (AVFC, 2006).

Examples of therapeutic interventions and approaches in CAMHS:

- psychological and psychosocial interventions, e.g. cognitive behavioural therapy (CBT), dialectic behavioural therapy (DBT), play psychotherapy, psychodynamic psychotherapy, interpersonal psychotherapy
- pharmacological intervention
- combined therapy, e.g. medication and psychological intervention
- arts therapies, e.g. dance movement, drama, music, art therapy/child art psychotherapy
- systemic (family) psychotherapy
- family-based treatment (FBT) for eating disorders
- occupational therapy
- speech and language therapy
- psychoeducation
- counselling, e.g. solution-focused therapy, motivational interviewing
- group-based parent training/education/parenting programmes
- group psychological treatment, e.g. CBT groups, DBT groups, recovery skills groups
- advocacy work

13.3.5 Training and Education

Investment in ongoing training for CAMHS is necessary in order to ensure that each CAMHS team can deliver the necessary interventions for each child and family. Training should be both profession-specific and interdisciplinary. Supervision should be integral to each CAMHS team.

Line managers should ensure that all new staff undergo an induction programme. This should be an evidence-based programme linked to the team's goals.

13.3.6 Tertiary Service Components

Unlike adult mental health services, community CAMHS teams do not have, as an integral part of their service, a day hospital and an inpatient unit. Both of these facilities are provided as tertiary-level services with CAMHS teams formally referring children for consideration for admission.

These tertiary services provide specialist mental health services for those children and adolescents who have complex and severe mental health problems, and who may be at high risk of harm. They consist of intensive community-based care or inpatient care provided through day hospital service or specialist mental health CAMHS inpatient service.

13.3.5.1 Intensive Community Treatment Services

Within CAMHS, intensive treatment services may be provided by day hospitals and assertive outreach teams. Currently, day hospitals are the only source of community-based intensive treatment services.

CAMHS Day Hospitals

CAMHS day hospitals provide a more intensive treatment programme to young people than community teams can provide. Day hospitals are used as a preferable alternative to admission and they also facilitate early discharge of patients from inpatient units. AVFC recommends that there be one day hospital per 300,000 population. CAMHS day hospitals generally cater for 12-18 year-olds with severe and/or complex mental illness. As day hospitals are a tertiary service, all young people are discharged back to their local CAMHS team.

Aims of CAMHS Day Hospitals:

- Provide enhanced care and treatment for young people and their families attending the community teams, where clinically indicated.
- Facilitate earlier discharge of young people admitted to inpatient units.
- Provision of group-based multidisciplinary therapeutic interventions to improve the young person's functioning; these interventions may be across a range of areas including cognitive, emotional, psychological, linguistic, social, and physical depending on the composition of the group. By providing group work, larger numbers of young people may be seen over a shorter period of time (up to six members per group).
- Provide nursing care on a daily basis: observing, monitoring and responding to issues relating to both general and mental health.
- Provide ongoing mental health assessment and treatment while also managing challenging behaviour and risk events.
- Administer prescribed medications and observe for efficacy and side effects; promote medication management and education for both the young person and their family.
- Provide a point of contact on a daily basis for parents and family to deal with immediate issues and concerns, and participate as part of the multidisciplinary team in family work.
- Provide ongoing education and information on the nature of the child's illness, relapse prevention and the discharge plan to the young person and their family.
- Advocate on behalf of the young people.
- Focus on recovery within the community and within the home environment

Staffing

Although AVFC does not recommend specific staffing for CAMHS day hospitals, the following disciplines should be represented in order to ensure that a multidisciplinary, recovery-focused approach is delivered:

- consultant child psychiatrist
- mental health nurses (CMNII, CNS, Staff nurses)
- administrator
- occupational therapist
- clinical psychologist
- social worker
- speech and language therapist
- childcare worker/social care worker

Referral Criteria for CAMHS Day Hospital:

The referral criteria are as follows:

- Age up to 18 years old
- The severity and complexity of the presenting mental health disorder is such that treatment at secondary care service level (CAMHS team) has not met the young person's needs.
- The young person has major mental illness such as depression, psychosis, bipolar affective disorder, severe anxiety disorder.

