Child and Adolescent Mental Health Services

Operational Guideline

Second Edition

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Child and Adolescent
Mental Health Services

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November 2019

Contents

Foreword

In the HSE, our vision for mental health services is to support the population to achieve their optimal mental health. We seek to achieve this through the following key strategic priorities:

- Ensuring that the views of service users, family members and carers are central to the design and delivery of mental health services
- Designing integrated, evidence-based and recovery-focused mental health services
- Delivering timely, clinically effective, standardised and safe mental health services that adhere to statutory requirements
- Promoting the mental health of our population in collaboration with other services and agencies including reducing loss of life by suicide
- Enabling the provision of mental health services by highly trained and engaged staff and fit for purpose infrastructure.

HSE mental health services are committed to the continued development of quality mental health services for children and adolescents. In keeping with this commitment we are pleased to publish this HSE Child and Adolescent Mental Health (CAMHS) Operational Guideline 2019. This Operational Guideline is based on the dedicated and consistent work of the staff of the mental health services and has been developed to provide consistency and transparency in how HSE CAMHS are delivered throughout the country. CAMHS are specialist mental health services for those aged up to 18 years, who have reached the threshold for a diagnosis of moderate to severe mental health disorders who require the input of a multi-disciplinary mental health team (approximately 2% of the population). We continue to seek to maximise the use of available resources to respond to the priority mental health needs of children and adolescents.

The HSE published the CAMHS SOP in 2015. This Operational Guideline is published following an extensive review and consultation process of that document to take into consideration the views of service users, family members, front line staff and management working within HSE mental

health services and in other organisations working with children and adolescents. As a result, there has been a significant number of changes made to the 2015 document to reflect the feedback received and this has been re-drafted as a new CAMHS Operational Guideline.

David Walsh

National Director, Community Operations

Figure 1: CAMHS Infographics – December 2018

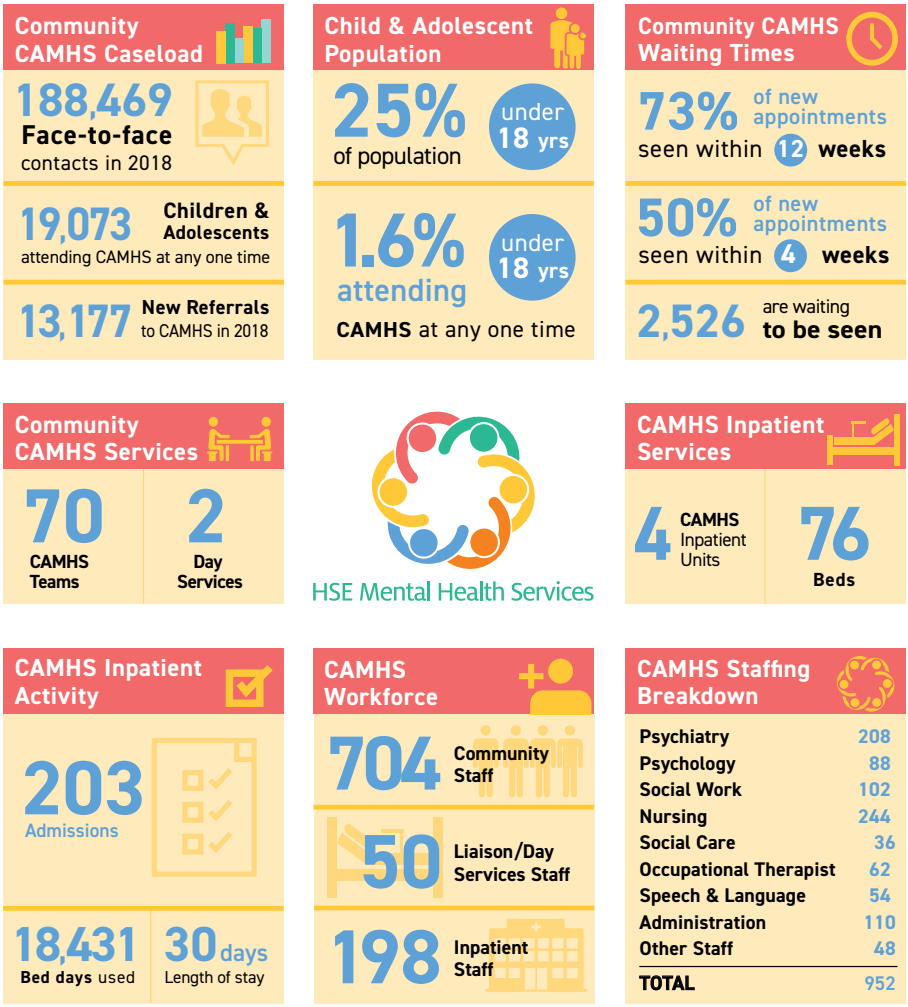
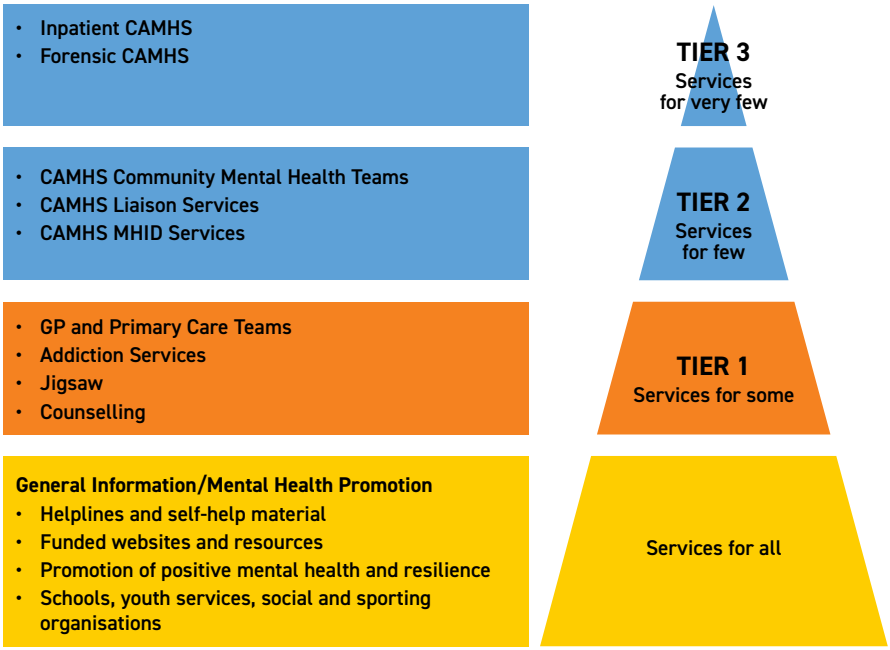


Figure 2: CAMHS within the Tiers of Mental Health Care



Note: Tiered Services enable services to be progressively tailored to the needs of the individual.

1

Guideline Structure

1.0 Health Service Executive Child and Adolescent Mental Health Services

Health Service Executive (HSE) Child and Adolescent Mental Health Services (CAMHS) provide mental health services to those up to the age of 18 years, who have moderate to severe mental disorders[1] that require the input of a multi-disciplinary team. These services are often referred to as CAMHS.

1.1 Guideline Statement

A guideline is a statement which guides or directs a certain course of action. It aims to streamline particular processes according to best practice. This Operational Guideline has been issued by the HSE to assist employees in having a consistent approach to delivering CAMHS nationally (*HSE PPPG Framework, 2016*).

1.2 Purpose

The purpose of the HSE CAMHS Operational Guideline is to provide consistency in the service delivery of CAMHS throughout the country. This Operational Guideline aims to:

- Build on the existing good practice already in place in CAMHS.
- Provide an Operational Guideline that CAMHS teams can adhere to.
- Ensure that legislative and regulatory requirements are met.
- Ensure that all employees and management are clear on their roles and responsibilities.
- Ensure that children, adolescents and their parent(s) (ref Glossary) are clear on the service provided by CAMHS.
- Ensure that referral agents and other agencies involved in the provision of care to children and adolescents are clear on the service provided by CAMHS.
- Provide a framework for audit and evaluation.

[1] For the purposes of this document, the World Health Organisation definition of mental disorder is used to cover both community and inpatient CAMHS. Ref glossary definitions in Section 7.

1.3 Scope

1.3.1 This Operational Guideline applies to all staff engaged in the delivery of CAMHS by, or on behalf of, the HSE in Community and Inpatient settings.

1.3.2 This Operational Guideline is available to partner agencies, stakeholders, children and adolescents and their parent(s).

1.3.3 The scope of this Operational Guideline is limited to guidance on the day-to-day operations in CAMHS. This is not a clinical guideline and therefore it does not provide direction in relation to clinical decision making. This is more appropriately covered by CAMHS staff members' clinical knowledge base and by professional, representative and regulatory bodies.

1.3.4 This Operational Guideline does not override the individual responsibility of CAMHS staff to make decisions appropriate to the circumstances of individual children and adolescents in consultation with their parent(s).

1.3.5 This Operational Guideline provides a summary overview of the process of referral, assessment, care planning, treatment and discharge in CAMHS. This is not to be viewed as a replacement for existing policies or legislation outlined in Section 1.4 below.

1.4 Legislation/Other Related Policies

This Operational Guideline should be read in conjunction with the legislation and policy in this Section. This is not an exhaustive list.

