# Mental Health Commission Response to Task Force Report on the Child and Family Support Agency

December 2012

# Executive Summary

The Mental Health Commission (MHC) supports timely access to appropriate services to address the mental health needs of all children in the State. It is important to understand, however, that mental health problems are not the sole remit of Child and Adolescent Mental Health Services (CAMHS). We strongly believe therefore that the starting point needs to be in tackling existing problems in children's services regarding the delivery of services from a preventative care model and early intervention perspective (CAMHS Review UK, 2008). Existing standards and regulations in child protection and welfare services related to mental health should be implemented in the first instance.

We propose a tiered, stepped approach to service provision (Department of Health, Social Services & Public Safety, 2012) as it is clear that children require intervention at various stages, with the right intervention at an early stage being paramount. Vulnerable children need to be prioritized and offered targeted support to reduce the likelihood of developing lifelong mental health problems (Department of Health, Social Services & Public Safety, 2012).

Priority must be given to strengthening the delivery of primary care services in line with government policies (DOHC, 2001a; 2001b; 2006). All young people, including children in care, should have readily available access to a general practitioner (GP) to assess their current health needs. For young people at risk, it is imperative that they have a social worker assigned who sees them on a regular basis appropriate to their current needs. Social workers play a crucial role in terms of identifying the needs of children under their care and in ensuring that appropriate referrals take place. It has been found in other jurisdictions that staff in universal services need a better understanding of their role in promotion, prevention and early intervention for mental health problems (CAMHS Review UK, 2008). Social workers need to be supported and provided with the necessary skills, training and supervision (HIQA, 2012; Shannon & Gibbons, 2012) in issues related to child development and mental health in order to deliver a robust service.

The MHC supports the primary care model espoused in A Vision for Change (DOHC, 2006), the national mental health policy, which recommends that the primary support for the mental health needs of children in care should be provided by psychological services in community care. We believe in line the United Nations MI Principles that people with mental health problems should access services in the least restrictive environment and have the least restrictive treatment commensurate with their mental health needs (UN MI Principles, 1991). For those suffering from a mental illness or disorder and requiring specialist services (which is estimated to be anywhere between 20 and 30% of children in care), it is imperative that timely access to CAMHS services is available. In order to deliver the best possible CAMHS to all children, it is important that a comprehensive service is developed in line with the requirements set out in our national mental health policy.

In relation to the proposed move of CAMHS out of health services to the new Child and Family Support Agency (CFSA), Richardson & Partridge (2003) assert that there has been considerable debate about the placement of CAMHS services. The authors suggest that the issue is not so much about where CAMHS sit rather they suggest that the lesson is to develop relationships with the existing management structure to enable the effective delivery of services.

The MHC strongly supports this viewpoint and suggests that any changes to the delivery of CAMHS, which is a specialist service should be carried out in partnership with relevant stakeholders and agencies including mental health service providers, frontline staff, service users and families, professional bodies and the Mental Health Commission so that change can be progressively realised in a planned manner.

It is important that the Department of Children and Youth Affairs is aware of the MHC's legal mandate to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of persons detained in approved centres provided for under Section 33 of the Mental Health Act 2001. The MHC has a number of regulatory responsibilities in relation to mental health services and maintaining the register of approved centres i.e. inpatient mental health services, which includes child and adolescent mental health services. Therefore, changes to the governance of CAMHS may necessitate legislative changes.

# Table of Contents

# Introduction

The Mental Health Commission's (MHC) principal functions are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of persons detained in approved centres.

The Mental Health Act 2001 is currently under review and the MHC made a detailed submission to the Department of Health in December 2011. In relation to children, the MHC recommended the importance of increasing the visibility of the child in mental health legislation and refocusing the best interest's principle in Section 4 of the legislation to ensure the delivery of truly child-focused mental health services. The Commission also emphasised the importance of the voice of every child using services being heard and taken on board (See http://www.mhcirl.ie/Publications/MHC_Submissions pgs 32-39 for further details). An expert group has been tasked with reviewing the legislation and is expected to deliver a report to the Minister for State with responsibility for Disability, Older People, Equality & Mental Health, Kathleen Lynch T.D., in March 2013 with recommendations for revising the Act.

In Ireland, we have seen many reports over the years detailing failures in respect of the welfare of children (Roscommon Child Care Inquiry, Monageer Inquiry Report, Ryan Report), the most recent being the report of the independent child death review group (Shannon & Gibbons, 2012). The Mental Health Commission therefore welcomes the Department of Children and Youth Affairs efforts to reform the child welfare and protection system in Ireland and to develop and deliver a more robust child welfare and protection service model which places the child at the centre of care and focuses on positive outcomes for young people. It is hoped that the establishment of the Child and Family Support Agency along with the recent passing of constitutional amendments in the children's referendum will pioneer the way for a radical shift in services where children are given a real voice and are at the centre of care. In line with the UN Convention on the Rights of Children (UN, 1989), it is imperative that the views of young people are actively sought and that their views are seen as a priority in addressing all issues relevant to them. We welcome attempts by the Task Force to deliver a more integrated model of care for children however we are concerned by the lack of mention of children with disabilities and their needs as these children are known to be at increased risk of abuse (Commission to Inquire into Child Abuse, 2009).

