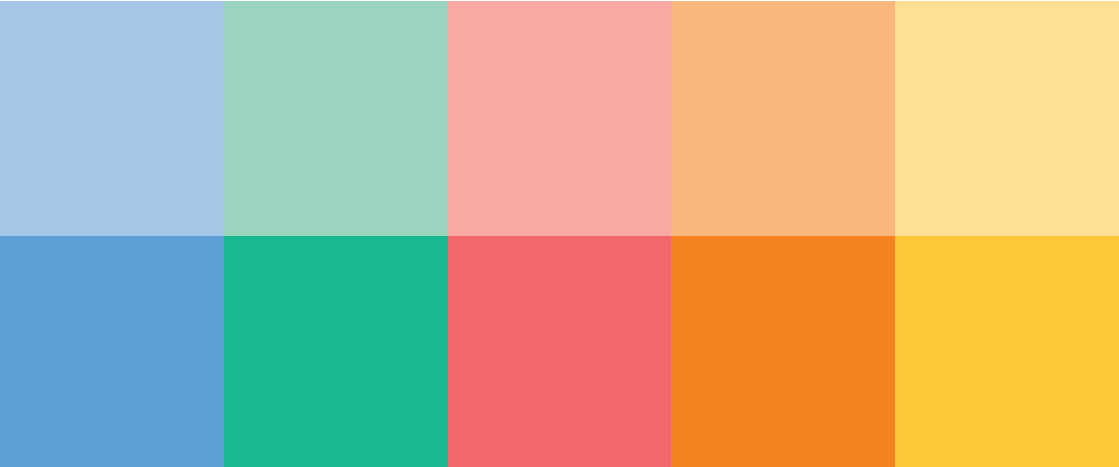


Child and Adolescent Mental Health Services

Standard Operating Procedure



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Child and Adolescent
Mental Health Services

Health Service Executive Corporate Plan 2015-2017

Vision

A healthier Ireland with a high quality health service valued by all

Mission

- People in Ireland are supported by health and social care services to achieve their full potential
- People in Ireland can access safe, compassionate and quality care when they need it
- People in Ireland can be confident that we will deliver the best health outcomes and value through optimising our Resources

Values

CARE

- We will provide care that is of the highest quality
- We will deliver evidence-based best practice
- We will listen to the views and opinions of our patients and service users and consider them in how we plan and deliver our services

COMPASSION

- We will show respect, kindness, consideration and empathy in our communication and interaction with people
- We will be courteous and open in our communication with people and recognise their fundamental worth
- We will provide services with dignity and demonstrate professionalism at all times

TRUST

- We will provide services in which people have trust and confidence
- We will be open and transparent in how we provide services
- We will show honesty, integrity, consistency and accountability in decisions and actions

LEARNING

- We will foster learning, innovation and creativity
- We will support and encourage our workforce to achieve their full potential
- We will acknowledge when something is wrong, apologise for it, take corrective action and learn from it

We will try to live our values every day and will continue to develop them over the course of this plan.

Child and Adolescent Mental Health Services

Standard Operating Procedure

June 2015

1. Community CAMHS Team

2. CAMHS In-Patient Units

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Implementation date 1st June 2015

Responsibility for implementation Chief Officer, Community Health Organisation

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Responsibility for review and audit

Local: CO, Head of MH, AMHMT

National: National Director, Mental Health Division

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1

Part 1 Policy Structure

1.0 Policy Statement

- 1.1** The development of comprehensive secondary care Child and Adolescent Mental Health Services (CAMHS) for young people up to the age of 18 years is described in the Department of Health and Children's policy document; *A Vision for Change* (2006).
- 1.2** The Vision for Change document describes how services must be coordinated and integrated to meet the full range of moderate to severe mental health needs of children and adolescents. 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 such as CAMHS.
- 1.3** There are many examples of excellent work that are being carried out within community and in-patient CAMHS across the country. However, there are also examples of inconsistencies across services, specifically in the areas of waiting times, treatment times, scope of treatment options available, clarity of information available to families and the interface with other agencies both internal and external to the HSE.
- 1.4** The HSE's Mental Health Division is committed to ensuring that all aspects of CAMHS are delivered in a consistent and timely fashion, regardless of where the service is accessed throughout the country. The Child and Adolescent Mental Health Services Improvement Steering Group, established a subgroup, the CAMHS Improvement Project to review and examine key performance indicators relating to how CAMHS are operating in Ireland. One of the primary objectives of the CAMHS project group has been to develop a Standard Operating Procedure (SOP) for both in-patient and community CAMHS.

2.0 Purpose

- 2.1** The purpose of this SOP will be to ensure that:
- » The delivery of services by child and CAMHS teams is carried out in a consistent and transparent manner in Ireland.
 - » The care and treatment offered reflects the identified clinical needs of the child.

- » The children and young people who access treatment programmes for similar clinical presentations will receive a level of clinical care that is consistent across all CAMHS.
- » Clear direction and information is provided for CAMHS teams and other partner services about CAMHS provision.

3.0 Scope

- 3.1** This SOP applies to all staff engaged in delivering CAMHS in or on behalf of the HSE in both community and in-patient settings.
- 3.2** The SOP is available to partner agencies, stakeholders, service users and their families.

4.0 Legislation/Other Related Policies

- » United Nations Convention on the Rights of the Child (UNCRC) (1989)
- » Child Care Act (1991)
- » Protection for Persons Reporting Child Abuse Act (1998)
- » The Mental Health Act (2001)
- » Disability Act (2005)
- » A Vision for Change (2006), DoHC
- » Quality Framework for Mental Health Services (2007)
- » Children First: National Guidance for the Protection and Welfare of Children (2011)
- » HSE National Consent Policy (2013)
- » Better Outcomes, Brighter Futures; The National Policy Framework for Children and Young People (2014)

5.0 Glossary of Terms and Definitions

AMHMT – Area Mental Health Management Team

CAMHS – Child and Adolescent Mental Health Services

CHO – Community Health Organisation

HSE – Health Service Executive

KPI – Key Performance Indicator

MDT – Multi-disciplinary Team

SOP – Standard Operating Procedure

VFC – *A Vision for Change*

Approved Centre – Under the Mental Health Act 2001, an Approved Centre means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder.

6.0 Roles and Responsibilities

6.1 Director General

Has overall responsibility for:

6.1.1 Ensuring that governance arrangements are in place to ensure that legislative, professional and organisational obligations in relation to the management and implementation of this SOP are being addressed.

6.2 Mental Health Division

Has overall responsibility for:

6.2.1 National oversight concerning the implementation, compliance and operation of the SOP.

6.2.2 Audit and measurement of CAMHS activities against key performance indicators (KPIs) as outlined in the annual Mental Health Divisional plan.

6.2.3 Performance management of CHO areas where CAMHS KPIs are not being met.

6.3 CHO Management Team

Has overall responsibility for:

6.3.1 Ensuring that arrangements exist for the ongoing monitoring of CAMHS teams activity and performance against the SOP.

6.3.2 Providing and monitoring resources necessary for implementing this SOP.

6.4 Local Area Mental Health Management Team

- 6.4.1 The day to day oversight management responsibilities are carried out by the Area Mental Health Management Teams (AMHMT). Each AMHMT consists of an executive clinical director, area director of nursing, business manager, and principals in psychology, social work, occupational therapy as well as a service user representative.
- 6.4.2 The AMHMT are responsible for ensuring the best use of allocated resources for the implementation of this SOP.
- 6.4.3 The AMHMT are responsible for ensuring that appropriate systems are in place to communicate the SOP and related local procedures to all employees and others directly affected by its implementation.

6.5 All Employees

Have responsibility for:

- 6.5.1 Familiarising themselves with the content of this policy.
Informing their line managers if they have concerns about the content of this SOP or if they experience any difficulties during the implementation stage of this SOP.

7.0 Implementation Plan

- 7.1 The Chief Officer of the CHO must oversee the implementation of this SOP and report any difficulties encountered to the Mental Health Division.
- 7.2 A roll-out implementation plan for this SOP will be developed within the CHO in consultation with both local management and staff. This should include awareness-raising sessions for staff detailing the contents/provisions of this SOP.
- 7.3 The Mental Health Division, through its monthly performance management meetings within each CHO management team, will monitor and measure compliance to the SOP. This will be achieved through face to face or teleconference calls with each CHO team and the collection of relevant national CAMHS activity data already in place.

8.0 Revision and Audit

- 8.1** This SOP will be reviewed within two years, or sooner if necessary, to reflect any relevant developments. This review will be carried out by the Project Lead of the CAMHS Improvement Group under the direction of the CAMHS Improvement Steering Group.
- 8.2** CAMHS activity data is currently collected over a number of different activity domains. This data will be reviewed on a monthly basis by the Project Lead for the CAMHS Improvement Group on behalf of the Mental Health Division. An annual CAMHS activity report is produced and will now be included as part of an overall Mental Health Division Oversight Report.
- 8.3** Each CHO Management Team will be responsible for monitoring employee practices in relation to compliance with this policy.

2

Part 2 – Community, Child and Adolescent Mental Health Service

9.0 Introduction

9.1 What this SOP Covers:

This SOP is for the Child and Adolescent Mental Health Services (CAMHS) – **Community Teams**. It provides information for team members and for other services about CAMHS provision and the care processes in the following areas:

- » Clinical Governance
- » Core Business of CAMHS
- » Referrals, Triage and Flow Chart
- » Diagnosis
- » Integrated Care Planning
- » Clinical Reviews
- » Service User Involvement
- » Management of DNAs (did not attend)
- » Transition to Adult Mental Health Services.

