Model of Care for CAMHS Hubs

September 2023

HSE CAMHS Hub Model of Care

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Contents

Foreword

This 'Model of Care for CAMHS Hubs was developed as a direct recommendation of the National Strategic Plan for Mental Health *Sharing the Vision.* It arose from the recognition that children and young people experiencing mental health crisis need specialist services to provide brief intensive supports in a timely way to assist the child or young person in their recovery journey. The needs for CAMHS service development are increasing significantly. Between 2020 and 2021, referral rates into CAMHS have increased by 33%, while the number of new cases seen has increased by 21% in that same period.

The organisation and delivery of Mental Health Services and supports into the future, requires the development of stepped care approaches, to ensure each person can access a range of options matched to their needs. For children and young people this means access to community based supports needed as close to home as possible and at the level of complexity that best corresponds to their needs and circumstances.

CAMHS Hubs which will play a vital role by providing intensive brief mental health interventions to support CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis. The CAMHS Hub Team will use the skills of the multidisciplinary Team to assess the child or young person's needs and to develop an individual care plan that supports them on their recovery journey. This Model of Care clearly outlines the functions and operational requirements for CAMHS Hubs, which will cater for a small group of service users with the greatest needs.

In conclusion, we would like to thank each member of the National CAMHS Hubs Steering Group, who we believe were very dedicated and committed to this project and who worked hard to enrich the final document with their own perspective and experience. We would also like to thank the project Team Michelle Butler and Sinéad Hardiman for their excellent work in driving this work forward and for leading on the design and development of this Model of Care.

John Meehan,
HSE Assistant National Director for Mental Health Planning,
Co-Chair of the National Steering Group.

Dr. Amir Niazi,
HSE National National Clinical Lead for Mental Health,
Co-Chair of the National Steering Group.

Message from the National Director Change and Innovation

It gives me great pleasure as the National Director for Change and Innovation to present this “Model of Care for CAMHS Hubs. This Model of Care is part of the HSE Mental Health Reform plans, as outlined in the National HSE Corporate Plan, and aligned to national strategic policies, including Sláintecare and *‘Sharing the Vision: A Mental Health Policy for Everyone’*. This Model of Care has been designed to support children and young people experiencing acute mental health crisis through the development of CAMHS Hubs Teams.

The vision for CAMHS Hubs is *“To provide intensive brief mental health interventions to support CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis”*. CAMHs Hubs will be piloted across five learning sites. There will be an independent evaluation undertaken of the pilot implementation of CAMHS Hub Service over the pilot testing phase 18 - 24 months in line with the Standard Operating Procedure and the Model of Care. I would like to take this opportunity to acknowledge the work and commitment of the five learning sites in accepting to co-design and to pilot implement this exciting and innovative initiative.

I would like to thank all members of the National CAMHS Hubs Steering Group, for their commitment, insight and collaboration in the development of this Model of Care. I would like to thank my Mental Health Change and Innovation Team for all their work in designing and developing this Model of Care and for supporting the sites in their implementation planning and delivery. I would also like to express my gratitude to all the key stakeholders that we engaged with in the design and development of this initiative.

Yvonne Goff
HSE National Director, Change and Innovation

Membership of the National Steering Group CAMHS Hubs

Name	Role	Representing
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Executive Summary

This Model of Care has been designed to support children and young people experiencing acute mental health crisis through the development of Child and Adolescent Mental Health Service (CAMHS) Hubs Teams.

Vision for CAMHS Hub

"To provide intensive brief mental health interventions to support CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis".

Definition of a CAMHS Hub

A CAMHS Hub provides enhanced intensive brief mental health interventions to support Community CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis, in the young person's own environment/ community facility and with the active involvement of the young person and their family/carers/supporters and interagency liaison with local partners. Support from these hubs is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different young people's or parent/carer needs. Typically, this entails a range of evidenced-informed therapeutic approaches, including medication management, psychotherapeutic based individual, group and family interventions. The service will be child and young person centred, recovery focused and trauma informed.

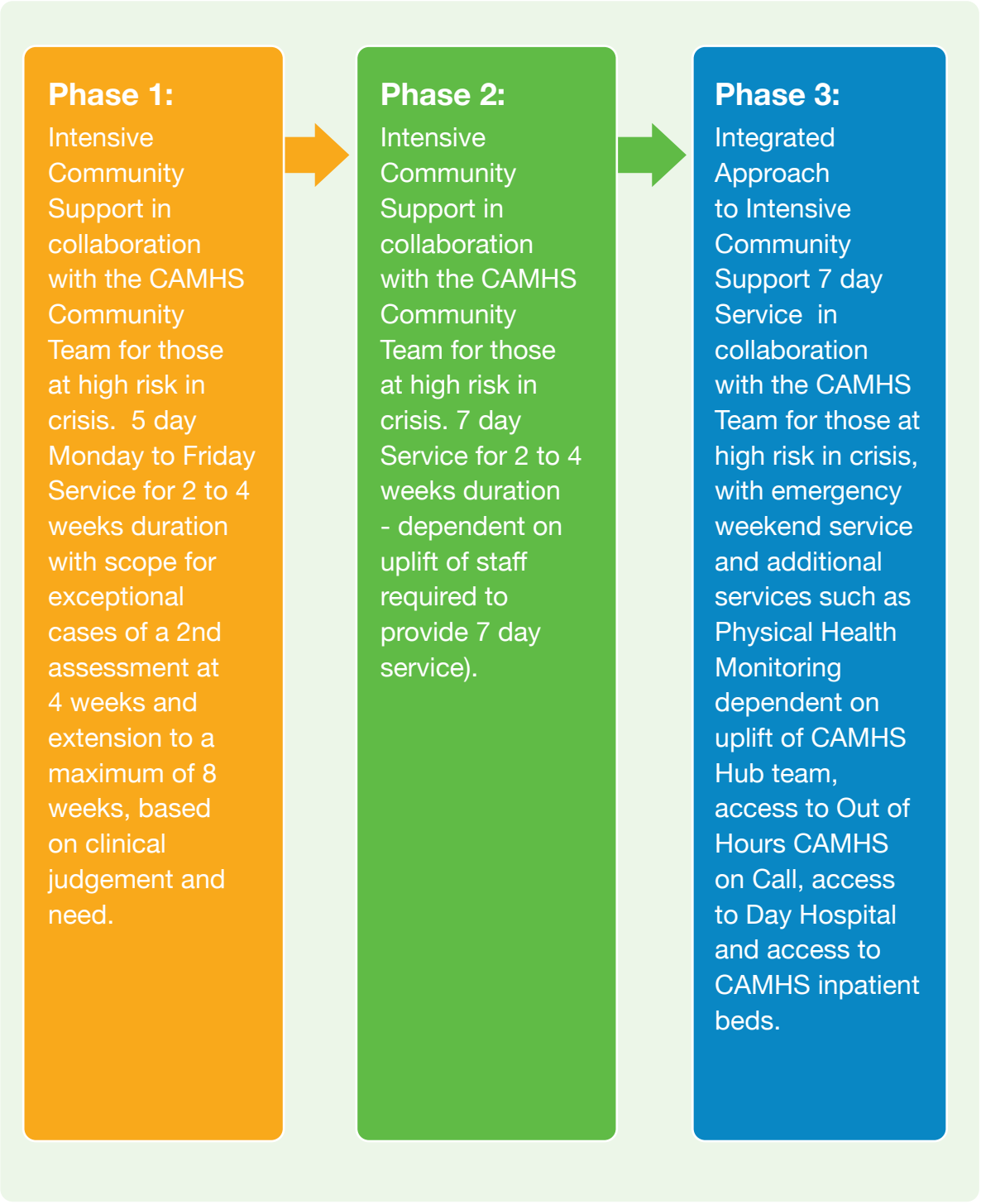
Pilot Implementation of the CAMHS Hub Model of Care

This Model of Care will be piloted across pilot learning sites. There will be an independent evaluation undertaken of the pilot implementation of CAMHS Hubs over the pilot testing phase 18 - 24 months in line with the Standard Operating Procedure and the Model of Care. On completion of the mixed methods evaluation across the five CAMHS Hubs learning sites, the pilot Model of Care will then be reviewed and optimised by the National Steering Group for CAMHS Hubs. Plans will then be put into place to support the mainstreaming and upscaling of CAMHS Hubs within HSE Mental Health Services.

Phased Development of CAMHS Hub Model of Care

It is envisaged as outlined below in Figure 1, that there will be a phased development of the CAMHS Hub model in line with resources available and access to existing services available in each of the learning site areas, such as access to Out of Hours CAMHS On Call, access to Day Hospitals and access to CAMHS inpatient beds. Phase 1 represents the initial focus of pilot implementation.

Figure 1: Phases to CAMHS Hub Development



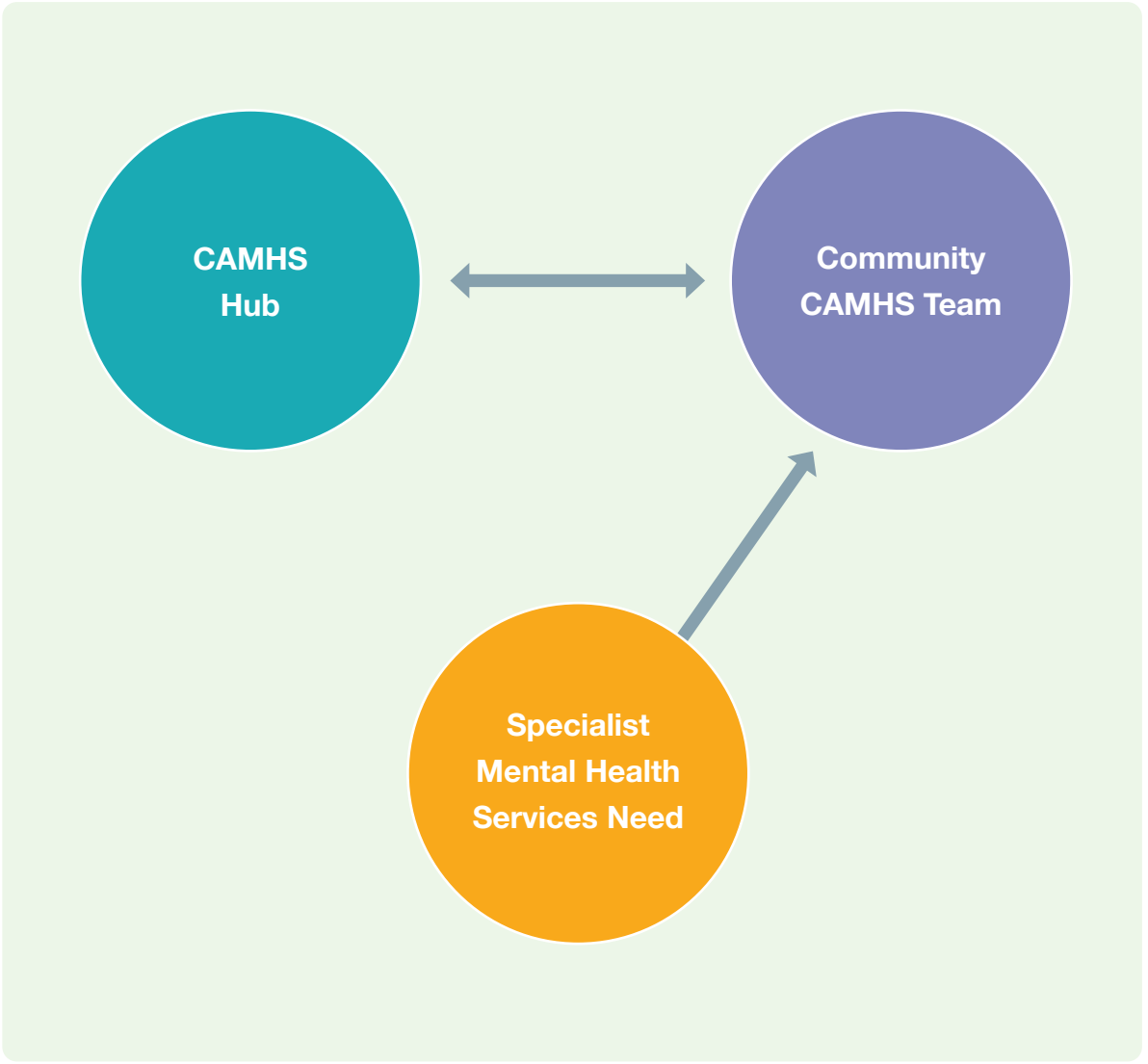
How the CAMHS Hub Model fits within the overall structure of HSE CAMHS Services

CAMHS Hub will support Community CAMHS Teams by providing an enhanced level of brief intervention mental health support for children and young people aged up to 18 years, experiencing an acute mental health crisis, where it is determined the needs of the child or young person require a rapid response, time-bound intensive brief intervention.

The CAMHS Hub Team will compliment and support the work of CAMHS Community Teams, at times where the CAMHS Community Mental Health Team requires an additional intensive brief intervention service to manage and de-escalate the acute mental health crisis.

Referral to the CAMHS HUB Team can only be made from a Community CAMHS Team. It is not directly accessible by Emergency Departments in Acute Hospitals or other first line responder services. It is not an alternative to a CAMHS Crisis/Liaison service but fits within the continuum of services required in the comprehensive service provision for children and young people with moderate to severe mental health difficulties.

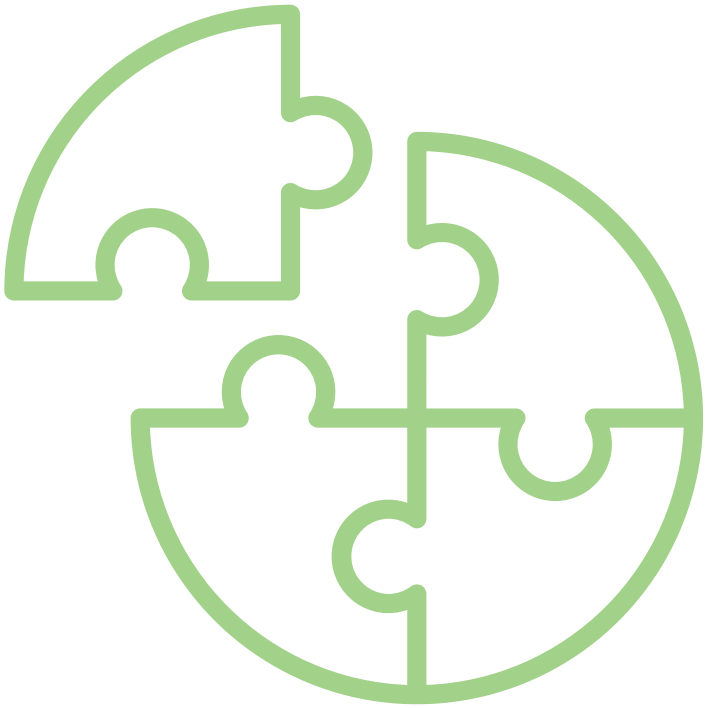
Figure 2: CAMHS Hubs and CAMHS teams will be operating within Specialist Mental Health Level of Need



Current Mental Health Context for Development of CAMHS Hubs

Between 2020 and 2021, referral rates into CAMHS have increased by 33%, while the number of new cases seen has increased by 21% in that same period. Gaps in existing children and young people's mental health services; such as reduced access to community-based services, the lack of early intervention, prevention, and 24/7 crisis care, has led to increased pressures on urgent and emergency care. These gaps prevent timely access to appropriate levels of care and can decrease children and young people's engagement with providers at the time of crisis[1].

The organisation and delivery of Mental Health Services and supports into the future, requires the development of stepped care approaches, to ensure each child and young person can access a range of care options matched to their needs. For children, young people and their family/carers this means access to the supports needed as close to home as possible and at the level of complexity that best corresponds to the individual's needs and circumstances. It is envisaged that through the delivery of CAMHS Hubs, alternative pathways of crisis response care will provide responsive and timely input required by children and young people, and will positively impact on CAMHS services.



1. Visou et al, (2021)

Introduction

Model of Care for CAMHS Hubs

This Model of Care has been designed and developed to specifically outline how CAMHS Hubs in Ireland should be organised and integrated across health and community services. The development of CAMHS Hubs is an important step in the journey to provide a modern, responsive, integrated and fit for purpose Mental Health Service for Children and Young People.

This CAMHS Hub Model of Care, will complement and enhance current CAMHS service delivery by adding a CAMHS Hub Team dedicated to supporting young people in acute mental health crisis. This Team will intervene swiftly to deliver focussed short term interventions for young people who are already under the care of a Community CAMHS Team, but are experiencing an acute mental health crisis, with the intention of reducing the likelihood of a deterioration in the young person's mental health, and reducing the likelihood of the need for acute inpatient care.

What is a Model of Care?

A Model of Care describes the way that health services are designed and delivered for a person, as they progress through the stages of a condition, injury, or event.[2] A Model of Care approach, is an approach to the design and delivery of health care services using information based on patient needs and clinical best practice to determine how services should be organised and integrated across sectors, professions, and settings (i.e. what type of care should be delivered, where that care should be delivered, and who should deliver that care)[3] The Model of Careapproach is informed by a number of key principles: quality improvement; evidence-based practice; project management; and, change management[4].

2. Agency for Clinical Innovation, (2013)
3. Cancer Care Ontario's (CCO's) Models of Care program (2011)
4. Davidson et al. (2006)

The Purpose of this Model of Care for CAMHS Hubs

The overall purpose of the Model of Care for CAMHS Hubs is to:

- Clearly define the role and purpose of CAMHS Hubs;
- Support the development of a comprehensive CAMHS Hub Mental Health Community Based Service across the learning sites to improve services and supports for children and young people and their family/carer/supporters, to meet the increased demand placed on community mental health services;
- Support the implementation of the pilot CAMHS Hubs model in line with best practice;
- Ensure that the CAMHS Hub is responsive in so far as possible to the mental health needs of the young person experiencing an acute mental health crisis;
- Ensure that legislative and regulatory requirements are met;
- Ensure that children, young people and their parents/carers are clear on the service provided by the CAMHS Hub Team;
- Ensure that the Community CAMHS Teams, who are the primary referrers and other agencies involved in the provision of care to children and young people are clear on the service provided by the CAMHS Hub Team.

The CAMHS Hub Model of Care – 4 Phase Cycle Process

The Model of Care process applied for the Pilot CAMHS Hub Model of Care is informed by an implementation science approach. This process involves a 4 phase cycle for implementing new pilot models of care incorporating 1) Design and Planning, 2) Implementation, 3) Evaluation and 4) Review, Sustain and Up-scale.