The Mental Health Commission also welcomes the new HIQA standards for Child Protection and Welfare, published in July 2012 which are aimed at "*protecting and promoting the welfare of children who are not receiving adequate care and protection and to address concerns in relation to the quality and safety of care which children are receiving"* (HIQA, 2012: 5). The Mental Health Commission was represented on the standards advisory group. The HIQA standards highlight the importance of a comprehensive assessment for all children accessing HSE Child and Family Services, which includes an assessment of whether they require the provision of child and adolescent mental health services. Importantly, the standards further emphasise the importance of staff working with vulnerable children in child and family services having the necessary skills and knowledge to appropriately deal with children experiencing mental health problems.

The following response comprises two parts in order to greater inform the CFSA on issues related to mental health service provision particularly in respect of CAMHS. Part 1 outlines some of our concerns regarding the task force report. Section 1 provides our evaluation of the report and section 2 highlights some of the steps which we believe will need to take place before a move from the current model of service provision for CAMHS can occur. Section 3 offers a number of recommendations which we are confident can further progress the delivery of effective services to children with mental health problems.

Part 2 then provides an overview of issues related to children's mental health. We highlight the latest available statistics on children's mental health in Section 4. Section 5 provides an overview of CAMHS services in Ireland and Section 6 highlights some of the latest available statistics and research related specifically to the mental health needs of children in care. This part provides the context and evidence base informing our recommendations.

# Part 1: Evaluation and Recommendations

## 1. Evaluation of the Task Force Report

- The Task Force report proposes an integrated model of service delivery with interagency working and recommends that the CFSA in addition to child protection and welfare services, includes a broad based range of primary prevention, early intervention, family support and therapeutic and care interventions. The report suggests that by bringing all of these services together under one agency, it will remedy deficiencies in child protection service delivery highlighted in previous child protection reviews. We believe that this is an overly simplistic solution to a more complex issue.

- We support strong interagency working for the provision of effective, timely and appropriate services as proposed in the report. It must be noted however that interagency and inter-disciplinary work is not simple and poses challenges for children's services in all countries (Shannon & Gibbons, 2012).

- We welcome the proposed multi-disciplinary approach where all professionals have a collective, shared responsibility for the well being and protection of children. CAMHS services in Ireland currently operate a multi-disciplinary approach to mental health treatment and a key worker system is also in place.

- We suggest that in order to create an integrated model of service delivery, consultation with key stakeholders from the outset is vital. The Task Force report does not detail how mental health services, CAMHS services, staff working in these services and other key stakeholder groups were consulted and involved in inputting into the proposed changes and new agency. Consultation would allow the new agency to gain a full understanding of the role of specialist CAMHS, how services operate and also to closer examine some of the issues and challenges faced by mental health service providers and staff.

- We welcome the proposed child- centred service delivery model (Munroe Review, 2011) where due regard is given to children's wishes and feelings. The report does not mention how the views of young people currently in the child protection system have been sought or taken into account regarding their mental health needs or how the design and delivery of services can best meet their needs.

- We were surprised that there is no mention of children with disabilities in the proposed new model given it is intended to integrate all services for children. It is not clear whether the views of those providing services to children with disabilities were sought, however they are an important stakeholder and we believe that their exclusion will create a fragmented model.

- It must be examined closely whether the proposed move of CAMHS services from health to what may be seen as a child welfare and protection agency would be in the best

interests of all young people of Ireland who require access to CAMHS, as 80% of children accessing CAMHS do not have any contact with social services (HSE, 2012).

- We believe that mental health services should be treated like any other health service. The proposed transfer of CAMHS to the new agency could be seen to further stigmatize people with mental health problems and mental illness by suggesting that because a child has mental health problems, they should automatically fall under child welfare services. This would be a retrograde move from the current movement to eradicate the stigma that surrounds experiencing mental health problems. Service acceptability could further be viewed as an issue by parents and families. This would not be considered a positive step for young people or their families and carers, where issues around self harm and suicide in young people are becoming ever more prevalent in society.

- There is concern on the ground that the separation out of CAMHS from other health services such as paediatric services and primary care services may impede timely referral and access to appropriate services.

- The report runs contrary to current health policies such as A Vision for Change (DOHC, 2006), Quality and Fairness (DOHC, 2001a) and the Primary Care Strategy (DOHC, 2001b), all of which adopt a lifespan approach to health and social care delivery with continuity of care from childhood through adulthood into older age. The Mental Health Commission's (2007) Quality Framework for mental health services, theme 1, highlights the importance of having a holistic, seamless service and the full continuum of care provided by a multidisciplinary team. Separating out child and adult mental health services would be counter intuitive to ensuring continuity of care particularly as some young people will transition from CAMHS to adult mental health services (Section 4).

- Furthermore, the association between parental problems such as poor mental health and child abuse and neglect has been well established (Cleaver et al, 1999 cited Munro, 2011). Therefore it is important that strong links are developed and maintained between CAMHS and adult mental health services to provide a holistic service.

- CAMHS is a specialist service and there is a danger that moving it to the new agency would lead it to becoming a more generic service. We were not convinced by the completeness of the evidence base for the proposed move and were disappointed that we were not permitted access to the papers referenced in the report on the international evidence despite endeavouring to do so.