9.2 This Policy Applies To:

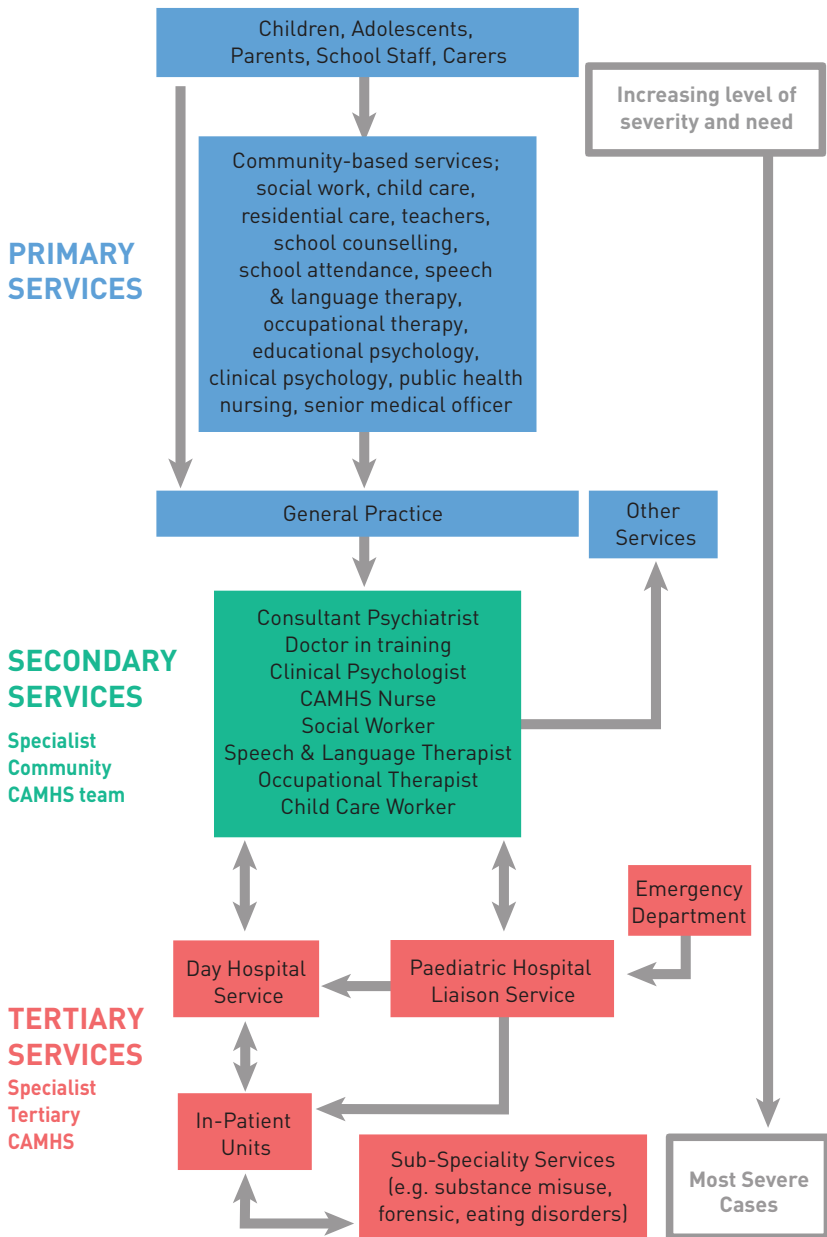
All staff engaged in delivering specialist mental health services as members of a CAMHS Team. The SOP is available to partner agencies, key stakeholders such as voluntary and community groups, service users and their families.

9.3 What is CAMHS?

CAMHS stands for 'child and adolescent mental health services'. While a broad range of services support the mental health of children and adolescents, the term 'CAMHS' is usually applied very specifically to services that provide specialist mental health treatment and care to young people up to 18 years of age through a multi-disciplinary team.

CAMHS are best conceptualised in a tiered model as shown in Section 10.

10.0 Model of Child and Adolescent Mental Health Services



10.1 Primary Care Services

- 10.1.1** Primary care services are usually the first point of contact for children when mental health problems arise and they provide a first line of response. These services include:
- » community psychologists
 - » speech and language therapists
 - » community occupational therapists
 - » public health nurses
 - » primary care social workers
 - » public health doctors
 - » specialist early intervention and school age services for children with developmental delay. This includes autism spectrum disorder.
- 10.1.2** Children with mild to moderate difficulties are seen by the relevant primary care services listed above. They and their parents/carers receive information, advice and specific interventions. These services are provided through both the Primary Care and Social Care Divisions.
- 10.1.3** An important role of primary care services is also to identify when a child or young person needs more specialist mental health care and to initiate such referral through the child's GP, or directly by a senior clinician in collaboration with the GP (*see 13.3*).
- 10.1.4** GPs are usually the first point of contact for families who seek help for various problems. With the appropriate information and training, GPs are best placed to recognise risk factors for mental health disorders, to provide treatment or advice where appropriate, and to refer to more appropriate services or specialist services when this is indicated.
- 10.1.5** Clear links must be developed between primary care and mental health services to coordinate appropriate service provision for children and adolescents with risk of mental health problems.

10.2 Secondary Services

10.2.1 This is the first line of specialist services. The community CAMHS team, under the clinical leadership of a consultant child and adolescent psychiatrist (*A Vision for Change*, chapter 9.3), is recommended to include junior medical staff, two psychologists, two social workers, two nurses, a speech and language therapist, an occupational therapist and a child care worker. The assessment and intervention provided by such a team is determined by the nature, severity and complexity of the presenting problem(s) in collaboration with the child/young person and their family.

10.2.2 To work effectively, a range of disciplines, skills and perspectives are required, so that children and adolescents are offered a care and treatment package which addresses their individual clinical needs. A multi-disciplinary composition to the team is therefore required that incorporates the range of skills necessary to address the clinical management of the varied and complex clinical problems presented. Community CAMHS teams must also work closely with other agencies present in the child's/young person's life.

10.3 Tertiary Services

10.3.1 These consist of intensive community based care and in-patient care through specialist mental health in-patient services. Tertiary services provide specialist mental health services for those children and adolescents who have complex and severe mental health problems.

11.0 Clinical Governance Structures

11.1 It is recognised that to assist CAMHS in assuming a full role as a secondary and tertiary mental health care service, it is essential that CAMHS are an integral part of the overall mental health services as envisioned in *A Vision for Change*.

11.2 *A Vision for Change* emphasises the importance of an enhanced multi-disciplinary mental health team. This is required in order to provide comprehensive multi-disciplinary interventions to address the range of needs of children and adolescents with moderate to

severe mental health disorder. *A Vision for Change* proposes a team co-ordinator role for each CAMHS team (see Appendix III, this is quite separate from the role of clinical lead of the team which must be held by the consultant psychiatrist).

- 11.3 In each of the Community Health Organisations (CHO), the day to day operational management responsibilities of the mental health service, including CAMHS, are devolved to the Area/CHO Mental Health Management Teams.
- 11.4 In line with the overall function of the CAMHS each member of the multi-disciplinary team will be accountable in the delivery of the agreed Individual Care Plan (ICP) as it is described in the relevant sections of this SOP. Team members must work collaboratively with clinical colleagues to fulfil the ICP.
- 11.5 Within each CAMHS team, the clinical lead role is carried out by the CAMHS Consultant Psychiatrist. In accordance with this, each child and adolescent attending CAMHS must have a named consultant who is responsible for overall care and treatment.
- 11.6 The CAMHS Consultant Psychiatrist is also responsible for providing clinical leadership to the team in close partnership and with support (professional input) from team colleagues, with the clear objective of delivering high quality care through the agreed ICP. In doing so the CAMHS Consultant Psychiatrist provides the clinical direction for the service in order that the child/young person and their family receive the appropriate care through the agreed ICP.
- 11.7 Members of the team will also have a professional and management reporting relationship through their discipline specific line management structure and the professional responsibility to work within their scope of practice as defined by their professional and regulatory body. Line managers are expected to liaise with the CAMHS Consultant Psychiatrist as required on any service, team or clinical matter, bearing in mind the need to fulfil the ICP.
- 11.8 All team members must be able to articulate the collective vision of the team and ensure clinical probity and its adherence to agreed standards.

12.0 The Service Function of CAMHS

12.1 It is the function of CAMHS teams to provide a specialist mental health service to those aged up to 18 years old who have moderate to severe mental health disorders that require the input of a specialist multi-disciplinary mental health team.

12.2 The mental health disorder is severe enough to cause substantial distress to the child/young person, their family or others, and to have a significant impact on various aspects of the child/young person's life within the domains of development, family relationships, school, peers, and leisure activity.

12.3 Service Aims

- » To provide clinical assessment with diagnosis, based on the needs identified with specific intervention appropriate to the needs of each individual child/young person and his/her family.
- » To enable families, carers and other professionals to positively support children/young people by providing them with appropriate strategies and skills to improve their mental health.
- » To provide training and consultation for primary care professionals in order to maximise their ability to promote mental health within primary care settings.
- » To promote improved mental health of children and young people.