- *Advancing Recovery in Ireland: A guidance paper on implementing organisational and cultural change in mental health services in Ireland*
- *Child Care Act 1991*
- *Children First Act 2015*
- *Tusla Child Protection Handbook 2*
- *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012*
- *Data Protection Act 2018*

- *General Data Protection Regulation 2016/679*
- *Better Outcomes, Brighter Futures: The National Policy Framework for Children & Young People 2014-2020*
- *National Youth Strategy 2015-2020*
- *Children First: National Guidance for the Protection and Welfare of Children*
- *LGBTI+ National Youth Strategy 2018-2020*
- *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015*
- *Healthy Ireland: A Framework for Improved Health and Wellbeing*
- *Reducing Harm, Supporting Recovery: A health-led response to drugs and alcohol use in Ireland 2017-2025*
- *National Traveller and Roma Inclusion Strategy 2017-2021*
- *Disability Act 2005*
- *A Vision for Change 2006*
- *Open Disclosure National Policy 2019*
- *Child Protection and Welfare Policy 2016*
- *Report on the Listening Meetings*
- *Best Practice Guidance for Mental Health Services*
- *A National Framework for Recovery in Mental Health*
- *Your Service Your Say*
- *Data Protection Policy 2018*
- *Family, Carer and Supporter Guide*
- *HSE Privacy Notice – Patients and Service Users*
- *HSE National Service Plan*
- *Eating Disorders Services HSE Model of Care for Ireland*
- *National Consent Policy 2019*
- *Self-Harm and Young People: An Information Booklet for Parents and Concerned Adults*
- *Report of the Quality and Safety Clinical Governance Development Initiative: Sharing our learning*
- *HSE Integrated Risk Management Policy*
- *Mental Health Act 2001 (Approved Centres) Regulations 2006*

- *Mental Health Act 2001 (Authorised Officer) Regulations 2006*
- *Mental Health Act 2001 (Involuntary Admission of Children)*
- *Code of Practice relating to Admission of Children under the Mental Health Act*
- *Judgement Support Framework (JSF)*
- *National Vetting Bureau (Children and Vulnerable Persons) Act 2012*
- *Joint Protocol for Interagency Collaboration between the HSE and Tusla – the Child and Family Agency, to promote the Best Interests of Children and Families*
- *The United Nations Convention of the Rights of the Child*
- *Section 25 Policy for Involuntary Admission of a Child*

1.5 Roles and Responsibilities

1.5.1 Director General: The Director General of the HSE has overall responsibility for establishing governance arrangements for the purposes of implementing this Operational Guideline.

1.5.2 National Director, Community Operations: The National Director, Community Operations has overall responsibility for national oversight concerning the implementation, compliance and operation of this Operational Guideline.

1.5.3 Community Healthcare Organisation (CHO) Management Team: The CHO Management Team has overall responsibility for ensuring that arrangements exist for:

- The ongoing monitoring of CAMHS teams' activity and adherence to this Operational Guideline.
- Providing the resources necessary for implementing and monitoring this Operational Guideline, subject to the resources available to them.

1.5.4 Local Area Mental Health Management Teams: The Local Area Mental Health Management Teams have responsibility for:

- Familiarising themselves with this Operational Guideline and how it applies in practice.
- Applying the best use of available resources for the implementation of this Operational Guideline.

- Ensuring that appropriate systems are in place to communicate this Operational Guideline to all employees, service users, parent(s) and other services and stakeholders directly affected by it.
- Ensuring this Operational Guideline is integrated into local policies and procedures, protocols and guidelines.

1.5.5 All CAMHS Employees: All CAMHS employees have responsibility for:

- Familiarising themselves and adhering to the content of this Operational Guideline.
- Seeking to ensure that the best interests of children, adolescents and their parent(s) are at the centre of all decisions made by CAMHS.

1.6 Implementation

1.6.1 The Chief Officer in each CHO must oversee the implementation of this Operational Guideline and report any difficulties encountered to the National Director, Community Operations.

1.6.2 An implementation plan, which reflects the local context, may be developed to guide and support services to implement this Operational Guideline in each CHO.

1.6.3 Training supports will be provided to all CAMHS employees to provide guidance and support in implementing this Operational Guideline.

1.7 Revision

In line with the *HSE National Framework for developing Policies Procedures, Protocols and Guidelines, 2016*, this Operational Guideline will be reviewed three years following its publication or sooner if there is a change in legislation or best practice.

1.8 Self-Assessment

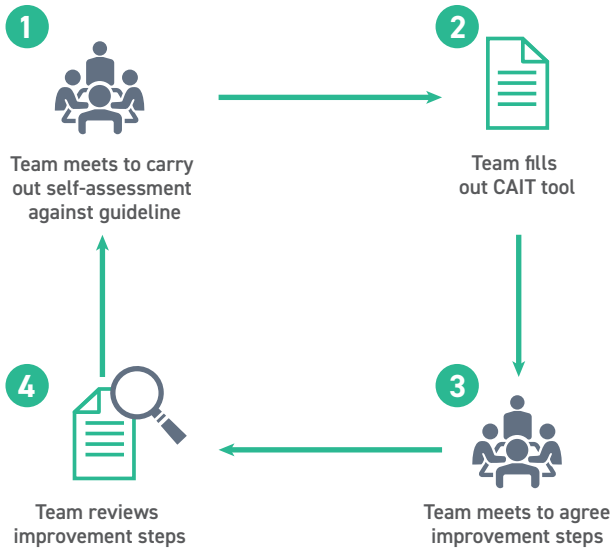
1.8.1 A Self-Assessment Tool has been developed to allow CAMHS teams to assess the service they deliver against this Operational Guideline. (See Appendix 3.10 for Community CAMHS and Appendix 3.11 for Inpatient CAMHS.)

1.8.2 Self-assessment contributes to continuous improvement by providing a structured opportunity to assess performance and identify improvements required for the CAMHS team.

1.8.3 Self-assessment against this Operational Guideline can be completed when the CAMHS team is engaging in the self-assessment process against the *HSE Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement, 2017*.

1.8.4 The CAMHS Assessment Improvement Tool (CAIT) can be used to record the self-assessment. This is a web-enabled tool which supports the development and implementation of quality improvement plans to address gaps identified during the assessment process.

Figure 3: Self-Assessment Process Flowchart



2

Principles and Values Guiding this Operational Guideline

2.0 Principles and Values

2.1 Recovery

2.1.1 A *National Framework for Recovery in Mental Health Services, 2018-2020* seeks to ensure that HSE Mental Health Services become more recovery-oriented.

2.1.2 Recovery means different things to different people. For most people it means being able to live their best life even with a mental disorder.

2.1.3 Adopting a recovery-oriented approach in CAMHS is about supporting children and adolescents and their parent(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.

2.1.4 HSE National Advancing Recovery Ireland (ARI) has established a working group to explore how the recovery process fits with CAMHS and to identify any adaptations that would support embedding recovery within the context of CAMHS.

2.2 Involving Children and Adolescents

2.2.1 Involving children and adolescents in their care is at the core of a recovery-oriented service and has many therapeutic advantages.

2.2.2 CAMHS teams should seek to ensure that children and adolescents are involved in all decisions which affect them, and that their views will be given due weight in accordance with their age and maturity (*Article 12 of the United Nations Convention on the Rights of the Child (UNCRC), 1990*).

2.2.3 Children and adolescents should be able to work with their CAMHS teams to achieve goals and outcomes that are important to them.

2.2.4 Children and adolescents should be empowered to participate meaningfully in the design, implementation, delivery and evaluation of mental health services.

2.2.5 Participation can be facilitated through the development of advocacy groups as well as in their day-to-day care. Examples of good practice already in place throughout the country include actively seeking feedback, ensuring communications are in plain English, placing suggestion boxes in the community CAMHS waiting areas and inpatient units, producing satisfaction surveys and conducting focus groups on specific topics. CAMHS teams should use the information gathered in these ways to continuously improve their service.

2.2.6 Children and adolescents are the recipients of the service and therefore have a unique perspective and knowledge of where mental health services are working well or where they need to be improved.

2.2.7 There is a range of user-friendly, free-to-access digital resources which can complement mental health service delivery such as information-based websites and mobile apps. Visit CAMHS videos - https://www2.hse.ie/wellbeing/mental-health/child-and-adolescent-mental-health-services/introduction-to-camhs.html. Consideration should be given to directing children, adolescents and family members towards the resources highlighted on the HSE's www.yourmentalhealth.ie website, e.g. by referencing the site on referral or appointment letters.

2.2.8 Where there is an advocacy service available to the children and families using the service, this should be highlighted to them at as early a stage in their treatment as possible, and the contact details supplied.

2.3 Involving Parent(s)

2.3.1 CAMHS teams should aim to build and maintain collaborative relationships with parent(s) and seek to involve them fully in their child or adolescent's care planning and mental health treatments. Parent(s) often have expert knowledge of their child or adolescent which is important in deciding on treatment and care planning.

2.3.2 CAMHS teams may inform and explain to parent(s) about their child or adolescent's diagnoses, coping strategies and may advise on how to support them at home. They may recommend other community and family support services which can be accessed outside of appointments.