- **In particular, the rationale provided for moving CAMHS (pages 45 and 46) to the new agency must be questioned.**

    - **The report asserts that CAMHS and Child and Family Services have a significant shared population, however according to the most recent national CAMHS activity report, this figure currently stands at only 20% of children (HSE, 2012).**

- **The Ombudsman for Children's (2008) submission to the Oireachtas Joint Committee on Health is referenced which made several valid points in relation to CAMHS services. These issues however, are not specific to children in care. The Task Force emphasises the importance of multi-disciplinary team (MDT) working. CAMHS currently operates a robust model of MDT working comprising of psychiatry, psychology, nursing, social work, occupational therapy and speech and language therapy, with a key worker system also in operation.**

- **The Ombudsman's submission highlights concerns over access for 16 to 18 year olds to mental health services. This issue is also of concern to the MHC (MHC, 2012; 2006), however it is a wider more complex issue affecting mental health services which is unlikely to resolve simply by changing the governance of CAMHS.**

- It is positive to note that the service delivery model proposed includes having clear and consistent referral pathways for children and families based on assessed needs. It will be vital that a robust assessment framework is put in place to accurately assess current needs and make appropriate referrals.

- The report does not acknowledge the significant progress made in recent years in the development of CAMHS in Ireland (See HSE, 2012). Nor does it mention the need for further resources for mental health services as set out in A Vision for Change in order to adequately meet the needs of all children requiring specialist mental health services.

## 2. Steps required to Change from Current Model of Mental Health Service Provision

The Task Force report recommends the relocation of CAMHS to the new Child and Family Agency. If such a move were to occur, it would require a number of changes to be made relating to, inter alia, legal, governance, and financial issues, as follows:

- **Legal issues**. The Mental Health Act 2001 governs mental health service provision in Ireland and the MHC regulates mental health services including CAMHS. Therefore the MHC need to be engaged on changes to the delivery of mental health services which might require legislative changes. This may include the following:
    - The MHC maintains the register of approved centres under Section 64 including child and adolescent units. A child can only be admitted for inpatient care to an approved centre.
    - The Inspector of Mental Health Services inspects (Section 51) mental health services including CAMHS.
    - The MHC makes rules (Section 59, Section 69) and codes of practice (Section 33) for services including CAMHS. We are currently reviewing rules with a view to making them Statutory Instruments; some of these rules apply to children.
    - Section 25 of the 2001 Act permits 'the HSE' only to make an application to the District Court to detain a child. This detention must be in an approved centre.

- Changes to **financial arrangements** and disaggregation and deployment of resources and budget transfer. This could lead to a further depletion of vital resources for mental health services.
- Changes to **employment contracts**, transfer of staff and workforce planning;
- **Governance issues**;
- **Physical location changes**. It has been suggested to us that some of the moves currently underway involve moving staff from HSE child and family services further away from the local community in which they are working. This may have a detrimental impact on the young people and families they work with and to adopting a preventative and early intervention approach; and
- **Collaborative arrangements** and **extensive consultation** with all key stakeholders.

## 3. MHC Recommendations

The following are our main recommendations, which we hope will support positive changes and the delivery of better services to meet the mental health needs of vulnerable young people.

### *1. Seeking the Views of Young People*

1.1 In order to deliver truly child- centred services, it is important that the views of young people are sought (Commission to Inquire into Child Abuse, 2009; Department of Health, Social Services & Public Safety, 2012; Munro, 2011; Roscommon report, 2010).

1.2 The Commission is aware that the Children's Mental Health Coalition is currently commissioning a review of the mental health needs of children in care and youth justice, which may provide some useful recommendations for the delivery of evidence-informed services. This study will seek the views of 18 to 24 year olds who have previous experience of services. The review is expected to be published in April 2013.

### *2. Strengthen Preventative Services / Early Intervention Strategies*

2.1 There is a clear need for assessment and early detection of the mental health needs of children accessing child and family services (Shannon & Gibbons, 2012).

2.2 All children in care should have their own GP to ensure that their health needs are adequately assessed and that timely referrals can be made, as appropriate. GP's are well placed to identify problems early (Munro, 2011). Early intervention is essential (Shannon, 2012) rather than waiting for the need for crisis intervention.

2.3 The primary support for the mental health needs of children in care should be provided by psychological services in community care (DOHC, 2006). Appropriate psychological services and counselling should be provided for children in care as a high percentage of children require access to these services to address issues arising.

2.4 The National Review of Psychology Services (2010) made the recommendation to have dedicated psychology posts for looked after children. This is something that should be closer examined as a major issue at present is that the needs of children in care are not prioritised above children in the general population despite their increased vulnerability and existing guidelines to this effect (DOHC, 2003; 2001c). Timely access is a critical issue to ensuring positive outcomes.

### *3. Robust Child and Family Services*

3.1 All children in care should have a social worker appointed in line with existing standards (DOHC, 2001c; 2003; HIQA, 2012) who will co-ordinate their care and ensure the development of an appropriate care plan.

3.2 Each and every child entering into care should be provided with a high standard of care commensurate with his/her needs (Shannon & Gibbons, 2012). It is imperative that all children in care have a care plan (Commission to Inquire into Child Abuse, (2009; DOHC, 2001c; 2003). The care plan should identify the services required by the child to meet his/her needs. The child should be involved in its development and it should be regularly reviewed (Commission to Inquire into Child Abuse, 2009).

3.3 A national common assessment framework (Munro, 2011; Roscommon report, 2010) should be introduced for all children where there are child welfare and protection issues. This should include assessment of mental health, psychological and emotional issues.