12.3.1 This can be achieved by:

- » Enabling the development of problem-solving skills among children/young people and their families.
- » Supporting parents, carers and other professional's ability to manage existing mental health needs more effectively.
- » Enhancing children/young people and families' coping abilities within their environment and linking them with other community supports.

12.3.2 In the context of:

- » Having a positive impact on the child/young person's resilience in order to assist them to manage negative stressors more effectively.
- » Devising an ICP based on an agreed diagnosis and formulation in collaboration with the child/young person and their parents/carer.
- » Providing evidence-based interventions from multi-disciplinary perspectives.
- » Building on the skills and knowledge base of staff in meeting the mental health needs of children/young people and families.
- » Promoting mental health and well-being to those who use the services.

12.3.3 The child/young person and their family/carers can expect:

- » To be treated with dignity and respect.
- » To have a named CAMHS Consultant Psychiatrist and key worker.
- » To be involved in the development of an ICP which clearly identifies needs, goals and strengths.
- » To receive treatment and care from a multi-disciplinary team that is appropriate to their need.
- » To have their privacy and rights to confidentiality respected, unless there is a risk to themselves or others. This needs to be clearly communicated to the child/young person at the outset of any clinical intervention.
- » To be collaborative partners in their care planning and treatment by having the information they need to help them make appropriate choices in the type and method of interventions.
- » That the team will be cognisant of the child/young person's autonomy and right to make decisions on their own care in line with their individual capacity.
- » Services to be accessible and appropriate to their mental health needs using the full range of media that is child/young person friendly so as to encourage them to engage in their treatment.

- 12.4** The diagnosis of autism and intellectual disability remains the remit of primary care and disability services. Children with a mild intellectual disability are seen by CAMHS only when there is a co-morbid moderate to severe mental health disorder. Where the child/young person has a moderate or severe degree of intellectual disability and co-morbid mental health disorder, they should be referred to the Mental Health Intellectual Disability Services for Children and Adolescents (CAMHS-MHID).
- 12.5** It is recognised that children/young people with autistic spectrum disorder (ASD) experience co-morbid mental health disorders. The role of CAMHS in relation to autism can then best be defined as “consultation on difficult diagnoses and specialist episodic treatment of acute mental disorders”.
- 12.6** It is not the role of CAMHS to make recommendations that determine the provision of specific educational supports/resources as this is the responsibility of the Department of Education and the National Educational Psychology Service.

13.0 Referral Process and Criteria

- 13.1** The referral criteria to Community CAMHS are as follows:
- » Age up to 18 years old.
 - » The severity and complexity of the presenting mental health disorder is such that treatment at primary care service level has been unsuccessful.
 - » Community CAMHS accepts referrals for the assessment and treatment of disorders such as:
 - Moderate to severe depression;
 - Mood disorders;
 - Psychosis;
 - Anxiety disorders;
 - Attention Deficit Hyperactive Disorder (ADHD/ADD);
 - Moderate/Severe Eating Disorder; and
 - Suicidal behaviours and ideation where intent is present.

13.2 Exclusion Criteria

13.2.1 Community CAMHS do not accept the following:

- » Children with a moderate or severe intellectual disability.
- » Children whose presentation is a developmental disorder, where there are no co-morbid mental health disorders present.
- » Assessments or interventions that pertain to educational needs specifically.
- » Where there is 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.

13.3 Referral Agents are:

- a) GPs are usually the first point of contact for families who seek help for various problems hence 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.
- b) paediatricians (informing the child's GP).
- c) consultant liaison psychiatrist (informing the child's GP).
- d) general adult psychiatrists (informing the child's GP).
- e) national educational psychologists - senior (in collaboration with GP*).
- f) community based clinicians (at senior/team leader level or above, in collaboration with GP*).
- g) Tusla – Child and Family Agency (Team leader level or above in collaboration with the GP*).
- h) assessment officers (as defined under the Disability Act, 2005).
- i) Jigsaw – senior clinician (in collaboration with GP).

**** In collaboration with the GP means the referring agent must ring the GP and discuss and agree the potential referral so it is a truly collaborative referral.***

13.4 Referral Response Times

13.4.1 All referrals will be screened daily by the nominated CAMHS team member in consultation with the clinical lead.

13.4.2 The CAMHS team will provide a timely response time to referrals received.

- » Routine referrals are seen within three months.
- » Urgent referrals are responded to within 72 hrs.
- » Emergency referrals are responded to within the same working day.

13.4.3 CAMHS will respond rapidly if there is a high risk of harm to the young person or others as a direct result of the mental health disorder.

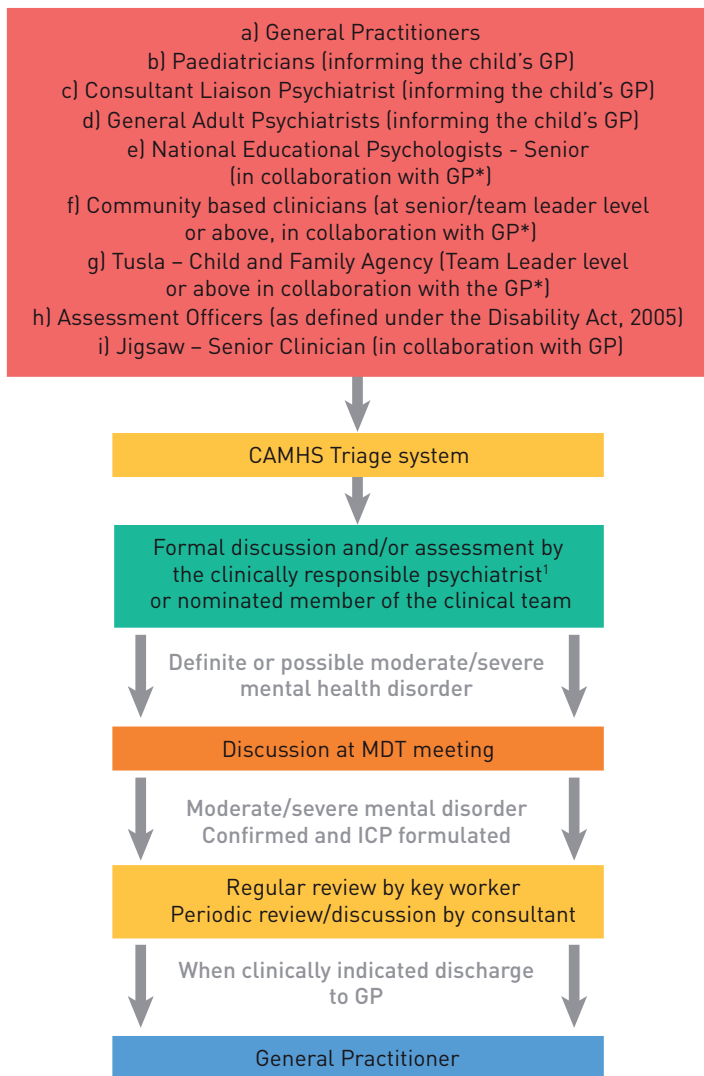
- » This may mean the involvement of the CAMHS team or it may mean, for example, telephone consultation to contain the crisis or organise another service response.
- » Similarly, follow-up may be by the CAMHS team directly or working with the local service provider. The local availability of other support services may have a bearing on the children and young people that CAMHS see.

13.4.4 Arrangements must be put in place in each area that addresses out-of-hours presentations.

13.5 CAMHS who Currently only Accept GP Referrals

13.5.1 Where a service is currently accepting referrals from GPs only, there must be local clarification with and acceptance by each relevant non-medical referral source at team leader level or above (*see Section 13.3*) on the referral criteria to CAMHS as listed in this SOP. This should include a clarification by the referral agency as to which issues are appropriate for their service. It is anticipated that where currently only GP referrals are accepted and where a broadening of referral agents is now being considered, it may take up to one year to complete the transition process fully.

13.6 Referral Process: Referral and Clinical Pathway for Children and Adolescents with Moderate/Severe Mental Disorder



* In collaboration with the GP means the referring agent must ring the GP and discuss and agree the potential referral so it is a truly collaborative referral.

¹ May be psychiatric registrar or senior registrar formally supervised by consultant psychiatrist.

13.7 Where the child/young person is assessed as having no moderate or severe mental health disorder, the GP/referring clinician will be advised and if further management is required this may be coordinated by the GP through the relevant primary care services. Information should be provided by the CAMHS team on appropriate services and supports available within the community if these are indicated.

13.8 Clinical Information Required for Referrals

13.8.1 Clinical information that is required for the referral includes:

- » Full description of presenting problem(s) and how they have developed.
- » Mental state of the child/young person.
- » Child/young person's development and current functioning.
- » Family composition and history.
- » Presence of risk and/or resilience factors.
- » Other agencies involved.
- » History of medical/mental disorder in child/young person and his/her family.
- » Outline of educational/occupational experience.
- » Parental/carers informed consent.

13.8.2 Referrals will only be considered if submitted on the Community CAMHS referral form attached (*Appendix V*).

13.9 Communication with Referrers

13.9.1 The CAMHS team must communicate with the referrer within two weeks of the assessment and a summary assessment report sent. Progress will be communicated at a minimum of six monthly intervals thereafter. On discharge from the CAMHS the child's GP must receive a written discharge summary.