Figure 3: CAMHS Hub Model of Care – 4 Phase Implementation Process

Phase 1 – Design & Planning

This phase incorporated the process of exploration of options and ideas to address the need for CAMHS Hubs resulting in a developed plan for the service delivery and the implementation of the service. The Health Service Executive (HSE) Mental Health Integrated Care Team provided the initial governance and oversight required, ensuring that CAMHS Hubs design and development was included in the HSE Corporate Plan and the HSE National Service Plan.

Following this a project team were assigned to undertake early exploration of the concept, review literature and facilitate engagement meetings with key stakeholders to inform the initial resource model, to enable incorporation into the health service estimates planning process for design, development and pilot implementation.

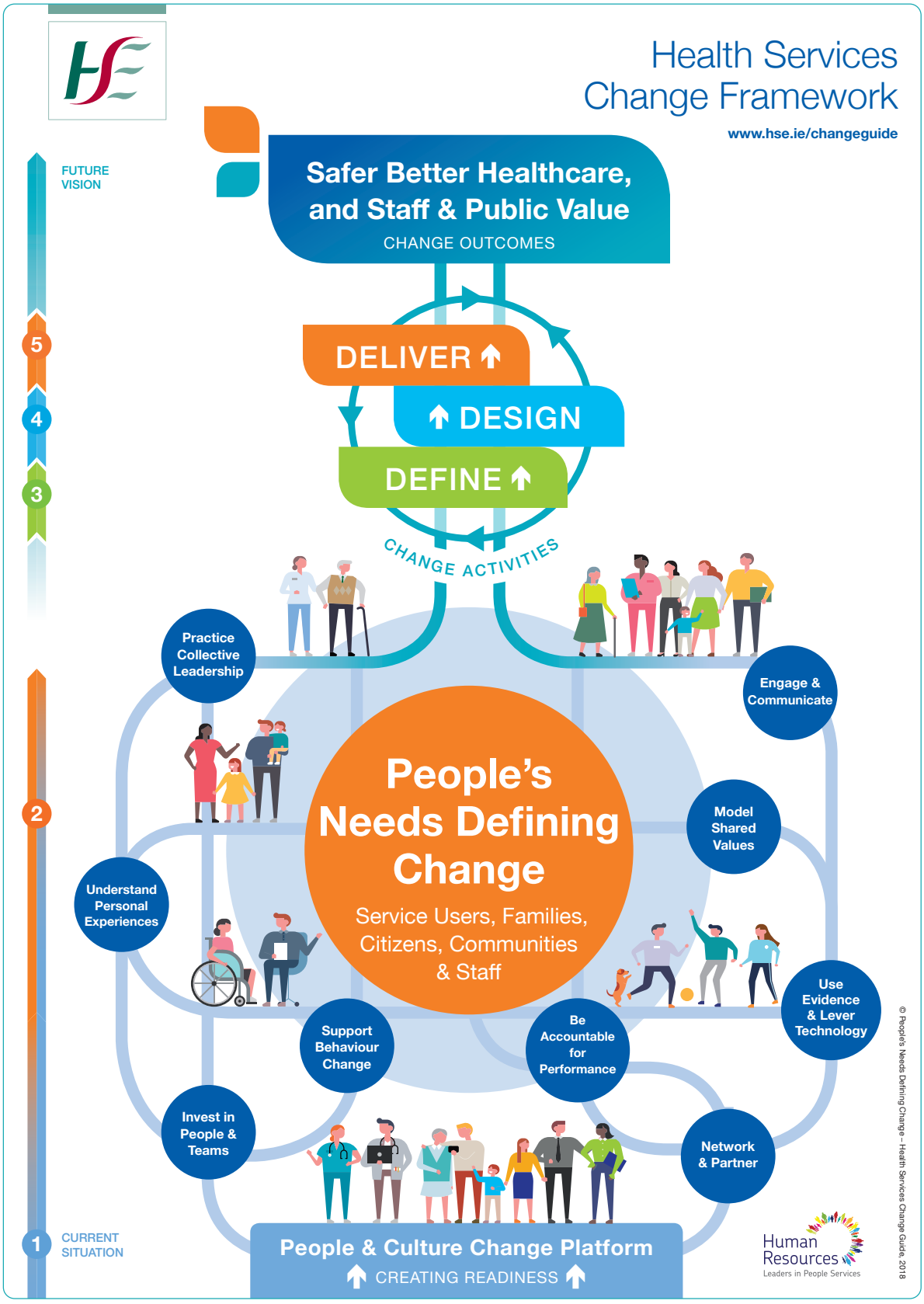
HSE Mental Health Change and Innovation led the Model of Care design, planning and development process. The National CAMHS Hub Steering Group was established in December 2021, to oversee the design and development of a Pilot Model of Care for CAMHS Hubs. Membership included representatives from each of the learning sites, national representatives from each of the core staff disciplines aligned to CAMHS Hubs, National Mental Health Clinical Programmes, Mental Health Engagement and Recovery, Mental Health Operations, Planning and Change and Innovation.

Working with key stakeholders (service users, clinicians, health and social care professionals, healthcare management and service providers), the overarching aim was to identify, design and develop this innovative new model of care for CAMHS Hubs that are child and young person centred, evidence based and are high quality services. This included reviewing international evidenced based best practice and engaging with key stakeholders internationally and in Ireland who are already providing intensive community based or tele-health assessments and interventions for children and young people experiencing crisis, to inform the design and planning process.

The HSE Organisation Development and Change Team presented the Health Services Change Framework to the National Steering group to support them in this design and planning phase, see Figure 2 below. A webinar for the National Steering Group was also held looking at national and international best practice. A logic modelling workshop was convened to inform and guide the work of the national steering group. Following this, a standard operating procedures was developed to inform practice in line with the Model of Care and these were approved by the National Steering group in February 2023.

More information on the core design components of CAMHS Hubs are outlined in detail in Section 4.

Figure 4: Health Services Change Framework



Phase 2 – Implement

This phase involves pilot implementation and testing of the new Model of Care for CAMHS Hubs. The first phase of implementation should primarily focus on the ecological fit between the innovation and the host setting[5]. Five learning sites were identified by the HSE Mental Health Integrated Care Team, with a mix of rural and urban locations and resources were allocated for pilot implementation of the CAMHS Hub Model of Care. The sites were selected based on the following:

- demand and capacity across Mental Health Services;
- the required resources (financial, capital, workforce) to implement CAMHS Hubs on a phased basis;
- identification of innovation champions across the system to support the development.
- evidence within the system of readiness to implement;
- consideration to population need across Mental Health Services;
- access to existing Mental Health Services and supports;
- a commitment to delivery and implementation of the pilot CAMHS Hubs in their CHO area.

All learning sites are represented on the National CAMHS Hubs Steering Group, which meets monthly, and provides ongoing operational insight and guidance to support the implementation process; identifying key enablers and potential barriers to implementation.

A significant focus in this phase is on providing guidance and support from Mental Health Change and Innovation for learning sites to implement the new model of care. Terms of reference and CAMHS Hubs recruitment documentation have been developed for the local CHO pilot implementation Teams and detailed implementation plans provided to Teams to support operationalisation and implementation of services. A National CAMHS Hubs Learning Sites Network has also been established to support the Teams in the delivery of this new innovative service. More information on Implementation of this Model of care is outlined in Section 6.

Phase 3 – Evaluate

The learning sites are commencing operations in 2023 with the aim of delivering CAMHS Hubs with fidelity to the Model of Care in 2023 and 2024. This phase ensures evaluation assessment and continuous improvement of the model. A national independent evaluation Team will design and undertake a mixed method multi-site evaluation of the pilot implementation of CAMHS Hubs over the pilot testing phase 18 months in line with the Standard Operating Procedure and the Model of Care. They will also develop and test a minimum performance indicator data set to support learning for the future expansion and mainstreaming of the project. The evaluation and monitoring of the learning sites will be undertaken alongside pilot delivery, with the final evaluation report to be completed in 2025. More information on the Monitoring and Evaluation of this Model of Care is outlined in Section 7.

5. Meyers et al. (2012a)

Phase 4 – Review, Sustain, and Upscale

This is an important phase of the implementation process as it involves the key steps to be taken to review, sustain and upscale the delivery of CAMHS Hubs Model of Care to ensure all geographical areas are resourced to deliver this Model of Care.

Step 1: Completion of mixed methods evaluation across the pilot CAMHS Hubs learning sites.

Step 2: National Steering Group to review the evaluation findings to inform what outcomes were achieved and where improvements or changes to the Model of Care are required.

Step 3: The pilot Model of Care will then be reviewed and optimised by the National Steering Group for CAMHS Hubs.

Step 4: Ensure alignment with National Policy and Strategy and to address any arising policy issues from pilot delivery to ensure that the final Model of Care will work as effectively as possible.

Step 5: Develop a CAMHS Hubs resourcing strategy to support the mainstreaming and upscaling of CAMHS Hubs within HSE Mental Health Services.

Step 6: Plan to incrementally scale up the delivery of CAMHS Hubs across additional geographical areas to ensure access for all.

Step 7: Secure resources for delivery as per revised Model of Care.

More information on the Review, Sustain and Upscale for this Model of Care is outlined in Section 8.

CAMHS Hubs Model of Care Design and Developmental Timeline 2021 to April 2023

Implementation of new innovative and evidence based approaches to service delivery are estimated to take two to four years. Our Implementation journey began in 2022. The following outlines the progress achieved in the design and development of the CAMHS Hubs Model of Care from December 2021 to May 2023.

Figure 5: CAMHS Hubs Model of Care Design and Developmental Timeline

January to December 2021

- CAMHS Hubs included in the HSE Corporate Plan and the National Service Plan
- Early exploration of concept and engagement meetings
- Initial resource modelling review and incorporation into estimates planning

December 2021

- National Steering Group established
- Data gathering and analysis of CAMHS Hubs
- 4 Learning Sites agreed – CHO 2, CHO 3, CHO 4 and CHO 6

January 2022

- Literature review of international best practice completed and presented to National Steering Group (NSG)

February 2022

- Further exploration and review of best practice approaches for Child and Adolescent mental health services in Irish context completed

April 2022

- CAMHS Hubs Development Webinar
- Stakeholder Consultation and Engagement

May 2022

- Logic Model Workshop held with key stakeholders
- CAMHS Hub Logic Model approved by National Steering Group
- CAMHS Hub Recruitment resources provided to Pilot Implementation Teams

June 2022

- Learning sites progressing local implementation plans

July 2022

- CHO 8 agreed to be a Learning Site
- National Steering Group agree core components of CAMHS Hubs Standard Operating Procedure
- Learning sites progressing local implementation plans

August 2022

- First draft of Standard Operating Procedure presented to National Steering Group
- Learning sites progressing local implementation plans

September 2022

- National Steering Group review first draft of the CAMHS Hubs Standard Operating Procedure
- Learning sites progressing local implementation plans

October 2022

- Learning sites progressing local implementation plans
- Revisions to Standard Operating Procedure draft 2 progressed

November 2022

- National Steering Group review second draft of the CAMHS Hubs Standard Operating Procedure
- Learning sites progressing local implementation plans

December 2022

- Learning sites progressing local implementation plans
- National Steering Group review third draft CAMHs Hubs Standard Operating Procedure

January 2023

- Learning sites progressing local implementation plans
- Implementation support resources provided to pilot implementation Teams

February 2023

- Learning sites progressing local implementation plans
- Standard Operating Procedure for CAMHS Hubs approved by National Steering Group

April 2023

- CAMHS Hub Model of Care in development
- Learning sites progressing local implementation plans

May 2023

- External evaluation consultants appointed
- CAMHs Hub National Learning Network established

June 2023

- Learning Teams commence pilot implementation of services
- National CAMHS Hub Data sub-group established
- Launch of Model of Care and Learning sites CHO 2, CHO 3, CHO 4, CHO 6 and CHO 8

Section 1

National Strategy & Policy Context to CAMHS Hubs

Government strategy and policy guides and directs the reform of health policies. The three primary strategies informing this Model of Care are *Sláintecare, Sharing the Vision – A Mental Health Policy for Everyone and Connecting for Life - Ireland's National Strategy to Reduce Suicide 2015-2020.* This Model of Care for CAMHS Hubs is part of the HSE and Sláintecare Mental Health Reform plans, which are incorporated in the National HSE Corporate Plan and are resourced under the HSE National Service Plan. The development of this Model of Care arose from the recognition that children and young people experiencing acute mental health crisis and their families/carers require specialist mental health services to provide brief intensive supports, interventions and enhanced responses in a timely way.

Figure 6: Strategy and Policy Guiding the Reform of Mental Health Services

1.1 Sláintecare

Sláintecare is the ten-year all Government programme to transform how we deliver our health and social care services in Ireland, building towards equal access to services for every citizen based on patient need and not their ability to pay.

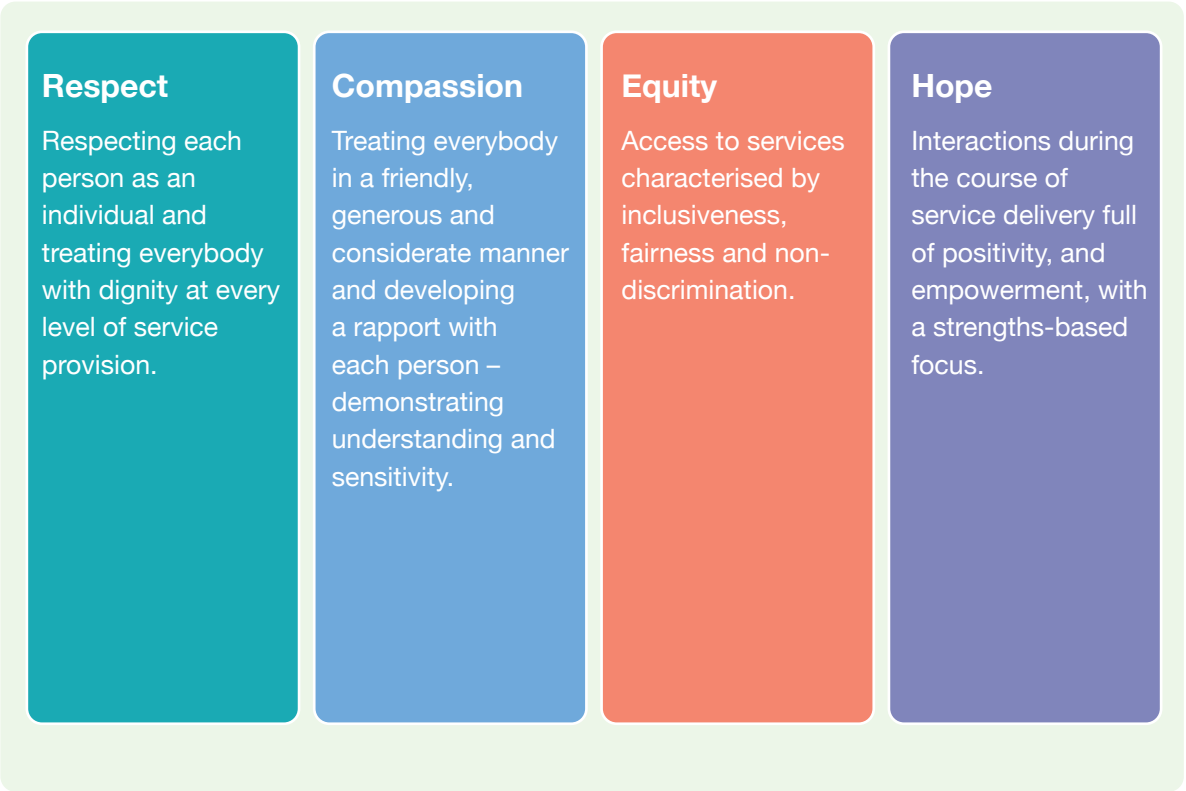
By putting people at the centre of the health system and developing primary and community health services, the Department of Health and HSE are working together to provide new models of care that allow people to stay healthy in their homes and communities for as long as possible.

Sláintecare aims to deliver one universal health service for all, providing *"the right care, in the right place, at the right time".*

1.2 Sharing the Vision: A Mental Health Policy for Everyone

Sharing the Vision: A Mental Health Policy for Everyone outlines national objectives and deliverables that build on the previous 10-year policy 'A Vision for Change' (AVFC) (2006-2016). The refreshed policy is strongly rooted in developing a broad-based, whole-system, population-wide Mental Health policy that is closely aligned to the main provisions of Sláintecare. The policy is underpinned by the following core values.

Figure 7: Sharing the Vision: A Mental Health Policy for Everyone Core Values



These values provide the framework for the implementation of the CAMHS Hubs delivery model. The policy was informed by a major stakeholder consultation process undertaken by the Oversight Group and supported by the Department of Health. Although there has been an increase in the number of CAMHS inpatient beds since the original AVFC policy was published, it is acknowledged that there have been some challenges in accessing sufficient age-appropriate inpatient beds, exacerbated by staff availability issues and complexity of cases. Adult inpatient units are, generally speaking, not appropriate environments for children and adolescents.

The Service Access, Coordination and Continuity of Care Domain under Sharing the Vision: A Mental Health Policy for Everyone seeks to ensure service users and their families, carers and supporters (FCS) have timely access to evidence-informed supports through Mental Health services that are evidence-informed and recovery-oriented, adopting trauma-informed approaches to care, based on lived experience and individual need. It notes that while people in need of support or urgent care attend emergency departments, stakeholder consultation prioritised the availability of non-ED based out of hour's alternatives offering referrals to Mental Health services[6].

The coordination of Mental Health Services takes place using a 'stepped care' approach to improve and maintain continuity of care. The tiers outlined in Figure 8 below reflect the response to need and the level of intervention required at that point in the service user's health experience. Sharing the Vision is underpinned by a population-based planning approach which helps to guide the distribution and development of Mental Health Services and supports in Ireland in response to need. Individuals move through different levels of support and services, from informal care and support in their own community to primary care, to specialist Mental Health Services, all based on their mental health needs[7].

Figure 8: Population Based Planning Approach for Mental Health

6. Sharing the Vision – A Mental Health Policy for Everyone, pg. 45
7. Sharing the Vision – A Mental Health Policy for Everyone, pg. 18

1.3 Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020

Connecting for Life is Ireland's national strategy to reduce suicide 2015-2020. *Connecting for Life* sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. The strategic goals and objectives of Connecting for Life are:

1. Better understanding of suicidal behaviour

2. Supporting communities to prevent and respond to suicidal behaviour

3. Targeted approaches for those vulnerable to suicide

4. Improved access, consistency and integration of services

5. Safe and high quality services

6. Reduce access to means

7. Better data and research

1.4 HSE Corporate Plan 2021-2024

The HSE Corporate Plan 2021-2024 sets out the key actions that the HSE will take over the timeline of the plan to improve our health service and the health and well-being of people living in Ireland.

