Mental Health Commission publishes Interim Report on Child and Adolescent Mental Health Services

Independent Interim Report authored by the Inspector of Mental Health Services

Monday 23 January 2023: An Interim Report arising from an Independent Review of the Provision of Child and Adolescent Mental Health Services (CAMHS) in the State, has found that children and young people accessing child and mental health services with open cases have been "lost" to follow-up care.

The Interim Report was authored by Dr Susan Finnerty, the Inspector of Mental Health Services, , . The inspector is appointed by the Mental Health Commission (MHC)) and has a statutory role under the Mental Health Acts 2002-2018.

The Interim Report published by the MHC found that in one Community Healthcare Organisation (CHO) alone, there were 140 "lost" cases within the CAMHS team. These children and young adults "lost" within the system did not have an appointment, in some cases for up to two years. These included some who had reached their 18th birthday with no planning, discharge or transition to adult services, or any advice about medication and others who should have had follow-up appointments including for review of prescriptions or monitoring of medication.

The Inspector also found that there was evidence that some teams were not monitoring antipsychotic medication, in accordance with international standards (there are currently no Irish national standards). Consequently, some children were taking medication without appropriate blood tests and physical monitoring, which is essential when on this medication.

The Report also identified significant deficits across many HSE teams and CHOs reviewed to date. These included team members working beyond their contracted hours, often without compensation, to continue to provide a service. There was evidence of stress and burnout in a significant number of team members. The Interim Report found that CAMHS staff worked extremely hard within the often-limited resources to try to provide a good service to the public.

The Inspector decided to produce an Interim Report due to "the serious concerns and consequent risks for some patients" that were found across four out of the five CHOs that have been examined so far so that urgent and targeted action can be taken to address these risks.

Within the Interim Report, the Inspector made two immediate recommendations to the HSE and the Minister for Mental Health -

- An immediate clinical review of all open cases in all CAMHS teams, with particular focus given to identifying and assessing open cases of children who have been lost to follow-up and physical health monitoring of those on medication.

- That the Minister for Mental Health ensures, as a priority, that there is immediate regulation of CAMHS, under the Mental Health Act 2001.

Other key risks identified in the Interim Report included:

- A team attempting to identify an unknown number of cases that had been "lost" to follow-up following a change in staffing.

- A lack of governance in many areas contributing to some inefficient and unsafe CAMHS services, through failure to manage risk, failure to fund and recruit key staff, to look at alternative models of providing services when recruitment becomes difficult, and failure to provide a standardised service across and within CHOs.

In addition, the review also found; long waiting lists, wide variation in acceptance rates, unacceptable variations in care, lack of capacity to provide appropriate therapeutic interventions, absent or poor care planning, lack of emergency CAMHS services and out-of-hours services, staff shortages, dedicated teams with overworked staff that were burnt out and stressed, lack of clinical governance, lack of joint working with other agencies, lack of child-centred care, lack of administrative support, and the lack of ICT systems.

The Inspector has made five escalations of risk to the HSE due to her serious concerns for the wellbeing and safety of children.

The MHC is continuing to monitor the actions taken on foot of these issues being escalated, however as the MHC does not regulate CAMHS Community Services, it has no legal power to enforce any action. Regulating CAMHS, under the Mental Health Acts, as recommended by the Inspector, would provide the MHC with the statutory powers to immediately work with stakeholders and clinical staff to develop standards and rules for the provision of CAMHS Community services in Ireland.

"The Inspector's Interim Report shows clear failings of governance and oversight with no evidence that a national coordinated approach is being taken to caring for children with a mental illness," said John Farrelly, Chief Executive of the Mental Health Commission.

"Our core concern should be for the health and welfare of these children and the priority now for the HSE must be identifying and safeguarding the children "lost" to follow-up. The Inspector of Mental Health Services has advised the HSE to commence an immediate clinical review of all open cases in all CAMHS teams, with particular focus given to identifying and assessing children who have been lost to follow-up and physical health monitoring of those on antipsychotic medication."

Mr Farrelly added "The HSE and the Department of Health have been furnished with the interim report and I can confirm that the CEO of the HSE has committed that the HSE will immediately conduct a review of all open cases. This review, we have been reassured, will include a focus on physical health monitoring of children who are on antipsychotic medication as we have recommended."