13.9.2 In the event that a referral does not require the CAMHS, the referrer will be informed in writing and alternatives recommended as indicated. Initial communication to the referrer can be by telephone in order to provide a timely response as long as it is supported by a written report.

14.0 Service User Involvement

14.1 The objective of the CAMHS team is to ensure that the child/young person is at the centre of the delivery of the service. The system of communications must ensure that the child/young person is involved in participating in planning his/her care through an individual care planning approach.

14.2 Young people will be encouraged to be an active partner in the planning and delivery of services, including the identification of other support services required that may aid recovery.

14.3 Independent advocacy, where present and required, should be made available by the mental health service that supports the person while they are involved with CAMHS.

15.0 Individual Care Plan (ICP)

15.1 It is recognised that an ICP is a changing document, reflective of the needs of the child/young person and the nature of the therapeutic process. Where changes are made, a revised copy must be provided to the child/young person and/or the parent/carer where appropriate. Following assessment, the case must be formally discussed with the responsible CAMHS Consultant. This should occur at a weekly multi-disciplinary team meeting. An ICP will then be agreed which identifies both the recommended interventions and the key worker for each child.

15.2 An ICP is a clear plan that is:

- » 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.

15.3 An ICP must be informed by evidence-based practice, clinical experience and individual service users' needs and preferences in the context of their characteristics and culture.

15.4 The child/young person's key worker is responsible for the maintenance and review of the ICP.

15.5 An ICP includes the following:

- » 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, the child/young person and the parent/carer.
- » Liaison arrangements with other relevant agencies.
- » Developed, implemented and reviewed in a timely and collaborative manner.
- » Discharge/transition plan as appropriate.

15.6 The ICP will be the basis on which all interventions will be provided.

15.7 Each ICPs must be presented in a manner that is simple and concise so that it informs the child/young person, families and other staff what is to be done and when in relation to the child's treatment (*Appendix IV*).

16.0 Formal Case Reviews

16.1 This is an integral component of the management of all open cases. Each team should have a weekly team meeting to discuss: newly referred cases to the team, ongoing cases requiring review or cases being considered for discharge. Each case must be formally reviewed by the CAMHS multi-disciplinary team at a **minimum of every six months** and reported at the weekly team meeting.

17.0 The Management of Non-Attendance at Initial Appointments

- 17.1** All initial appointments should be communicated to the parents/ carers in writing with a copy to the child/young person's GP and the original referrer if not the GP. The letter will also state that if the appointment is not confirmed by a given date, it will automatically be withdrawn and reassigned to another child.
- 17.2** The use of a 'text reminder' sent before the scheduled appointment should be considered as a means to encourage confirmation and reduce non attendance.
- 17.3** The parents/carer is asked to confirm the appointment at least two weeks prior to the date of the appointment. In services where the parent/carer is phoned with an appointment, the appointment will be confirmed on the phone.
- 17.4** In the event that a child/young person does not attend, the GP and other referrer (if applicable) must be informed and asked to re-refer if still clinically indicated and the parent/carer agrees. A pro-forma letter may be used for this purpose to ensure referring agent/s are made aware of non-attendance as soon as possible.
- 17.5** If the clinical information in the referral form (Appendix V) suggests the child may be very unwell or at risk, the GP/referrer is phoned as well as receiving a letter so that he/she can initiate any further intervention that may be required.
- 17.6** A second appointment may be offered following discussion with the GP/referrer as described above.

18.0 The Management of Non-Attendance of Subsequent Appointments

- 18.1** As far as possible, the booking of appointments should be flexible and made in consultation with the parents/guardian of the child/young person in order to minimise the risk of non attendance.
- 18.2** Where a child/young person fails to attend an appointment, contact is made by a nominated CAMHS team member with the parent/carer by telephone.

- 18.3** Based on the reason for the non attendance, a decision will be made on whether a further appointment is required.
- 18.4** If contact with the parent/carer cannot be achieved, then the CAMHS team must inform the GP of the non-attendance. A decision will need to be made whether an assertive outreach visit is warranted.
- 18.5** A risk assessment of the referral is undertaken by the CAMHS team when the decision is made to take no further action in the event of a failure to attend. This decision is informed by and recorded within the ICP document.
- 18.6** All closures of cases who do not attend must be discussed and recorded at the multi-disciplinary team meeting and the GP notified in writing that the child/young person has been formally discharged. Any other agents involved in the referral of the child/young person should also be informed of discharge in writing.

19.0 Transition to Adult Mental Health Services

- 19.1** Every young person of 17 years and above will require a 'transition' plan within their ICP if it is intended that their care will move onto general adult mental health services.
- 19.2** Not all young people require a transition plan, but it is essential that all are assessed for it and the outcome of the assessment of future need is recorded clearly.
- 19.3** The issue of joint working between CAMHS and adult mental health services should be considered as an option in the initial weeks of handover to aid a smooth transition from one service to the other. The young person's key worker will be responsible for managing a smooth handover to the adult mental health service.

20.0 Transition to other CAMHS

- 20.1** Where a child/young person is on an active case load with one CAMHS team and moves to a different geographical area, there must be clear communication and planning between both CAMHS teams to facilitate a smooth transition of care.

- 20.2 Such communication and planning should ideally be started before the move to another area occurs and should be organised by the key worker.
- 20.3 It is not acceptable that a child/young person who is actively engaged with a particular CAMHS team should go on a waiting list with a new CAMHS team if they move from one area to another in Ireland.

21.0 Children First Principles

- 21.1 All CAMHS clinical staff are designated officers as defined within the Protection for Persons Reporting Child Abuse Act (1998).
- 21.2 As designated officers all clinical CAMHS staff must abide by Children First Guidance.
- 21.3 CAMHS staff should complete the training provided on Children First as required by their role.

22.0 Service User Feedback

- 22.1 CAMHS welcome feedback from all users of the service. Formal mechanisms are in place to provide feedback such as 'Your Service, Your Say'. This feedback will be used to inform and improve service delivery.
- 22.2 All complaints must be managed within the 'Your Service, Your Say' – The Management of Consumer Feedback to include Comments, Compliments and Complaints in the Health Service Executive.
- 22.3 Children/Young people and their parents/carers must be informed and made aware of the process to give feedback and/or make a complaint by the CAMHS team. Information must be displayed clearly in public areas and presented in a format that can be easily understood.

3

Part 3 – In-Patient Child and Adolescent Mental Health Services

23.0 What is In-Patient CAMHS?

- 23.1** While a broad range of services support the mental health of children and adolescents, the term 'CAMHS' applies very specifically to services that provide specialist mental health treatment and care to young people up to 18 years of age through a consultant led multi-disciplinary team. CAMHS are best conceptualised in a tiered model as already described in Section 10.0. In-patient CAMHS is a specific service for children and young people up to the age of 18 years with severe and often complex mental illness that cannot be safely managed in the community.
- 23.2** The CAMHS in-patient units are Approved Centres under the Mental Health Act 2001 and not statutory residential special care facilities for children.
- 23.3** Currently there are four HSE provided in-patient CAMHS units across the country to which this SOP applies.

Table 1

Unit Name	Unit Location	Bed Numbers	Primary Catchment Area
Eist Linn	Cork – CHO 4	20	CHO 4 and 5
Merlin Park	Galway – CHO 2	20	CHO 1 (partial) ^a , 2 and 3
Linn Dara	West Dublin – CHO 7	14*	CHO 6,7 and 8 (partial) ^b
St. Joseph's	North Dublin – CHO 9	12	CHO 9, 1 (partial) ^c , 8 (partial) ^d

a) Sligo-Leitrim, Donegal

b) Laois/Offaly/Longford/Westmeath

c) Cavan/Monaghan

d) Louth/Meath

* *New purpose-built unit opening in Cherry Orchard in Q4 2015*

- 23.4** In the tiered model of CAMHS, in-patient services are located at the tertiary level (Section 10).

24.0 Clinical Governance Structure

- 24.1** It is recognised that to assist CAMHS in assuming a full role as a secondary and tertiary mental health care service, it is essential that the CAMHS are an integral part of the overall mental health services as envisioned in *A Vision for Change*.
- 24.2** *A Vision for Change* emphasises the importance of an enhanced multi-disciplinary mental health team. This is required in order to provide comprehensive multi-disciplinary interventions to address the range of needs of children and adolescents with moderate to severe mental health disorder.
- 24.3** In each of the CHOs, the day to day operational management responsibilities of the mental health service, including CAMHS, are devolved to the Area/CHO Mental Health Management Teams.
- 24.4** In line with the overall function of the CAMHS each member of the multi-disciplinary team will be accountable in the delivery of the agreed ICP as it is described in the relevant sections of this SOP and all team members must work collaboratively with clinical colleagues to fulfil the ICP.
- 24.5** Within each CAMHS team, the clinical lead role is carried out by the CAMHS Consultant Psychiatrist. In accordance with this, each child and adolescent attending CAMHS must have a named consultant who is responsible for overall care and treatment.
- 24.6** The CAMHS Consultant Psychiatrist is also responsible for providing clinical leadership to the team in close partnership and with support (professional input) from team colleagues, with the clear objective of delivering high quality care through the agreed ICP. In doing so the CAMHS Consultant Psychiatrist provides the clinical direction for the service in order that the child/young person and their family receive the appropriate care through the agreed ICP.
- 24.7** Members of the team will also have a professional and management reporting relationship through their discipline specific line management structure and the professional responsibility to work within their scope of practice as defined by their professional and regulatory body. Line managers are expected to liaise with the CAMHS Consultant Psychiatrist as required on any service, team or clinical matters, bearing in mind the need to fulfil the ICP.

