The College of Psychiatry of Ireland
Coláiste Síciatrachta na hÉireann

The College of Psychiatry of Ireland Response to the Report of the Task force of the Child and Family Agency (CFSA)

4th October 2012

The College welcomes the establishment of the Child and Family Support Agency and would welcome the opportunity to work closely with the agency. Members of many College specialties, and in particular the Faculty of Child and Adolescent Psychiatry, would like to be involved in development discussions & decisions to ensure the mental health services provided to children now and in the future are of the highest standard.

The College supports the recommendations of *A Vision for Change*, including the introduction of programmes addressing health promotion and primary prevention early in life, targeted at child populations at risk. The introduction of services within primary care and community care to provide assessment, monitoring and support services for children who are at risk of mental health difficulties or in need of care and protection, is supported.

The College also supports the need to develop clear links between the mental health services and all primary care /community resources, including the Child and Family Support Agency.

However the College does not agree with the proposal that specialist mental health services should be provided by the CFSA.

In order to ensure all children have a right to the enjoyment of the highest standard of mental health care, the College recommends specialist mental health care remains under the remit of the Department of Health and the services continue to be developed as recommended under *A Vision for Change*. The reasons are as follows:

1. **Role of CAMHs and potential inefficient use of resources:** We consider that the task force group demonstrates a poor understanding of the core business of Child & Adolescent Mental Health Services (CAMHS). CAMHS provides an assessment, diagnostic and treatment service for children and adolescents with severe mental health disorders. As outlined in *A Vision for Change* CAMHS is mandated to see the 2% of children and adolescents who are most mentally unwell in the population. As such, this is a specialist mental health service i.e. a tier three service with Primary Care and Community services as tier one and two. There is a strong evidence base to support this stratification and this ensures the specialist service is used to treat mental health disorders in children and adolescents e.g. depression, Attention Deficit Hyperactivity Disorder, Anxiety Disorders, Tourettes Syndrome, psychotic illness, eating disorders etc.

There is a risk that moving CAMHS into the CFSA will result in specialist staff being used for primary care work, leading to an inefficient use of resources. It is our belief that a more appropriate approach would be to enhance the training of the Child Protection and other primary services at undergraduate level i.e. the College curriculum, and at postgraduate level. The need for training of both social work practitioners and supervisors was clearly identified in the Roscommon Report.

2. **Misalignment with other government policy:** The move is not in line with other government policies in relation to CAMHS and mental health e.g. *A Vision for Change*, the Clinical Programmes in Mental Health and the Mental Health Act 2001, all of which emphasise seamless care from the cradle to the grave through the mental health services.

3. **Unitary governance of mental health:** It is planned that the governance of all mental health would be unitary i.e. under a mental health directorate which we understand would be rolled out shortly with the other proposed directorates. We are at a loss to understand as to how moving one arm of mental health away from this proposed mental health directorate into the CFSA would improve services for children and families.

4. **Detrimental effect for children with mental health difficulties:** CAMHS is a specialist medical service for disorders of childhood with multidisciplinary input. It is no different from other medical specialities as is recognised by the Medical Council. It is difficult to understand the rationale for moving Child Psychiatry into the CFSA while leaving paediatrics as a medical speciality and education and juvenile justice out of this agency. Historically, Child Psychiatry has strong linkages with paediatrics, neurology, accident & emergency departments, intellectual disability, adult mental health and of course our GP colleagues. A move to the Child & Family Support Agency would isolate Child Mental Health Services from these linkages and be detrimental for children with mental health difficulties.

5. **Effect on training standards & necessary experience to support children with mental health difficulties:** The current system of training of psychiatrists, nurses, and other members of the multidisciplinary team, relies on ensuring the professionals develop expertise in managing severe mental illness, while at the same time gaining an understanding of the requirements under tier one and two of the system. If Child Psychiatry is moved into the Child & Family Support Agency and we are expected to carry out tier one and tier two work, i.e. attachment work, life story work, preventative and parental training, it is likely that this will jeopardise the training of Junior Hospital Doctors to become Consultants. Consequently they would not receive the experience in severe mental health disorders in a community setting, training would not be ratified, and standards would deteriorate. This would worsen the service available to those with severe mental illness **and ultimately their recovery**.