Exclusion Criteria

CAMHS day hospitals do not provide for:

- children with a moderate or severe intellectual disability (ID)
- children whose presentation is a developmental disorder, where there are no comorbid mental health disorders present
- assessments or interventions that pertain to educational needs specifically
- child-abuse assessments and investigations

Interventions offered in CAMHS Day Hospitals may include:

- individual and group therapy
- dialectical behavioural therapy-informed treatment
- outreach and home-based treatment
- a variety of groups such as:
 - mindfulness
 - problem-solving
 - recovery-focused
 - outings
 - family groups
 - parents/carers group
 - life skills

13.3.5.2 CAMHS Inpatient Services

Specialist mental health CAMHS inpatient services are registered Approved Centres under the Mental Health Act, 2001, which operate under the legislative framework of the Act and the regulatory codes of practice and standards of the Mental Health Commission.

Referrals accepted for admission to an Approved Centre will have a severe mental illness where there is clear evidence that:

- Intensive treatment is required that cannot be provided in the community or at home, such as when the mental illness affects all aspects of the young person's life.
- There is a high level of risk due to mental illness that cannot be safely managed in the community and where admission would be expected to manage this risk.

Determining the 'seriousness' of a child or young person's condition – its severity, complexity and risk – is always a clinical judgement and every case referred will be assessed on a case-by-case basis. The final decision regarding admission rests with the inpatient consultant psychiatrist who assumes clinical responsibility for the young person once they have been admitted.

Detailed information on the operational guidance and model of service provision can be found in the Child and Adolescent Mental Health Services: Standard Operating Procedure (HSE, 2015). A brief outline of these guidelines is provided in the sections that follow.

Referrals

Referrals must be made by a consultant psychiatrist, in line with the referral criteria outlined above. Inpatient units generally admit young people aged 12-17 years, and referrals below this age will be considered on a case-by-case basis. An undertaking to provide ongoing care and treatment post discharge by an appropriate team must be given at the point of referral.

Admission

Young people are admitted to Approved Centres under the legislative framework of the Mental Health Act 2001. Young people may be admitted as 'voluntary' patients under parental consent, or detained under Section 25 of the Act.

The Mental Health Act, 2001 in Relation to Children and Adolescents

The Mental Health Act, 2001 specifically deals with the involuntary admission of patients to Approved Centres (inpatient psychiatric units). The Act defines a child as a person under the age of 18 who has not been married. In general, most young people admitted to CAMHS inpatient units are admitted on a voluntary basis. Under the Act, a voluntary patient is a person who is receiving care and treatment in an Approved Centre but who is not the subject of an admission order. Essentially, this means that young people are admitted to Approved Centres with the consent of their parents as enshrined in the Irish Constitution. Currently, in Ireland, there are six CAMHS inpatient units which are Approved Centres, four provided for by the HSE in Cork (1), Galway (1) and Dublin (2), with two further units in Dublin in the independent sector.

There is some discussion about the appropriateness of some of this legislation, e.g. at what age a young person can be deemed to have the capacity to make decisions about their own mental health. Currently, while the assent of a young person is sought on admission, it is his or her parents, or those acting in loco parentis, who consent to their admission to an Approved Centre.

In certain circumstances it may be necessary to obtain an order under the Mental Health Act, 2001 for a young person to be admitted. This may arise where a young person, e.g. a 16-year-old or 17-year-old, is refusing admission to the inpatient unit and it is deemed necessary for them to be admitted in order for them to receive the necessary

care and treatment (this will be discussed in the next paragraph). It may also arise where the parents are objecting to the admission of a young person to an Approved Centre, but the treating consultant psychiatrist feels that it is necessary. Currently, all children on a Care Order (Child Care Act, 1991) must be admitted on an involuntary basis. However, this may be revised where the child, legal guardian and parent/s all agree to the admission.