24.8 All team members must be able to articulate the collective vision of the team and ensure clinical probity and its adherence to agreed standards.

25.0 Service Aims and Objectives

25.1 The aim of the in-patient service is to provide an evidence-based and cost effective service for children/young people with severe and often complex mental illness.

25.2 The in-patient programme should offer a comprehensive recovery focused treatment approach and education programme operating within a therapeutic milieu. There should be the provision of a therapeutic and nurturing environment with developmentally appropriate evidence-based treatment approaches. The service should be able to provide a range of therapeutic interventions.

25.3 The in-patient service will provide appropriate assessment and treatment which will bring about the change necessary to effect the child/young person's discharge home to the care of their local Community CAMHS team as soon as it is clinically appropriate in line with his/her ICP.

25.4 The in-patient CAMHS must be accessible and be provided for a catchment area specifically so that the child/young person can be as near home as possible. Therefore, each of the CAMHS units have a regional remit based on the administrative areas of the HSE as outlined in Table 1.

25.5 In addition in-patient CAMHS teams should:

- » Promote and improve mental health of children and young people.
- » Enable families, carers and other professionals to positively support children and young people, by providing them with appropriate strategies and skills to improve mental health.
- » Provide timely assessment and interventions appropriate to the needs of each individual child and their family.

- 25.6** Each child/young person and their family/carers can expect:
- » To be treated with dignity, respect and appropriate privacy.
 - » To receive treatment and care that is appropriate to their need which is clearly documented and reviewed within an ICP.
 - » To have their privacy and rights to confidentiality respected.
 - » To be collaborative partners in their treatment and care, by having the information they need to help them make appropriate choices in the type and method of their interventions.
 - » To receive assessment and treatment that considers the systemic context of each child/young person such as family, school, peer group and local community.

26.0 Referring to In-Patient CAMHS

- 26.1** The purpose of CAMHS in-patient units is to offer assessment and treatment to children/young people with severe and often complex mental illness, when out-patient or day-patient care has ceased to meet the needs of that child/ young person. In-patient services should be seen as a last resort, where all other interventions have been exhausted. As CAMHS units are regional, tertiary services, a child/young person must be assessed and referred by a Consultant Psychiatrist.
- 26.2** It is recommended that there be a screening process prior to admission. This may include telephone consultation with the referring team, further information gathering from other services and/or screening/day visit by the in-patient team to ensure suitability for admission. Where the decision is not to admit, feedback must be provided to the referring agent. This should include offering advice on the appropriate service.
- 26.3** CAMHS in-patient units must not be viewed as a replacement for Child and Family Services (Tusla) or to fill gaps in local community CAMHS. Appropriate accommodation outside the units must be maintained throughout an admission to facilitate a young person's discharge.

26.4 The normal age range is 12-17 inclusive. Consideration will be given on a case by case basis to young people under the age of 12. Young people who may become 18 while on the in-patient unit must have a transfer plan to adult services negotiated by the in-patient CAMHS team in the months preceding their 18th birthday. This should be arranged prior to admission to the CAMHS in-patient unit where possible.

27.0 Appropriate Referrals

27.1 Referrals accepted for admission will in general have a severe mental illness and 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.

27.2 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 in-patient Consultant Psychiatrist who assumes clinical responsibility for the child/young person once they have been admitted.

28.0 Exclusion Criteria

28.1 Where exclusion criteria are applied, the CAMHS in-patient service shall advise the referrer of the appropriate service to which the referral should be directed. The following presentations may be considered as reasons for not admitting, for example where:

- » Primary diagnosis is substance misuse or conduct disorder.
- » Primary diagnosis is autistic spectrum disorder in the absence of a co-morbid psychiatric disorder.
- » There is a moderate or severe intellectual disability.

- » The care needs of the child/young person should be managed primarily by Tusla – Child and Family Agency, e.g. the child/young person does not have a severe mental illness.
- » The child/young person is deemed to be medically unstable and should be managed in an appropriate medical setting in the first instance.
- » In the view of the in-patient consultant, the effect of removing a child/young person from their home environment or admitting a child/young person may compound their difficulties. Examples include where a vulnerable child/young person may be exposed to further dysfunctional behaviour on the unit or where the child/young person has a severe attachment disorder.

29.0 Referrals which may Require Use of the Mental Health Act 2001

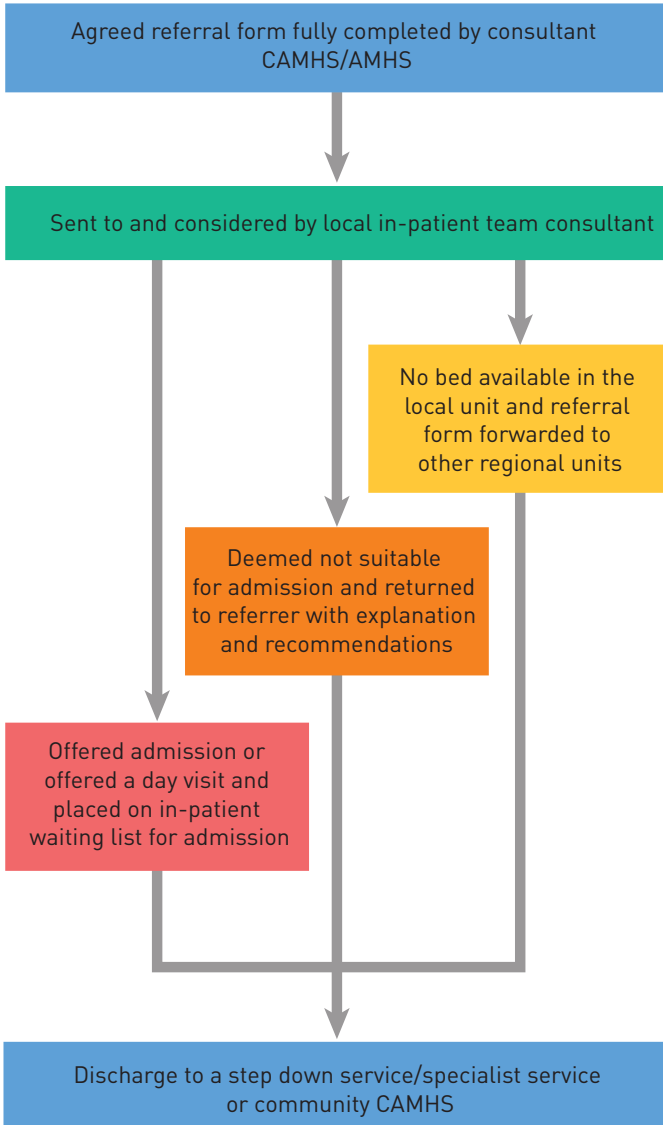
29.1 When a referrer considers that an order under Section 25 of the Mental Health Act 2001 may be required or where a child is under a Care Order (Child Care Act 1991), contact must be made with the relevant in-patient Consultant Psychiatrist in advance to discuss the case. It is the responsibility of the referring Consultant to ensure that a bed is available before going to court to apply for the order.

30.0 Children with Severe Mental Illness and Challenging Behaviour

30.1 Where a child with severe mental illness has been admitted and exhibits seriously violent and aggressive behaviours which also compromises the safety of other children/young people and staff on the unit, a referral to a secure in-patient CAMHS unit or if indicated, a child and adolescent forensic mental health service will be considered.

31.0 Referral pathway

Figure 2: Referral pathway for children and adolescents with moderate/severe mental illness to in-patient CAMHS Team



Note: Referral may be considered by a psychiatric registrar or senior registrar formally supervised by consultant psychiatrist

32.0 Referral Response Times

32.1 The CAMHS in-patient service applies the following response times to each referral.

32.2 Contact will be made by a senior clinician from the in-patient service within:

- » four hours (emergency).
- » 24 hours (urgent).
- » seven days (routine).

The referrer must ensure that they are contactable by phone to discuss the referral. In an emergency situation – telephone contact must be made to the CAMHS in-patient unit by the referrer to ensure receipt of referral.

32.3 Until the young person has been admitted by the in-patient team, the referring consultant continues to hold clinical responsibility for the child/young person's care.

32.4 Explanation of Terms

Emergency: Involves cases where there is a clear and imminent risk to the young person's safety.

Urgent: Where there is a clear and present level of acute symptoms and where there is a strong likelihood of considerable deterioration in mental state if left untreated.

Routine: Where there are clear and present levels of acute symptoms which have been ongoing and can be managed in the short-term by the child/young person's support network (i.e. family and community CAMHS).

33.0 Emergency Referrals

33.1 Same day admissions are possible but are dependent on the CAMHS in-patient's bed capacity. In the interest of safety, admissions are usually planned during routine working hours. However, emergency admissions (i.e. within 24 hours of referral) are possible. In the event of an emergency admission which may be unknown to the responsible catchment area community CAMHS team or the emergency presentation of a known young person who is new to the in-patient team, a joint review meeting with the responsible Community CAMHS team must take place within five working days following admission.