2.3.3 CAMHS teams should encourage parent(s) to recognise their own needs, strengths and resources in supporting their child or adolescent.

2.3.4 CAMHS teams should also be mindful of addressing barriers to engagement, and seek to ensure that services are culturally responsive and designed to fit the family's needs and preferences.

2.3.5 Parent(s) should be encouraged to take part in Engagement Forum meetings, organised through local mental health services or the office of HSE Mental Health Engagement and Recovery. More details can be found on www.hse.ie/mentalhealthengagement.

2.3.6 In an inpatient setting, parent(s) and families should be encouraged to visit regularly and there should be dedicated visiting space for families.

3

Clinical Governance and Children First

3.0 Clinical Governance Structures in HSE Mental Health Services

Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of service users when delivering care.

- Clinical governance involves having the necessary structures, processes, standards, and oversight in place to ensure that safe, person-centred and effective services are delivered.

3.1 Clinical Governance in Community Healthcare Organisations

3.1.1 The Chief Officer in each CHO devolves day-to-day operational management responsibilities for Mental Health Services, including CAMHS, to the CHO Mental Health Management Teams.

3.1.2 In each CHO, the Chief Officer works in partnership with the Head of Service – Mental Health, the Executive Clinical Director/Clinical Director, the Director of Nursing, and the Health and Social Care Professional Leads to ensure that clinical governance structures are in place. This means that clear lines of accountability, responsibility and authority to oversee quality and safety are identified within the service.

3.2 Clinical Governance in CAMHS Teams

3.2.1 Each CAMHS team has clear accountability structures in place to achieve the delivery of high-quality, safe and reliable services (*Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement, 2017*), and all staff should be informed of this as part of their induction process.

3.2.2 There is a clear management structure which includes corporate and clinical governance responsibilities and reporting relationships.

3.2.3 The Consultant Psychiatrist is the Clinical Lead on the team. Each member of the CAMHS team also has a professional and management reporting relationship through their discipline-specific line management structure.

3.2.4 Each member of a CAMHS team has the professional responsibility to carry out clinical work with children and adolescents within their scope of practice, as defined by their professional and regulatory bodies such as the Medical Council, the Health and Social Care Professionals Council (CORU), the Nursing and Midwifery Board of Ireland (NMBI) and the Psychological Society of Ireland (PSI).

3.2.5 Each individual CAMHS team member knows their responsibility, level of authority and to whom they are accountable.

3.2.6 Each individual CAMHS team member seeks to demonstrate how the principles of quality and safety can be applied in their diverse practice to pursue improved outcomes for children and adolescents and their families. This is best achieved in a culture of trust, openness, respect and caring.

3.2.7 Clinical governance is covered in detail in the HSE publication, *An Initiative of the Quality and Patient Safety Division: Sharing our Learning, 2014*.

3.3 Children First

3.3.1 The Children First Guidance (*Children First: National Guidance for the Protection and Welfare of Children, 2017*) promotes the protection of children from abuse and neglect. It sets out the definitions of abuse, how to recognise it, and explains how reports should be made to Tusla – The Child and Family Agency.

3.3.2 All CAMHS staff are obliged to complete the Children First e-learning module (*Tusla*) *Introduction to Children First* through HSELanD and any other child safeguarding trainings as required by their role.

3.3.3 CAMHS staff, who are mandated persons (ref Glossary), can be asked by Tusla to provide "such information and assistance as it may reasonably require and is, in the opinion of the Agency, necessary and proportionate in all of the circumstances of the case". This assistance will aid Tusla in assessing if a child who is the subject of a mandated report (or any other child), has been, is being or is at risk of being harmed.

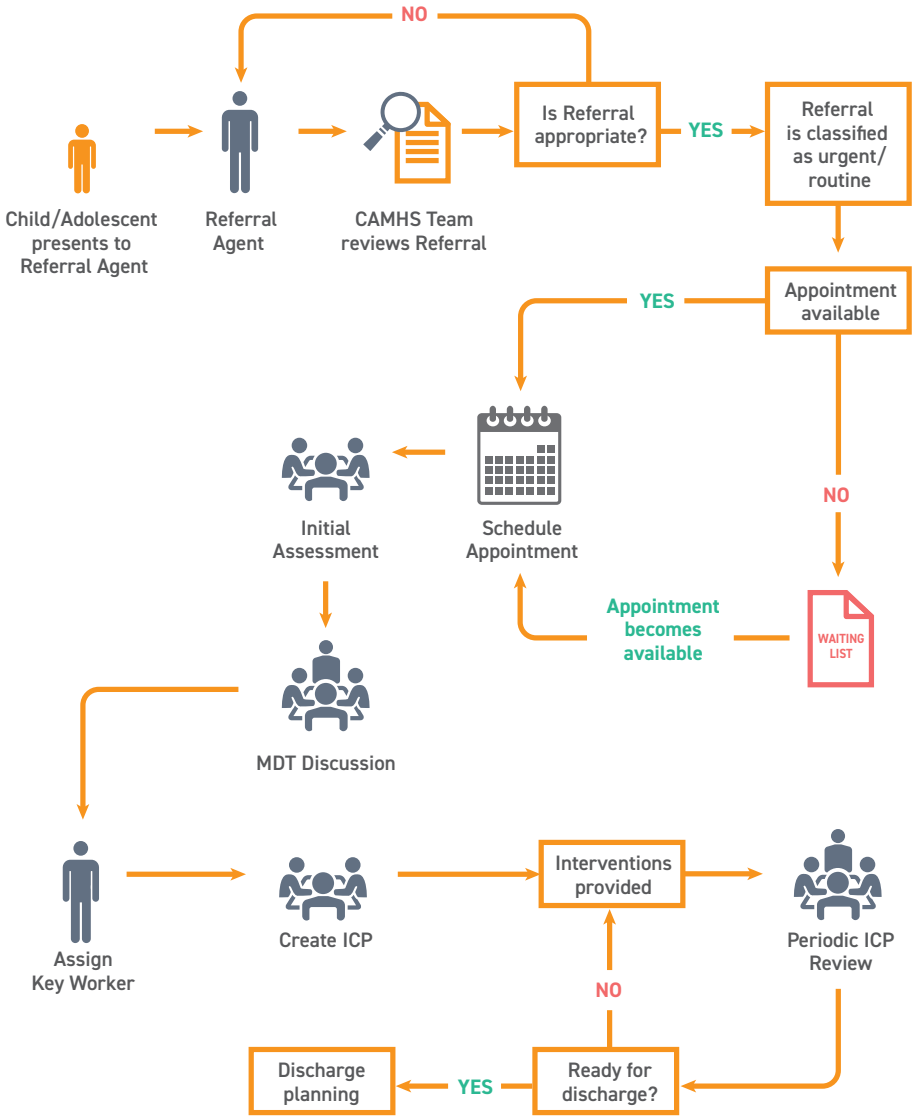
3.3.4 Assistance may include the provision of verbal or written information or reports and attendance at meetings arranged by Tusla. Extensive information and training on Children First can be found on the Tusla website (www.tusla.ie).

4

Community Child and Adolescent Mental Health Services

Figure 4: Journey through Community CAMHS

Referral and Clinical Pathway: CAMHS Community Team



Note: Continue to assess at every stage whether CAMHS is the right service for the child or adolescent.

1. Child/adolescent presents to Referral Agent.
2. Referral Agent completes Referral Form (see Appendix 3.1) and sends to relevant CAMHS Team.
3. CAMHS Referral is reviewed by CAMHS team.
4. Decision is made regarding whether CAMHS is the right service for the child or adolescent.
5. If referral is deemed inappropriate, it is returned to the Referral Agent.
6. If CAMHS is deemed the right service for the child or adolescent, the referral is classified as either urgent or routine.
7. If appointment is available, it is scheduled based on level of urgency.
8. If appointment is not available, the child or adolescent is added to the waiting list until an appointment becomes available at which point an appointment is scheduled.
9. An Initial Assessment is carried out by CAMHS team.
10. Multi-disciplinary Team (MDT) discussion takes place following the Initial Assessment.
11. A Key Worker is assigned following MDT discussion.
12. An Individual Care Plan (ICP) is developed in collaboration with the child or adolescent, the parent(s) and the CAMHS team.
13. Interventions are provided according to the ICP.
14. Regular periodic reviews of the ICP are carried out.
15. On review, if the child or adolescent is deemed ready for discharge, discharge planning is initiated.
16. On review, if the child or adolescent is not deemed ready for discharge, further interventions are provided.

4.0 Community CAMHS

CAMHS provide mental health services to those aged up to 18 years, who have moderate to severe mental disorders that require the input of a multi-disciplinary mental health team.

- Community CAMHS refers to child and adolescent mental health services that are delivered in outpatient and day hospital settings. The vast majority of CAMHS interventions are delivered in the community, close to people's homes.
- The assessments and interventions provided by CAMHS teams depend on the severity and complexity of a child or adolescent's presentation. These assessments and interventions are carried out in partnership with the child or adolescent and their parent(s).

4.1 Community CAMHS Aims

The aim of Community CAMHS is:

4.1.1 To provide clinical assessment, formulation, diagnosis and multi-disciplinary interventions to children and adolescents based on their identified needs.

4.1.2 To provide advice, information and support to parent(s). This will assist them to positively support children and adolescents with moderate to severe mental disorders at home.