The criteria for an application for an admission order are similar to those for an adult, and are outlined in Section 3 of the Mental Health Act, 2001. These are:

- (i) the child is suffering from a mental disorder and that as a result of this disorder the child is at serious likelihood of causing immediate and serious harm to himself/herself or to other persons
- (ii) because of the severity of the disorder that failure to admit would likely lead to a serious deterioration in his/her condition, or would prevent the administration of appropriate treatment that could only be given by such admission, and that reception, detention and treatment of the person in the Approved Centre would be likely to benefit the condition of that person to a material extent.

All applications for admission orders are heard in the local District Court. The treating consultant psychiatrist must assess the young person and provide a report for the Court. An initial order is valid for up to 21 days, at which point the consultant psychiatrist must return to the District Court to give a report on the child's progress. A renewal order may then be granted for a further period of three months and thereafter for six-month periods, subject to further reports and attendance at the local District Court. On rare occasions, an ex parte application may be made if the urgency of the case so requires.

Prior to attendance at court for an application under the Mental Health Act, a bed must be identified and reserved for a young person in an Approved Centre. It is also important that the views of a young person and his/her parents are represented in court.

Interventions

- While an inpatient, the young person, and their family, will receive intensive multidisciplinary assessments and interventions.
- All young people will receive an initial treatment plan, and undergo risk assessment and physical examination within 24 hours.
- A detailed, collaborative, multidisciplinary ICP will be completed within seven days with the young person and his/her family agreeing inpatient treatment goals.
- Ongoing evaluation of risk.
- Discharge planning will be an active process from the point of admission. A number of strategies to support successful transition back to local community services will be implemented, such as:
 - (i) Regular clinical review meetings with the referral agent/identified community service providing ongoing therapeutic support post discharge, and other agencies involved in the young person's ongoing care.
 - (ii) Interagency working with other supports relevant for the young person, e.g. Tusla, educational and training services, other community support services, or other specialist psychotherapy services that the young person may attend.
 - (iii) The provision of therapeutic leave.
 - (iv) Clarity regarding discharge processes, the provision of a clear discharge plan for a young person, and the provision of written discharge summaries and reports to relevant agencies.
- Medication management.
- Organised medical consultation and treatment for children with comorbid medical complications, e.g. children with eating disorders.

Staffing

The staffing of inpatient units should also be multidisciplinary, reflecting the ethos of care and treatment and taking into account the acuity of clinical presentations.

Interdependencies with other services

Inpatient services interact with a significant number of services, from the point of referral through to discharge. These include:

- community CAMHS teams
- community CAMHS day hospital services
- paediatric liaison services
- adult mental health services – outpatient and liaison/emergency services
- Tusla/community support services
- primary care services (GPs)
- acute (paediatric and adult) hospitals

13.3.7 Paediatric Liaison Psychiatry

Liaison psychiatry is the medical specialty concerned with the care of individuals presenting to a hospital setting with both mental and physical health symptoms, regardless of presumed cause. The specialty adopts a bio-psychosocial approach, considering the inter-relationship between physiology, psychology and sociology of ill health. While addressing the patient's mental and physical health along with their social care needs, liaison psychiatry formulates and delivers brief psychotherapeutic interventions, most commonly cognitive behavioural therapy or psychodynamic interpersonal therapy. The liaison psychiatry service has clear benefits for the individuals treated, in terms of limiting morbidity, improving quality of life and reducing hospital admission stays, and also achieves financial savings in medical costs. These benefits are most clearly documented in, but not limited to, the adult population.

It is known that having a medical illness doubles the risk of developing mental health problems. Hence, children presenting to a hospital setting will be at substantially increased risk of comorbid mental health problems.

As noted earlier, AVFC recommended one team to provide a hospital liaison service per 300,000 population, i.e. a total of 15 teams for Ireland based on 2011 Census data. Each team should be staffed in line with AVFC recommendations (see Section 2.4.1). Currently, there are three Specialist Paediatric Liaison Services in Ireland, operating in each of the three paediatric hospitals in Dublin (Our Lady's Children's Hospital Crumlin, Temple Street Children's University Hospital, National Children's Hospital Tallaght). Each of these teams has varying staffing mixes and numbers, and a new team approved for Cork in late 2014 is currently being recruited. Elsewhere, paediatric liaison services are provided by local arrangements involving the community CAMHS teams while awaiting the development of the liaison teams as recommended by AVFC.