3.4 Staff working with vulnerable children, and in particular social workers, need to have the necessary skills, experience and competencies to meet the needs of children using the service (HIQA, 2012; Munro, 2011). They also need adequate professional supervision and support (Commission to Inquire into Child Abuse, 2009; Shannon & Gibbons, 2012). A training needs analysis should be carried out for social workers, which looks at training in areas such as developmental issues and attachment theory, emotional and psychological issues, child protection, managing separation, early trauma, abuse and neglect (Munro, 2011; Roscommon report, 2010).

3.5 Staff working with vulnerable children need to have the necessary skills and knowledge to appropriately identify children experiencing mental health problems (HIQA, 2012). Consideration could be given to a carrying out a training needs analysis of social workers and social care workers in respect of mental health education and training. This could examine needs at undergraduate level and postgraduate and CPD levels. This might have the effect of increasing detection of mental health problems and enabling appropriate referrals. This should be targeted in the first instance at social care staff working with those most at risk i.e. children in residential care (See Recommendation 4.8).

### *4. Development of Comprehensive CAMHS*

4.1 It is important that CAMHS is delivered in a manner that best meets the needs of all children and their families who require such services. Eighty percent of children accessing CAMHS have no contact with social services.

4.2 CAMHS is a specialist service and many children with mental health needs do not require this level of intervention. Therefore, priority must be given in the first instance

as to how the mental health needs of young people can be met at primary care level.

4.3 The MHC recognizes that access to CAMHS for some vulnerable young people may be an issue for several reasons e.g. detection, referrals, waiting lists. There is a clear need to examine this issue more closely to identify the main impediments to access.

4.4 CAMHS teams currently have 38% of the recommended staffing levels set out in A Vision for Change. The government committed €35 million to the further development of mental health services for 2012. We strongly urge the delivery on this commitment of additional resources and investment in fully staffing multi-disciplinary teams including those in CAMHS. The full development of these teams will enable more timely access for all young people requiring CAMHS.

4.5 There are approximately half of the recommended inpatient bed numbers in CAMHS (DOHC, 2006), which again impacts access to these services for all children.

4.6 It is important that further efforts are made to develop clear and strong links between CAMHS and other services and agencies (Department of Health, Social Services & Public Safety, 2012) such as primary care services (DOHC, 2006), child welfare and protection services (Shannon & Gibbons, 2012) and education services. This is essential to ensure effective coordination and delivery of appropriate services for young people at risk and to ensure appropriate care pathways are in place so that a child requiring CAMHS can access the service in a timely manner.

4.7 The HSE has a CAMHS advisory group which aims to, amongst other things, develop relationships with primary care and other services, put in place clear pathways about the nature of support CAMHS provide for other services working with children and young people with mental health problems, and improve access for older adolescents who can find it difficult to engage with services (HSE, 2011). This group could liaise with the children's services committees to address some of the issues raised in the Task Force report.

4.8 The CFSA should consider liaising with CAMHS in relation to input into the training of colleagues. The MHC is aware of recent research examining training of social workers and care workers and some current work being carried out in the area of training teachers in children's mental health by CAMHS. This may be something that could be rolled out to the training of relevant staff under the new agency. There are also a number of post graduate courses in child mental health in Irish universities.

4.9 Richardson & Partridge (2003) assert that there has been considerable debate about the placement of CAMHS services. The authors suggest that efforts should instead be focused on developing relationships with the existing management structure to enable the effective delivery of services. The MHC is strongly supportive of this viewpoint. Further, it has been suggested that the development of close relationships and dialogue rather than necessarily a multi-agency approach can be more effective in helping people work together in a more child- centred way (CAMHS Review UK,

2008).

### *5. Interagency Collaboration and Stakeholder Consultation*

5.1 We believe it is imperative that the CFSA has a complete understanding of the functions of CAMHS and how the service operates as we were not convinced by the completeness of the evidence base. It is suggested that the new agency when commenced engages in ongoing consultation and dialogue with CAMHS and other relevant agencies and stakeholder groups i.e. professional bodies, representative groups, MHC.

5.2 It is important that the views of relevant stakeholders including frontline staff are sought in order to foster strong interagency and intra-disciplinary co-operation. Interagency co-operation and inter-disciplinary working have been highlighted as problematic in children's services in child protection reviews (Munro, 2011; Roscommon report, 2010; Shannon & Gibbons, 2012).

The Task Force report recommends that *"the development of Children's Services committees provides a strong basis for interagency working and for planning, co-ordinating and delivering services at local level."*

These committees could work to progress and facilitate integrated working and inter-agency collaboration and communication in respect of addressing the mental health needs of children in contact with child welfare and protection services.

5.3 Policies and protocols should be put in place between child protection services, primary care services, mental health services, education and youth justice (Department of Health, Social Services & Public Safety, 2012) in relation to interagency working, information sharing and referral pathways for mental health problems. Numerous reports have highlighted the need for information to be shared across disciplines and services (e.g. Shannon & Gibbons, 2012).

### *6. Evidence Base and Good Practice*

6.1 All existing standards and regulations pertaining to child welfare and protection services (e.g. DOHC, 2003; 2001c; HIQA, 2012) should be fully implemented in order to identify both the immediate and longer term needs of children.

6.2 We believe it is important that existing evidence and good models of care delivery internationally are fully examined. Good professional practice should be informed by knowledge of the latest research and theories (Munro Review, 2011).

6.3 Any recommendations in relation to changes in the delivery of mental health services and the structure of CAMHS should be underpinned by a strong evidence base and take into consideration the lessons learned from other jurisdictions.