Objective 4 of the HSE Corporate Plan seeks to "Prioritise early interventions and improve access to person-centred Mental Health services". Recognising the challenges in accessing mental health services, and the significant positive impact early intervention for mental health issues and timely access to treatment can have on individuals and their families. It seeks to focus on addressing the mental health needs of the population through a focus on the requirements of the individual. It promotes the development of service delivery models that are integrated and person-centred; whereby people will be able to access care when and where they need it.

One of the strategies to deliver on this objective is to *'implement Child and Adolescent Mental Health Services (CAMHS) Hubs to offer increased access to assessments'.* The pilot implementation of CAMHS Hubs in five learning site offers one-step forward in progressing the delivery of Objective 4.

1.5 National Service Plans 2021, 2022 and 2023

National service planning is the means by which the organisation implements its Corporate Plan on an annual basis. The objectives and enablers as set out in the HSE Corporate Plan are the key foundations for HSE annual service planning. The strategic goal for Mental Health service planning, in collaboration with other services, is to promote the mental health of our population, support those seeking recovery from mental health difficulties and suicide prevention. Priority areas for action reflect a commitment to the implementation of National Mental Health policy, a continued focus on the design and development of evidence based, recovery focused services that are timely and clinically effective, while also ensuring that the views of service users, family members and carers are incorporated and that the provision of service is by highly trained and engaged staff.

The National Mental Health Integrated Care Team provides governance, oversight and strategic direction to all Mental Health Service planning activity. This Team includes membership across Mental Health Clinical Programmes, Mental Health Operations, Mental Health Engagement and Recovery, Mental Health Planning, Mental Health Change and Innovation, Finance and HR. Meeting monthly, the Team provides the overarching governance required to support the implementation of the Mental Health components of the HSE National Service Plan. Resourcing for CAMHS Hubs has been secured under the 2021, 2022 and 2023 national service planning process.

1.6 Mental Health Change and Innovation

The Mental Health Change and Innovation Team led on the design and development of this Model of Care and provide support to the pilot implementation learning sites. The Change and Innovation sub-function of the HSE is accountable for planning and delivery of priority strategic change programmes across the HSE, aligned with strategic objectives. The Team are responsible for expert input into the development of strategies and implementation plans and coordinates delivery of prioritised programmes. The Team also supports implementation of programmes by providing change and readiness capabilities and delivers a systemic approach to improving change capacity across the whole organisation, and drives interventions, optimisation, and innovation for the HSE.

Section 2

Current Context of Mental Health Services

2.1 Current Context of Mental Health for Children and Young People

Currently, children and young people with an out of hours emergency are required to attend out of hours GP services as the first point of contact, or to present at the Emergency Department of the local general hospital. An assessment by either the on-call GP or consultant at the Emergency Department will make a referral to the CAMHS Community Mental Health Team or to a consultant psychiatrist for emergency admission to an inpatient psychiatric unit[8].

Child and Adolescent Mental Health Teams (CMHTs) are the first line of specialist mental health services for children and young people who are directly referred to the Community CAMHS Team from a number of sources. The Community CAMHS Teams accept referrals for moderate to-severe mental health difficulties of children and adolescents who cannot be managed within primary care. Referrals to CAMHS also support children and young people with a mental illness and intellectual disabilities.

Gaps in existing children and young people's mental health services, such as reduced access to community-based services, the lack of early intervention, prevention, and 24/7 crisis care, has led to increased pressures on urgent and emergency care. These gaps prevent timely access to appropriate levels of care and can decrease children and young people's engagement with providers at the time of crisis[9].

Globally, mental disorders are the largest cause of disability among those aged 10-24 years, with approximately half of all mental disorders emerging during adolescence, broadly the period between the ages of 12 and 18. Disorders that frequently develop during this time include mood, anxiety, substance use, and psychotic disorders as well as suicidal behaviour[10].

Between 2020 and 2021, referral rates into CAMHS have increased by 33%, while the number of new cases seen has increased by 21% in that same period. As of January 2023, a total of 4,434 children and young people were waiting to be seen, of which 1,820 were waiting less than 12 weeks. 92.7% of urgent referrals to Child and Adolescent Mental Health Teams were responded to within three working days in 2022. 10,957 new (including re-referred) child/young person referrals were seen in 2022.

8. HSE CAMHS Operational Guidelines, (2019)
9. Visou et al, (2021)
10. McMahon, E.M., O'Regan, G., Corcoran, P., Arensman, E., Cannon, M., Williamson, E. & Keeley, H. (2017).

The Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020, shows there were 486 admissions for under 18s in 2020, with the total number of admissions for under 18s including admission to adult acute units and specialised child and adolescent in-patient units.

- 75% of all admissions for under 18s were first admissions.
- 27 admissions for under 18s to adult units and hospitals in 2020, down from 54 in 2019.
- 72% of all admissions for under 18s were female.
- 33% of all admissions were aged 17 years on date of admission, 24% were aged 16 years, 20% were aged 15 years, 15% were aged 14 years and 8% were aged 13 years or younger.
- Females accounted for 74% of admissions to child and adolescent in-patient units.
- 31% of all admissions for under 18s had a diagnosis of depressive disorders, relatively unchanged from 32% in 2019, 18% had a diagnosis of eating disorders, up from 11% in 2019, 10% had a diagnosis of neuroses, down from 16% in 2019, 8% had a diagnosis of schizophrenia, down from 10% in 2019, with the remaining proportions distributed amongst the other diagnostic groups.
- Almost 10% of all admissions for under 18s were involuntary. Almost ninety per cent of all admissions for under 18s in 2020 were discharged in 2020.
- Of those admitted and discharged in 2020, 14% were discharged within one week of admission, 11% were discharged within one to two weeks of admission, 26% were discharged within two to four weeks of admission and 43% were discharged within one to three months of admission. Almost 6% were discharged within three months to one year of admission.
- Average length of stay was longest in child and adolescent units, at 38.7 days (median 28 days), while that for general hospital psychiatric units was 5.7 days (median 3 days).
- In 2020, 94% of all admissions for under 18s were to child and adolescent units, with 6% to general hospital psychiatric units and psychiatric hospitals/continuing care units[11].

2.2 Challenges Affecting CAMHS Services

Impact of COVID-19

In Ireland, the demand for child and adolescent mental health services has been increasing in recent years. The COVID-19 pandemic has further exacerbated the level of mental health difficulties experienced by young people[12]. However, the provision of these services has been impacted by a shortage of mental health professionals internationally. Waiting lists for services can be long, and there have been reports of young people experiencing long delays in receiving assessment, care and treatment. A higher number of presentations by children and young people (aged 5 – 15 years) during the first 12 months of COVID19 was recorded at Emergency Departments in Ireland[13]. Children needing acute mental health care increased significantly following the initial COVID-19 lockdown. It was suggested that long term stressors linked to the pandemic may have created chronic mental health problems.

11. HRB StatLink Series 5 National Psychiatric In-patient Reporting System (NPIRS) 2020

12. Wong et al, (2021)

13. McDonnell et al, (2021)

Staffing

Availability of skilled staff is a significant issue in mental health services where demand outstrips supply and where our workforce, particularly younger staff, are availing of employment opportunities outside of Ireland. As of December 2022, 789 WTE were employed in CAMHS (673 Clinical), which equates to 59% (60% Clinical) of the recommended A Vision for Change (AVfC) staffing levels, based on preliminary 2022 Census results. There is some variation in staffing levels across the CHOs, ranging from 44.8% - 74.7% of AVfC recommendations (based on 2016 Census results), and work is underway to analyse the level of 'unfunded posts'.

Clinical Governance and Service Provision

The Maskey Report commissioned by the Health Service Executive (HSE), examined the provision of Child and Adolescent Mental Health Services (CAMHS) in the Kerry region. The review identified a need for improved access, additional staffing and better collaboration to support the care delivered to young people. Furthermore the review highlighted the need for crisis intervention support for young people in mental health crisis. The HSE has taken a range of actions to address report findings and to ensure full implementation of the 35 recommendations outlined in the report.

Service Improvement

Recognising the challenges in current service provision including levels of access, capacity and consistency in quality of services provided, the HSE has prioritised targeted improvements and investment over recent years, including building capacity in CAMHS and youth mental health, developing specialist services and clinical programmes, suicide prevention, investing in mental health in primary care, modernising forensic services and digital platforms for accessing services.

Building on these ongoing initiatives, the HSE is prioritising an overall youth mental health improvement programme with a focus on early intervention and 'upstream' youth mental health services; enhanced capacity, governance and Team organisation in CAMHS; interim and long-term digital case management solutions; continued innovation, tele-psychiatry and digital mental health. The need to develop non-hospital crisis responses has emerged from the unique aspects of children and young people in mental health crisis and the limited numbers of inpatient beds. These interventions have placed a focus on family and community involvement, increasing self-supports and coping skills, and quickly returning the child or young person to their home and school environments when it is appropriate and clinically safe to do so[14].

2.3 Conclusion

This CAMHS Hub Model of Care has been designed to complement and enhance current CAMHS service delivery by adding a multi-disciplinary CAMHS Hub Team dedicated to supporting young people in acute mental health crisis. This CAMHS Hub Team will intervene swiftly to provide assessment and deliver focussed short term interventions for children and young people as outlined in Section 4.

14. Thurbar, 2017

Section 3

Literature Review Informing the Design Phase of CAMHS Hubs

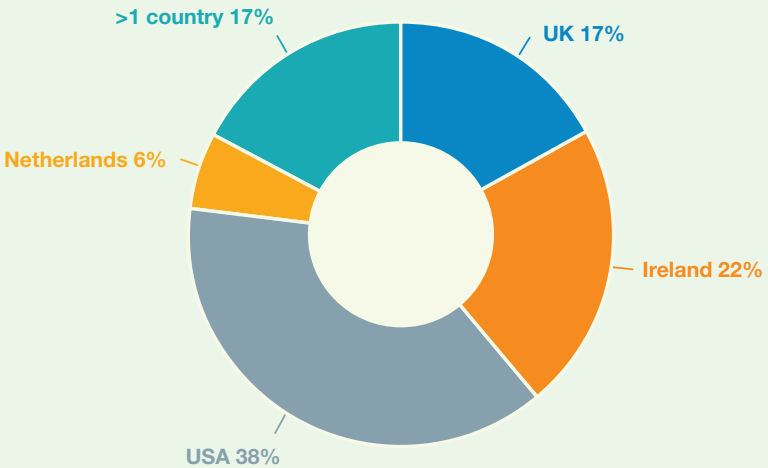
3.1 Overview

This Model of Care for CAMHS Hubs has been informed by national and international best practice. A rapid review incorporating a total of 18 papers were selected as the final inclusion studies/guidelines/systematic reviews pertaining to CAMHS Hub models of care. The 18 papers can be grouped in terms of their focus and evidence contribution

- CAMHS crisis care (out-of-hours) provision
- CAMHS hub descriptions and model configuration
- Tele psychiatry and telehealth interventions
- Systematic reviews
- System level impacts (clinical outcomes, hospital admissions, readmissions and cost-effectiveness
- Children and Young People (CYP) outcomes
- Service user experiences (CYP and parents/carers)
- Guidelines

The inclusion of systematic reviews and meta-analysis resulted in 17% of the papers covering more than one country. The largest number of studies was in the USA (38%), followed by Ireland (22%) and the UK (17%). A single study from the Netherlands was also included.

Figure 9: Distribution of studies by country



3.2 Literature Review Methodology

The interventions/models identified were directly linked to the scope of the rapid review and related search strategy. This resulted in studies/guidelines/systematic reviews of CAMHS response in out-of-hours care. Specifically, the examples included:

- Urgent behavioural health care for youth;
- Paediatric crisis services;
- Urgent care alternatives at Emergency Departments;
- Role of peer specialists on CAMHS crisis Teams;
- Experiences of CYP and families of alternative models to inpatient settings;
- Out-of-hours adolescent mental health emergency;
- Triage system for children in mental health crisis;
- Intensive home treatment for adolescents in psychiatric crisis;
- Supported discharge service for adolescents with psychiatric emergencies;
- Tele psychiatry for children and young people in mental health crisis;
- Mental health crisis toolkit for children and young people;
- Digital health interventions for children and young people with mental health problems.

Primary outcomes and indicators explored in the studies included the following:

- The clinical and demographic trends of youth referred for urgent evaluation and the effect of this service on ED utilisation;
- A literature review of psychiatric crisis care services for CYP;
- Implementation of a behavioural health urgent care model in a large paediatric hospital;;
- Community Intensive Therapy Teams on reducing and diverting CYP to inpatient services
- Patient profile and outcomes of a Crisis and Transition Services Programme (CATS);
- Impact of peer specialist on CAMHS Teams on inpatient admission and outpatient visits;
- To understand the experiences of children and young people of the accessibility of alternative models to inpatient care, as well as overall CYP/parental satisfaction;
- National and local contexts of a 0-19 service model and crisis response and the rationale, aims, organisational structure, strengths and limitations of the model;
- Implementation details for each intervention and use of the Irish Child Triage System (ICTS)
- International examples of triage tools with CYP;
- The role of CAMHS and paediatric liaison psychiatry services (PLPs) in their role in the management of CYP presenting with an acute mental health crisis;
- To describe the model of service provision and to describe the demand for and outcome of emergency assessments over a 6 year time period;

- Clinical outcomes, hospital admission and readmission and cost effectiveness of an intensive home treatment programme for adolescents in psychiatric crisis;
- The primary outcomes measured was the number of inpatient bed-days, change in Strengths and Difficulties Questionnaire (SDQ) scores, and change in Children's Global Assessment Scale (CGAS) scores at 6 months and cost-effectiveness;
- Duration of stay at the Emergency Department and CYP and parental satisfaction with crisis care services;
- Clinical evidence from child-specific tele mental health research, general tele mental health evidence base and expertise of child and adolescent tele psychiatry providers;
- Toolkit for staff developing and providing Urgent and Emergency care and support for Children and Young People who may be experiencing a mental health crisis in the East of England;
- An overview of the current evidence base in tele-psychiatry and reviews of administrative and clinical issues in videoconferencing-based treatment;
- Investigating the effectiveness of digital health interventions for mental health problems in CYP.

3.3 Rapid Review Findings – Interventions and Models Identified

Findings reported in the studies selected by this rapid review process suggest positive trends in averting psychiatric inpatient admissions for CYP, improved clinical outcomes for individuals, increased patient access to specialised services and provision of out-of-hours response to psychiatric crisis presentations. In particular the studies found:

- Behavioural health urgent care for youth in crisis recorded that Emergency Department volume decreased by 11%, and inpatient admissions decreased by 10% in a one year period which was supported by CAMHS and primary health providers[15];
- Repeat visits to the Emergency Department decreased by nearly 70%, while inpatient mental health admissions dropped by about 15% in the delivery of an urgent care service for CYP[16];
- Crisis and Transition Services (CATS) programmes targeted a high-acuity population, helping stabilise youth and connect youth and families to long-term resources. CATS provides short-term intensive outpatient care for CYP and families after a mental health crisis which was presented to an Emergency Department. CATS work with CYP who meet the criteria for inpatient admission but have the potential to safely transition home with sufficient support and the initial evaluation and safety planning. 92% of carers reported confidence in handling a crisis who had been through CATS, and 82% reported that their child or youth's care was meeting their needs[17]. Family support specialists are part of the MDT of CATS and help the family to develop the capacity for crisis management, systems navigation and self-advocacy. The MDT delivered the programme to existing service users out of routine hours where required and to CYP in a crisis presenting for the first time or not currently receiving support from CAMHS;

15. Alvarado & Feuer, (2019)

16. Feuer, (2020)

17. Marshall et al, (2019)

- CYP reported increased satisfaction with alternative models compared to care as usual in an inpatient setting, but a high level of parental burden was identified with perceived barriers to help-seeking from crisis services highlighted as a concern[18];
- In an out-of-hours child and adolescent mental health emergency service, 3-4 patients were seen per night in a 7 month period across 3 delivery sites. A dedicated and specially organised place within the Emergency Department and/or on the wards, to meet CYP presenting either with a psychiatric emergency or in crisis, and their family, was viewed as a critical component of service delivery. Furthermore, the provision of observation or short hospitalisation beds in this system could help for the assessment/monitoring of some patients and also help to diffuse crises and avoid inappropriate referrals to a saturated CAMHS system[19];
- The provision of a 24-hour CAMHS found that across a 6 year period, 59% presented outside standard working hours and at weekends, 80% presented with self-harm and suicidal ideation and 52% required admission[20];
- Reviews of treatment outcome studies have concluded that tele-therapy is feasible, applicable to diverse populations, tolerable in different therapeutic formats, and acceptable to users with outcomes that are comparable to in-person treatment[21];
- The cost-effectiveness acceptability curve based on quality-adjusted life-years (QALYs) showed that the probability of Supported Discharge Service being cost-effective compared with usual care was around 60% with a willingness-to-pay threshold of £20,000–30,000 per QALY, and that based on the Children's Global Assessment Scale (CGAS) showed at least 58% probability of SDS being cost-effective compared with usual care[22];
- There was some support for the clinical benefit of Digital Health Interventions (DHIs), particularly computerised cognitive behavioural therapy (CBT), for depression and anxiety in adolescents and young adults[23].

Different models of CAMHS provision have been identified in the literature in response to CYP presentations outside working hours. These can be grouped into four categories of provision. These are not mutually exclusive and are likely to have been featured in service models of response to some extent or with a full portfolio of service options[24].

18. Vusio et al, (2020)
19. Naviaux & Zdanowicz, (2019)
20. Byrne et al, (2018)
21. American Academy of Child and Adolescent Psychiatry Committee on Telepsychiatry and Committee on Quality Issues, (2017)
22. Ougrin et al, (2018)
23. Hollis et al, (2016)
24. NHS England, (2017)

1. Paediatric Liaison Teams

– Teams provide assessments of emergency situations including overdose or self-harm. They also offer support in the management of psychological sequelae of chronic physical health conditions like diabetes, asthma and support the management of medically unexplained symptoms. Crisis assessments by paediatric liaison Teams are embedded within acute hospital settings. Short paediatric stays with skilled multi-disciplinary liaison and interventions are offered to avoid the need for inpatient psychiatric care.

2. 24/7 Crisis Care Home Treatment Teams

– These Teams support young people on discharge from inpatient units, aiming to reduce the length of stay and to prevent readmission. Home Treatment Teams specifically seek to prevent admission to inpatient care. Services provide a 'step down' function aiming to facilitate early discharge from inpatient care. Both of these sorts of services are catering to a vulnerable and high risk population, managing complexity and risk. Clinical input should involve Consultant Child and Adolescent Psychiatrists. It has been found that some Home Treatment Teams may also be successful in engaging with groups who would not typically take up outpatient or inpatient services.