The findings in the Interim Report require a national response, rather than a piecemeal ad hoc approach, which is not consistently applied and monitored across each HSE CHO, or CAMHS team.

Following the HSE's report on the Look-back Review into CAMHS in South Kerry by Dr Seán Maskey earlier this year, the Mental Health Commission formally wrote to the Minister for Mental Health and Older People, Mary Butler, to inform her that the Inspector would be conducting an independent review of the provision of CAMHS in the State in accordance with her powers under the Mental Health Acts.

Dr Finnerty had already been scheduled to do this review prior to the publication of Dr Maskey's report to assess whether there had been improvements in CAMHS provision since a similar review was conducted in 2017.

At this stage in the review of the provision of CAMHS, five out of nine Community Healthcare Organisations have been completed. These are CHO 3 (Clare, Limerick, North Tipperary/East Limerick) CHO 4 (Kerry, North Cork, North Lee, South Lee, West Cork) CHO 5 (South Tipperary, Carlow Kilkenny, Waterford, Wexford) CHO 6 (Wicklow, Dun Laoghaire, Dublin Southeast) and CHO 7 (Kildare/West Wicklow, Dublin West, Dublin South City, Dublin Southwest.)

The Inspector's review is continuing with the remaining four CHO CAMHS, and this will involve further meetings with young people, parents, and stakeholders. These areas CHO 1 (Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan) CHO 2 (Galway, Roscommon, Mayo) CHO 8 (Laois/Offaly, Longford/West Meath, Louth/Meath), and CHO 9 (Dublin North, Dublin North Central, Dublin Northwest).

The Inspector's final Report is due for publication later this year.

ENDS

Notes to the Editor

About the Mental Health Commission
The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

The Inspector of Mental Health Services is an independent statutory office appointed by the Mental Health Commission whose independent functions include:

- to visit and inspect every approved centre at least once in each year after the year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate, and

- carry out a review of mental health services in the State and to furnish a report in writing to the Commission on –

I. the quality of care and treatment given to persons in receipt of mental health services,
II. what he or she has ascertained pursuant to any inspections carried out by him or her of approved centres or other premises where mental health services are being provided,
III. the degree and extent of compliance by approved centres with any code of practice prepared by the Commission under section 33 (3)(e), and
IV. such other matters as he or she considers appropriate to report on arising from his or her review.

CAMHS
Child and Adolescent Mental Health Services (CAMHS) provides assessment and treatment for young people up to 18 years of age who experience moderate or severe mental illness. CAMHS treat depression, problems with food and eating, self-harm, attention deficit hyperactivity disorder, psychosis, bipolar disorder, schizophrenia, and anxiety, among other difficulties.

While a broad range of services, including primary care, community disability network teams, Jigsaw, and Tusla, support the mental health of children and adolescents, the term CAMHS is usually applied very specifically to services that provide specialist mental health treatment and care to young people through a multidisciplinary team.

Evidence shows that a substantial proportion of mental health problems in adults originate during childhood and adolescence. Approximately two-thirds of affected adults exhibit signs of a mental disorder earlier in life. This applies to most if not all disorders, including substance use disorders, psychosis, and emotional disorders.

Background to the review:
This independent review of HSE CAMHS commenced in April 2022, following the publication of the Maskey Report (January 26th) of a review by Dr Seán Maskey into the care received by children and young people at South Kerry Child and Adolescent Mental Health Services between July 2016 and April 2021. The Maskey review found that the care received by 240 young people did not meet acceptable standards. Dr Maskey found "unreliable diagnoses, inappropriate prescriptions, poor monitoring of treatment and potential adverse effects" which exposed many children unnecessarily to the risk of significant harm in South Kerry CAMHS. The report also details that significant harm was caused to 46 children and young people, including weight gain; sedation; elevated blood pressure, and galactorrhoea (the production of breast milk).

The Maskey report was confined to South Kerry CAMHS and did not look at CAMHS across the rest of the country. Concerns were expressed publicly and at the Government level whether similar concerns and risks were present in other parts of the country in CAMHS. This review by the Inspector of Mental Health Services looks at the provision of CAMHS since January 2021 across the State, measured against national and international standards.