13.3.6.1 Specialist Paediatric Liaison Psychiatry Teams

Paediatric liaison psychiatry teams are designed to operate in hospital emergency departments, wards and outpatient settings.

Ward/Outpatients Department Component

Referrals are received from consultant medical/surgical colleagues within the hospital, where the young person is either an inpatient or is attending on a regular basis as an outpatient. Assessing and attending to the child's

mental illness may be a fundamental part of their overall treatment. The team works to understand the ways in which medical illness and its treatment can impact on psychological experiences and how these experiences can influence coping with a medical illness or its treatment. The goal is to alleviate the psychological burden on the child and family that is linked to some medical conditions and to optimise the young person's care. One example is the presentation of a young child, medically compromised due to intentional weight loss, and the need for the psychiatry team to link with medical colleagues in the creation of a treatment plan to effect medical stabilisation and address eating disorder psychopathology. Such a treatment plan would typically involve family-based work, individual therapy, liaison with dietitians, physiotherapists, the young person's school, nursing staff and, on occasions, social workers and the hospital legal team.

Emergency Department Component

Many referrals will originate from the emergency department (ED). The ED represents an essential and necessary provision of overall mental health services for children, allowing for urgent assessment of acute mental health presentations, which is often not available in any other setting. Children are often referred by their GPs or by relevant local services, or parents may self-present children. Self-harm has become an increasing reason for emergency assessment in the ED and, in many cases, children repeat and re-present (Cassidy et al., 2009; McNicholas et al., 2010; Morgan and Fitzpatrick, 2009). Effective management of acute mental health presentations may be appropriate and safe in the hospital setting; however, on occasion, referral to CAMHS inpatient units will be necessary. Good communication between CAMHS, the outpatients department (OPD) and inpatient services of the paediatric hospital is vital for the appropriate, safe and ongoing management of these young people. However, the capacity to provide a specialised and rapid response needs to be adequately resourced and should also include a properly staffed on-call system.

Model of Care

The model of care in paediatric liaison psychiatry is split between emergency, inpatient and outpatient services, with some services being limited to normal office hours and others, e.g. in EDs, offering 24/7 on-call provision.

In line with other CAMHS services, the paediatric liaison team should be multidisciplinary.

The particular issues that benefit from input from a paediatric liaison psychiatry service include:

- self-harm and children presenting with suicidal ideation
- mental illnesses such as depression, psychosis and post-traumatic stress disorder
- psychosomatic diagnostic problems in children admitted primarily with physical symptoms but which, on assessment, have mainly psychological or social causation
- mood disturbance or psychotic symptoms due to chronic or long-term mental illness or which are treatment induced, e.g. drug-induced psychosis
- evaluation of children and adolescents who are having difficulties adhering to their medical treatment regimen
- evaluation and treatment of infants with feeding disorders and growth deficiency
- evaluation and treatment of children and adolescents with eating disorders and growth deficiency
- pre-surgical psychiatric evaluation, e.g. surgery for epilepsy

Reflecting the range of referral sources, the assessment and service delivery may occur across a range of settings within the acute paediatric hospital. These include:

- Inpatient wards: referrals come from medical and surgical teams and, where the child is too unwell to leave the ward, the assessment is carried out by the bedside or in an appropriate room on the ward.
- The Emergency Department: the assessment is best managed in a safe, quiet room away from the busy section, but also ensures safety for the child, family and clinical staff.
- Short-term stabilisation of children with acute psychiatric presentations and at high risk, e.g. suicidal children and children with acute onset of psychosis.
- Outpatient clinics: referrals come from outpatient medical and surgical hospital teams requiring assessment or follow-up. This service may also be needed by those discharged from an inpatient stay, who require CAMHS follow-up pending a community CAMHS appointment. There may also be referrals from other services requesting second opinions, e.g. from other CAMHS consultants specifically for eating disorders.