6. **Enhance mental health support & service already in place for children in Social Services:** We wish it to be noted that a substantial proportion of our work already takes place with children known to Social Services and children in the care of the HSE. About 10% of children referred to CAMHS have involvement with social services. However about 16,000 children and adolescents attend mental health services while 6,000 are in care. It is difficult to understand the rationale for moving children in receipt of mental health services and their provider, CAMHS, into a completely new structure based on the

premise that children in care have been failed. While we acknowledge that in some respects and areas the interface between Child Psychiatry and Social Services is less than ideal, nevertheless a lot of good work is undertaken by CAMHS in relation to children in the care of the HSE. It is our belief that good working models should be studied and replicated rather than a whole new model put in place. The solution to problems and challenges of the children in the care of the HSE and known to Social Services are not solely in the realm of CAMHS. Many are in the realm of Community Care Social Work training and wider community resources, for example secure home placements, respite, specialised interventions, foster care, attachment therapies etc.

7. **Current deficiencies not due to existing model of care:** It is unclear what, if any, alternative model for provision of mental health services would be developed if CAMHS were to move into the CSFA. Rather there seems to be an expectation that by their very proximity CAMHS and social work would function better. There are very obvious examples in many areas of government policy where structural change has not led to any real improvement in the consumer's experience of the service provided. Introducing a destabilising paradigm in an already unstable environment, rather than addressing difficulties and strengthening the existing arrangements seems foolhardy. The deficiencies in the service are directly attributable to lack of adequate funding. Only two thirds of the CAMHS teams recommended under *A Vision for Change* are in place, and only half of the recommended bed capacity is in place.

8. **Similar move in the UK unsuccessful:** Our understanding is that the experience of transferring CAMHS in the UK and elsewhere to a tier one service has not been successful and has ultimately been reversed. It would be tragic if mistakes are repeated, especially in times of financial constraint and also given that CAMHS is well regarded nationally and is indeed often lauded as a model service in terms of its productivity and has statistical support for this.

9. **Quality of outcomes for recovery will be compromised:** While there is no doubt that some children in care have been failed by the State and lessons need to be learned from this, it is our belief that moving CAMHS into the CFSA will not achieve this. Instead it will result in a reduction in the quality and quantity of specialised therapeutic services necessary to deal with the 2% of the population that are very vulnerable and in need of specialised complex multidisciplinary treatment, including the 16,000 who are already attending CAMHS services. In addition, this move will not affect improvement in the outcomes and quality of life for children in care as many of their needs are for secure home placements, specialised foster care, attachment therapies, respite care etc, all of which are outside the remit of specialist mental health teams.

A Vision for Change recommends a multidisciplinary care plan approach to these patients. The idea that children and adolescents without mental health disorders could be referred directly into a CAMHS team thereby reducing the available multidisciplinary input to this severely unwell group would further disadvantage them.

Summary

- The core business of CAMHS is to provide an assessment diagnostic and treatment service for children and adolescents with severe mental health disorder i.e. 2% of children and adolescents who are the most mentally unwell in the population.
- CAMHS is a specialised mental health service i.e. a tier three service and there is strong evidence to support our treatment protocols for depression, Attention Deficit Hyperactivity Disorder, Anxiety Disorders, Tourettes Syndrome, psychotic illness, eating disorders etc.
- The multidisciplinary nature of CAMHS teams, with strong medical leadership, has been shown to be the most effective means of delivering a quality service.
- CAMHS teams have built up strong linkages with adult mental health, paediatrics, neurology, intellectual disability and Primary Care. Moving Child Psychiatry into the CFSA is akin to moving a cardiologist and his team into a GP practice. The role of the latter would encompass providing education about not smoking, proper diet and exercise rather than cardiac surgery and procedures that would be needed. The solution in that case would be to up-skill the GP, the practice nurse and other community professionals to deal with the preventative aspect.

We therefore cannot support or agree with the recommendation that Child Psychiatry move to CFSA.

We do so in the interest of the children and the families we serve.

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Faculty of Child and Adolescent Psychiatry

and

Dr Anthony McCarthy
President