34.0 Use of In-Patient Beds and Bed Capacity

- 34.1** Each unit should as far as possible ensure that it has an emergency bed available to enable the unit to respond to emergency admissions on a 24/7 basis where clinically indicated.
- 34.2** The capacity of the service at any given time to meet the needs of a particular child/young person will be considered when accepting a referral. The capacity of the unit is dependent on the acuity of a child/young person's presentation and relates to the case mix and staffing levels. The in-patient unit must be in a position to meet the therapeutic needs of the child/young person safely while maintaining a safe and functioning unit. If admission is clinically indicated but the unit's capacity/therapeutic milieu is a major concern, then communication between the referring and in-patient consultant must be maintained to ensure that a suitable alternative can be identified or that the next appropriate and available bed can be offered to that young person.
- 34.3** A weekly teleconference takes place between the four in-patient units to ensure that any additional capacity in any of the units may be offered to a child/young person if they are on another unit's waiting list. Distance from home must be considered as this can place a considerable burden on families.

35.0 Home leave

- 35.1** Home leave is an integral and therapeutic part of the overall treatment and discharge plan. Leave is an essential part of ongoing risk assessment, and helps to ensure successful reintegration into home, education and peer activity. It assists with the transition from in-patient to community-based CAMHS. In many cases, attending community CAMHS will be part of this step-down on a shared care arrangement with the in-patient service.

36.0 Admission Process

- 36.1** Consent for admission to the in-patient unit is provided for under the Mental Health Act 2001.
- 36.2** While the young person's assent will be sought, consent to admission and treatment must be given by parents and/or legal guardian in the case of mental health treatment.
- 36.3** Families and young people should be provided with valid, up-to-date and accurate information on consent on admission to the in-patient unit. It should not be assumed that they are knowledgeable and informed despite previous contact with CAMHS. The level of information should be inkeeping with their level of understanding.
- 36.3** All consent forms should be completed on admission and copies made available to families if requested.
- 36.4** Goals for admission will be set collaboratively with the referring team, child/young person and parents/carers.
- 36.5** Treatment must be based on best practice guidelines. Treatment must be systemically informed. Families/carers will be part of the assessment and treatment process throughout the child/young person's admission.
- 36.6** The initial admission must include a risk assessment and an initial individual treatment plan which is completed within 24 hours. The individual treatment plan is usually completed by the admitting doctor and unit staff. It details basic treatment interventions during the first week of admission such as medication, levels of observation required, etc.
- 36.7** The initial individual treatment plan is not a replacement for the ICP which must be completed within seven days of admission.
- 36.8** A physical examination must be completed with 24 hours of admission. If this is not possible, the reasons must be documented clearly in the clinical notes.

37.0 ICP

- 37.1** All children/young people within in-patient CAMHS will have an ICP which must include the following;
- » Must be completed within seven days of admission.
 - » Agreed goals between team, young person and parent/guardian (where appropriate).
 - » Be person centred with input from the young person, parent/guardian and other relevant people as appropriate.
 - » An ICP must be developed, implemented and reviewed in a timely and collaborative manner.
 - » Specification of care and treatment required in accordance with best practice.
 - » Identification of required resources.
 - » All multi-disciplinary records are kept in one composite set of documents.
 - » Consideration of young person's educational requirements.
 - » A copy of the ICP is stored on the young person's file and a copy is given to the young person and/or the parent/guardian.
 - » Each child/young person's ICP is reviewed regularly by the multi-disciplinary team.
- 37.2** It is recognised that an ICP is a changing document, reflective of the needs of the child/young person and the nature of the therapeutic process. Where changes are made, a revised copy must be provided to the child/young person and/or to the parent/guardian where appropriate.

38.0 Risk Assessment and Risk Management

- 38.1** The range and nature of risk behaviour in a CAMHS in-patient unit can be complex. They can include a risk of self-harm, suicide, absconsion as well as a risk of violent and aggressive behaviours which are a direct result of the child/young person's mental illness.
- 38.2** Risk assessment and management planning must involve a consideration of the individual child/young person's risk and environmental factors. Within an in-patient setting, consideration

of the overall group dynamics and impact of other children should also be considered.

- 38.3** CAMHS in-patient units therefore require a broad understanding of risk assessment and management planning and have available a range of risk management strategies which can be tailored to the needs of individual children/young people.
- 38.4** The in-patient unit should have a dynamic risk assessment system in place to support clinicians in making day-to-day decisions about the individual care of a child/young person.
- 38.5** The in-patient service should meet the risk assessment requirements appropriate for the care and safety of all children/young people, including but not limited to measures whereby:
- » The risk assessment and management system must incorporate the principles of risk identification, risk reduction, risk evaluation, and a recognised risk communication process, e.g. regular risk incident review meetings, health and safety meetings, ligature audits, serious untoward incident reviews and identification on the risk register for serious risk incidents.
 - » Positive risk taking should be considered within the context of a well thought out and robust risk assessment and management plan. Positive risk taking may be considered where there is a clear clinical benefit to the child/young person and where the identified risks can be managed.
 - » Identified risks within the in-patient environment must be addressed through risk management plans so that the environment meets recognised standards and regulation for mental health in-patient settings.
 - » Staffing levels should be adequate and deployed effectively to manage risk.
 - » Staff need to be skilled in managing risk and can employ a range of techniques including the engagement of children, distraction and de-escalation techniques as well as offering support and supervision.

- » The CAMHS in-patient team must ensure that risk is assessed and evidenced throughout the treatment process. Collaborative ICPs must be developed with the child's parents/carers and the child/young person in order to manage identified risks.
- » The in-patient team must record and evaluate the profile of risk incidents at a service level so as to identify any patterns and themes which should then be addressed through risk management strategies on the unit.
- » The in-patient team must have structures in place to undertake significant event analysis of all serious incidents with evidence of identified learning.

39.0 Clinical Review Meetings

39.1 Clinical review meetings should be held throughout the in-patient admission at a minimum of every six weeks or at a frequency determined by the child/young person's clinical needs, especially if their stay is likely to be short.

39.2 People attending such reviews should include the child/young person, his/her family, the responsible in-patient CAMHS team representative (consultant, key worker and primary nurse) and any other agency involved in the child/young person's ongoing care.

39.3 It is essential that a senior clinician from the referring community CAMHS team and/or adult mental health service team attend reviews during the period of in-patient care, especially in circumstances whereby the transition of care is being considered to another care agency, possible discharge to the community, or a move to adult mental health services on turning 18.

40.0 Discharge Planning

40.1 Many children/young people and their families find the containment of an in-patient unit very safe. The discharge process and the return to their home environment will need to be carefully planned.

40.2 Discharge needs to be a part of the child/young person's ICP that is considered from the outset.

- 40.3** Discharge should take place when the child/young person's mental state is such that they can be managed by the community CAMHS team and/or day hospital services. This should happen as soon as the community based alternatives are able to meet the child/young person's mental health needs.
- 40.4** Discharge may need to be considered where it is deemed that continued admission is counter-productive and appears to worsen the child/young person's mental state or compromises the safety of others on the unit.
- 40.5** The discharge plan must ensure that there are clear processes in place for follow-up thereafter with agreed appointments and a clear understanding of who is responsible within the CAMHS in-patient team and community CAMHS team for ensuring that all of this is organised and adhered to. This must be put in place in advance of discharge.
- 40.6** At the completion of treatment, referrers will receive a written discharge summary outlining the outcomes of the in-patient interventions and ongoing recommendations.
- 40.7** Where indicated, there will be multi-agency involvement in discharge planning. These may include but are not limited to;
- » Tusla – Child and Family Agency including aftercare programmes for 16/17 year olds moving out of care.
 - » Specialist autism spectrum disorder service.
 - » Specialist intellectual disability services including mental health of ID.
 - » Local paediatric hospital/unit.
 - » Primary/Post-primary/Youthreach and third level college.
 - » Adult Mental Health Services.
 - » Residential care services if young person is in the care of Tusla – Child and Family Agency.
 - » Private providers of in-patient treatment or ongoing residential placement.
 - » Voluntary agencies supporting the young person's recovery e.g. but not exclusively; Barnardos, Bodywhys, Out and About Association, Aware, Pieta House, etc.

41.0 Transition to Adult Services

- 41.1** Every young person approaching 18 years will require a 'transition' plan within their ICP if it is intended that their care will move to adult mental health services. This must be completed well in advance of the young person's 18th birthday by the responsible key worker.
- 41.2** Joint care review/handover meetings must be organised by the CAMHS in-patient team with the key agencies/services who will be taking on the care of the young person once they move on from the in-patient unit.
- 41.3** Where in-patient treatment is nearing completion, but might need to be continued beyond the 18th birthday, consideration may be given by the CAMHS in-patient team to complete the intervention as an in-patient within the CAMHS unit. In all such cases, the Mental Health Division must be informed through the appropriate Community Health Organisation management structure that is responsible for the CAMHS in-patient unit. The Mental Health Commission should also be informed.
- 41.4** In such cases, best interest principles must apply. Such principles must take into account the needs of the individual young person who has just turned 18 as well as the other children/young people who are on the unit.
- 41.5** The decision to continue in-patient treatment within a CAMHS unit beyond the 18th birthday must be clearly recorded in the young person's ICP. The ICP must also have a clearly documented risk assessment which addresses identified risk factors (if any) for the young person who will turn 18 as well as for the other adolescents/young people who are residing on the unit at the same time.
- 41.6** The maximum period of time that a young person who has just turned 18 should remain as an in-patient within a CAMHS unit is no longer than two weeks. If it is felt that the young person will require a longer period of in-patient care post 18th birthday, then immediate arrangements must be made to transfer the person's in-patient location to an adult unit.