4.1.3 To provide advice and consultation to referral agents. This aims to enhance their understanding of the role of CAMHS and its referral thresholds to ensure that children and adolescents can access help within the right setting.

4.1.4 To implement the Recovery Approach as outlined in the HSE *A National Framework for Recovery in Mental Health Services 2018-2020*.

4.2 Referral and Access

4.2.1 When deciding if a child or adolescent needs to attend CAMHS, a number of factors are considered by the CAMHS team. These include consideration of the child or adolescent's clinical presentation, their level of social and family support and the availability of resources and treatment options at primary care level or within community networks.

4.2.2 It is the role of the CAMHS team to decide if the child or adolescent reaches the threshold for community CAMHS, i.e. whether their mental disorder is moderate to severe.

4.2.3 Moderate to Severe Mental Disorders

- Mental disorders are often described on a continuum of severity, ranging from mild to moderate to severe. A number of factors are taken into account when defining whether someone has a moderate to severe mental disorder and these include the diagnosis, formulation, the duration of the symptoms and level of functioning in daily living.
- In practice the term *moderate to severe* means that the mental disorder is severe enough to cause substantial distress to the child or their family or others. The child or adolescent would have a significant impairment in functioning in various aspects of their life including development, family relationships, school, peers, self-care and play or leisure activities.

4.3 Referral Criteria

Children or adolescents referred to community CAMHS must fulfil the following criteria:

4.3.1 The child or adolescent is under 18 years old.

4.3.2 Consent for the referral has been obtained from the parent(s).

4.3.3 The child or adolescent presents with a suspected moderate to severe mental disorder.

4.3.4 Comprehensive treatment at primary care level has been unsuccessful or was not appropriate in the first instance.

4.4 Types of Referrals Suitable for CAMHS

The list below gives some guidance on what constitutes a moderate to severe mental disorder. As this is an Operational Guideline and not a clinical guideline it is not an exhaustive list. It is also important to note that not all children and adolescents will fit neatly into a diagnostic category:

- Moderate to severe Anxiety disorders.
- Moderate to severe Attention Deficit Hyperactive Disorder/ Attention Deficit Disorder (ADHD/ADD).
- Moderate to severe Depression.
- Bipolar Affective Disorder.
- Psychosis.
- Moderate to severe Eating Disorder.
- Suicidal ideation in the context of a mental disorder.

4.5 Types of Referrals Not Suitable for CAMHS

4.5.1 CAMHS is not suitable for children or adolescents whose difficulties primarily are related to learning problems, social problems, behavioural problems or mild mental health problems.

4.5.2 There are many services available to respond to these needs for children and adolescents, e.g. HSE Primary Care Services, HSE Disability Services, Tusla – The Child and Family Agency, Jigsaw, National Educational Psychology Services (NEPS) and local Family Resource Centres.

4.5.3 CAMHS does not accept the following children or adolescents where there is **no evidence of a moderate to severe mental disorder present**:

- Those with an intellectual disability. Their diagnostic and support needs are best met in HSE Social Care/HSE Disability Services. However those children or adolescents with a mild intellectual disability with moderate to severe mental disorder are appropriate to be seen by CAMHS.
- Those with a moderate to severe intellectual disability and moderate to severe mental disorder. Their needs are best met by CAMHS Mental Health Intellectual Disability (MHID) teams, if present.

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. Refer to Shared Care arrangements in Section 4.6.

- Those whose presentation is 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.
- Those 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).
- Those 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.
- Those who have a 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, it is the role of CAMHS to provide appropriate multi-disciplinary mental health assessment and treatment for the mental disorder. This may involve joint working or shared care with other agencies including HSE Primary Care, Children's Disability Network Teams, and other agencies supporting children and adolescents.

4.6 Joint Working and Shared Care

4.6.1 There are some children and adolescents who may present with complex needs and a moderate to severe mental disorder at the same time.

4.6.2 Where the child or adolescent presents with a moderate to severe mental disorder, it is the role of CAMHS to provide appropriate multi-disciplinary mental health assessment and treatment for the mental disorder. This may involve joint working or shared care with other agencies, including HSE Primary Care, Children's Disability Network Teams and other agencies supporting children and adolescents.

4.6.3 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.

4.6.4 Prior to sharing information and communicating with other services, CAMHS Teams should obtain consent and comply with local and national policies, procedures, protocols and guidelines including the 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*. (See Appendix 3.9).

4.6.5 Services need to agree on the roles and responsibilities of each service in supporting the child or adolescent including which service has lead responsibility for coordination of care.

4.6.6 It is in the best interests of children and adolescents for CAMHS to work in partnership with other agencies and groups who have a role in supporting children and adolescents' well-being, health and emotional development. These may include schools, community groups and other statutory agencies.

4.7 Referral Agents to CAMHS

Approved referral agents to CAMHS are listed below. All these referral agents must work in collaboration* with the child or adolescent's General Practitioner (GP) to ensure continuity of care.

- The GP**
- Paediatricians (informing the GP)
- Consultant Psychiatrists (informing the GP)
- Emergency Department (ED) doctors in conjunction with the ED Consultant (informing the GP)

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* *In collaboration with the GP means the referral agent must ring the GP and discuss and agree the potential referral so it is a truly collaborative referral. Best practice would suggest that a physical health assessment is completed by the relevant medical practitioner (usually the child or adolescent's GP) and the details of this assessment are included in the referral.*

** GPs are usually the first point of contact for families. Therefore they are ideally placed to recognise risk factors for mental disorder and refer to specialist services such as CAMHS.

- Community-based clinicians (at senior/team leader level or above, in collaboration with the GP*)
- Tusla – The Child and Family Agency (team leader level or above in collaboration with the GP*)
- Assessment Officers, as defined under the Disability Act 2005 (in collaboration with the GP*)
- Jigsaw (senior clinician in collaboration with the GP*)
- Community Medical Doctors (informing the GP)
- National Educational Psychologists (senior – in collaboration with the GP*)

4.8 Clinical Information required for Referrals

Clinical information required regarding the child or adolescent includes:

- Indication of when the child or adolescent was last seen by the referral agent.
- Full description of presenting problem(s) and how they have developed.
- Description of their presentation and/or mental state.
- Development and current functioning.
- Family composition and history.
- Presence of risk and/or resilience factors and evidence of urgency.
- Details of any other professionals or agencies involved.
- Medical and psychiatric history of the child or adolescent and their family.
- Outline of educational/occupational experience.
- Child or adolescent's view of their current situation.
- Parental view of current situation.
- Consent by parent(s).

Referrals should be submitted on the Community CAMHS Referral Form to facilitate a timely response. (See Appendix 3.1).

4.9 Process following receipt of Referral by CAMHS

4.9.1 When a referral is received from the list of approved referral agents (see Section 4.7), it is screened by a member of the CAMHS team, such as the Team Coordinator, in consultation with the Consultant Psychiatrist.

4.9.2 Referrals are screened daily during working hours (Monday to Friday 9.00 a.m. to 5.00 p.m.)

4.9.3 All new referrals are discussed at a weekly team meeting.

4.9.4 If the referral form does not include adequate information, the CAMHS team may contact the referral agents and other relevant contacts such as parent(s), schools and HSE Primary Care services to ask for additional information. This information can be used to best inform levels of risk, need and functioning in different settings. Consent must be obtained from the parent(s) prior to contacting other agencies.

4.9.5 When a referral has been screened, it is then categorised into:

- Emergency
- Urgent
- Routine
- Not appropriate for CAMHS

4.10 Referral Response Times

4.10.1 Community CAMHS teams will provide a timely response to all referrals received, dependent on their categorisation of emergency, urgent, routine or not appropriate for CAMHS.

4.10.2 A response means that contact is made with the referral agent and parent(s) by a clinician on the team, in consultation with the Consultant Psychiatrist.

4.10.3 The contact should seek to provide information to the referral agent or parent(s) so that they understand the status of the referral and any steps they need to take prior to the first appointment.

4.10.4 Emergency Referrals

- During office hours CAMHS Community Teams operate from Monday to Friday 9.00 a.m. to 5.00 p.m.
- CAMHS Community Teams can be contacted during these hours to discuss emergency referrals in consultation with

the Consultant Psychiatrist. They can provide advice and consultation when the emergency or crisis is due to a diagnosed or suspected mental disorder.

- Outside of these hours, or in an emergency situation where no Community CAMHS Team is available, it is advised that the emergency services are contacted or that the child or adolescent is brought to the Emergency Department of the nearest hospital to access a mental health assessment.
- In many areas of the country a Consultant Child and Adolescent Psychiatrist is on call 24 hours and can be contacted by the Accident and Emergency services if required.
- Where this is not currently available a child and adolescent can access a mental health assessment through the Emergency Department and be referred, if required, as priority to the Community Team on the next working day.

4.10.5 Urgent Referrals

- An urgent referral is one where there is a clear and present level of acute symptoms of mental disorder and where there is a strong likelihood of considerable deterioration in mental state if left untreated.
- Urgent referrals should be responded to within three working days of receipt of referral and seen as soon as possible based on clinical risk.
- CAMHS teams need to have a mechanism to respond to urgent referrals on a daily basis within working hours (Monday to Friday 9.00 a.m. to 5.00 p.m.) This can be done, for example, by the Team Coordinator or the Consultant Psychiatrist or through a triaging function.
- Responding to an urgent referral may mean the direct involvement of the CAMHS team or it may mean, for example, telephone consultation with the parent(s) or other agencies to organise an appropriate response to the referral agent.