# Part 2: Current Issues related to Children's Mental Health

## 4. Children's Mental Health

- The World Health Organisation estimates that one in 10 children have a mental illness (WHO, 2005). It has been found that there is a significant risk of mental illness that arises during childhood persisting into adulthood (Knapp et al, 2011). A US study found that half of all mental disorders emerge by 14 years of age and 75% by 25 years of age (Kessler et al, 2005).

- Experiencing a mental health problem can have a significant impact on one's physical health, relationships and family, education, employment, and housing opportunities. The long term costs (human and economically) of untreated mental health problems are therefore high (US Surgeon General, 1999).

- In Ireland estimates of the prevalence of mental disorders in young people vary from 16 to 27% (Lynch et al, 2005; Martin et al, 2006; Sullivan et al, 2004).

- A recent Irish study of 6,085 secondary school children aged 12-19 years found that 11% had reported previously seeing a mental health professional (Headstrong & UCD, 2012).

- According to the World Health Organisation, Ireland now has the fourth highest rate of suicide of persons aged 15 to 24 in the EU, with young men presenting a significantly greater risk than young women. Recent research suggests that young males aged 16-20 years have a particularly high risk of suicide (Malone et al, 2012).

- In a recent seminar entitled '*Being Young and Irish'* organised by the President Michael D. Higgins in September 2012, 'mental health and suicide' emerged as one of the top five priorities for young people today in Ireland.

- The MHC strongly supports the delivery of services in line with the International Covenant on Economic, Social and Cultural Rights (CESCR, 1966), the UN Convention on the Rights of Persons with Disabilities (UN, 2006) and the UN Convention on the Rights of Children (UNCRC, ratified by Ireland in 1992). We believe that children have "*the right [of everyone] to the enjoyment of the highest attainable standard of physical and mental health*" and without discrimination on the basis of disability (Article 12.1, CESCR; Article 25. CRPD, 2006). Children also have the right to express themselves and be listened to on all matters affecting their mental health (Article 12, UNCRC). The MHC produced a self advocacy and rights-based toolkit for young persons in 2010 called the '*Headspace toolkit'* to greater enable their involvement in services (MHC, 2010).

- The MHC's Quality Framework for Mental Health Services in Ireland (MHC, 2007) published in 2007 emphasises the importance of prevention, early detection, early intervention and mental health promotion in Irish society. Standard 1.4 of the Framework states that every service user should receive care and treatment from a community-based service that addresses these issues. A recent report identified the economic pay offs of mental health prevention, promotion and early intervention (Knapp et al, 2011).

- Several reports identify schools as a key player in the early identification of mental health problems in young people (Bamford Review of Mental Health and Learning Disability NI, 2006). A whole school approach where teachers have training on mental health promotion, could help to identify mental health problems early and create a culture of greater mental well-being within the entire school community (Children's Mental Health Coalition, 2012). The Department of Education and Skills is current drawing up guidelines on '*Well being in Post Primary Schools'*.

## 5. Child & Adolescent Mental Health Services (CAMHS) in Ireland

- Section 2 of the Mental Health Act 2001 defines a child as a person under the age of 18 years other than a person who is or has been married.

- CAMHS is a specialist service that assesses and treats children and adolescents with mental illness or mental disorder. Approximately 2% of children in Ireland come into contact with CAMHS in any given year (HSE, 2011).

- The Mental Health 2001 is the main legislation governing mental health services in Ireland. Section 64 provides that the Mental Health Commission shall maintain a register of approved centres. There are five approved centres in child and adolescent services on the register. These centres comprise 60 operating inpatient beds (latest MHC figures, 1st December, 2012). In addition, there are 12 beds in the Genesa Suite which is registered as part of St. John of God Hospital Ltd. (MHC, 2011). There is additional bed capacity of 18 beds in Cork and Dublin (HSE, 2012), but these services are waiting on the necessary staffing levels before the beds become fully operational. A Vision for Change recommended 108 beds for children and adolescents (DOHC, 2006).

- Section 25 of the Mental Health Act 2001 provides the procedures that must be followed in order to involuntarily admit a child. This can only occur to an approved centre. This section of the Act closely interfaces with the Child Care Act 1991, in particular, Sections 21, 22, 24-35, 37, and 47 of the 1991 Act. A child on a full child care order can only be admitted under Section 25 of the 2001 Act.

- A Vision for Change proposed approximately 100 CAMHS multi-disciplinary teams. There are currently 58 CAMHS teams operating in Ireland, two adolescent day services and three paediatric liaison teams (HSE, 2012). A new adolescent day service is due to commence in West Dublin.

- There are 461.94 WTE's on CAMHS teams, of which 385.58 are clinical posts (HSE, 2012). There are additionally 17.45 WTE's in the day services, 31 WTE's on the liaison teams, and 169.4 WTE's in the four HSE child units (HSE, 2012). In 2012, 150 clinical MDT posts have been allocated to MDT teams in mental health (although not specific to CAMHS teams) which are due to commence in December 2012. The above represents 38% of the staffing level recommended in A Vision for Change (DOHC, 2006).

- The government committed €35 million to the further development of comprehensive mental health services for 2012 and in particular investment in fully staffing multi-disciplinary teams including those in CAMHS. Prioritisation of services for children will enable more timely access for all young people requiring CAMHS.

- In September 2012, community CAMHS had 16,664 active cases (HSE, 2012). Overall, community CAMHS teams saw 8,671 new cases for the year running 1st October 2011 to 30th September 2012.