Therapeutic Approach

The therapeutic approach is in line with other CAMHS services and involves assessment and diagnosis followed by a multidisciplinary ICP. The assessment must be adjusted to suit the presentation and will often require information exchange with a range of health and social care professionals both in and outside the hospital. These may include CAMHS colleagues and Tusla.

The therapeutic interventions are typically multimodal, including family work, individual cognitive behavioural therapy, behavioural or counselling support and medication, as appropriate. Co-working with other medical disciplines such as the occupational therapy and physiotherapy departments for physical rehabilitation, dietetics for children with eating disorders, speech and language therapy, psychology, play therapy, and social work is also common.

While the key role of the paediatric liaison psychiatric service is to assess and advise/manage mental health presentations in hospital in a timely manner, it also acts as a resource for staff who may require advice on patient needs and treatment. The service may also provide education to increase awareness of mental health among non-mental health hospital staff, to assist them in the recognition and management of common mental health presentations in order to encourage early referral of children, and may advocate for improved mental health services.

13.3.6.2 Hospitals without Specialist Paediatric Liaison Psychiatry Teams

Due to the lack of dedicated paediatric liaison psychiatry teams nationally, hospitals that do not have these services in house are provided with them under local arrangements with community CAMHS services. Pending the provision of these specialist teams, there are a number of strategies that may support paediatric services and CAMHS teams in providing these important services. These include:

- Agreed local arrangements regarding the provision of liaison services to local paediatric services, with guidance on processes of referral of cases, initial management of cases that present to emergency departments or on the acute ward
- Considering the use of referral documents highlighting critical information to allow communication of risk or inform assessment of urgency for review by CAMHS/paediatric liaison services
- Regular shared audit of presentations of young people with mental health needs within paediatric services, and outcomes of referrals, such as bed occupancy days, staffing requirements, risks identified, and any barriers to discharge

- Regular scheduled meetings of senior clinicians and/or managers of paediatric and CAMHS services to identify patterns of presentation, process or operational challenges that have arisen, and shared risk planning regarding management of such cases.

16- and 17-year-olds

The paediatric emergency departments are accessible to children under the age of 16 years, and therefore emergency presentation of children between the ages of 16-18 years occurs at the adult general hospitals, most if not all of which have no child psychiatry cover. Both the resourcing and standardisation of on-call provision to children under 16 and in the 16-18 years age group have been recognised as being in need of urgent attention, as identified in the HSE Mental Health Division: Operational Plan 2015.

Areas for Development

- There is an urgent need for the provision of the 15 paediatric liaison psychiatry teams nationally.
- Existing teams require additional resourcing, in particular to increase staffing levels in line with AVFC recommendations.
- Local service level agreements will have a valuable role in supporting arrangements for the assessment of emergency presentations.
- Resourcing and standardisation of on-call provision to children aged under 16 years as well as to 16-17 year-olds requires urgent attention.

13.3.8 CAMHS for Children with Intellectual Disability

It is known that 3.8% of the population have an intellectual disability (ID). This is mild in 3% of cases, and more severe in the remainder, i.e. moderate to profound. The seriousness of a child's disability may not become apparent until they start school. As happens in adult mental health services, and in line with AVFC, children with mild ID are seen by generic CAMHS services, while those with moderate or greater degrees require specialist CAMHS mental health of intellectual disability (MHID) services, due to the special expertise needed to recognise and treat mental illness in this group of children. Furthermore, frequent medical comorbidities must be taken into account by the treating team and this, too, requires special expertise.

The issue of mental health provision for children with a learning disability was addressed by the College of Psychiatrists of Ireland in its Position paper on Mental Health Provision for Children with a Learning Disability (2011). The paper elaborates on the recommendations of AVFC and the relevant points are outlined in the sections that follow.

Rationale for separate service

Children with ID may suffer the full range of psychiatric disorders experienced by children of average intelligence. The most commonly encountered problems include Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD) with associated mental illness, Tourette syndrome and behavioural phenotypes (Lesch-Nyhan syndrome, Pradar-Willi syndrome). Due to medical advances, which may lead to many preterm or very sick babies spending increased lengths of time in intensive care, there is an increased risk of attachment disorders.