4.10.6 Routine Referrals

- A routine referral is one where there are clear and present levels of acute symptoms of moderate to severe mental disorder which have been ongoing but can be managed in the short-term by the child or adolescent's support network (i.e. parent(s) or other agencies.)
- Routine referrals should be seen within 12 weeks or sooner depending on service demands.
- Responding to a routine referral means that a letter is sent by the CAMHS team to the child or adolescent and their parent(s) to offer them an initial assessment appointment.

4.10.7 Responding to Referrals

- An initial letter should be sent within 2 weeks of referral receipt and should include the following:
  - Acknowledgment of the referral.
  - Indication of whether the referral has been deemed an urgent or routine referral.
  - Estimated waiting time for the first appointment or contact from the CAMHS team. Information on how waiting times may go up or down depending on the demand in the area should be included.
  - A list of local community supports and/or useful websites to access while they are awaiting their appointment, including HSE's www.yourmentalhealth.ie (ref Section 2.2.7).
  - Advice of what to do in an emergency or if the child or adolescent's presentation worsens.
- A copy of the letter should also be sent to the GP/Referral Agent.

4.10.8 Referrals that do not require CAMHS:

- If a child or adolescent is screened or assessed as not having a moderate or severe mental disorder and as not requiring CAMHS, the GP/referral agent and the parent(s) will be advised in writing as soon as possible.
- The reason for the child or adolescent not being accepted should be clearly outlined in the letter.

- If further management of this referral is required, this may be coordinated by the GP through HSE Primary Care or community services.
- Initial communication to the referral agent can be by telephone in order to provide a timely response as long as it is supported by a written letter.

4.11 Communication, Sharing and Disclosure of Information

4.11.1 CAMHS teams should obtain consent from parent(s) and comply with the *General Data Protection Regulation 2016/679* and the *Data Protection Act, 2018* prior to and when sharing information and communicating with other services in line with local and national policies including HSE *National Consent Policy, 2019*, *HSE Data Protection Policy, 2018*, *HSE Privacy Notice, 2018-2020*, the *General Data Protection Regulation 2016/679* and the *Data Protection Act 2018*.

4.11.2 The CAMHS team must communicate with the referral agent within four weeks of the initial assessment (see Section 4.13) and a summary assessment report should be sent to them.

4.11.3 The CAMHS team should communicate with the parent(s) throughout the assessment process to keep them informed and to advise them of local supports.

4.11.4 Progress in the form of a brief written update to the referral agent should be communicated at a minimum of six monthly intervals thereafter.

4.11.5 On discharge from CAMHS, a written discharge summary should be provided to the child or adolescent's GP, the referral agent and the parent(s). (See Section 4.25). This should be a brief summary of the assessment and interventions and progress made, in plain English.

4.12 CAMHS Community Mental Health Team

4.12.1 CAMHS teams are multi-disciplinary in nature. This means that they are made up of a range of disciplines with different skills and perspectives, so that children and adolescents can be offered a care and treatment package that addresses their individual clinical needs.

4.12.2 *A Vision for Change – Report of the Expert Group on Mental Health Policy, 2006* recommends that the needs of different groups of service users should determine the precise mix of skills required within their local Community Mental Health Team (CMHT).

4.12.3 CAMHS teams may consist of a range of professionals including psychiatrists, psychologists, social workers, nurses, speech and language therapists, occupational therapists, social care workers, administrators, team coordinators, dieticians and other therapists as required. The precise number of mental health professionals on a CAMHS team will vary according to the particular requirements of the sector population and within the available resources.

4.13 The Initial Assessment

4.13.1 When a referral is accepted by CAMHS, the child or adolescent and their parent(s) are offered their first appointment which is known as an initial assessment.

4.13.2 One of the aims of an initial assessment is to gather background information to try and understand what has been going on in the child or adolescent's life. An initial assessment also seeks to ensure that CAMHS is the right service for the child or adolescent and that they and their parent(s) are happy to attend the service.

4.13.3 The initial assessment will cover a range of areas including personal information, social history, family history, education, physical health, lifestyle factors, risk assessments, strengths and protective factors and the views of the child or adolescent and their parent(s) on the current situation. (See Appendix 3.3).

4.14 The Key Worker

4.14.1 *A Vision for Change – Report of the Expert Group on Mental Health Policy, 2006* recommends the allocation of a key worker to each child or adolescent and their parent(s) so that they have direct and easy access to a known team member.

4.14.2 Each child or adolescent and their parent(s) should be informed of who their key worker is.

4.14.3 The role of the key worker is to establish a relationship with the child or adolescent, and to take responsibility for actively remaining in contact with them and their parent(s).

4.14.4 The role of the key worker can be assigned to any clinical CAMHS team member.

4.14.5 The key worker coordinates the care provided by all other team members and provides feedback to the team on progress. The role of the key worker may not involve delivering all of the treatment for the child or adolescent, however they are responsible for making sure that clinicians are following the Individual Care Plan (*HSE Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement, 2017*).

4.15 Individual Care Plan (ICP)

4.15.1 After the Initial Assessment is complete, each child or adolescent is involved in developing an Individual Care Plan (ICP) with their key worker and their parent(s).

4.15.2 An ICP 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 adolescent while they are attending CAMHS. (See Appendix 3.4).

4.15.3 An ICP should be developed in collaboration with the child or adolescent and their parent(s) and a copy should be provided to them. The ICP should be signed off by all parties.

4.15.4 The ICP can be shared with referral agents such as the GP and Primary Care Services if deemed appropriate and if consent is given by parent(s). (See Section 4.11).

4.15.5 An ICP is outcomes focused, and should consider what goals the child or adolescent wishes to achieve while attending CAMHS. It should also be recovery focused (*HSE A National Framework for Recovery in Mental Health, 2018-2020*).

4.15.6 All CAMHS staff should be aware of communication needs and take these into account when designing the ICP. 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*.

4.15.7 The child or adolescent's key worker is responsible for the maintenance and regular review of the ICP.

4.15.8 An ICP includes the following:

- A clinical formulation
- A diagnosis if available
- Agreed goals between the CAMHS team, the child or adolescent and the parent(s)
- A list of other agencies involved with the child or adolescent
- An individual risk and safety management plan (See Appendix 3.5)
- A discharge/transition plan which includes a provisional discharge date

4.16 The Team Coordinator

4.16.1 *A Vision for Change – Report of the Expert Group on Mental Health Policy, 2006* proposes a Team Coordinator role for each CAMHS team. This individual carries out a clinical and administrative function to ensure the smooth running of CAMHS and is an integral part of the CAMHS team.

4.16.2 The role of the Team Coordinator can only be taken on by a clinical member of the CAMHS team.

4.16.3 The Team Coordinator's functions may include the administration and triage of referrals in consultation with the Consultant Psychiatrist and the MDT, coordination of waiting lists, organisation of team meetings, and liaison and consultation with GPs and Primary Care professionals and other community agencies and resources (*HSE Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements* and *Towards Continuous Quality Improvement, 2017*).

4.17 Multi-disciplinary Team (MDT) Reviews

4.17.1 Formal reviews are an important part of the management of all open cases.

4.17.2 Each CAMHS team has a weekly team meeting to discuss:

- New Referrals.
- Open Cases requiring review.
- Cases being considered for discharge from the team.

4.17.3 Each open case is formally reviewed by the CAMHS multi-disciplinary team at a minimum of every six months.

4.17.4 The key worker and the administrative staff on the CAMHS team are often best placed to coordinate and make sure that this review takes place when required.

4.18 Promoting Attendance at Appointments

4.18.1 CAMHS services try to manage non-attendance so that the service can see as many children and adolescents as possible.

4.18.2 If an appointment is cancelled in time, it can be offered to someone else and reduce waiting lists.

4.18.3 As far as possible, the booking of initial appointments should be flexible and made in consultation with the parent(s) in order to minimise the risk of non-attendance.

4.18.4 All initial appointments should be communicated to the parent(s) in writing with a copy to the GP and the original referral agent.

4.18.5 When offering appointments, CAMHS teams should be conscious of literacy issues and communication barriers and how they may affect attendance and access to services.

4.19 Management of Non-Attendance at Initial Appointments

4.19.1 The CAMHS administrator or other team member contacts the parent(s) by phone at least two weeks before the date of their initial appointment to confirm attendance. This timeline does not apply to urgent appointments.

4.19.2 If possible, the use of a *text reminder* sent before the scheduled appointment should be considered as a means of encouraging confirmation and reducing non-attendance.

4.19.3 In the event that a child or adolescent does not attend, the GP and other referral agent (if applicable) should be informed. A new appointment date may be offered or it may be appropriate to re-refer depending on the individual circumstances and if still clinically indicated. A pro-forma letter may be used for this purpose to ensure referring agent(s) are made aware of non-attendance as soon as possible.

4.19.4 If the clinical information in the referral form (Appendix 3.1) suggests the child or adolescent may be very unwell or at risk, the GP/referral agent should be contacted so that they can initiate any further intervention that may be required. A follow-up letter should also be sent.