- Under the Act a young person under 18 years of age can be admitted on a voluntary basis for inpatient care and treatment with the consent of their parents/guardians. There were 421 admissions of children to approved centres i.e. inpatient mental health units in 2011 (MHC, 2012).

- Of those admitted in 2011, approximately, two thirds (68.6%) were admitted to child and adolescent units while 31.4% (n=132) were admitted to adult units.

- Of the number of children admitted to inpatient mental health units in 2011, 21 of these were involuntary admissions under the Mental Health Act 2001 (MHC, 2012). The procedures outlined in Section 25 of the Act had to be followed for such admissions.

- There can be particular difficulty in 16 and 17 year olds accessing age appropriate mental health services in some areas (MHC, 2012; MHC, 2006). There are a number of contributing factors to this including a lack of available beds in child units, and difficulties accessing CAMHS due to the fact that under the Mental Treatment Act 1945 CAMHS only dealt with children up to 16 years of age. Only 25% of CAMHS teams accept new referrals of children up to and including 17 years of age (HSE, 2012). The HSE management team recently approved the new "*Access protocols for 16 and 17 year olds to mental health services*" which commits to all CAMHS delivering services to all new cases up to 17 years of age from 1st January 2013 onwards.

- Based on the latest available figures, 66% of new cases are seen by CAMHS within 3 months, 10% waited 3 to 6 months, 7% 6 to12 months, and 5% waited more than 1 year (HSE, 2012).

- CAMHS is a specialist secondary service; therefore it largely does not operate direct referrals. The majority of referrals to CAMHS are from GP's (64.6%). In the previous year, 9% of referrals were from education, 3.7% were from primary care services (e.g. psychology services, OT, speech and language) and 2.2% of referrals were from social services (HSE, 2012).

- There is a need for clearer care pathways for children accessing mental health services. The HSE Clinical Care Programmes Directorate is currently working on three relevant care pathways relating to self harm, eating disorders and early intervention for psychosis, which are due for implementation by Quarter 3 of 2013.

## 6. The Mental Health of Children in Care

- There were 6160 children in care in Ireland in 2011 (Department of Justice & Equality, 2012), up 8% from the previous year (n=5682). The number of children in care has risen by 27% in the past 10 years (McNicholas et al, 2011). In 2011, the Courts granted 2287 care orders and 972 supervised orders (Courts Service, 2012).

- Over 90% of children are in foster care with the remainder in residential care (Shannon & Gibbons, 2012) and half reside in the Dublin area (McNicholas et al, 2011).

- It is recognized that children in care are one of the most vulnerable groups in society. Children in care often face complex and enduring interpersonal and mental health problems affecting every aspect of their lives making it difficult for them to accept help and for staff and carers to maintain therapeutic relationships (Bamford Review of Mental Health and Learning Disability NI, 2006). Many children in care have experienced stressful life events, including abuse and neglect, prior to their placement in care (Children's Mental Health Coalition, 2009).

- It is well established that young people in care have a higher rate of mental health problems than the general population (Bamford Review of Mental Health and Learning Disability NI, 2006). A national study in the UK has found that the prevalence of mental illness is significantly higher in children in care with 45% having mental health problems (Meltzer et al, 2002).

- The latest HSE CAMHS activity report found that 20% (n=1684) of children who attended community CAMHS teams were in contact with social services and an additional 743 had a history of contact, based on an audit they carried out in November 2011 (HSE, 2012). This is a twofold increase on the previous year, where only 10% (n= 795) of children who attended community CAMHS teams were in contact with social services (HSE, 2011). This increase is not accounted for by the rise in number of children in care from 2010 to 2011 which is negligible by comparison.

- A recent Irish study of the perceived mental health needs of 174 looked after children i.e. children in care, in Dublin found a high rate of CAMHS attendance with 28.7% of looked after children reportedly attending CAMHS and 24.9% attending counselling services. It was reported that 35.5% had had an assessment by CAMHS and 34.1% had a psychological evaluation (Mc Nicholas et al, 2011).

- CAMHS attendance has been found to be significantly more likely where a child is in residential care and where they have an increased number of placements (Mc Nicholas et al, 2011).

- It appears likely from the available figures that attendance at CAMHS amongst children in care, although rising, is still lower than expected given the reported prevalence of mental health problems. This may be for a variety of reasons including difficulties with accessing the service due to waiting lists, referral criteria, reluctance of social workers to

make referrals or lack of education of social workers around identifying mental health problems and reluctance of young people themselves to engage with CAMHS. Difficulty accessing CAMHS was highlighted in the Shannon & Gibbons (2012) report.

- The Mc Nicholas et al (2011) study found that 16.7% of children did not have a social worker and 37.7% had no GP.

- A HSE (2010) audit of compliance with the foster care standards and regulations in 2010 found several shortcomings with 282 children not having had a comprehensive needs assessment, 18% being without care plans, and 481 children not having an allocated social worker.

- In the UK, it is a requirement to have a Strengths and Difficulties questionnaire completed for all children in care to help identify mental health and psychological needs (CAMHS Review UK, 2008).

- In the McNicholas et al (2011) study, the most common diagnosis were ADHD and oppositional/conduct disorder. Just over half (53.6%) of children in foster care had behavioural problems, which rose to 88.9% for children in residential care.

- Children in care, aftercare and known to services are also at greater risk of premature death (Shannon & Gibbons, 2012). The greatest risk is for those 14 years and older, particularly for those in care.