3. 'Tiered response Teams

– A crisis and home care Team offers assessment, intervention and support to young people experiencing significant mental health difficulties. The assessment can be offered initially in hospital if the young person has presented there and then care and support offered when the young person goes home to ensure their safety and care needs are met. The Teams work with CYP already engaged in the service but also respond to first time crisis presentations.

4. 'Assertive outreach' or 'intensive community' CAMHS service

– Intensive Community CAMHS services aim to prevent inpatient psychiatric care. Teams work from within the community to enable young people to stay at home while ensuring that admission, if needed, is made to the appropriate service. They will work to support young people access education, employment and meaningful daily activities, support families in coping and managing young people with mental illness/health issues, support young people and families through education and identification of relapse and crisis signature work and provide opportunities to increase physical as well as mental wellbeing of young people.

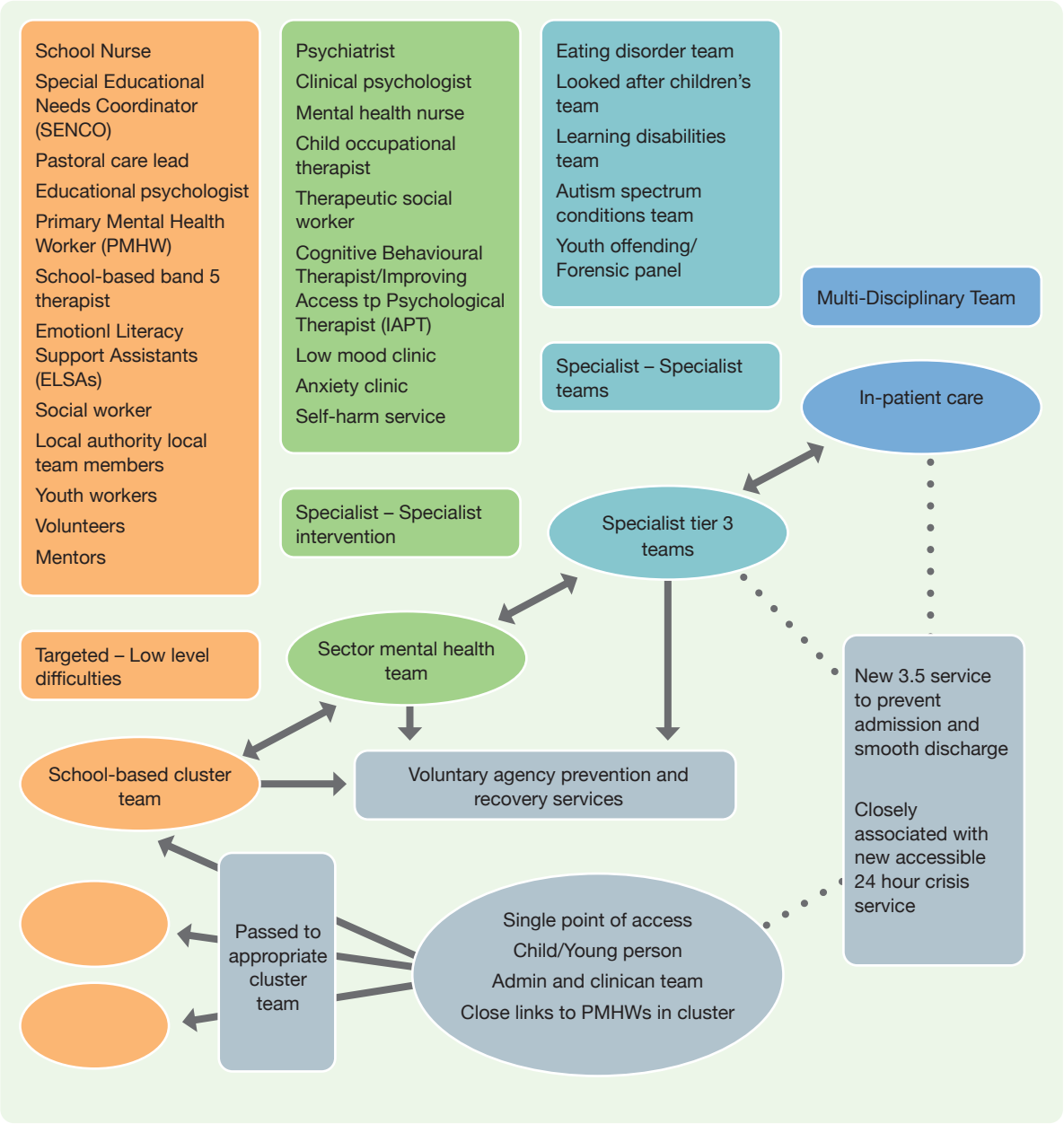
While there has been a small number of hub specific examples, the rapid literature review has highlighted key components common across CAMHS crisis response service models. Configuration of delivery has been mediated by resource allocation, policy framework, multiagency working and the viability of service integration within existing structures of implementation.

Examples of CAMHS Crisis Models

The following specific examples highlighted from the literature offer practice examples, details of implementation and outcomes.

The York Model: This is a multidisciplinary, fully integrated community-based model that works in partnership with both statutory and voluntary sectors to provide multiagency provision for CYP within the UK. The main advantages of this model lie in its accessibility, responsiveness, single point of entry, 24/7 urgent and emergency provision for CYP, and fully integrated service which enables smooth navigation through care pathways for CYP. These features of the model reduce the need for re-referrals, as all the services are closely integrated, which consequently prevents CYP to fall through the gaps between the services, particularly outside normal working hours[25]. Details on how the model was operated within a CAMHS referral system is outlined in Figure 10 below. The ecosystem of the connected services and supports are illustrated which pinpoints the referral routes and the step-up to 3.5 services.

Figure 10: The York Model



25. Healthwatch, (2019)

One Stop Shop Model: This is a nurse-led drop-in clinic for CYP with the nurse specialist in the role of care-coordinator. Clinical oversight was provided by a consultant psychiatrist with the support of a paediatrician, clinical psychologist and nurse specialists. This particular model is innovative, as it allows a reduction in waiting time for CYP who are experiencing a crisis, with swift access to appropriate crisis help, flexibility with care, and has improved efficiency and CYP satisfaction[27]. The collaborative approach of this project meant that service users could access both medication reviews and psychosocial intervention services at a single point of access. An integrated referral system with a wraparound approach was developed as part of this model over a 12 month period in the Midlands of England.

Supported Discharge Service (SDS): This refers to a mixed model between intensive and assertive community treatment that shows a promising reduction in the need for hospitalisation or emergency admission, self-harm rates and improved school reintegration in comparison to care as usual[28]. Staff tasks included assisting young people with creating customised care plans, psychiatric care, psychological interventions, helping with school reintegration, and optimising physical health care and social support. The SDS intervention was informed by the principles of the Care Programme Approach (CPA) which supports the implementation of a 'care co-ordination model'. This seeks to develop personalised care plans and aims to integrate care for Service Users from a range of providers[29].

The use of such community models may help in reducing a need for hospital or Emergency Department admissions. Extended inpatient care can disrupt relationships that are essential for positive development, including those with family, school, peers, the community, and workplaces. A service system that allows the re-establishment of these connections at an early point is intuitively appealing. The SDS package, which was tailored to individual needs, provided a flexible mixture of psychotherapeutic approaches and focused on re-engagement with families, school, and peers[30].

The UK Club House Model: This model of mental health recovery is a community mental health service model that supports CYP with complex mental health needs to reintegrate them back into society. In some cases, the use of clubhouses were a suitable alternative to acute and emergency settings. Even though the model is utilised in non-clinical settings, the clubhouse model signposts individuals to appropriate mental health services where appropriate. The flexible and fluid approach of the model aids early intervention and prevention of CYP in crisis. It was also suggested that this particular model could bridge the gap in transition of CYP between CAMHS and AMHS services[31].

Tele Mental Health (TMH): The tele-psychiatry and mobile application solution applied to urgent and emergency care has been reported as reliable and cost effective method for assessment and follow-up, particularly where service delivery at specialist intervention level is sparse and not easily accessed[32].

26. Jhiescidupress.com, Journal of Hospital Administration (2017), Vol 6, No. 1.
27. Sfar-Gandoura, (2017)
28. Ougrin et al, (2018)
29. Goodwin et al, (2010)
30. Patton, (2018)
31. Pardi, (2018)
32. Robert et al, (2017)

Orygen Specialised Programmes Youth Mental Health Service, Melbourne Australia

Orygen Specialist Programmes is the youth mental health service of North Western Mental Health (NWMH), a division of The Royal Melbourne Hospital. This state funded program provides comprehensive care to young people residing with the north western and western metropolitan Melbourne, aged 15 to 25, experiencing mental health disorders and they are delivered across three streams of care. Young people can refer themselves to Orygen or they can be referred by a family member or caregiver, teacher or counsellor, general practitioner, other mental health service clinician and emergency departments. Referrals undergo an initial triage over the telephone and they can then progress to an assessment. At present, there are two entry points for potential clients of Orygen – the Youth Access Team (YAT) which is the acute care Team and the Inpatient Unit (IPU). Young people undergo an initial assessment and the appropriate stream of care for the individual is determined.

Orygen operates three streams of care within the specialist services:

1) *The Early Psychosis Stream* provides care to young people experiencing a first episode psychosis by the Early Psychosis Prevention and Intervention Centre (EPPIC) service and young people identified as being at ultra-high risk for psychosis receive care within the Personal Assessment and Crisis Evaluation (PACE) clinic.
2) *The Youth Mood Clinic (YMC)* provides specialist care to young people experiencing mood disorders such as depression or bipolar affective disorder.
3) *The Helping Young People Early (HYPE)* clinic provides care to young people with established or emerging borderline personality disorder and other personality disorders.

Hospital in The Home (HiTH) Model of Care – Orygen, Melbourne Australia

The overarching aim of the Youth HiTH is to provide an alternative, equivalent level of care to inpatient hospital admission for young people and their caregivers who are acutely unwell and would ordinarily require inpatient hospital treatment. HiTH offer:

Individualised treatment - allowing greater adaption of care provision and setting to suit the needs of the individual young person, whilst seeking to minimise trauma associated with the first experience of accessing mental health services. Care and treatment offered in Youth HITH is youth-specific, person-centred, collaborative and involves families, significant others and carers.

Relapse prevention - Youth HITH provide a clear avenue for community treating Teams to respond to early warning signs of relapse. Young people who are identified as showing early warning signs, will be considered for a Youth HITH admission. The aim of the admission would be early stabilisation of mental state, review and management of factors leading to relapse, and avoidance of more significant relapse requiring admission to a bed based inpatient unit. Orygen places a strong emphasis on empowering young people to become aware of their early warning signs and supporting them to learn strategies to prevent progression into a full relapse.

Physical health - The improvement or preservation of the young person's physical health is imperative. Due to the restricted environment of the bed based inpatient unit, individuals often become more sedentary and the food served can be high in calories. In addition to this, individuals may be prescribed medications that have a high propensity for sedation, appetite stimulation and weight gain. All of these factors combined can result in young people gaining clinically significant amounts of weight in a short period of time. It is envisaged that by providing care to an individual in their home and by providing lifestyle interventions aimed at increased physical activity, improved diet and the use of first line medication that has a better physical health side effect profile, that their physical health could be preserved or improved.

Extension for Community Health Care Outcomes (ECHO) Model

The *Extension for Community Health Care Outcomes [ECHO]* was originally developed in New Mexico (United States). The ECHO model was developed to improve access to care for persons with complex health needs that were being underserved with the aim of democratising knowledge from specialist medical hubs out into the community. As time progressed the ECHO model has been extended to address a growing awareness of a shortage of specialists, long waiting lists and problems around patients having to travel long distances for care/ treatment. Initially designed for management of medical illnesses, ECHO has subsequently been successfully extended to include neurodevelopmental and mental health (MH) disorders. This model is seen as an affordable healthcare intervention for rural communities where certain chronic diseases have reached epidemic levels and healthcare resources are scarce[33].

The Oregon ECHO Network Program is an interactive educational and community-building experience that allows healthcare professionals throughout the state of Oregon to create a case-based learning environment through the convenience of video connection. Oregon healthcare professionals use videoconferencing to connect with specialists for multi-week interactive learning sessions. Expert presenters share their knowledge and clinicians bring their tough cases to get feedback from their peers and specialists. Programmes are always free and most offer no-cost continuing education credits[34]. One programme offering in Child Psychiatry provided a 12-session ECHO series to enhance the ability of primary care clinicians throughout the state to identify and treat mental health issues in children. Both pharmacological and non-pharmacological treatment methods were presented on the following topics, ADHD, Anxiety Disorder, Depression, Learning Disabilities, Trauma, Post-Traumatic Stress Disorder, Eating Disorders and Learning Disorders.

33. The Extension for Community Health Care Outcomes [ECHO] Child and Adolescent Mental Health Service: Extension for Community Health Care Options [CAMHS ECHO] L. Rooney1 , A. Harrold2 , F. McNicholas1,3,4,5 , B. Gavin1,5, W. Cullen1,5 , E. Quigley

34. https://www.oregonechonetwork.org/programs

Design Principles of CAMHS Crisis Models[35]

Studies included in the rapid review collectively recommend that when designing mental health services for children and young people they should aim to be:

- ***Person centred:*** ensuring that the perspective of the service user and their family or carers is a core consideration
- ***Asset (strength) based:*** where support is planned around the strengths and assets available individually and within the family unit and wider support network
- ***Least restrictive:*** options are available that help support the service user and their family with minimum restriction where possible
- ***Proportionate:*** service options are available that allow for thorough assessment, immediate and short term support and intervention, but also offer more intensive crisis resolution support. For children and young people safeguarding must be prioritised and should be central to all assessments to ensure young people are safe
- ***Learning from experience:*** post crisis debriefing will allow CYP, their carers and multi-agency professionals to identify what works and what doesn't for individuals
- ***Self-management focused:*** the crisis is viewed as a turning point where an intervention has the potential to help the child or young person using the service to make changes that will resolve the crisis but also provides a change and learning opportunity supporting future self-management
- ***Effective multi-agency working:*** Is an essential aspect of service delivery to address the varying needs of children and young people. In particular the review highlighted the potential significant risks for children and young people in the absence of effective multi-agency working
- ***Systemic:*** For a child or young person, crisis presentations are not the same as adults, as there is likely to be a psychosocial crisis, requiring assessment and intervention related to physical health, mental health and safeguarding. Past serious case reviews have repeatedly referenced the very significant risks for children and young people when agencies fail to work effectively together.

Best Practice Review Webinar

Following the completion of the literature review, further review and exploration of the current challenges within an Irish context for child and adolescent services was completed incorporating data reviews, service development reviews and identification of existing challenges within service delivery. A webinar for the CAMHS Hub National Steering Group was convened to further explore best practice examples within HSE mental health services incorporating triage/active waiting list models and approaches, complex case management and crisis outreach and crisis management approaches.

In conclusion, we would like to acknowledge the work undertaken on the CAMHS Hub Rapid Review in January 2021 by Dr Katrina Collins and Kate Wilkinson.

35. NHS England, (2017)

Section 4

Irish Model of Care for CAMHS Hubs

4.1 Introduction to CAMHS Hubs

CAMHS Hubs have been designed and developed to offer intensive brief mental health interventions to support Community CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis[36].

4.1.1 The Vision for CAMHS Hubs

The Vision for CAMHS Hubs is:

To provide intensive brief mental health interventions to support Community CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis

4.1.2 Definition of a CAMHS Hub

A CAMHS Hub provides enhanced intensive brief mental health interventions to support Community CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis, in the young person's own environment/ community facility and with the active involvement of the young person and their family/carers/supporters and interagency liaison with local partners. Support from these hubs is time-limited, providing intensive intervention and support with sufficient flexibility to respond to different young people's or parent/carer needs. Typically, this entails a range of evidenced-informed therapeutic approaches, including medication management, psychotherapeutic based individual, group and family interventions. The service will be child and young person centred, recovery focused and trauma informed.

36. The CAMHS Hub Model of Care shared definition of ' acute mental health crisis' is such that the acute mental health crisis requires multiple interventions weekly

4.1.3 CAMHS Hubs Aims and Objectives

CAMHS Hubs aims to:

- Provide timely access to expert assessment and brief intensive intervention for young people known or referred to the Community CAMHS Teams requiring urgent care;
- Provide individual support to young people and their parent/carer(s) with high-risk acute mental health needs/illness (step-up & step-down) in collaboration with Community CAMHS Teams;
- Provide a range of brief interventions for children, young people and family/carers;
- Ensure that the CAMHS Hub actively engages in collaboration with Community CAMHS Teams to support all children and young people accepted onto the CAMHS Hub caseload;
- Ensure that the CAMHS Hub actively promotes and engages children, young people, parents/ carer(s) in all aspects of care and recovery planning;
- Ensure that engagement and recovery principles are integrated into all aspects of CAMHS Hub delivery;
- Promote that telehealth is used as a blended approach to provide timely support and care to the young person, parent/carer(s);
- Demonstrate learning outcomes from delivery of pilot Model of Care shared across the learning sites.