4.20 Management of Non-Attendance at Subsequent Appointments

4.20.1 If a child or adolescent is already attending CAMHS but does not attend their appointments, contact should be made with the parent(s) in the first instance to understand the reasons for the non-attendance.

4.20.2 If contact with parent(s) cannot be achieved, the CAMHS team must inform the GP or referral agent of the non-attendance. A decision will need to be made whether an assertive outreach visit is warranted.

4.20.3 If a decision is made to close a case due to non-attendance, it should be discussed and recorded at the multi-disciplinary team meeting and the GP/referral agent and parent(s) notified in writing that the child or adolescent has been formally discharged from CAMHS.

4.20.4 Any other agencies involved in the referral of the child or adolescent should also be informed of discharge in writing, if appropriate, and if consent from parent(s) has been obtained to do so.

4.21 Out-of-Hours Arrangements

4.21.1 Out-of-hours is defined as outside of normal working hours (i.e. outside Monday to Friday 9.00 a.m. to 5.00 p.m. and throughout Saturday and Sunday).

4.21.2 Children and adolescents and parent(s) must be provided with details of local out-of-hours arrangements while they are waiting for their first appointment, and again at their first appointment in person.

4.21.3 Emergency out-of-hours presentations are currently required to first attend out-of-hours GP services or if necessary to attend the Emergency Department of the local general hospital.

4.21.4 Following assessment by an hour-of-hours GP or a Consultant in the Emergency Department, and where there is a need, a referral will be made to a CAMHS community team. In an emergency, a child or adolescent may be referred by a consultant psychiatrist for an emergency admission to an inpatient psychiatric unit.

4.21.5 The HSE is working to develop a seven-day service for CAMHS within the resources available for vulnerable young persons in line with *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020*.

4.22 Feedback and Complaints

4.22.1 Every child and adolescent attending CAMHS, and their parent(s), should be invited to contribute to feedback about their experience of CAMHS. This can be in the form of positive comments, suggestions or complaints.

4.22.2 The details of the complaints procedure and the nominated person for dealing with complaints should be on display in a prominent position within each CAMHS premises.

4.22.3 Formal mechanisms are in place to provide feedback such as Your *Service Your Say: The Management of Service User Feedback for Comments, Compliments and Complaints, HSE Policy, 2017*. This feedback is used to inform and improve service delivery.

4.22.4 CAMHS staff should explain the complaints procedures to all children and adolescents and their families.

4.22.5 The appeals process should also be outlined to all children and adolescents and their parent(s) if they are unhappy with the outcome of a complaint or investigation (*Your Service Your Say, 2017* and *Best Practice Guidance, 2017*).

4.22.6 There are a number of ways in which feedback and complaints about HSE CAMHS can be made which are outlined below:

- **In Person:** Talk to any member of HSE staff, service manager or complaints officer.
- **Online Form:** Send your complaint securely through the online feedback form.
- **Paper Form:** Fill out the paper feedback form and put it in the feedback box or give it to a member of staff.
- **By Email:** Email yoursay@hse.ie with your feedback.
- **By Letter:** Send a letter or fax to any HSE location. Staff can help you put your complaint in writing if you require assistance.
- **Ring us:** LoCall 1890 424 555 from 9.00 a.m. to 5.00 p.m. Monday to Friday or call 045 880 400. Your call will be answered by a staff member from the National Complaints Governance and Learning Team.
- **Through Advocacy Services:** Contact an Advocacy Service.

4.23 Transition to Adult Mental Health Services

4.23.1 If an adolescent of 17 years requires a referral to adult mental health services, a *transition* plan within their ICP will be required. This should ideally begin at least 6 months before their 18th birthday. Not all adolescents require a transition plan, but it is essential that all are assessed for transition and that the outcome of the assessment of future need is recorded clearly.

4.23.2 Joint working between CAMHS and adult mental health services should be considered in the initial weeks of handover to aid a smooth transition from one service to the other. These services operate in a different way to each other and this can be a significant change for adolescents and their parent(s).

4.23.3 The adolescent's Consultant Psychiatrist and key worker will be responsible for initiating a handover to the adult mental health service and ensuring that appropriate information is shared in accordance with the *General Data Protection Regulation, 2016/679* and the *Data Protection Act, 2018* and the consent of the parent(s).

4.23.4 The information required for a transition includes as a minimum a detailed referral letter or a copy of the ICP, a risk assessment, a record of all medication, details of any physical health needs, and a summary of all MDT interventions. (See Appendix 3.8).

4.23.5 If there are any challenges during the transition process, this should be escalated to the Area Mental Health Management Team in the relevant CHO area.

4.24 Transition to Other CAMHS

4.24.1 Where a child or adolescent is on an active caseload with one CAMHS team and moves to a different geographical area, there must be clear communication and planning between both CAMHS teams to facilitate a smooth transition of care.

4.24.2 Such communication and planning should commence prior to the child or adolescent's move to another area, and should be organised by the Consultant Psychiatrist and key worker with a written indication of the current clinical need/risk assessment.

4.24.3 A child or adolescent who is actively engaged with a particular CAMHS team should not be placed on a waiting list with another CAMHS team if they move from one area to another in Ireland.

4.24.4 The clinical care should remain with the referring team until the case is formally handed over and accepted by the new CAMHS team.

4.24.5 The child or adolescent's parent(s), the GP and other referral agents should be kept informed of the status of the referral by the referring team throughout the process.

4.25 Discharge from Community CAMHS

4.25.1 Discharge from Community CAMHS occurs when a child or adolescent no longer requires the intervention of CAMHS. This may mean that they have achieved their goals or it may mean that they are not benefitting from CAMHS and their needs are better met in another service. (See Appendix 3.7).

4.25.2 Discussions about discharge planning should begin at the Initial Assessment or when the ICP is drawn up, in collaboration with the child or adolescent and their parent(s).

4.25.3 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 adolescent's recovery and should include a follow up plan with the GP and other community services. It should also include advice and information on the re-referral process to CAMHS in the event of a relapse.

4.25.4 A discharge summary should be shared with parent(s) and referral agents, subject to consent (see Appendix 3.6).

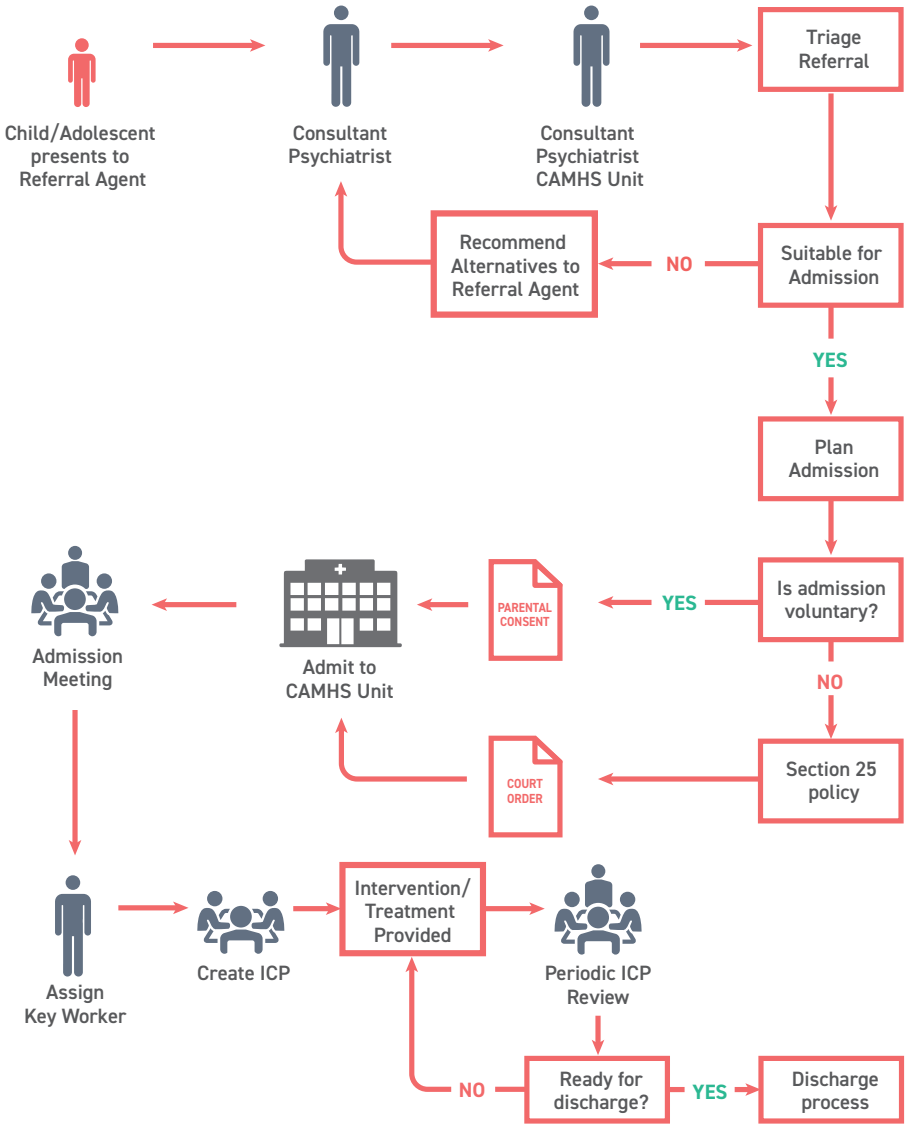
4.25.5 A discharge meeting with the child or adolescent, the parent(s) and any community supports who are involved, should occur prior to the formal discharge.