41.7 The practice of keeping a young person in a CAMHS in-patient unit after their 18th birthday must be seen as an exception only resorted to where a transfer to an adult service would have a high likelihood of destabilising the young person's progress and treatment. As stated above, any such extension is only on the condition that CAMHS in-patient treatment is necessary and will be completed within the two week timeframe immediately after their 18th birthday.

42.0 Service User Involvement

42.1 It is the aim of the in-patient CAMHS team to ensure that the child/young person is at the centre of the delivery of the service.

42.2 Each service should review their system of communications to ensure that the child/young person is involved in participating in planning their care and also in planning the future delivery of service.

42.3 Children/Young people should be encouraged to let clinicians know their views. Identified time must be set aside for each child/young person within their admission to be able to do this with the clinical team.

42.4 Where available, independent advocacy should be offered by the team to provide support to the person whilst going through mental health intervention. The Headspace toolkit should be given to all young people on admission.

Appendices

Appendix I: Membership of the CAMHS Improvement Project Group

Name	Title
Paul Braham	Project Lead, Senior Operations Manager, Mental Health Division
Nicola Byrne	Principal Social Worker, CAMHS
Bernie Walsh	Senior Psychologist, CAMHS
Isobel Duffy	Acting Occupational Therapy Manager, CAMHS
Dr Brendan Doody	Clinical Director, CAMHS
Dr Maria Lawlor	CAMHS Consultant Psychiatrist
Dr Keith Holmes	CAMHS Consultant Psychiatrist
Catherine White	Principal Social Worker, CAMHS
Michael O'Sullivan	Area Director of Nursing, CAMHS
Colman Noctor	Advanced Nurse Practitioner, CAMHS
Brian O'Malley	Assistant Director of Nursing, CAMHS
Lisa Brennan	Principal Social Worker, CAMHS
Dr Dermot Cohen	CAMHS Consultant Psychiatrist

Appendix II: Members of the CAMHS Improvement Steering Group

Name	Title
Anne O'Connor	National Director, Mental Health Division
Jim Ryan	Assistant National Director, Mental Health Division
Dr Margo Wrigley	National Clinical Advisor and Group Lead, Mental Health Clinical Programmes
Dr Amanda Burke	Executive Clinical Director, CAMHS
Margaret Brennan	Lead for Quality and Service User Safety
Gerry Maley	Business Manager to the Head of Service User, Family Member and Carer Engagement

Appendix III: Recommended Job Specification – Team Co-ordinator

The National Vision for Change Working Group recommends that each mental health catchment area management team prioritise the selection of a suitable individual on each CMHT, to undertake the role of team co-ordinator, where the role does not currently exist. The Group has developed a recommended job specification to assist mental health services in this process. It is important that the selection process itself is open and transparent.

1	Reporting Relationship	The Team Co-ordinator will report to the relevant Line Manager for their professional discipline.
2	Essential Requirements Qualifications and Experience	Recognised Professional Qualification in Nursing, Occupational Therapy, Psychology or Social Work. At least 3 years experience of working in a multi-disciplinary mental health setting. Previous management experience and/or a relevant management qualification would be highly desirable.
3	Salary	The role of Team Co-ordinator will be remunerated in accordance with the post holder's existing salary scale and terms and conditions.
4	Purpose of the Post	<p>As an integral part of the shared management structure within the multi-disciplinary Community Mental Health Team, you will work towards achieving:</p> <ul style="list-style-type: none"> • A recovery orientated value base among team members; • Effective clinical governance and risk management processes within the team; • Good liaison with the continuum of primary care services, for which you will have a lead role; • The required standards of care and treatment outlined by the Mental Health Commission through a process of clinical audit, performance monitoring and evaluation.
5	Principal Duties and Responsibilities	<p><i>(In accordance with the CMHT's operating protocols and procedures as agreed by the CMHT consultants and the relevant heads of discipline);</i></p> <ul style="list-style-type: none"> • The Team Co-ordinator will report to the lead consultant in relation to clinical issues, such as, the triaging and prioritisation of referrals.

continued

5

cont'd

- Informed by team discussion and service user care co-ordinators, ensure routine referrals are processed efficiently in accordance with the team's operational policy.
- Ensure meaningful service user, and where appropriate, carer involvement in clinical decisions.
- Liaise with Primary Care Teams (GPs and primary care professionals), and other relevant local community services, external agencies, self-help and other community resources.
- Take the lead role in organising all relevant team meetings.
- Co-ordinate agreed CMHT clinical inputs and communicate the resources required, to the Executive Mental Health Service Management Team.
- Monitor team members' workloads in line with agreed discipline-specific workload guidelines (as agreed with relevant heads of discipline) in order to facilitate equitable workload distribution and appropriate service throughput.
- Co-ordinate team members' leave, in accordance with the protocols agreed with relevant line managers so as to ensure that there is an adequate number of staff on duty to deliver the required level of service.
- Organise on-going audit of clinical records and integrated care plans, and teamwork practice, and address any emerging concerns.
- Promote, and ensure progression towards, evidence-based, optimal team working practices.
- Develop and update the CMHT's operational policies and monitor clinical activity levels in line with nationally agreed key performance indicators, monthly Health Statistic measures and the HSE's National and Regional Service Plans
- Take a lead in establishing the clinical needs of local service users/populations.
- Profile the need for, and organise, teamwork training.
- Ensure services are planned, delivered and evaluated in a recovery-centered manner, to the required standard within the HSE's organisational philosophy and service delivery framework.

continued

<p>5 <i>cont'd</i></p>		<ul style="list-style-type: none"> • In collaboration with the lead consultant and area business manager, be responsible for strategic and operational planning and identifying new initiatives to facilitate the development of the service. • Manage all allocated resources and formulate, implement and evaluate service plans and budgets in co-operation with the wider healthcare team. • Promote a culture that values diversity and respect in the workplace. • Ensure compliance with the legal requirements of the Mental Health Act, 2001 and any other relevant legislation. • Participate in disciplinary, grievance and other procedures in accordance with HSE policies, e.g. attendance management, Dignity at Work, etc. • The Team Co-ordinator will report to the Area Mental Health Management Team on matters relating to team co-ordination and team working issues and in this regard, will provide a quarterly written report on progress towards evidence-based, optimal team working practices within the CMHT.
<p>6</p>	<p>Other Professional Duties and Responsibilities</p>	<p>While this is a key post within the CMHT' shared management structure, the post holder will also be required to carry a limited caseload, to provide a clinical service within the CMHT and to maintain their own professional competence.</p>
<p>7</p>	<p>Supervision/ Professional Development</p>	<p>As a member of the shared management structure you will offer advice and support to all members of the CMHT and ensure that all team members have access to relevant professional clinical supervision and continuing professional development planning. In addition, you may have supervisory responsibilities for professional staff within your own discipline</p>

This Job Specification is not intended to be a comprehensive list of the duties and responsibilities pertaining to the role of Team Co-ordinator, which is likely to evolve over time, in the context of the further future implementation of *A Vision for Change* and continued reconfiguration of the Irish healthcare system.

Appendix IV: Individual Care Plan (ICP) Template



Individual Care Plan (ICP) Template

Individual Care Plan (ICP)			
Service user name:		Consultant:	
Service user no:		Key Worker:	
Date of birth:		ICP no:	
Date ICP completed:		Next ICP review date:	
Formulation (including strengths)			
Goals			
	Child/young person /parent/guardian's Goals		Rate 1 – 10 (now & goal)
1.			
2.			
3.			
4.			
5.			
Action/Plan			
Outline the action/plan including who is responsible, when it will be completed and any other comments...			
ICP discussed/agreed with child/young person:	Yes	Date	If not, why not...
ICP discussed/agreed with both parent(s)/guardians:	Yes	Date	If not, why not...
Copy of ICP given to child/young person	Yes	Date	If not, why not...
Copy of ICP given to both parent(s)/guardians:	Yes	Date	If not, why not...
Database updated:	Yes	Projected discharge date:	
ICP completed by: (print name/title):		Signature:	

Appendix V: Community CAMHS Referral Form



Community CAMHS Referral Form

Important note to referring Referrer: Please complete all sections. Failure to provide requested information could result in a delay in assessment. Please attach any other clinical reports that are relevant to this referral.