- Children in care, aftercare and known to child protection services have a higher rate of suicide than the general population. The recent independent report put the figure at around 8% of the young people who had died between 2000 and April 2010 (Shannon & Gibbons, 2012).

- For many children in care access to psychology services is critical to address problems. A Vision for Change (DOHC, 2006) recommends that the primary support for the mental health needs of children in care be provided by psychological services in the community. However, presently the needs of children in care are not prioritised above children in the general population and therefore they must join lengthy waiting lists which can be anything up to 2 years for an assessment. As highlighted in the report of the independent child death review group (2012; 19), *"in one case a child had to wait over a year to obtain an appointment with a psychologist*." These are highly vulnerable children often with multiple issues. In some instances, the HSE must buy services privately from private practitioners for very vulnerable children, which is costly and inadequate in terms of continuity of care (Minister for Children and Youth Affairs, 2012).

- Of the 421 admissions of children to inpatient mental health services in 2011, 1% represented children in care. Two admissions were of children subject to a Child Care Order S18(1) under the Child Care Act 1991, and one was of a child subject to an Interim Care order S17(1). A child on a full child care order can only be admitted to an approved centre under Section 25 of the Mental Health Act 2001.

- In a recent survey examining mental health training of 97 social workers and social care workers working with looked after children, it was found that 17.4% had no experience in mental health training, 60.9% had some clinical placements, 21.7% had formal mental health education in college. Almost all respondents (97.8%) requested training in specific mental disorders (Mc Nicholas, 2012).

- Child and family social workers require knowledge of child development and attachment in order to assess a child's developmental state, as well as to gain an understanding of the impact of parental problems on children's health and development (Munro, 2011).

## 7. Good Practice Guidance and Standards on addressing the Mental Health Needs of Children in Care in Ireland

- The Department of Health and Children's (2003) Standards for Foster Care Services lay down requirements for foster care services. Some relevant standards are provided as follows:

  - All children in foster care are required to have a social worker (5.1) who draws up their care plan (7.1).

  - The social worker is also required to carry out an assessment of the child which considers the emotional, psychological, medical, educational and other needs of children (Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 6(1) and Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 7(1)) and take account of any previous assessments of the children (6.2).

  - Children undergo a medical and developmental examination on admission to care (11.3).

  - Children are to have prioritised access to medical, psychiatric, psychological, dental, ophthalmic, therapeutic and other specialist services and treatment when required (11.6).

  - Where possible and appropriate, children continue to attend their family GP. Child and family social workers and foster carers share information with GPs to enable appropriate care/ treatment to be provided (11.7 and 11.8).

- The Department of Health and Children also have standards for children in residential centres (DOHC, 2001). Some key standards are as follows:

  - All children in residential centres have an allocated social worker (3.5);

  - All children in residential centres should have a care plan (5.7);

- Individual statutory care plans include an assessment of each young person's educational, social, emotional, behavioural and health requirements and identify how the placement will support and promote the welfare of each young person (5.8);

- Staff are aware of the emotional and psychological needs of young people, and through the key worker role and the general ethos of the centre, facilitate the assessment and meeting of those needs (5.28).

- The external manager arranges for external support to staff to provide for assessments, consultancy and treatment or counselling for individual young people. Child Care (Placement of Children in Residential Care) Regulations,1995, Part III, Article 9.

- All children in care shall have early access to specialist services they may require. Supervising social workers and centre staff should keep a record of attempts to access these services (5.29).

- All young people have access to a GP (9.4).

- The national mental health policy '*A Vision for Change'* (DOHC, 2006) recommends that the primary support for the mental health needs of children in care should be provided by psychological services in community care.

- The new HIQA standards for Child Protection and Welfare (HIQA, 2012) recommend the following:

    - All children accessing HSE Child and Family Services should have a comprehensive assessment which includes an assessment of whether they require the provision of child and adolescent mental health services (Standard 2.5)

    - Staff working with vulnerable children in child and family services should have the necessary skills and knowledge to appropriately deal with children experiencing mental health problems. (standard 5.4).

## Conclusion

The MHC's vision is to "*work together for quality mental health services".* As an organisation we are committed to promoting, encouraging and fostering the development of quality mental health services for all care groups including children at risk and in care. As highlighted in the literature, we believe that creating more integrated services for children should start with engagement and dialogue in order to build close working relationships between all services working with children. We also believe that the needs of all children including children with disabilities should be considered in order to truly integrate children's services. Such measures are likely to lead to more child centred services and better outcomes for young people than purely structural changes.

In respect of mental health service provision, we strongly believe that efforts should be focused by the CFSA on developing robust preventative services and early intervention strategies for mental health problems. This of course needs to take place alongside the further development of comprehensive CAMHS in line with recommendations set out in our national mental health policy (DOHC, 2006). If any changes are to take place in the governance of CAMHS services, the CFSA will need to be mindful of, amongst other things, legislative changes that will be required as outlined in this response. Therefore it is vital that consultation with key stakeholders in mental health services take place. It is hoped that the recommendations contained therein will help pave the way for more effective services to meet the mental health needs of all children, particularly those at risk. The MHC would be happy to engage with the CFSA further on these matters.

# References


Aras an Uachtarain (2012). Young people offer positive vision for Ireland at President's workshop. Available at: http://www.president.ie/young-people-offer-positive-vision-for-ireland-at-presidents-workshop Accessed 28th November 2012.