Psychiatric disorders in these children are complex and best responded to by a bio-psychosocial model for assessment and treatment. These children have multiple needs, and therefore assessment and diagnosis is multifaceted and multidisciplinary. There is also an increased risk of medical conditions due to the greater incidence of congenital abnormalities.

Assessments are lengthier and involve a high level of interagency collaboration. This includes close liaison with primary care, paediatrics, CAMHS, adult mental health services for people with ID, disability services and schools. While assessment tools are helpful, they have not been validated for children with ID. The 2011 position paper from the College of Psychiatrists, referred to above, suggested that the Developmental Behaviour Checklist and the Nisonger Child Behaviour Rating Form may be considered for use. Both of these are used to screen populations and are of assistance in the diagnosis and assessment of response to psychopathology in this group.

Treatment Approaches

The child psychiatrist, working closely with the family, has a key function in the coordination of treatment interventions that need to be adapted to the ability level of the child. The more common range of treatments used includes psychoeducation (of the wider family and supporting community), behaviour therapy, family therapy, pharmacological therapy, social skills training and other specialised individual therapies specific to children with ID.

Pharmacological Therapy

Drug treatments are valuable in targeting symptoms of psychiatric disorders. While they can help to alleviate challenging behaviours, they should always be used in conjunction with, rather than as a substitute for, MDT assessment and intervention.

Children with ID often have idiosyncratic responses to medication, so their reactions must be monitored closely because side effects can go unreported. A high level of investigation is also recommended prior to commencement because of other comorbidities such as epilepsy, which also brings the potential for drug interactions.

Service Development

Services should be catchment-area based and should be located in the community. This may be in conjunction with generic CAMHS services, as part of a comprehensive service. However, these services require separate funding and should not be an integral part of the CAMHS service but rather a parallel service for children with ID and comorbid mental health problems. In line with the fact that ID is a lifelong condition, close links with coterminous adult MHID services are essential.

The team must be a multidisciplinary mental health team led by a consultant psychiatrist with training in CAMHS Psychiatry of Learning Disability. The MDT recommended is as listed in AVFC, and is akin to that recommended for generic CAMHS teams. It is recommended that one fully staffed multidisciplinary team covers a catchment area of 300,000 population. The team should have access to an MHID day hospital and outpatient facilities. AVFC does not specify an inpatient bed norm, but the Royal College of Psychiatrists (Lamb et al., 2008) recommends three beds per 500,000 population.

A community outreach service is the model found to be most effective for children with ID. There is often a need to visit children in the home or school setting, particularly where challenging behaviour is a major issue. Likewise, attendance at network meetings with other agencies involved in the child's care is the norm. The team has a key role in providing support to teachers in both mainstream and special needs schools and also to staff in residential placements.

13.3.9 CAMHS Substance Misuse Service

Alcohol is the most widely used drug, and cannabis the most widely used illicit drug. Significant amounts of other drugs are used by young people: benzodiazepines, ecstasy, cocaine, other stimulants, hallucinogens, opiates, solvents, and a myriad of newly developed 'headshop' type drugs. Drug use may begin in pre-teen years, but often only presents for treatment during adolescence. Frequently, adolescents are reluctant to come for treatment, as they wish to continue drug use.

Substance misuse in young people is responded to largely at primary care level, with secondary care mental health services becoming involved where comorbid mental illness and/or ADHD exist. Given the importance of this issue for young people, the primary care response will be outlined in some detail in this section together with the mental health response.

Primary Care Service

The Drugs Taskforce, which has a presence in each area, should be contacted for advice on the services available within the area, as these vary throughout Ireland. Once referred, the young person will undergo an assessment which should cover the following parameters:

- The young person will be interviewed, preferably without a family member present, so that issues parents may not know or approve of can be discussed.
- The pattern and type of drug abuse, together with details of drug/s used, should be elicited.
- It is important to establish the method of administration, e.g. oral, smoking or nasal administration, with injecting being much less common.
- Information on the peer group and its drug use, as well as the family and its drug use, should also be elicited.
- Other problems such as behavioural, school, legal issues, financial worries, along with the names of any other professionals involved, should be recorded.
- Finally, it is important to obtain a collateral history, ideally from the parents or guardians.