Details of which CAMHS Team Referral is being sent to:

CAMHS Consultant:	Address:
Contact No:	Fax No:
E-mail Address:	

Name of Child:	D.O.B:												
Address:	Parents/Carer Contact No:												
Name of Child's G.P:	<table border="1"> <thead> <tr> <th>Please tick</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>G.P. informed of Referral</td> <td></td> <td></td> </tr> <tr> <td>In Writing</td> <td></td> <td></td> </tr> <tr> <td>By Telephone</td> <td></td> <td></td> </tr> </tbody> </table>	Please tick	Yes	No	G.P. informed of Referral			In Writing			By Telephone		
Please tick	Yes	No											
G.P. informed of Referral													
In Writing													
By Telephone													
Practice Address:	Date G.P. informed:												
School/Occupation:	Family Composition:												
How long have you know the child/young person?	Describe the presenting problems, symptoms, when did they start and other problems identified:												
What is the child/young person's current mental state?	What Risk and/or resilience factors are currently present?												
Is the child/young person currently suffering from any medical problems? If so describe:	Has the child/young person been previously referred to: <table border="1"> <thead> <tr> <th>Please tick</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Social Services</td> <td></td> <td></td> </tr> </tbody> </table>	Please tick	Yes	No	Social Services								
Please tick	Yes	No											
Social Services													

continued

<p>Is the child/young person currently suffering from any medical problems? If so describe:</p>	<p>Has the child/young person been previously referred to:</p> <table border="1" data-bbox="524 480 854 592"> <thead> <tr> <th>Please tick</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Social Services</td> <td></td> <td></td> </tr> <tr> <td>Another Mental Health Service</td> <td></td> <td></td> </tr> <tr> <td>Psychology Services</td> <td></td> <td></td> </tr> <tr> <td>This Service</td> <td></td> <td></td> </tr> </tbody> </table> <p>If yes to any, please provide details:</p>	Please tick	Yes	No	Social Services			Another Mental Health Service			Psychology Services			This Service																													
Please tick	Yes	No																																									
Social Services																																											
Another Mental Health Service																																											
Psychology Services																																											
This Service																																											
<p>Have you obtained consent for this referral: Yes/No (it is advisable that consent is obtained from both parents if practicable)</p> <table border="1" data-bbox="176 799 505 935"> <thead> <tr> <th>Please tick</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Both Parents</td> <td></td> <td></td> </tr> <tr> <td>Mother only</td> <td></td> <td></td> </tr> <tr> <td>Father only</td> <td></td> <td></td> </tr> <tr> <td>Neither parent</td> <td></td> <td></td> </tr> <tr> <td>Other (specify below)</td> <td></td> <td></td> </tr> </tbody> </table>	Please tick	Yes	No	Both Parents			Mother only			Father only			Neither parent			Other (specify below)			<p>Are there other agencies currently involved with the child/young person?</p> <table border="1" data-bbox="524 783 854 967"> <thead> <tr> <th>Please tick</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Community Care Social Work</td> <td></td> <td></td> </tr> <tr> <td>Paediatrician</td> <td></td> <td></td> </tr> <tr> <td>Community care Psychology</td> <td></td> <td></td> </tr> <tr> <td>Speech & Language</td> <td></td> <td></td> </tr> <tr> <td>Autism Services</td> <td></td> <td></td> </tr> <tr> <td>Child & Family Agency (Tusla)</td> <td></td> <td></td> </tr> <tr> <td>Others (please specify)</td> <td></td> <td></td> </tr> </tbody> </table> <p>If yes to any, please provide details:</p>	Please tick	Yes	No	Community Care Social Work			Paediatrician			Community care Psychology			Speech & Language			Autism Services			Child & Family Agency (Tusla)			Others (please specify)		
Please tick	Yes	No																																									
Both Parents																																											
Mother only																																											
Father only																																											
Neither parent																																											
Other (specify below)																																											
Please tick	Yes	No																																									
Community Care Social Work																																											
Paediatrician																																											
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Child & Family Agency (Tusla)																																											
Others (please specify)																																											
<p>Referrer's Name:</p> <p>Referrer's Clinical Discipline:</p>	<p>Referrer's Address:</p>																																										
<p>Date of Referral:</p>	<p>Contact Number:</p> <p>Fax No:</p> <p>E-Mail:</p>																																										

Appendix VI: CAMHS In-Patient Referral Form



CAMHS In-Patient Referral Form

Important note to referring Consultant/GP/Clinician: Please complete all sections. Failure to provide requested information could result in a delay in assessment. Please attach any other clinical reports that are relevant to this referral.

To be Completed by Referring Consultant

Name of Child:	D.O.B:
Address:	Parents/Carer Contact No:
Gender:	Nationality:
Religion:	Country of Birth:
Any Known Allergies:	Any Special Needs Requirements:
Any Known Drug Allergies:	

Details of Referring Consultant

CAMHS Consultant:	Address:
Contact No:	Fax No:
E-mail Address:	Date of Referral:

continued

Loco Parentis Details (if applicable)

Name :	Contact Number:
Address:	Relationship to Child:

Please tick	Yes	No	Not Asked
Is the Child agreeable to admission			
Are both parents/Loco Parentis agreeable to admission			

Additional Comments:

Health Insurance Cover

Please tick	Yes	No
Private Insurance		
Medical Card		

Additional Comments:

continued

School's Contact Details:

Name:

Tel No:

Address:

Current School Placement:

Reason for Referring Child to an Inpatient Facility:

Child's Current Mental State:

continued

Referrer's Goals for Admission:

Child's Views and Expectations:

Family's Views and Expectations:

continued

Child's Psychiatric History:

Therapeutic Interventions the Child has received to Date:

Medication: Please provide details of current medications including dosage and/or details of medications previously tried and rationale for why they may have been discontinued.

continued

Child's Medical History:

PHYSICAL INVESTIGATION:	Yes	No	Date
EEG	<input type="checkbox"/>	<input type="checkbox"/>	
MRI	<input type="checkbox"/>	<input type="checkbox"/>	
CT	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological Assessment	<input type="checkbox"/>	<input type="checkbox"/>	

Relevant Medical/Psychiatric History of Family:

Child's Social Circumstances: Including details of precipitating/perpetuating/protective factors information on family constellation etc.

Education: School/Youthreach/Fas, Level of functioning, Year (if applicable)

Contact Details of Other Agencies Involved: For example CAMHS, Psychology, Social Work, Tusla, JLO, Speech & Language etc. (Please include reports from agencies if available).

continued

Risk Assessment Tool

Please complete and provide further explanation of any relevant concerns/incidents in the spaces provided below.

Please tick the appropriate box		
	Yes	No
Suicide & Safety		
Does the child have a history of suicide attempts? <i>(If so provide details below)</i>		
a) Is the child currently experiencing suicidal ideation?		
Is there a family history of suicide?		
Within the child's social network have there been instances of suicide or suicide attempts? If so, when? <i>(Provide details below at a)</i>		
Has the child experienced or is the child currently experiencing an event, which may be perceived as traumatic <i>(e.g. Bullying, Physical/Sexual Abuse, Diagnosis of a Physical/Mental Illness etc.)</i>		
Has the child experienced a significant loss either recently or in the past? <i>(Family member, Relationship, Pet etc.)</i>		
Has the child exhibited or is the child currently exhibiting signs of inappropriate sexual behaviour?		
Has the child in the past or is the child currently presenting with behavioural problems?		
Has the child a history of absconding?		
Is the child compliant with his/her current treatment plan?		
Additional Comments:		

continued

Please tick the appropriate box		
	Yes	No
Self Neglect		
Does the child have a history of self-neglect? (e.g. poor hygiene, inadequate dietary intake etc.)		
Does the child have a history of an eating disorder or body image problems?		
Does the child have low self-esteem?		
Does the child have difficulty communicating his/her needs?		
Are there significant financial constraints that may affect the child's ability to self-care?		

Additional Comments:

Please tick the appropriate box		
	Yes	No
Drugs & Alcohol		
Has the child a history of drug or alcohol abuse? (If so give details)		
Has any member of the child's family a history of drug or alcohol abuse?		

Additional Comments:

continued

Please tick the appropriate box		
	Yes	No
Violence and Aggression		
Does the child have a history of violence or aggression towards adults, children, peers or animals?		
Has the child ever made specific threats of harm towards others?		
Does the child often talk about death, killing or weapons?		
a) Do TV shows; films or games of a violent nature fascinate the child?		
Does the child have access to, or carry weapons?		
Is the child experiencing a psychotic episode with thoughts of violence?		

Additional Comments:

Any other Relevant Information:

continued

Has this child been referred to any other Inpatient Unit or Community Service?

If yes Please provide details:

Identified Person on referring team to liaise with *..... staff throughout the child's admission:

SUMMARY OF DIAGNOSIS	
AXIS I	1. 2. 3.
AXIS II	
AXIS III	
AXIS IV	
AXIS V	

continued

*In the event that this referral is accepted and the identified child is admitted to *.....in-patient unit, the service specified below will accept back the care of this child upon his/her discharge from hospital. This has been discussed and agreed upon with the relevant service.*

Name of Service:

Address:

Tel No:

Fax:

Please forward on an agreement in writing from the relevant service.

REFERRING CONSULTANT SIGNATURE

PRINT NAME:

DATE:

CAMHS In-Patient Unit Contact Details

Name	Telephone	Fax
Merlin Park, Galway	091 731 408	091 731 508
Linn Dara, Dublin	01 620 7412 / 01 620 7405	01 620 7450
St. Joseph's, Fairview	01 884 2460	01 884 2461
Eist Linn, Cork	021 452 1100	021 452 1164

References

A Vision for Change, Department of Health Ireland, 2006.

Building and sustaining specialist CAMHS to improve outcomes for children and young people, Royal College of Psychiatrists, November 2013.

Inpatient Child and Adolescent Mental Health Services Performance Report 2012-2013, HSE.

NHS Standard Contract for Tier 4 Child and Adolescent Mental Health Services: Children Services, NHS England, 2013.

NHS Standard Contract for Tier 4 Child and Adolescent Mental Health Services: General Adolescent Services, NHS England, 2013.

Working within child and adolescent mental health in-patient services; A practitioner's Handbook, Angela Sergeant, 2008.

International Literature Review of CAMHS; Colman Noctor, 2015.



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