Bamford Review of Mental Health and Learning Disability (Northern Ireland). (2006). *A Vision of a comprehensive child and adolescent mental health service.*

Child and Adolescent Mental Health Services Review UK (2008). *Children and young people in mind: the final report of the National CAMHS Review*.

Children's Mental Health Coalition (2012). *Submission to the Department of education and Skills in relation to mental health in the education system*.

Children's Mental Health Coalition. (2009). *Manifesto.*

Commission to Inquire into Child Abuse (2009). *Report of the Commission to Inquire into Child Abuse (Ryan Report)*. Available at: http://www.childabusecommission.com/rpt/ExecSummary.php 613. Accessed 19th November 2012.

Department for Education UK (2011) *The Munro Review of Child Protection: Final report. A child-centred system*. Professor Eileen Munro.

Department of Justice & Equality (2012). *The Courts Service Annual report 2011.*

Department of Health and Children (2006). *A Vision for Change. Report of the Expert Group on mental health policy.* Stationery Office, Dublin.

Department of Health and Children (2003). *Standards for Foster Care Services.* Stationery Office, Dublin.

Department of Health and Children (2001a). *Quality and Fairness: A Health System for you.* Stationery Office, Dublin.

Department of Health and Children (2001b). *Primary Care: A New Direction*. Stationery Office, Dublin.

Department of Health and Children (2001c). *National Standards for Children's Residential Centres.* Stationery Office, Dublin.

Department of Health, Social Services and Public Safety NI (2012). *Child and Adolescent Mental Health Services. A Service Model.*

Headstong & UCD (2012). *My World Survey. National Study of Youth Mental Health in Ireland*.

Health Information and Quality authority (2012). *National Standards for the Protection and Welfare of Children.* HIQA, Dublin.

Health Service Executive (2012). *Fourth Annual Child & Adolescent Mental Health Service Report 2011-2012.*

Health Service Executive (2011). *Third Annual Child & Adolescent Mental Health Service Report 2010-2011*.

Health Service Executive (2010). *National Audit of foster Care Services: Final Report.*

Kessler, RC., Berglund, P., Demler, O., Merikangas, K.R. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62(6)*: 593-602.

Knapp, M., Parsonage, M., McDaid, D (eds.) (2011), *Mental health promotion and mental illness prevention: The Economic Case,* London, Department of Health.

Lynch, F., Mills, C., Daly, I., & Fitzpatrick, C. (2005). Challenging times: prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents. *Journal of Adolescence, 29(4)*, 555-73.

McNicholas, F., O'Connor, N., Bandyopadhyay, G., Doyle, P., O' Donovan, A., Belton, M. (2011). Looked after children in Dublin and their mental health needs. *Irish Medical Journal,* 105-108.

McNicholas, F. (2012). *The Mental Health of Children in Care*. Conference Proceedings. The National Mental Healthcare conference. 27th September 2012. Available at [http://www.slideshare.net/Investnet/prof-fiona-mcnicholas]. Accessed 15th November 2012.

Malone, K., Quinlivan, L., Grant, T., & Kelleher, C. C. (2012). Ageing towards 21 as a risk factor for Young Adult Suicide in the UK and Ireland. *Epidemiology and Psychiatric Sciences*, First View Article, November,15.

Martin, M., Carr, A., Burke, L., Carroll, L., & Byrne, S. (2006). *The Clonmel Project: Mental Health Service Needs of Children and Adolescents in the South East of Ireland*. Accessed 28th November 2012 from http://www.lenus.ie/hse/bitstream/10147/44644/1/6159.pdf

Meltzer, H., Corbin, T., Gatward, R., Goodman, R., & Ford, T. (2003). *The mental health of young people looked after by local authorities in England: summary report.* The Office for National Statistics, London.

Mental Health Commission (2012). *Mental Health Commission Annual Report 2011 including the report of the Inspector of Mental Health Services*.

Mental Health Commission (2010). *Headspace toolkit: for young people who are inpatients of mental health services*. MHC, Dublin.

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

Mental Health Commission (2006). *Code of Practice relating to the Admission of Children under the Mental Health Act 2001,* MHC, Dublin.

Ombudsman for Children (2008). *Submission Ombudsman of the Children*. Oireachtas Joint Committee on Health and Children Consultation on Primary Medical Care in the Community.

Richardson, G. & Partridge, I. (2003). *Child and Adolescent Mental Health Services: an Operational Handbook*. Glasgow, The Royal College of Psychiatrists.

Report of the Inquiry Team to the HSE (2010). *Roscommon Child Care Case*.

Shannon, G. & Gibbons, N. (2012). *Independent Report of Child Death Review Group.*

Shannon, G. (2012). *Fifth Report of the Special Rapporteur on Child Protection: A Report Submitted to the Oireachtas*. 2011 Report.

Sullivan, C., Arensman, E., Keeley, S. H., Corcoran, P., & Perry, I. J. (2004). *The National Suicide Research Foundation. Young people's mental health: A report of the findings from the lifestyle and coping survey*. Cited in Headstong & UCD (2012). *My World Survey. National Study of Youth Mental Health in Ireland*.

UN General Assembly (2007), *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*, 24 January 2007.

United Nations (1989) *UN Convention on the Rights of Children*.

UN General Assembly (1991), *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (New York: UN).

United Nations (1966). *International Convention on Economic, Social and Cultural Rights*.

US Department of Health and Human Services (1999). *Mental Health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

World Health Organisation (2005), *WHO Resource book on mental health, human rights and legislation,* Geneva: WHO.