The assessment process should identify risks that may need attention prior to, or in parallel with, intervention for the drug abuse itself. These risks may include the need for urgent medical intervention, opiate substitution therapy, abuse, homelessness or criminality. The potential impact of intervention on compliance with treatment of medical conditions such as diabetes and asthma should be identified. Sexual activity with risk of pregnancy and sexually transmitted infections (STIs), and injecting drugs with risk of hepatitis and HIV, should be explained and tested for.

Drug testing kits like 'dipstick testing' are cheap and may be useful for the initial assessment. If headshop products are suspected, testing can be done by prior agreement at the National Treatment Centre.

After stabilisation, the main work to be carried out is to motivate for behavioural change. This is provided through one-to-one counselling, sometimes in conjunction with family therapy. An important element of this is to maximise engagement by the young person, without which it is difficult to effect change. The counselling relies on cognitive behavioural therapy and motivational interviewing.

Mental Health Services

Referral to mental health services should be considered where there are moderate or greater degrees of depression or anxiety. It should also be considered where psychosis is evident and where the child or young person has ADHD. In Dublin there are specialist CAMHS addiction services available; outside of Dublin, the pathway is referral to the local CAMHS team.

13.4 REQUIREMENTS FOR SUCCESSFUL IMPLEMENTATION OF MODEL OF CARE

The resources required for CAMHS services are, for the most part, outlined in Section 2 of this document. However, there are a number of barriers that need to be addressed urgently. These are described in the sections that follow.

13.4.1 Primary Care Provision

As outlined previously, primary care provision includes primary care psychology, educational psychology and early and school-age intervention teams. Gaps in primary care provision result in increased referrals to CAMHS, impeding the capacity of CAMHS to respond in a timely fashion to those with moderate to severe mental health problems. Of particular note is the fact that the number of referrals to CAMHS teams rose from 8,663 in 2011 to 13,062 in 2014 – an increase of approximately 50% without a concomitant increase in staffing.

There is an urgent need for a comprehensive mapping of primary care provision for children with mental health and developmental problems, together with a plan on how to augment the provision to provide a comprehensive service for children at this level of care.

13.4.2 Tusla

There is an urgent need to provide increased community services for children with social care needs, including “out-of-hours” services.

13.4.3 Under-resourcing of CAMHS

Despite developments in recent years resulting from special ring-fenced funding provided by the Department of Health, CAMHS teams remain under-resourced, as outlined in the earlier section.

- Currently, CAMHS teams have approximately 50% of the staffing recommended by AVFC, thereby limiting the number and range of therapeutic interventions they can provide.
- Day hospital services remain underdeveloped, with only four day hospitals in operation compared with the AVFC recommendation of 15.
- Inpatient beds both generic, and specialist, (for young people with very complex eating disorders, ID, and forensics), are inadequate in number and type. Currently, only 58 out of the 108 beds recommended by AVFC are available and there are no specialist beds.
- Paediatric liaison services are deficient in both number of services and the resourcing of existing services. There is also a deficit in on-call provision.
- CAMHS services for children with moderate or greater degrees of ID are few in number and, where they exist, do not have the full complement of disciplines recommended by AVFC.

13.4.4 Effective Interagency Working

In order to respond comprehensively to the needs of children, interagency or multi-agency working by CAMHS, involving not just primary and social care, but also the child and family agencies (e.g. Tusla), educational and judicial services, is vital as are general health services at primary care and secondary care level. This requirement is well recognised and an integrated care pathway for children’s services is currently being drawn up by the Clinical Strategy and Programmes Division.

13.4.5 Youth-based Approach/Transition

Within the defined mental health services as a whole, it is recognised that there can be difficulties in ensuring a smooth transition between CAMHS and adult mental health services at the age of 18. This is also the age when young people transition from school to seeking work or entering third-level education. This transition can pose a particular problem for young people with ADHD, as general adult mental health services do not provide for this condition. There are two initiatives which, it is hoped, will constitute the beginning of a youth-based approach. These are the Clinical Programmes for Eating Disorders and First Episode Psychosis, both of which recognise the importance of a smooth transition at the age of 18 years. This approach could be usefully considered for all other conditions requiring transition from children's to adult services.