5

Inpatient Child and Adolescent Mental Health Services

Figure 5: Journey through Inpatient CAMHS

Referral and Clinical Pathway: CAMHS Inpatient Unit



Note: Continue to assess at every stage whether CAMHS is the right service for the child or adolescent.

1. The child or adolescent presents to Referral Agent i.e. Consultant Psychiatrist. (See Appendix 3.2).
2. Consultant Psychiatrist contacts the Consultant Psychiatrist of the CAMHS Inpatient Unit.
3. Referral is triaged to determine whether Inpatient CAMHS is the right service for the child or adolescent.
4. If Referral is deemed not suitable for admission, the CAMHS Inpatient Consultant recommends alternatives to the referring Consultant Psychiatrist.
5. If inpatient setting is deemed to be the right service for the child or adolescent, the admission is planned.
    a. If admission is voluntary, parental consent is obtained.
    b. If admission is involuntary Section 25 policy is invoked and a court order is obtained.
6. The child or adolescent is admitted to the CAMHS Inpatient Unit.
7. Admission meeting is held.
8. A Key Worker is assigned.
9. An Individual Care Plan (ICP) is developed in collaboration with the child or adolescent, the parent(s) and the CAMHS Inpatient Team.
10. Interventions and treatments are provided according to the ICP.
11. Regular periodic reviews of the ICP are carried out.
12. On review, if the child or adolescent is deemed ready for discharge, discharge planning is initiated.
13. On review, if the child or adolescent is not deemed ready for discharge, further interventions and treatments are provided.

5.0 Inpatient CAMHS

CAMHS Inpatient Units offer assessment and treatment to children and adolescents up to the age of 18 with severe and often complex mental disorders.

- CAMHS Inpatient Units are known as *Approved Centres* and they are registered, regulated and inspected by the Mental Health Commission. This means CAMHS Inpatient Units are subject to the *Mental Health Act, 2001*, as amended, corresponding regulations, and the *Mental Health Commission Codes of Practice*. There are regulatory requirements in relation to care and treatment, the facility and premises, staffing and governance. Specific examples include: physical examination, physical restraint, risk assessment, admission, transfer and discharge from a CAMHS Inpatient Unit.
- Currently there are four CAMHS Inpatient Units across the country to which this Operational Guideline applies.

Figure 6: Map of CAMHS Inpatient Units

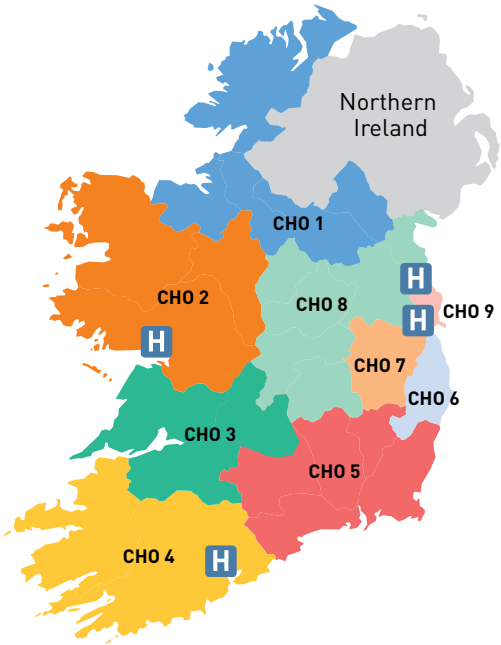


Table 1: Catchment Areas of CAMHS Inpatient Units

Unit Name	Unit Location	Current Number of Registered beds with MHC	Primary Catchment Area
Eist Linn	Cork CHO4	20	CHO4 & CHO5
Merlin Park	Galway CHO2	20	CHO1(a) Sligo/Leitrim/Donegal, CHO2, CHO3.
Linn Dara	West Dublin CHO7	24 (22+2 High Observation Beds)	CHO6, CHO7, CHO8(a) Laois/ Offaly/Longford/Westmeath.
St. Joseph's	North Dublin CHO9	12	CHO9, CHO1 (b) (Cavan Monaghan), CHO8(b) (Louth/Meath).
		Total	**76 beds (74 beds + 2 high obs beds.)**

5.1 CAMHS Inpatient Service Aims

The aim of Inpatient CAMHS is:

5.1.1 To provide evidence-based assessment and treatment for children and adolescents with severe and often complex mental disorders.

5.1.2 The inpatient service provides appropriate assessment, recovery-focused treatment and education within a therapeutic environment, with the ultimate aim of achieving clinical improvement.

5.2 Referral and Access to CAMHS

5.2.1 The vast majority of CAMHS interventions are delivered in the community close to people's homes, in the least restrictive environment possible. Therefore inpatient services are seen as a last resort when all other interventions in the community have been exhausted.

5.2.2 When a decision is being made to admit someone to an inpatient unit, the child or adolescent, their families and the CAMHS team will consider the clinical improvements expected against any potential negative impact from an inpatient stay. These may include the impact of being separated from family and friends, any disruption to their education, or the potential for further trauma from being admitted to an inpatient unit.

5.2.3 Children and adolescents should be able to maintain contact with their families and friends during their inpatient stay, and their education and future health should not be impaired through a prolonged stay in an inpatient unit.

5.3 Referring to Inpatient CAMHS

5.3.1 As CAMHS Inpatient Units are regional tertiary services, children must be assessed and referred by a Consultant Psychiatrist. (See Appendix 3.2).

5.3.2 It is recommended that there be a triage process prior to admission. This may include telephone consultation with the referral agent, further information gathering from other services, and/or a day visit by the inpatient team to ensure suitability for admission.

5.3.3 Where the decision is made not to admit a child or adolescent to the CAMHS Inpatient Unit, the child or adolescent, their parent(s) and the referral agent should be informed of the reasons in writing (*Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2010*).

5.4 Referring to the Appropriate CAMHS Inpatient Unit

5.4.1 The Community CAMHS team should make referrals to their designated regional unit. Designated catchment areas for the four CAMHS Inpatient Units are outlined in Section 5.0, Table 1 above.

5.4.2 When a local CAMHS Inpatient Unit is unable to offer a bed due to capacity issues, the referring Consultant Psychiatrist may, with parental consent, make a referral to other CAMHS Inpatient Units around the country.

5.4.3 Referrals from outside catchment areas will be considered when the local unit cannot offer a bed. These referrals are prioritised based on clinical need.

5.4.4 This process is supported by weekly communication between the four regional CAMHS Inpatient Units and the HSE National Mental Health Operational Management Team.

5.5 Appropriate Referrals to Inpatient CAMHS

5.5.1 When deciding if a child or adolescent needs inpatient care, a number of factors are considered. These include consideration of their clinical presentation, their level of social and family support and the availability of resources and treatment options in the community. The final decision regarding admission rests with the Inpatient Consultant Psychiatrist who assumes clinical responsibility for the child or adolescent once they have been admitted as defined by the *Mental Health Act, 2001*, as amended.

5.5.2 Children and adolescents accepted for admission will, in general, have a severe and complex mental disorder which requires the level of treatment provided in an inpatient setting with clear evidence that:

- Intensive treatment is required within an inpatient setting.
- There is a level of risk due to their mental disorder that is more appropriately managed in an inpatient setting.

5.6 Referrals Not Appropriate for a CAMHS Inpatient Unit

5.6.1 CAMHS Inpatient Units are specifically designed and staffed to meet the needs of children and adolescents with severe and complex mental disorders. Therefore not all referrals will be accepted, or will benefit from an admission to a CAMHS Inpatient Unit.

5.6.2 The following presentations may be considered as reasons for not admitting **when there is also an absence of a moderate to severe mental disorder:**

- Children and adolescents who are deemed to need treatment in an appropriate medical setting in the first instance
- Children and adolescents with substance misuse issues
- Children and adolescents with a behavioural or conduct disorder
- Children and adolescents with a diagnosis of Autism Spectrum Disorder (ASD)
- Children and adolescents with moderate or severe intellectual disability

- Children and adolescents whose clinical presentation may be further exacerbated or compounded by removing them from their home environment
- Children and adolescents who present with extreme behavioural disturbance and emotional instability that cannot be managed safely by the Inpatient Service

5.7 Clinical Information required for Referrals to CAMHS Inpatient Unit

Clinical Information that is required for the referral should be included in the Inpatient Referral Form. (See Appendix 3.2). This includes:

- Level of urgency
- Indication of when the child or adolescent was last seen by the referral agent
- Full description of presenting problem(s) and how they have developed
- Description of their presentation and/or mental state
- Child or adolescent's development and current functioning
- Family composition and history
- History of medical/mental illness in the family
- Outline of educational/occupational experience
- Goals for admission or expected outcomes after admission
- Child or adolescent's views and expectations for admission
- Parent(s)' views and expectations for admission
- Therapeutic interventions or treatment received to date
- Presence of risk and/or resilience factors
- Details of other agencies involved
- Parent(s)' informed consent

5.8 Process following Referral to a CAMHS Inpatient Unit

5.8.1 When a referral is received from an approved referral agent, it is triaged immediately by a senior clinician in the Inpatient Unit and the status of the referral communicated to the referral agent. A senior clinician could be, for example, the Consultant Psychiatrist or a Nurse Manager on the Unit.