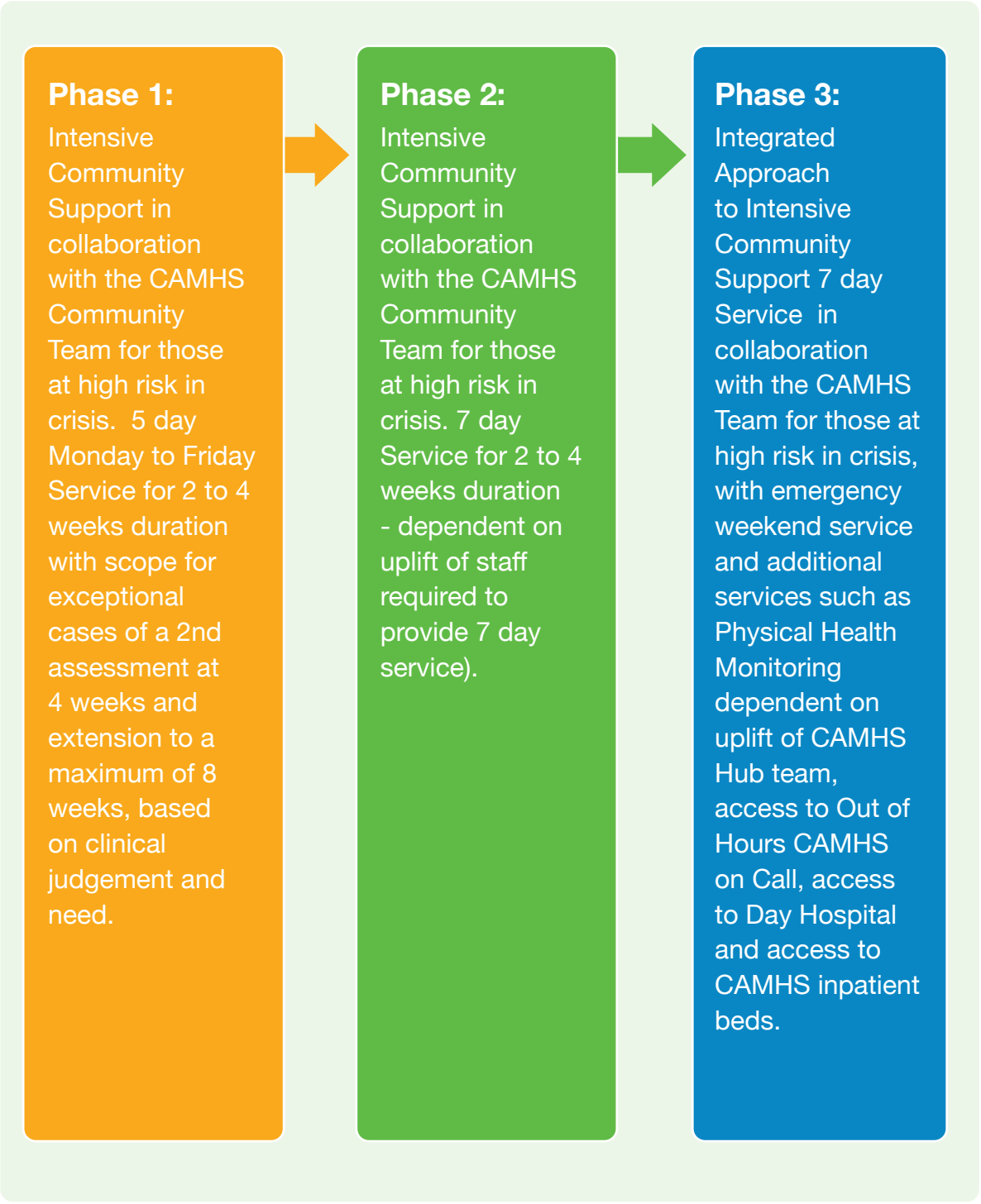
4.1.4 Pilot Implementation of the CAMHS Hub Model of Care

This Model of Care will be piloted across five learning sites. There will be an independent evaluation undertaken of the pilot implementation of CAMHs Hubs over the pilot testing phase 18 - 24 months in line with the Standard Operating Procedure and the Model of Care. On completion of the mixed methods evaluation across the five CAMHS Hubs learning sites, the pilot Model of Care will then be reviewed and optimised by the National Steering Group for CAMHS Hubs. Plans will then be put into place to support the mainstreaming and upscaling of CAMHS Hubs within HSE Mental Health Services.

4.1.5 Phased Development of CAMHS Hub Model of Care

It is envisaged as outlined below in Figure 11 below, that there will be a phased development of the CAMHS Hub model in line with resources available and access to existing services available in each of the learning site areas, such as access to Out of Hours CAMHS On Call, access to Day Hospitals and access to CAMHS inpatient beds.

Figure 11: Phases to CAMHS Hub Development



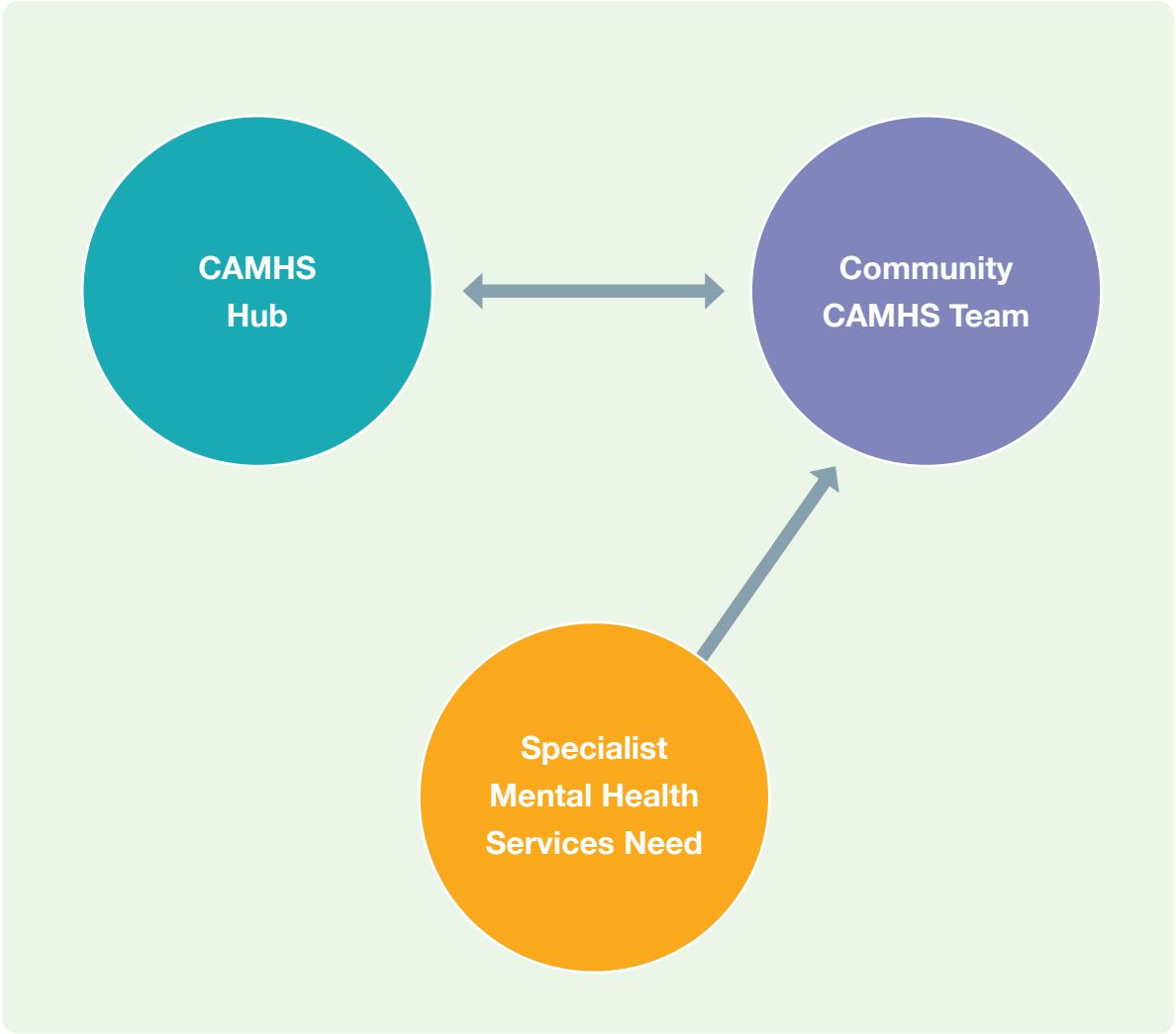
4.1.6 How the CAMHS Hub Model fits within the overall structure of CAMHS Services

CAMHS Hub will support Community CAMHS Teams by providing an enhanced level of brief intervention mental health support for children and young people aged up to 18 years, experiencing an acute mental health crisis, where it is determined the needs of the child or young person require a rapid response, time-bound intensive brief intervention.

The CAMHS Hub Team will in collaboration with the Community CAMHS Teams. The Hub Team will compliment and support the work of Community Mental Health Teams, at times where the CAMHS Community Mental Health Team requires an additional intensive brief intervention service to manage and de-escalate the acute mental health crisis.

Referral to the CAMHS HUB Team can only be made by referral from a CAMHS Community Mental Health Team. It is not directly accessible by Emergency Departments in Acute Hospitals or other first line responder services. It is not an alternative to a CAMHS Crisis/Liaison service but fits within the continuum of services required in the comprehensive service provision for children and young people with moderate to severe mental health difficulties.

Figure 12: CAMHS Hubs and CAMHS teams will be operating within Specialist Mental Health Level of Need



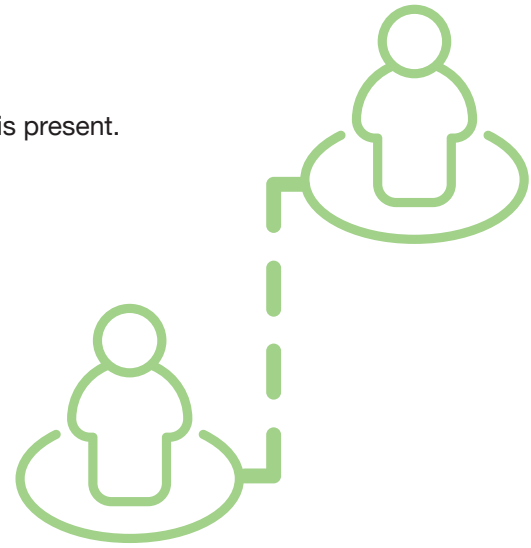
4.2 Core Operational Components of the CAMHS Hubs Model of Care

4.2.1 Who is the CAMHS Hub Service for?

CAMHS Hub provide a multi-disciplinary service for children and young people under 18 years attending a Community CAMHSTeam (referrals via CAMHS CMHT) who are presenting in acute mental health crisis and / or are in need of a short period of intensive community treatment, where it is determined the needs of the young person can be met more effectively in the community, through a rapid response, time-bound intensive brief intervention. The CAMHS Hub Team will compliment and support the work of Community CAMHS Teams, at times where the Community CAMHS Team requires an additional intensive brief intervention service to reduce the potential of admission or relapse.

To be eligible for referral and intake on to the CAMHS Hub caseload, children and young people must meet the following criteria:

- Age up to 18 years old;
- The young person and parents / family / carers are agreeable to CAMHS Hub brief intervention treatment;
- Consent for the referral has been obtained from the parent(s);
- The child or young person is residing in the learning site catchment area;
- Experiencing an acute phase of mental ill-health/crisis - The severity and complexity of the presenting mental health crisis is such that enhanced brief intervention is required in the short term;
- Eligible for an inpatient admission, which would be denoted by a need for daily review initially, that would be expected to persist beyond a few days and Home/Community based treatment is indicated as appropriate;
- Require urgent assessment and treatment of disorders such as:
  - Moderate to severe depression
  - Mood disorders
  - Psychosis
  - Anxiety disorders;
  - Moderate/Severe Eating Disorder; and
  - Suicidal behaviours and ideation where intent is present.



4.2.2 CAMHS Hub Exclusion Criteria

The CAMHS Hub is not suitable for children or young people whose difficulties are primarily related to learning problems or mild mental health problems. The CAMHS Hub do not accept the following:

- Children and young people who present with high levels of disorganisation and / or severe psychiatric, at a severity at which an admission to an in-patient unit would be required;
- Children and young people with an intellectual disability. Their diagnostic and support needs are best met in HSE Social Care/HSE Disability Services. However, those children or young people with a mild intellectual disability with moderate to severe mental disorder are appropriate to be seen by the Community CAMHS Team and CAMHS Hub Team;
- Children and young people with a moderate to severe intellectual disability and moderate to severe mental disorder. CAMHS Mental Health Intellectual Disability (MHID) Teams if present, best meet their needs. In the absence of CAMHS MHID Teams, multi-disciplinary assessment, intervention and support is provided by the Children's Disability Network Teams in HSE Disability Services;
- Children and young people who have a developmental disorder. Examples of these could include Dyslexia or Developmental Coordination Disorder. Their needs are best met in HSE Primary Care services and/or Children's Disability Network Teams;
- Children and young people who require assessments or interventions that relate to educational needs: Their needs are best met in services such as Children's Disability Network Teams or the National Educational Psychology Service (NEPS);
- Children and young people who present with child protection or welfare issues where there is no moderate to severe mental disorder present: Their needs are best met by Tusla – The Child and Family Agency;
- Children and young people who have a primary diagnosis of Autism: Their needs are best met in services such as HSE Primary Care and/or Children's Disability Network Teams. Where the child or adolescent presents with a moderate to severe mental disorder and autism, the role of CAMHS may include in-reach consultation where the child or adolescent remains with the referrer or the child/adolescent is accepted for multidisciplinary case management for mental health condition; with autism supports if required remaining the remit of Primary Care or Disability services;
- Children and young people whose accommodation, that due to factors other than the young person, poses a risk to clinician safety.

When considering home based treatment an underlying principle is that, the safety of staff is paramount and therefore if the person or the circumstances of their living arrangements poses a risk to healthcare staff, then they would be considered not to be eligible for support from the CAMHS Hub. In these situations, it may be possible to support individuals with appointments at other locations e.g. Primary Care Centres, Day Hospitals.

4.2.3 CAMHS Hub Function

- Provide a rapid response following urgent referral from the Community CAMHS Team.
- Provide intensive brief intervention and support in the early stages of the acute mental health crisis.
- Enable active involvement of the young person, parent/ family and carers.
- Ensure an assertive approach to engagement.
- Provide a time-limited/ short-term intervention initially for 2 to 4 weeks that has sufficient flexibility to respond to differing children and young people's needs, with scope for exceptional cases of a 2nd assessment at 4 weeks and extension to a maximum of 8 weeks, based on clinical judgement and service user need.
- Support the young person and parent/carer(s) to start to develop insight with a view to reducing/preventing recurring crises based on Recovery Model principles.
- Develop collaborative partnership working arrangement with other services to enable credible alternative pathways to admission.

4.2.4 The CAMHS Hub Operational Process

There are eight stages in the CAMHS Hub process.

1. **Referral received** from Community CAMHS Team to CAMHS Hub Team.
2. **Triage** - CAMHS Hub Team triage the referral. This is where the CAMHS Hub Team screen the referral information received about a child or young person referred to the CAMHS Hub service to see if they meet the criteria and are appropriate for the service.
3. **Key Worker assigned** – Key worker assigned on the CAMHS Hub Team to the child and young person being referred. To support the referral, the Community CAMHS Team Keyworker has a collaborative case review and discussion about the referral and the needs of the young person with the CAMHS Hub Key Worker.

Figure 13: CAMHS Hub Process

4. **Decision Re: Acceptance of referral on caseload** - Community CAMHS Team are advised if referral has been accepted or not to the CAMHS Hub Team.
5. **Assessment** – CAMHS Hub Team review assessments completed by the Community CAMHS Team and then meet with young person & parent/carer(s) to establish predisposing, precipitating and perpetuating factors relating to the current mental health crisis.
6. **Crisis Care Planning** – CAMHS Hub Team will develop strategies for managing the crisis & mental health risks identified in the community setting.
7. **Crisis Intervention** – Implementation of the interventions as set out in the Crisis Care Plan.
8. **Stabilisation & Discharge planning from the CAMHS Hub** – CAMHS Hub Team to identify when the crisis is resolved to a level where the young person feels safe and no longer requires intensive support from the Team. The CAMHS Hub Team to ensure that the Crisis Care Plan tasks are completed prior to transfer of care back to the Community CAMHS Team. Referrals to community services can be made by the CAMHS Hub Team when identified and required.

This is not a linear process. Indeed, at a single point in an individual's care all aspects of this process may be active. It is also important to note the inter-dependence of each of these stages to support the children and young people and to enable their recovery journey. For example, if the assessment is either not comprehensive or is incomplete, the planning and intervention are very likely to be ineffective.

4.2.5 Core Values of CAMHS Hub Team

- We will provide timely care services that promote recovery and hope supporting young people and their parent/carer (s) to have hope; to feel empowered to make choices about their own care, and to have control over their own goals and how to achieve them.
- We will seek to ensure that young people and their parents/carers are involved in all decisions which affect them, and that their views will be given due weight in accordance with their age and understanding (Article 12 of the United Nations Convention on the Rights of the Child (UNCRC), 1990).
- We are committed to ensure equity of access & respect for diversity
- Within legislative constraints, we will seek to empower young people to exercise autonomy and responsibility for themselves and their mental health.
- We will deliver a high quality service aligned with best practice principles.
- When agreeing on treatment options the young person and their parent/carer's wishes and beliefs, will be balanced, with clinical judgment and evidence base.
- We will deliver care in partnership with the young person & their parent/carers, statutory and non-statutory organisations, in order to provide an integrated service.
- We will promote the discharge of young people as soon as they are ready to return to the Community CAMHS Team.
- We will promote open communication for all.
- We will adhere to national and local policies, professional codes of conduct and the legal and ethical framework in the provision of care.

- We will promote investment in training and development for staff, in order to build a skilled and compassionate workforce.
- We will ensure to capture the experience of children and young people using the service through continuous monitoring and evaluation in the delivery of the service in order to inform and support quality improvements.

4.2.6 CAMHS Hubs Working Principles

- Children and young people experiencing an acute mental health crisis should receive timely care in the least restrictive environment suitable for them.
- Children and young people experiencing an acute mental health crisis and their families or carers will be supported to be involved in making decisions about their care as fully as possible.
- Parents, families or carers of those experiencing an acute mental health crisis will be supported appropriately in their own right, and involved with their child's care as much as possible.
- The CAMHS Hub Team will be appropriately trained and supported to carry out their jobs competently, safely, and with regard to their wellbeing as practitioners.
- The CAMHS Hub Team will develop and maintain good links with other mental health and physical health services, and social care.

4.2.7 Location of CAMHS Hub Care Provision

CAMHS Hub Teams will provide a blended approach to the location of treatment for the child or young person, with a mix of care in the home, community setting or virtually as deemed appropriate. Consideration to the needs and circumstances of the child or young person, and health and safety policy requirements for staff will be central to all decision making. Where a child or young person or the circumstances of their home and living arrangements poses a risk to healthcare staff, then they would be considered not to be eligible for home support. In these situations, it may be possible to support children and young people with appointments at other locations e.g. Primary Care Centres, Day Hospitals etc.

4.2.8 CAMHS Hub Operating Hours

In phase one of implementation the CAMHS Hub Team will operate from Monday to Friday 9.00 a.m. to 5.00 p.m. The CAMHS Hub Service will work towards the phased development of an extended service, (as outlined in Figure 11), informed by service availability, demand and capacity within each learning site area. Core hours will be delivered in line with resource availability within each area, and will be needs and demand led. CAMHS Hub requires an integrated approach to crisis response service delivery for children and young people with existing Mental Health, Primary Care and Acute services.