In the meantime, it is recommended that there be a six-month lead-in for those adolescents requiring transfer from CAMHS to adult mental health services. To ensure that this works smoothly, a key worker should be appointed specifically to ensure that the transition takes place with minimum disruption to the young person, with the key worker acting as advocate as well as coordinator for the transition process.

13.5 METRICS AND EVALUATION

Current data collected on CAMHS by the HSE include the quantitative metrics shown in Table #.6 below.

Table 13.6: Access Metric in CAMHS

Metric	Target
The percentage of accepted CAMHS referrals offered first appointment within 12 weeks	78%
The percentage of accepted CAMHS referrals offered first appointment and seen within 12 weeks	72%
The percentage of admissions of children to CAMHS Acute Inpatient Units as a percentage of total number of admissions of children to Mental Health Acute Inpatient Units	95%

These data have been invaluable in providing some measure of activity in CAMHS, with its focus on timely access. However, data on paediatric liaison activity are not collected. Currently, all data are quantitative rather than qualitative. An example of qualitative data includes variations in case complexity. There is a need to implement routine outcome measures in order to gauge the effectiveness of treatment, with a particular focus on symptom reduction and quality-of-life improvement.

Suggested Outcome Measures:

1. The Strengths and Difficulties Questionnaire (Goodman, 1997) is a brief child mental health questionnaire for children and adolescents aged 2-17 years. It exists in several versions, all of which ask about 25 attributes, some positive and others negative. These 25 attributes are divided among five scales:
 - i. emotional symptoms (five items) added together to generate a total difficulties score (based on 20 items)
 - ii. conduct problems (five items)
 - iii. hyperactivity/inattention (five items)
 - iv. peer relationship problems (five items)
 - v. prosocial behaviour (five items)

2. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (1999) is an assessment and outcome measurement tool intended to be used routinely to score the behaviour, symptoms and social functioning of children and young people with mental health difficulties. It is a 15-item questionnaire, to be completed by the team, designed to establish the severity of each problem, on a scale of 0-4. Thirteen items relate to the child and two relate to parental access to services. Child and parent self-rate versions are also available, each as a single A4 sheet, and take approximately ten minutes to administer.
3. The Children's Global Assessment Scale (CGAS) (Schaffer et al., 1983) is a numeric scale (1-100) used by mental health clinicians to rate the general functioning of children under the age of 18 years. Service stakeholder satisfaction could also be sought and might include referring agents e.g. GPs.
4. In relation to service satisfaction, the Patient, Friends and Family Test (PFFT) is useful, as it is brief, reliable and allows for international comparisons.

The Quality Network for Inpatient Care (QNIC) is a UK-based organisation which facilitates collection of qualitative data on inpatient CAMHS provision. There is also a community equivalent and it is recommended that this be introduced so that both qualitative and quantitative data are collected in order to monitor the activity of CAMHS teams.

Adoption of these routine outcome measures would complement the qualitative data now collected, and their implementation is strongly recommended.

13.6 ABBREVIATIONS AND ACRONYMS

ADHA/ADD	Attention Deficit (Hyperactivity) Disorder
ASD	Autism Spectrum Disorder
AVFC	A Vision of Change
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioral Therapy
CGAS	Children's Global Assessment Scale
CHO	Community Health Organisation
DBT	Dialectic Behavioral Therapy
ED	Emergency Department
FBT	Family Based Treatment
GPs	General Practitioners
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents
ICP	Individual Care Plan
ID	Intellectual Disability
NEPs	National Educational Psychology Service
PFFT	Patient, Friends and Family Test
QNIC	Quality Network for Inpatient Care
SDQ	Strength and Difficulty Questionnaire
SLTs	Speech and Language Therapists
SPHE	Social Personal and Health Education
UNCROC	United Nations Convention on the Rights of the Child

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