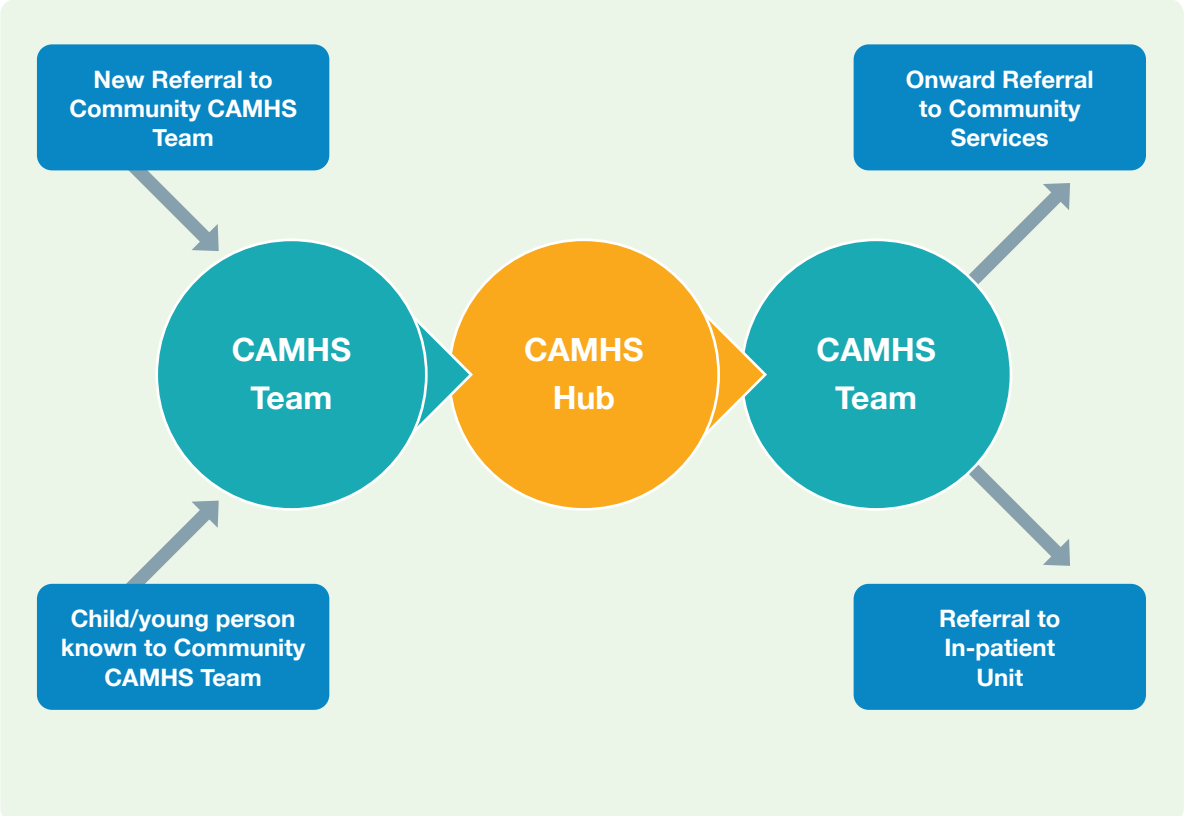
4.3 Referral Pathway

Referral to the CAMHS Hub Team can only be made by referral from a Community CAMHS Team. The CAMHS Hub Team will receive referrals for children and young people up to 18 years experiencing an acute mental health crisis, where it is determined the needs of the child or young person require a rapid response, time-bound intensive brief intervention.

If the child or young person requires in-patient care the referral needs to be made by the Community CAMHS Team.

CAMHS Hubs are not directly accessible by Emergency Departments in Acute Hospitals or other first line responder services. It is not an alternative to a CAMHS Crisis/Liaison service but fits within the continuum of services required in the comprehensive service provision for children and young people with moderate to severe mental health difficulties.

Figure 14: Referral Pathway



4.4 CAMHS Hub Assessment, Treatment and Interventions

4.4.1 Criteria for Acceptance on to the CAMHS Hub Caseload

The CAMHS Hub Team should to be able to respond to referrals and make decisions about whether the Hub is suitable and appropriate for the young person in a rapid manner. Therefore, at the initial point of contact with a referrer, the pertinent clinical information needs to be obtained and then relayed to the CAMHS Hub Team. The CAMHS Hub Team will make the decision to treat based on entry criteria to the Team and initial assessment; this is reviewed every day re: on-going risk assessment and suitability for acute care. A decision will then be relayed rapidly to the referring Community CAMHS Team. The Team member making this decision will also have up to date information about other acute services that might be appropriate for the young person.

To be eligible for referral and intake on to the CAMHS Hub caseload, children and young people must meet the following criteria:

- Age up to 18 years old;
- The young person and parents / family / carers are agreeable to CAMHS Hub brief intervention treatment;
- Consent for the referral has been obtained from the parent(s).
- Residing in the learning site catchment area;
- Experiencing an acute phase of mental ill-health/crisis - The severity and complexity of the presenting mental health crisis is such that enhanced brief intervention is required in the short term;
- In need of a short period of intensive community treatment, where it is determined the needs of the young person can be met more effectively in the community, through a rapid response, time-bound intensive brief intervention;
- Eligible for an inpatient admission, which would be denoted by a need for daily review initially, that would be expected to persist beyond a few days and Home/Community based treatment is indicated as appropriate;
- Require urgent assessment and treatment of disorders such as:
  - Moderate to severe depression
  - Mood disorders
  - Psychosis
  - Anxiety disorders
  - Moderate/Severe Eating Disorder; and
  - Suicidal behaviours and ideation where intent is present.

4.4.2 CAMHS Hub Assessment

All young people will receive a CAMHS assessment via the Community CAMHS Team and staff may use different assessment tools depending on the individual presentation. On referral from the CAMHS Team to the CAMHS Hub, the Consultant on the Community CAMHS Team will discuss the case with the designated CAMHs Hub Team member. Assessment information will be shared; thereby reducing the requirement to complete same assessment. A range of evidence informed assessment tools will be used by the CAMHS Hub staff as relevant to the referral received from the CAMHS Team and assessments informing the referral. The CAMHS Hub Assessment will be based on:

- Reason for referral to the Hub;
- What assessment happened to inform that referral;
- The presentation of crisis.

The CAMHS Hub Team will aim to provide a prompt and responsive, multidisciplinary assessment of the young person's needs and level of risk that takes into account cultural, religious and language aspects of the child and family.

- A holistic biopsychosocial assessment should actively involve the young person, parents/ carers / family and all relevant other stakeholders e.g., GP.
- The outcome of the assessment will be communicated to the Community CAMHS Team. Possible outcomes of assessment are:
  - Acceptance on to the CAMHS Hub caseload
  - Onward referral back to referrer with advice re: management, or
  - Recommendation for referral for admission to inpatient facility.
- After the assessment, if the young person is accepted for treatment onto the CAMHS caseload they will be provided with a CAMHS Hub Service Information leaflet, which will contain information and contact details for service.
- All assessments are discussed at the weekly scheduled CAMHS Hub Team meetings.
- All assessments will be reviewed as soon as is deemed necessary or in any case within 72 hours (allowing for weekend referrals where service is Monday to Friday). Every effort will be made to arrange review of assessments for the next working day. The Key Worker will link with the person during this time.
- All initial assessments will be conducted by a CAMHS Hub staff member and in complex or high-risk cases at least two CAMHS Hub staff members will undertake the assessment, this may include support from the relevant Community CAMHS Team.
- Initial assessments may be conducted at the young person's home or at an agreed other venue in the community. Decision making on location of assessment will be subject to both a risk assessment and needs assessment.
- The initial assessment will inform the development of a clear and structured treatment plan, including the identification of the goals through assessment. The nature of the community consultation or home visits will be decided upon, dependent on the needs of the young person and any identified risk factors that could occur in accordance with current signed care plans.

- The Hub Team will ascertain whether family members, significant others and carers are able to support the young person during the period of intervention with the CAMHS Hub Team.
- Discharge planning will commence at point of assessment. The projected discharge date is identified and discussed with the young person, parent/carer(s) at the time of admission.

4.4.3 Individualised Treatment for CAMH Hubs Service Users

Treatment by the CAMHS Hub Team is patient centred & recovery focused.

- Care will be planned as a collaborative process with young people, their parents/carer(s) with the CAMHS Hub and Community CAMHS Team.
- A designated named Key Worker will facilitate and coordinate each young person's care planning and care. Contact details for the named key worker within the CAMHS Hub and its operating hours will be supplied to the young person and their parents/family/carers on admission to the CAMHS Hub.
- Staff will have frequent contact with the children, young people and parents as agreed within the care plan. This includes face-to-face contacts, telephone contact and video calls, graduating down towards discharge, or onward referral back to the Community CAMHS Team.
- Discharge planning will begin upon admission to the CAMHS Hub.
- The CAMHS Hub Team will refer back to the Community CAMHS Team, and agree alternative services, within agreed timeframes in conjunction with the servicer user, family/carer and Community CAMHS Team where need indicates this.
- The CAMHS Hub will provide a blended approach to the location of treatment for the child or young person, with a mix of care in the home, community setting or virtually as deemed appropriate, e.g., risk location, ability to travel etc.
- Treatment can be accessible in an agreed location in either a community/primary care setting, if the young person, parent/carer has expressed an interest in the young person receiving care and treatment outside of the home setting.
- The treatment and care plan will be formulated at the start of the CAMHS Hub intervention process, which will be reviewed regularly and will be dynamic and adaptable depending on the young person's needs and progress. It will outline the agreed detail on the number of visits and level of multi-discipline input from the Team. It will be inclusive of but not limited to information on the following:
  - Pharmacotherapy;
  - Psychosocial interventions;
  - Peer involvement;
  - Substance use disorder treatment;
  - Physical health monitoring and lifestyle interventions;
  - Frequency of visits and who will attend;

- Estimated onward referral date and onward referral plans;
- Emergency Care Plan, that provides young people, their parents and carers with instructions regarding how to access services in the case of unforeseen emergencies, including what protective / risk factors to consider based on individual needs.
- Relapse Prevention.

The Individual Crisis Care plan will be discussed at each weekly team meeting. Care plans must be flexible enough to respond rapidly to changes in the clinical situation. A crisis care and safety plan will be developed and a copy given to the young person +/- parents/ carers. All care plans will be recovery focused, will work to enable greater self-management, and work on relapse prevention strategies. There should be a shared understanding of what happened and why. All care planning will also consider referral back to Community CAMHS Team at an early stage of intervention.

4.4.4 CAMHS Hub Interventions

The CAMHS Hub multi-disciplinary staff will use their clinical judgement, expertise, experience and training in each situation when considering how best to respond and what interventions will be provided to support the young person's needs and the needs of the family member/ carer supporting the young person.

4.4.5 CAMHS Hub Crisis Care Planning

After the Initial Assessment is complete, each child or young person is involved in developing an Individual Crisis Care Plan (ICP) with their key worker and their parent(s)/carers. An ICCP is a clear plan, in plain English, that describes the levels of care and treatment needed to meet the assessed needs of the child or young person while they are attending a CAMHS Hub. An ICCP should be developed in collaboration with the child or adolescent and their parent(s)/ carers and a copy should be provided to them. All parties should sign off the ICCP. The ICCP will be shared with the referring Community CAMHS Team if parent/carers give consent.

An ICCP is outcomes focused, and should consider what goals the child or adolescent wishes to achieve while attending the CAMHS Hub and it should also be recovery focused. All CAMHS Hub staff should be aware of communication needs and consider these when designing the ICCP. This may involve the use of pictures or other multimedia tools but they must still be in line with HSE policies on privacy and consent, including HSE National Consent Policy, 2019, HSE Data Protection Policy, 2018 and HSE Privacy Notice, 2018-2020, the General Data Protection Regulation, 2016/679 and the Data Protection Act, 2018.

The child or young person's key worker is responsible for the maintenance and regular review of the ICCP for the duration of the brief intervention.

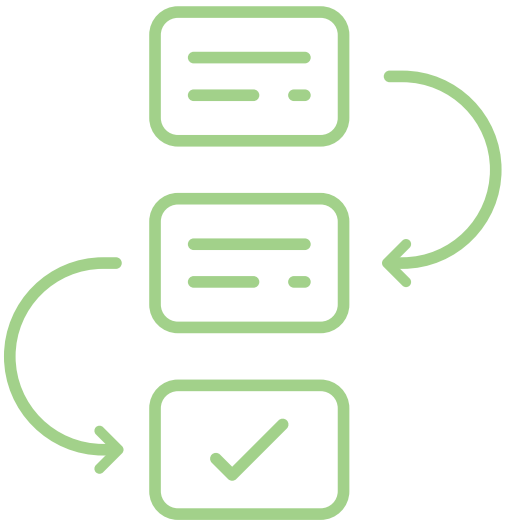
An ICCP includes the following:

- A clinical formulation
- A diagnosis if available; where the referral is a first engagement.
- Agreed goals between the CAMHS Hub Team, the child or young person and the parent(s).
- A list of other agencies involved with the child or young person.
- An individual risk and safety management plan.
- A discharge/transition plan, which includes a provisional discharge date and named Community CAMHS Team if required.

4.5 Discharge from the CAMHS Hub

Discharge from the CAMHS Hub occurs on completion of the planned intervention. If further input from the Hub Team may be required this will be subject to a case review with the Community CAMHS Team, the Hub Team, the young person and the parents/carers. This may mean that the acute mental health crisis is no longer presenting a significant risk, or they have achieved their goals or it may mean that they are not benefitting from the CAMHS Hub and their needs are better met in another service.

Discussions about discharge planning should begin at the Initial Assessment or when the ICCP is drawn up, in collaboration with the child or young person and their parent/carer(s). Discharge for most individuals should be seen as a positive outcome and part of the recovery process. Discharge planning should focus on the child or young person's recovery and should include a follow up plan with the Community CAMHS Team, GP and other community services as appropriate. It is advised that there is a written agreement between the CAMHS Hub and the Community CAMHS Team that an appointment will be offered to the child or young person within an agreed minimum timeframe as deemed safe and appropriate for the young person. The ICCP should also include advice and information on the re-referral process to CAMHS services in the event of a relapse. A discharge summary should be shared with parent/carer(s) and referral agents, subject to consent. A discharge meeting with the child or young person, the parent/carer(s) and any community supports who are involved, should occur prior to the formal discharge.



4.6 CAMHS Hub Staffing

4.6.1 CAMHS Hub Team Staffing

The CAMHS Hub Team for phase one pilot implementation will be staffed by a core multidisciplinary team, which consists of the following disciplines.

- Child and Adolescent Consultant Psychiatrist
- Nursing, ANP
- Senior Social Worker
- Senior Occupational Therapist
- Administrator

4.6.2 Key Worker Role and Function on the CAMHS Hub Team

- Every child / young person attending the CAMHS Hub will have an identified key worker. A key worker is the service user's designated point of contact on the CAMHS Hub.
- The key worker will coordinate each young person's individual care plan and they will coordinate the provision of evidence-informed interventions by the multidisciplinary Team members throughout their engagement with the service. A holistic, collaborative, optimistic and recovery focused approach will underline all of their work with the young person and their family/ supporters/carers. All CAMHS Hub Team members will manage caseloads and will undertake the Key Worker role and cases will be distributed equitably across all team members.
- All team members in their role as key worker will complete complex initial risk assessments in addition to their discipline specific roles.

Key to this role is assertive and active engagement and assessment with the young person and their parent/family/carers, accepted to the CAMHS Hub Team, with provision of day-to-day clinical services and support.

4.7 Joint Working and Shared Care Process

Some children and young people may present with additional complex needs (ASD, LD, DCC etc.) and an acute mental health crisis at the same time. Where the child or adolescent presents with a moderate to severe mental disorder, it is the role of Community CAMHS Teams to provide appropriate multidisciplinary mental health assessment and treatment for the mental disorder. This may involve joint working (as per the Joint Working Protocol, 2021) or shared care with other agencies, including HSE Primary Care, Children's Disability Network Teams, Integrated Children's Services Forum and other agencies supporting children and young people.

When information indicates that there is more than one HSE service that could best meet the child or adolescent's needs, consultation should take place with the other service to determine which is the most appropriate or whether a joint approach to assessment and intervention is indicated.

As the primary role of the CAMHS Hub Team is to provide brief intervention for acute mental health crisis, the Community CAMHS Teams will continue to manage and oversee joint working and shared care for children and young people accessing services, in line with the CAMHS Clinical Operational Guidance. The CAMHS Hub staff will liaise with the Community CAMHS Team as required in relation to shared care arrangements.

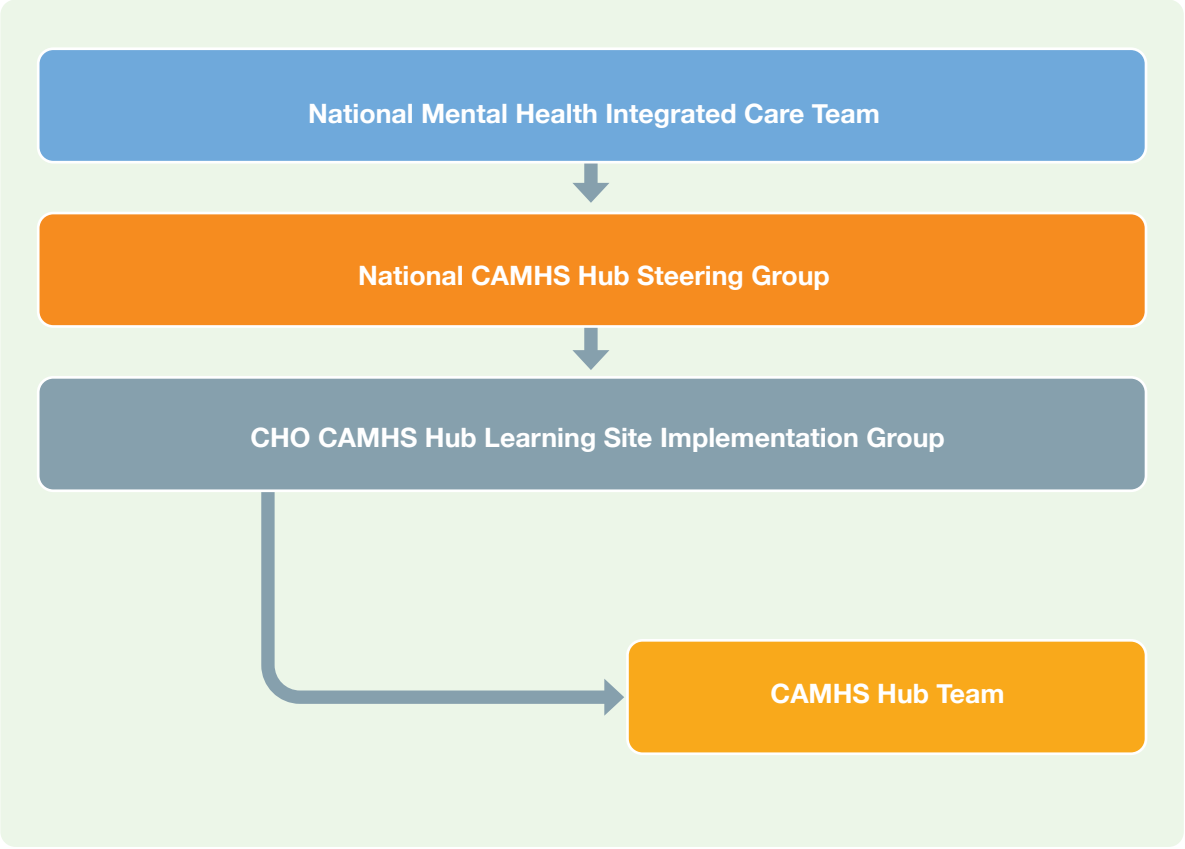
Section 5

Governance of CAMHS HUBS

5.1 CAMHS Hubs Governance

The Executive Clinical Director (ECD), Clinical Director (CD) and the Consultant Psychiatrist and Heads of Discipline provide clinical leadership, governance and oversight for the pilot CAMHS Hub Initiative in the designated CHO area. The pilot CAMHS Hub Teams are accountable to their local CHO Area Mental Health Management Team, which will then be accountable to the National Mental Health Integrated Care Team governance structures.

Figure 15: CAMHS Hub Governance



5.2 Clinical Management and Shared Clinical Responsibility

- The CAMHS Hub Service Team will be led by a Lead CAMHS Hub Consultant Psychiatrist.
- All MDT Team members will report to and receive professional supervision for operational governance and oversight as per their professional standards and will report clinically to the clinical lead for day-to-day clinical governance.
- The CAMHS Hub Team will receive referrals for children and young people up to 18 years from Community CAMHSTeams within the specified catchment area. The CAMHS Hub will be clinically responsible for the management of the young person's case for the duration of their support with the CAMHS Hub Team.
- The Community CAMHS Team will retain *clinical responsibility* for the client until they are accepted by the CAMHS Hub Team and *clinical responsibility* will be transferred back to the Community CAMHS Team once the CAMHS Hub Team intervention has been completed.
- If the child or young person does need an admission to an inpatient unit, the responsibility for referral to and liaising with the inpatient Team remains with the Community CAMHS Team to ensure continuity of care. The CAMHS Hub Team may become re-involved again following discharge on referral.

The overall organisational responsibility for the implementation of CAMHS Hubs is led by the HSE National Mental Health Integrated Care Team; informed and guided through the work of the National CAMHS Hub Steering Group. The HSE Mental Health Change and Innovation project Team led the CAMHS Hubs Model of Care design, planning, development and implementation process. The National CAMHS Hubs Steering Group was established in December 2021, to oversee the design and development of a Pilot Model of Care for CAMHS Hubs. Membership included representatives from each learning site, national representatives from each of the core staff disciplines aligned to CAMHS Hubs, National Mental Health Clinical Programmes, Mental Health Engagement and Recovery, Mental Health Operations, Planning and Change and Innovation.

The CAMHS Hubs learning sites are accountable to their local CHO Area Mental Health Management Team, which will then be accountable to the National Mental Health Integrated Care Team governance structures.

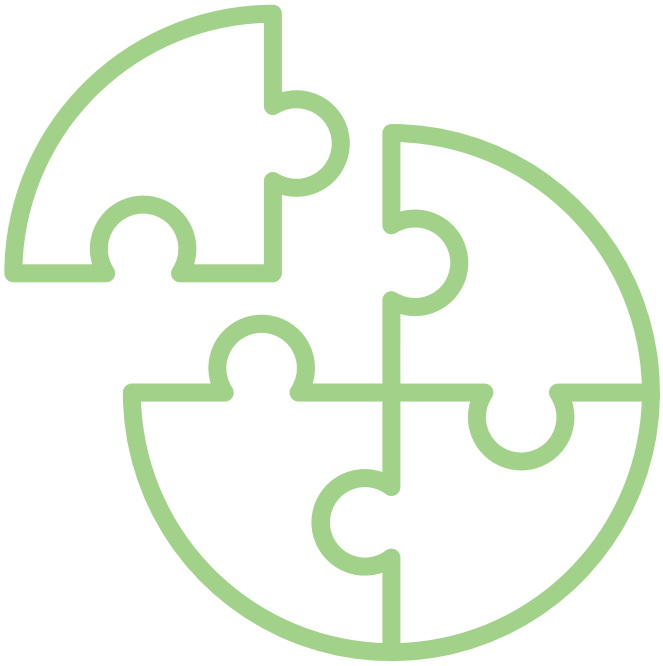
5.3 CHO CAMHS Hubs Learning Site Implementation Group

There is evidence that creating Implementation Teams that actively work to implement interventions results in quicker, higher-quality implementation. Each of the five learning sites have established learning site implementation groups. The Implementation Groups are responsible for all elements of the management, oversight and monitoring of the pilot CAMHS Hubs for the CHO area. The CHO CAMHS Hubs Local Implementation Group will be the governing body of the project providing strategic leadership and governance oversight ensuring:

- Fidelity with the National Model of Care for CAMHS Hubs.
- That the service meets the needs of the CHO learning site, agreed catchment area and is fully integrated with all other mental health services and wider statutory and community and voluntary services.
- That all developments are agreed, overseen, implemented and monitored against the local area implementation plan.

The Local Implementation Group will have the delegated authority to make decisions that are in accordance with the objectives, approach and scope of the project as set out in the Model of Care for CAMHS Hubs. Monthly meetings need to be held to ensure strong governance and oversight. Membership to include:

- Head of Service Mental Health
- General Manager, CHO area Mental Health CHO MH
- Executive Clinical Director
- CHO Discipline leads for CAMHS Hubs
- Person with lived experience or Family/Carer representative



Section 6

Implementation

6.1 Definition of Implementation

Implementation is the carrying out of planned, intentional activities that aim to successfully turn **evidence and ideas** *into* **policies and practices** *that work for people in the real world. It is about putting a plan into action the* ***'how'*** *as well as the* ***'what'***[37].

6.2 Introduction to Our Approach to Implementation of CAMHS Hubs

This section aims to outline the key components and enablers of ***'how'*** to successfully implement the CAMHS Hubs Model of Care by applying an implementation science approach and framework. Working closely with the five implementation learning sites, we have collectively developed and agreed dedicated implementation systems and standard operating processes in order to collectively achieve our vision, which is ***'To provide intensive brief mental health interventions to support Community CAMHS Teams in delivering enhanced responses to children, young people and their families/carers, in times of acute mental health crisis'.***

6.2.1 What is Implementation Science?

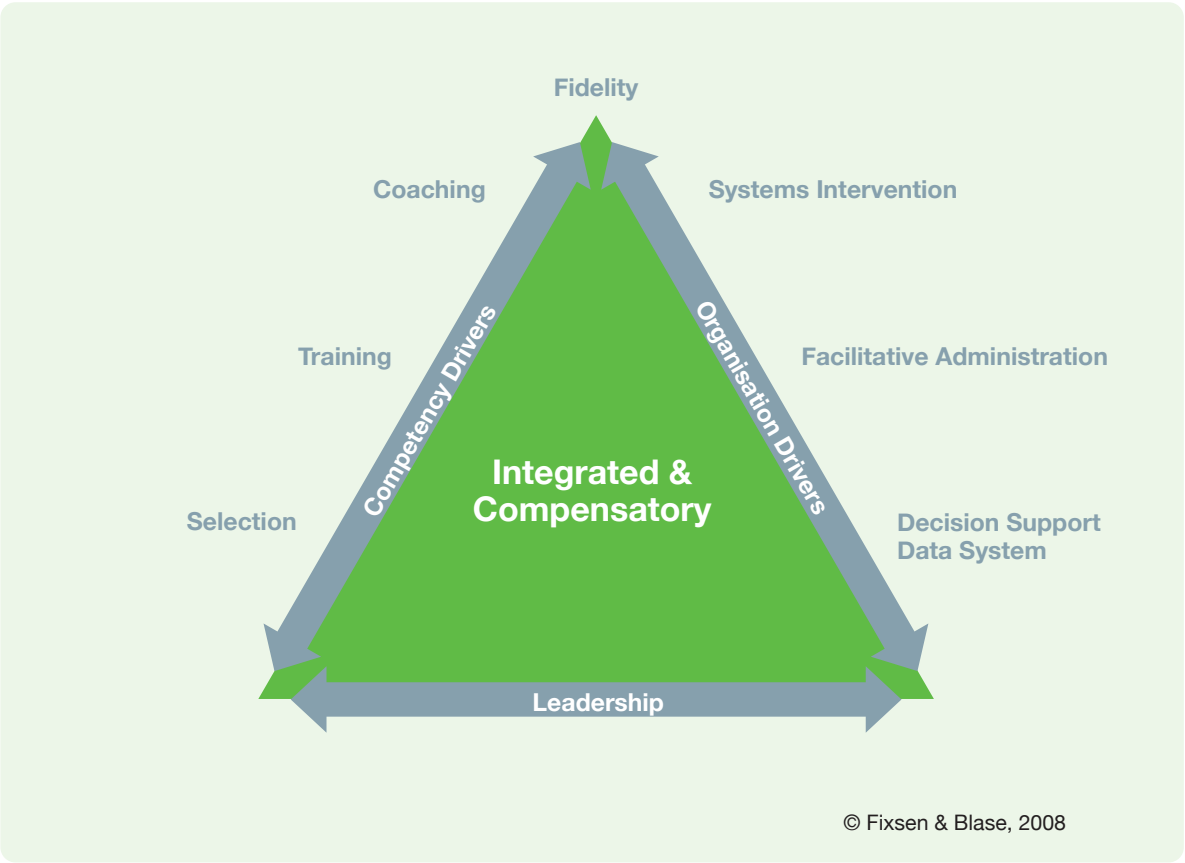
Implementation science is the scientific study and inquiry of methods and strategies that facilitate and promote the adoption and integration of evidence-based practice and research into regular use by practitioners and policymakers. It seeks to identify specific activities, contexts and other factors that increase the likelihood of successful implementation and lead to improved outcomes for people. It also assists in the identification and addressing of the barriers that slow or halt the uptake of proven health interventions and evidence based practices.

6.2.2 Implementation Drivers

Implementation Drivers are the key components needed to develop, improve and sustain the ability of the learning sites, the CAMHS Hubs Teams to implement this innovative CAMHS Hubs Model of Care as intended that will benefit service users and their families. There are three categories of Implementation Drivers outlined in Figure 18 below, which are ***1) Competency Drivers, 2) Organisational Drivers,*** and ***3) Leadership.***

37. Burke et al, (2012)

Figure 16: Implementation Drivers



1. Competency Drivers are the key capacity building activities required to develop, improve and sustain the core elements required to successfully deliver and implement the CAMHS Hubs Model of Care as intended with fidelity to the Model of Care in order to benefit children and young people using the service and their families. Building staff capacity is a core component of implementation and is pivotal in ensuring that the desired outcomes are achieved[38]. Careful staff selection, quality training and on-going coaching and assistance are all crucial in building capacity in staff for effective implementation. The Competency Drivers are ***Selection, Training, Coaching and Fidelity Assessment.***

1.1 Selection refers to the purposeful process of recruiting, interviewing, and hiring *'with the end in mind'.* Selection through an *active implementation lens* includes identifying skills and abilities that are pre-requisites and/or specific to the innovation or programme, as well as attributes that are difficult to train and coach. A consistent recruitment approach for CAMHS Hubs has been supported and applied across all learning sites for CAMHS Hubs Teams with a view to selecting the right staff with the right skills for these positions.

1.2 Training through an *active implementation lens* is defined as purposeful, skill-based, and adult-learning informed processes designed to support staff in acquiring the skills and information needed to begin using a new programme or innovation. New staff for CAMHS Hubs Teams will receive a period of induction, where they are introduced to all key stakeholders, provided with a copy of the CAMHS Hubs Model of Care and a copy of the CAMHS Hubs Standard Operating Procedures. All staff will be required to complete mandatory training and other relevant training courses to enhance their skills and knowledge.

38. Burke et al, (2012)

1.3 Coaching is a necessary component for promoting professional confidence and ensuring competence in the delivery of CAMHS Hubs. Coaching is defined as regular, embedded professional development designed to help staff to use the CAMHS Hubs Model of Care as intended. Evidence states that training alone is not enough, as only 5% of knowledge gained through training is applied in practice. Therefore, there is a need to combine training and coaching to ensure successful implementation of new innovative services.

Supervision, monitoring and support are active coaching processes that need to be embedded in the CAMHS Hub learning sites to support adherence to effective practices and quality instruction. This coaching approach also supports the development of judgment needed to differentiate instruction, use data for decision-making, and engage in evidence-based and evidence-informed instructional and innovation practices. The CAMHS Hub Team will be supported in performance development and clinical supervision and are required to maintain their endorsements, registrations, credentialing and eligibility for membership of professional associations, and adhere to the CPD requirements of these regulatory or self-regulatory entities. The role of support and supervision is considered central to ensure staff wellbeing and effective performance of roles. Supervision requirements will reflect the operational functioning of each individual CAMHS Hub service and will support fidelity assessment in each learning site. Quality coaching offers critical support for trying out new approaches during that “awkward stage” just after initial exposure through training, and helps staff persist in developing skill, judgment, and the artful and individualised use of the new CAMHS Hubs.

1.4 Fidelity Assessment refers to measuring the degree to which CAMHS Hubs Teams are able to deliver the Model of Care as intended and the degree to which service users can use the services as intended. Fidelity assessment measures the extent to which an innovation is implemented as intended. Did we do what we said we would do? This Fidelity Assessment will be built into the monitoring and evaluation processes for CAMHS Hubs.

2. Organisation Drivers – are the key mechanisms to create and sustain hospitable organisational and system environments, which enable and result in effective and integrated CAMHS Hubs. In order for children and young people to have access to 24/7 mental health specialist services an integrated approach is required across Mental Health, Primary Care, Acute services and Community Services. This Model of Care requires a systemic change in practice across a number of services in order to provide an integrated seven day, 24 hour service for children and young people in crisis. The Model of Care needs to be appropriately resourced to deliver up to phase 3, which aims for CAMHS Hubs to provide a seven day service in collaboration with the Community CAMHS Team for those at high risk in crisis, with emergency weekend service resourced and available with access to additional services such as Physical Health Monitoring, access to Out of Hours CAMHS on Call, access to Day Hospital and access to CAMHS inpatient beds.

The Organisation Drivers are the organisational, administrative and systems components that are necessary to implement new CAMHS Hubs. Organization Drivers include Decision Support Data Systems, Facilitative Administration and Systems Intervention.

2.1 The Decision Support Data System (DSDS) is a system for identifying, collecting, and analysing timely, reliable data that are useful to the CAMHS Hub implementation learning sites across the CAMHS Hubs Teams for decision-making and measurement of achievements and outcomes. There is more information on this implementation driver in Section 7 Monitoring and Evaluation.

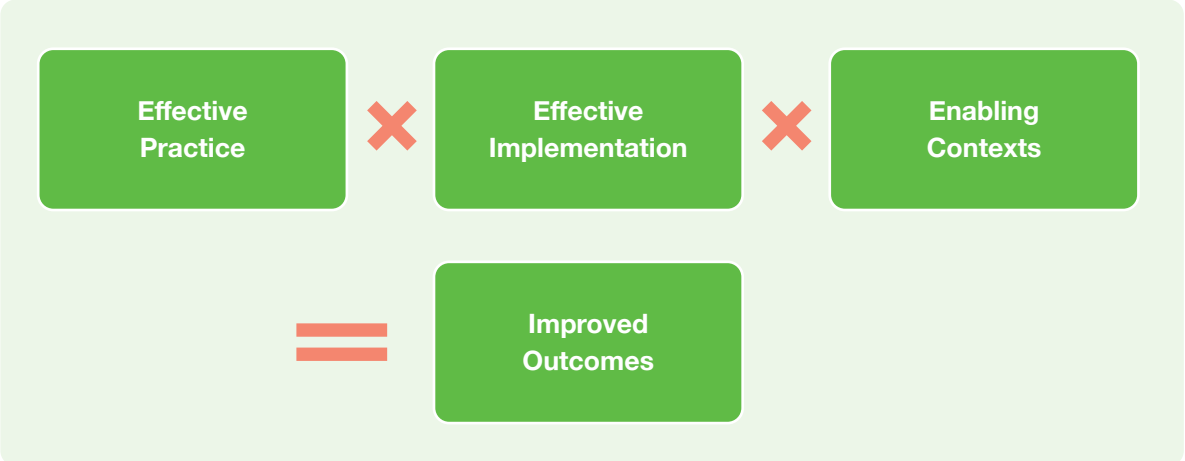
2.2 The Facilitative Administration Driver focuses on the internal processes, policies, regulations, and structures over which a health service has some control. Health Service governance and the learning site Implementation Teams are responsible for activating this Driver.

2.3 The Systems Intervention Driver is focused on the external variables, political and government policies, environments, systems, structures that influence, or have impact on the implementation of CAMHS Hubs. HSE governance and local learning site implementation teams may identify barriers during the pilot implementation process that are beyond their level of authority/control and will need to strategise and escalate issues to the attention of those who can address such barriers.

3. Leadership / Governance – The Governance for CAMHS Hubs is outlined in Section 5. A key driver for successful implementation of CAMHS Hubs is Leadership. Leadership includes elements of Team work, control, decision making, effectiveness of organisational structures and issues related to empowerment[39]. Leadership needs to focus on providing the right leadership strategies for different types of leadership challenges. These leadership challenges often emerge as part of the change management process needed to make decisions, provide guidance, and support organisation functioning. Implementation leaders or champions are the early adopters of change[40]. They take positive action to encourage others to participate in the implementation process, and provide direction and vision for implementation, overcoming challenges that occur during the process. The use of the Leadership Driver in the context of active implementation focuses on leadership approaches related to transforming systems and creating change.

For successful implementation, we propose applying the active implementation formula (see below), positive outcomes for service users represent the "why" in the equation.

Figure 19: Active Implementation Formula



It is why we want to improve to ensure effective CAMHS Hubs for service users. The "what" in the equation the detail of CAMHS Hubs is as outlined in section 4 and in the detailed Standard Operating Procedure which incorporates effective practice and effective implementation. The enabling contexts are the resources required such as staffing, finance and infrastructure required to deliver CAMHS Hubs. If all components are collectively delivered it will ultimately result in improved outcomes for service users.

39. Helfich et al. (2009)

40. Burke et al, (2012)

4. Integrated and Compensatory

A key feature of Implementation Drivers is their integrated and compensatory nature:

4.1 Integration – means that the philosophy, goals, knowledge and skills related to the programme or practice are consistently and thoughtfully expressed in each of the Implementation Drivers.

4.2 Compensatory – means that the skills and abilities not acquired or supported through one driver can be compensated for by the use of another driver.

6.2.3 CAMHS Hub Implementation Teams and Implementation Planning

As outlined in Section 5 Governance – Implementation Teams have been established in each of the five CHO learning sites. There is evidence that creating Implementation Teams that actively work to implement interventions results in quicker, higher-quality implementation. High quality implementation is central to support the achievement of positive outcomes. The development of dedicated implementation plans with clear expectations of staff and implementation Team members will facilitate and ensure successful implementation of programmes and services. Each CAMHS Hub Site Implementation Team will develop a CAMHS Hub Implementation Plan using a dedicated planning template, outlining the steps required to support successful implementation.

The plan will act as a consistent progress-monitoring tool; supporting teams to identify key milestones achieved, potential risks and challenges arising.

6.2.4 Implementation Support Resources

A suite of standardised implementation resources have been developed by the Mental Health Change and Innovation Team to support learning sites as they progress through the stages of implementation to ensure consistency of implementation approach across all of the sites.

- Standard Operating Procedure for CAMHS Hubs Teams;
- Terms of Reference for CAMHS Hubs Implementation Teams;
- CAMHS Hubs Standardised Implementation Plan template;
- Sample job descriptions for CAMHS Hub Teams.

6.2.5 CAMHS Hubs Learning Site National Network

A dedicated CAMHS Hubs Learning Site National Network has been established as a Community of Practice to create and encourage opportunities for both the pilot implementation Teams and the CAMHS Hubs staff to learn from each other's experience, to address common challenges as they arise, and to develop networking opportunities across the five learning sites. This network will further inform the implementation and evaluation process, acting as an active feedback loop throughout the pilot testing phase.

Section 7

Monitoring & Evaluation

7.1 Monitoring and Evaluation Process

Monitoring and evaluation are essential to determine whether desired indicators are being met and outcomes being achieved. Such activities also help to identify risks to implementation and inform future actions[41]. Appropriate reporting and review mechanisms must be in place to facilitate this process. Evaluation relates to how an organisation measures its performance, and how (or whether) feedback is provided to people within the organisation, as well as the quality of measurement and feedback[42].

To ensure that the HSE CAMHS Hubs Model of Care improves access, improves outcomes and is cost-effective, it will require a robust evaluation framework to be established. An independent evaluation team will be commissioned to design and undertake a mixed method multi-site evaluation with consideration of contextual influences of real world application across diverse sites. This will ensure appropriate evaluation assessment, continuous improvement of the CAMHS Hub Model of Care and will support learning for the future expansion and mainstreaming of CAMHS Hubs.

7.2 CAMHS Hubs Monitoring and Evaluation Framework

A monitoring and evaluation framework for CAMHS Hubs will seek to identify minimum data outcomes to support the systematic evaluation of CAMHS Hubs into the future; and will encompass:

- Service User Outcomes (the service user, family, carer and supporters)
- Service Level Outcomes (incorporating clinical and service level outcomes for CAMHS Hubs Teams and Service users)
- System Outcomes (the health and community system incorporating stakeholders across the healthy system and within communities).

Performance indicators and outcome measures will be developed and tested to reflect service provision by all of the stakeholders involved, including service users, family/carers, clinicians and service management. As a new service development, measurements will need to evolve and develop throughout the pilot testing phase. On-going monitoring and feedback loops will be incorporated into the CAMHS Hubs delivery, to maximise the opportunity for service delivery to respond to the needs of stakeholders engaged with the service.

The development of a Minimum Data Outcomes Framework for CAMHS Hubs will be central throughout the pilot- testing phase to support the ongoing monitoring and evaluation of

41. Burke et al, (2012)

42. Helfich et al. (2009)

CAMHS Hubs into the future. Standardised scales will be employed in consultation with all of the learning sites to support benchmarking against international evidence and practice. The Service User Perspective will remain critical at all stages of the development, implementation, evaluation and review of the pilot model of care. This will ensure that issues arising from the experience of service users and their family/carer are considered and reflected in the decision making process.

To complement the ***Service User Outcomes***, the ***Service Level Outcomes*** and the ***System Outcomes*** outlined above and to encourage a consistent approach to data collection across all five of the CAMHS Hub learning sites minimum performance indicators will be set from the following:

- Referral numbers received
- Referrals accepted
- Assessments completed
- Interventions provided
- Caseload numbers
- Demographics of Service Users
- Duration of treatment
- Referral Reason
- Referral Time
- Time from referral to assessment
- Time to finalise Individual Care Plan (ICP)
- Service user satisfaction
- Family carer satisfaction
- Effectiveness of the intervention in reducing distress/ alleviating acute mental health crisis
- Service user understanding of CAMHS Hubs
- Family/ Carer understanding of CAMHS Hubs

7.3 Progress Reporting and Performance Reviews

- Monthly Pilot Site Implementation Team meetings will provide the governance and oversight and feedback mechanisms required to actively assess progress developments and address risks or issues escalated.
- Monthly pilot site reports will be submitted nationally for ongoing monitoring of the implementation of CAMHS Hubs.
- Agreed performance indicators will be collated by each pilot site as appropriate to capture core data to inform service design.

7.4 Feedback Mechanisms

A range of feedback mechanisms will be applied as appropriate to the service to promote continuous quality improvement throughout the testing phase.

Section 8

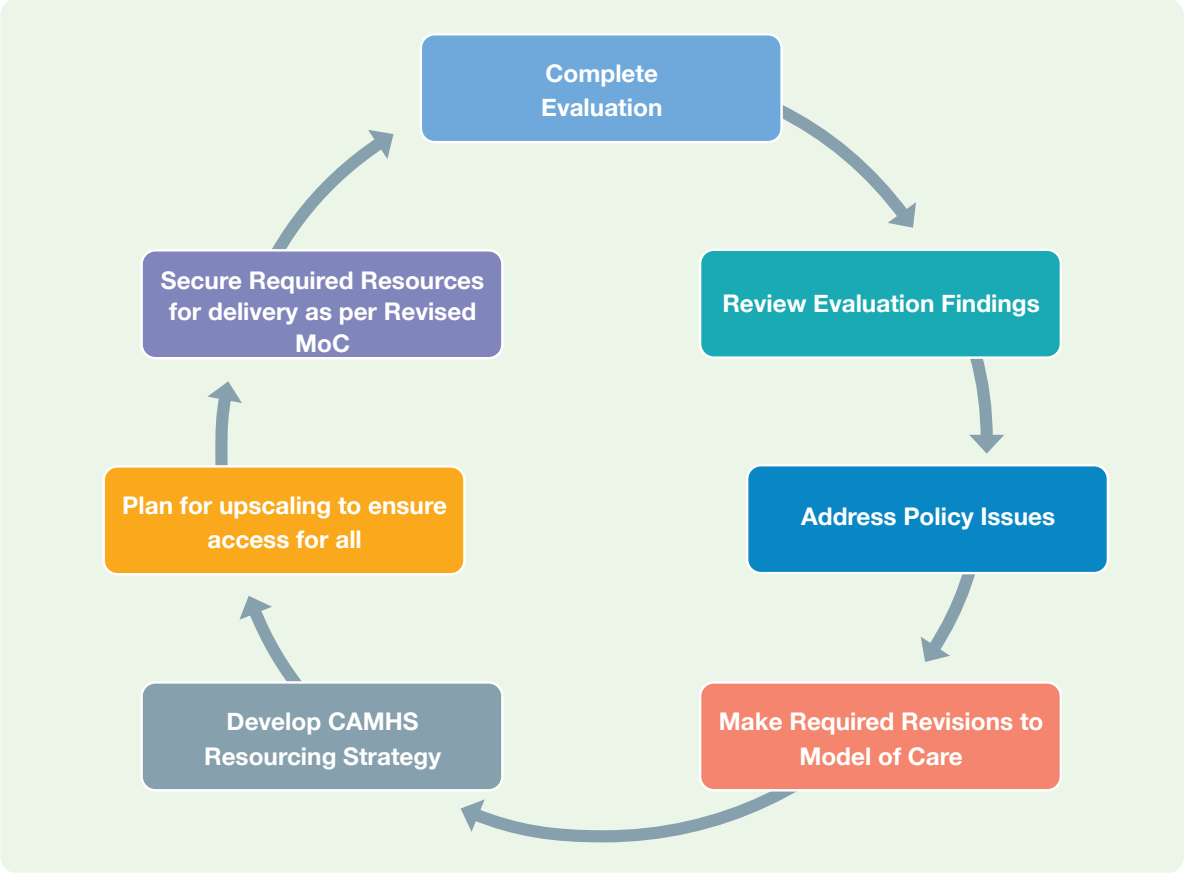
Review, Sustain & Upscale

The final phase of the Model of Care for CAMHS Hubs Implementation Process is review, sustain and upscale.

Review: Following completion of the mix methods evaluation across the five CAMHS Hubs learning sites of the pilot implementation of the CAMHS Hubs Model of Care, the findings will inform what outcomes were achieved and where improvements or changes to the MOC are required. The pilot Model of Care will then be reviewed and optimised by the National Steering Group for CAMHS Hubs, whilst also ensuring alignment with national policy and strategy and to address any arising policy issues from pilot delivery to ensure the final Model of Care is working as effectively as possible.

Sustain and Upscale: This phase will include the development of a CAMHS Hubs resourcing strategy to support the mainstreaming and upscaling of CAMHS Hubs within HSE Mental Health Services. This Strategy will clearly outline the required allocation of resources to fully implement the revised Model of Care for CAMHS Hubs and will include plans to incrementally scale up the delivery of CAMHS Hubs across additional geographical areas to ensure access for all. Finally the most important ingredient to successful sustaining and upscaling of the CAMHS Hub Model of Care is to secure resources for delivery as per the revised Model of Care.

Figure 17: Process to Review, Sustain and Upscale CAMHS Hubs



Glossary of Terms

Activity scheduling: A behavioural therapy for depression, which encourages scheduling activities, which improve mood.

Acute inpatient care: Care provided on a residential psychiatric ward in a hospital.

Administer medication: To prepare and check medications, ensuring that the right amount goes to the right person at the right time.

Advanced Nurse Practitioner (ANP): Advanced nurse practitioners (ANPs) are experienced and highly educated registered nurses who manage the complete clinical care of their patients, not focusing on any sole condition.

Approved Centre: An "approved centre" is defined in the Mental Health Act 2001 as "a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder". It is registered with the Mental Health Commission.

Carer: Also described as a friend or family member. A person who looks after a person with mental health problems. The term usually refers to an informal carer, e.g. a relative or friend.

Caseload: This is the number of service users receiving treatment.

Child: a child is defined under the Child Care Act 1991 as a person under the age of 18 years other than a person who is or has been married.

Clinical supervision: Clinical supervision provides an opportunity for staff to; reflect on and review their practice; discuss individual cases in depth and change or modify their practice and identify training and continuing development needs.

Community Healthcare Organisations: Nine Community Healthcare Organisations (CHOs) deliver Health Services at a local level across both the Statutory and Voluntary Sectors in the Community setting.

Conflict resolution/de-escalation: Resolving a conflict situation and preventing it from becoming a major incident.

Consent (National Consent Policy 2019): Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which sufficient information has been given to enable the understanding of the nature, potential risks and benefits of the proposed intervention or service. For a child under the age of 18 being treated for a Mental Disorder covered by the Mental Health Act 2001, a parent or legal guardian can consent to the treatment of the child. For further details, refer to HSE National Consent Policy 2019. https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-hse-v1-3-june-2019.pdf

Consultant Psychiatrist: a Consultant Psychiatrist has a Medical Degree (MD) and is a medical doctor who further trains for 7-8 years in psychiatry, which specialises in the care and treatment of people with mental illness and mental disorders. They assess patients, make diagnoses, they may investigate medical problems, offer advice, and recommend different treatments including medication, counselling or other life style interventions.

CPA: Care Programme Approach. A way of coordinating care for people with mental health problems and/or a range of different needs

Crisis: An episode of mental illness, which is severe enough that the person experiencing it would usually, be admitted to hospital.

Dual diagnosis: Experiencing both severe mental illness and problematic drug and/or alcohol use.

Early intervention Team: A Team, which works with people who are at risk of, or currently experiencing, their first severe mental health episode.

Evidence-Informed Practice: An evidence-informed approach to practice can be defined as the integration of research evidence alongside practitioner expertise and the people experiencing the practice within the context of available resources.

Family and social systems therapy: Therapy that takes into account a service user's social connections and how these may worsen their mental health, or improve it.

Individual Crisis Care Plan (ICCP): An ICCP is a clear plan, in plain English, that describes the levels of care and treatment needed to meet the assessed needs of the child or young person while they are attending a CAMHS Hub.

Implementation Fidelity: Implementation fidelity refers to the degree to which an intervention or programme is delivered as intended.

Key worker: A key worker is a point of contact on the CAMHS Hub Teams who coordinates care, not only within the mental health service but also across systems (e.g. education, social welfare, etc.) for the children/young person using the CAMHS Hub service. Key workers do not deliver all of the treatment but they are responsible for making sure that other professionals are keeping to what was agreed in the care plan. (HSE mental health best practice guidance)

Line Management: A process that provides an opportunity for staff to evaluate their performance, set objectives that align with the organisation's objectives and needs of the service, and identify areas for further training and development. It is carried out by a supervisor with authority and responsibility for the supervisee.

Logic Model: A logic model is a graphic illustration of the relationship between a programme's resources, activities, and its intended effects. Logic models clearly and concisely show how interventions affect behaviour and achieve a goal. They can be described as road maps that specify causal pathways and the step-by-step relationship between planned work and intended results. Specifically, a logic model is a visual way to illustrate the resources or inputs required to implement a programme, the activities and outputs of a programme, and the desired programme outcomes (short-term, long-term).

Mandated person: Mandated persons are people who have contact with children and/or families who, by virtue of their qualifications, training and experience, are in a key position to help protect children from harm. The Children's First Act 2015 places a legal obligation on these people, many of whom are professionals, to report child protection concerns at or above a defined threshold to Tusla – Child and Family Agency. Schedule 2 of the Children First Act 2015 provides a full list of people who are classified as mandated persons.

Management supervision: Usually a one-to-one meeting in which a staff member is supported by a more senior staff member to reflect on their work practice.

Mental Health: The World Health Organisation defines Mental Health as not just the absence of mental illness but also the presence of "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". (World Health Organisation)

Mental Health Act: A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interest or for the safety of themselves or others.

Mental Health Advocacy: A group of people with similar experiences who meet to discuss and put forward shared views to service managers.

Mental Disorder (World Health Organisation definition): The World Health Organisation defines Mental Disorder as "a broad range of problems with different symptoms. However, they are generally characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others. (World Health Organisation).

Mental Disorder (Mental Health Act 2001 definition): 'Mental Disorder' is defined in section 3 of the Mental Health Act 2001. It means mental illness, severe dementia or significant intellectual disability where – (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

Mental Illness (Mental Health Act 2001 definition): 'Mental Illness' means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons.

Multi-disciplinary Team (MDT): A multi-disciplinary Team is a group of health care workers who are members of different disciplines or professions, e.g. Psychiatrists, Social Workers, etc., each providing specific services to the children and young people. The Team members independently treat various issues children and young people may have, focusing on the issues in which they specialise. The activities of the Team are brought together using a care plan. This helps coordinate individual services and encourages Team working towards a specific set of service user goals.

NICE: National Institute for Health and Clinical Excellence. Publishes guidance for health services

OT Occupational Therapist: A healthcare profession offering support to people with physical, psychological and social problems to enable them to live life to the fullest. Occupational Therapists help people to do the everyday activities they want and need to do when faced with illness, injury, disability or challenging life circumstances or events.

Parent(s): In this document parent(s) is used throughout to refer to a child's father or mother, or both, or their legal guardian or anyone acting in loco parentis. Detailed information on guardianship is available on: https://services.courts.ie/Family-Law/

Partner Agencies: The Community/Voluntary/NGO Sectors provide a range of services to people with mental health problems. These include support services, self-help, and community groups. Most organisations operating in this sector are closely linked with HSE Primary Care, and are situated on the first tier of service provision.

Peer support worker: A service user or carer employed by the Team to support other service users and/or carers.

Positive risk taking: Allowing people to take responsibility for their actions, to empower them and to improve understanding of decision-making and consequences.

Primary care: Usually the first port of call for health problems. Includes general practitioners (GPs), dentists, community pharmacies and high street optometrists.

Psychosocial Interventions: Therapeutic interventions focused on addressing a person's psychological, emotional, social and occupational needs.

Reflective Practice: A process of reflecting on one's professional practice and interactions with others for the purpose of better understanding and learning from one's experience and that of others. Reflective practice plays a key role in the provision of safe, high quality care, and in the ongoing improvement of service delivery. Reflective practice can be carried out at the level of the individual as well as Team, in order to improve effective Team working.

Section 25 Order: A Section 25 Order is an order made by the District Court pursuant to Section 25 of the Mental Health Act 2001 that a child may be admitted and detained for treatment in a specified approved centre for a period not exceeding 21 days. http://mhs.hseland.ie/media/1110/section-25-policy-revised-v2-08-2019.pdf

Solution focussed brief therapy: A therapy focussing on the present, future, and what a service user can achieve.

Social Worker: Social workers are professionals who aim to enhance overall well-being and help meet basic and complex needs of communities and people. Social workers work with many different populations and types of people, particularly focusing on those who are vulnerable, oppressed and living in poverty.

Tiered Services: Tiered Services enable services to be progressively tailored to the needs of the individual. Over 90% of mental health needs can be successfully treated within a Primary Care setting with less than 10% being referred to more specialised community-based mental health services.

Triage: To screen information about a person referred to a service to see if they are appropriate for the service.

Tusla: Child and Family Agency: The specific role of Tusla is to promote the welfare of children who are at risk of not receiving adequate care and protection. Tusla has responsibility for child welfare and protection services, family support, educational welfare and a range of other services, including those relating to domestic, sexual and gender-based violence. (Children First: National Guidance for the Protection and Welfare of Children, 2017) https://www.tusla.ie

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