5.8.2 When a referral has been triaged it is then categorised into:

- Emergency
- Urgent
- Routine

5.8.3 CAMHS staff will often contact the referral agent to seek further information. They may also seek consent from the parent(s) to contact other services or supports in the child or adolescent's life such as schools and HSE Primary Care services for additional information. This is subject to the GDPR and should be in line with the CAMHS team responsibilities as set out in Sections 2.2 and 2.3.

5.9 Referral Response Times

5.9.1 When a referral is received, a senior clinician from the CAMHS Inpatient Unit will respond to the referral agent.

5.9.2 A response means that contact will be made by telephone within the following timeframes:

- 4 hours (emergency)
- 24 hours (urgent)
- 7 days (routine)

5.9.3 The referral agent must ensure that they are contactable by mobile phone to discuss referrals.

5.9.4 In an emergency situation, telephone contact must be made to the CAMHS Inpatient Unit by the referral agent to ensure receipt of referral and to ensure compliance with the GDPR.

5.9.5 Until the child or adolescent has been admitted by the inpatient team, the referring consultant continues to hold clinical responsibility for the child or adolescent's care.

5.9.6 Explanation of types of referrals:

- An **emergency** referral to an inpatient unit is appropriate where the is a clear and imminent risk to the child or adolescent or to others due to their mental disorder.
- An **urgent** referral to an inpatient unit is appropriate where the child or adolescent has active symptoms of acute mental illness and where there is a strong likelihood of considerable deterioration in mental state if left untreated.

- A **routine** referral to an inpatient unit is appropriate where the child or adolescent has active symptoms of acute mental illness which have been ongoing, but which can be managed in the short-term by the child or adolescent's support network (i.e. family and community CAMHS).

5.9.7 Emergency Referrals

- In the interests of safety and continuity of care, admissions are usually planned during routine working hours. However, emergency admissions (i.e. within 24 hours of referral) are possible.
- Where a child is not previously known to the CAMHS Inpatient Service and is admitted in emergency circumstances through the Emergency Department, a joint review meeting with the responsible community CAMHS team must take place within 5 working days following their admission to the Unit.
- Even in the case of an emergency, it is not always possible to secure a CAMHS inpatient bed. Therefore all other community alternatives will need to be explored, such as attendance at a day hospital, increasing community supports or, as a last resort in exceptional circumstances, and where clinically indicated, admission to an adult psychiatric unit.

5.10 Admissions to Adult Psychiatric Units

5.10.1 Admissions of children and adolescents to adult psychiatric units do occur in exceptional circumstances, for the shortest period of time, where there is no safe community or inpatient alternative.

5.10.2 An admission to an adult unit can only be made if there is no bed available in any CAMHS Inpatient Unit nationally or where a clinical decision is made in the best interests of the child or adolescent.

5.10.3 There are rules and legislation governing how an admission to an adult unit is carried out. These are detailed clearly in the *Mental Health Commission Code of Practice Relating to admission of children under the Mental Health Act 2001, 2006* and the *Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act 2001 Addendum, 2009*. The Mental Health

Commission (MHC) have recommended the following guidance for an admission to an adult unit:

- the child or adolescent must have access to a CAMHS team and consultant
- there should be 1:1 nursing
- the child or adolescent should have a single room and segregated bathroom facilities
- the MHC must be notified within 72 hours of the admission.

5.10.4 There are a number of reasons why a child or adolescent under 18 years would be admitted to an adult inpatient unit and these include:

- The child or adolescent is an immediate risk to themselves or others.
- A clinical decision has been taken which is made in the best interests of the child or adolescent. For example, distance of the inpatient unit from the child or adolescent's home may make it difficult for families to maintain contact or to be involved in interventions and treatment.

5.10.5 The referring CAMHS team or Consultant Psychiatrist should be able to demonstrate what alternatives were considered and trialled prior to admission.

5.11 Admission to a CAMHS Inpatient Unit

5.11.1 When a decision is made to admit a child or adolescent to a CAMHS Inpatient Unit and a bed is available, they are brought to the Inpatient Unit.

5.11.2 The child or adolescent is oriented to the Inpatient Unit along with their parent(s) and an information booklet is provided to them.

5.11.3 An assessment and formulation of their needs is carried out in an area which ensures the privacy and dignity of the child or adolescent and their parent(s). (*Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2010*).

5.11.4 An initial care plan is usually completed by the admitting clinician. It details the immediate treatment and interventions required for the child or adolescent. This may include for example levels of observations required, medication, etc.

5.11.5 An initial care plan is not a replacement for the multi-disciplinary Individual Care Plan which must be completed within seven days of admission.

5.11.6 Treatment will take place alongside assessments and starts at the point of admission. The care and treatment plan will be modified and updated regularly as the child or adolescent's needs change.

5.12 Admission Process – Voluntary

5.12.1 The vast majority of admissions to CAMHS Inpatient Units are voluntary admissions. Consent for admission of a child to the Inpatient Unit is required from one of the child's parent(s)/guardians. The consent process is guided by the *National Consent Policy (HSE 2019)*.

5.12.2 Under the *Mental Health Act, 2001*, as amended, a child is a person under the age of 18 years other than a person who is or has been married. This means that while the child or adolescent's views on a voluntary admission should be sought, consent for admission and treatment can only be given by their parent(s).

5.12.3 Valid consent for admission and treatment must be informed consent. This means that the parent(s) and child have sufficient information to be able to understand the nature of what is proposed and the potential risks and benefits involved.

5.12.4 Information should be provided in plain English to facilitate understanding, and should be provided at regular intervals.

5.13 Involuntary Admissions to CAMHS Inpatient Units

5.13.1 A small minority of children or adolescents will need to be admitted to a CAMHS Inpatient Unit involuntarily. *Section 25 of the Mental Health Act, 2001*, as amended, allows for the involuntary admission of children.

5.13.2 It sets out that the HSE may make an application to the District Court for an order authorising the detention and treatment of a child, who is suffering from a mental disorder and requires treatment which they are unlikely to receive unless this order is made.

5.13.3 The following policy for involuntary admission of children has been recently updated by the Mental Health Legislation Group in 2019: *Application for a Section 25 order for the Examination, Admission or Treatment of a Child under the Mental Health Act 2001.* http://mhs.hseland.ie/media/1110/section-25-policy-revised-v2-08-2019.pdf

5.14 CAMHS Inpatient Team

5.14.1 A CAMHS Inpatient Unit is staffed by a range of multi-disciplinary professionals who have experience in treating severe and complex mental disorders in children and adolescents, which require the level of treatment only available in an inpatient setting.

5.14.2 These multi-disciplinary professionals may include psychiatrists, occupational therapists, psychologists, nurse managers, nurses, social workers, speech and language therapists, dieticians, social care staff, pharmacists, and other therapists as required.

5.15 Use of Inpatient Beds and Bed Capacity

5.15.1 Each CAMHS Inpatient Unit should, as far as possible, ensure that it has an emergency bed available so that the Unit can respond to emergency admissions on a 24/7 basis.

5.15.2 The capacity of the Inpatient Unit to meet the needs of a particular child or adolescent will be considered when accepting a referral.

5.15.3 The capacity of the Inpatient Unit is dependent on how acute the child or adolescent's presentation is, the presentation of the other children or adolescents on the Unit, and the available staffing levels.

5.15.4 The Inpatient Unit must be in a position to meet the therapeutic needs of the child or adolescent while maintaining a safe and functioning unit within available resources.

5.15.5 If an admission is clinically indicated but the Unit's capacity or mix of current inpatients is a major concern, then communication between the referring and inpatient consultants must be maintained to ensure that a suitable alternative can be identified. The next appropriate and available bed can then be offered to that child or adolescent.

5.15.6 Ongoing communication takes place between the four CAMHS Inpatient Units to ensure that available capacity in any of the units may be offered to a child or adolescent if they are on another unit's waiting list.

5.15.7 Distance from home must be carefully considered when planning an inpatient admission, as visiting and supporting a child or adolescent who is placed at a distance from their home could place a considerable burden on parent(s).

5.16 Home Leave

5.16.1 Home leave is an integral and therapeutic part of the overall Individual Care Plan and discharge plan. Home leave is an essential part of ongoing risk assessment, and helps to ensure successful reintegration into home, education and social activities. It assists with the transition from inpatient to community-based CAMHS.
In many cases, attending community CAMHS will be part of this step down on a shared-care arrangement with the inpatient service.

5.16.2 Prior to home leave taking place, parent(s) should be provided with support, advice and emergency contact numbers should a crisis arise while a child or adolescent is on leave at home.

5.16.3 If a child or adolescent has been admitted under Section 25 of the *Mental Health Act, 2001*, as amended, the Consultant Psychiatrist responsible for the care and treatment of the child or adolescent may grant permission in writing for an absence from the approved centre. The Court must be informed when leave is granted.

5.17 Individual Care Plan (ICP)[2]

5.17.1 An Individual Care Plan is a set of goals describing the care and treatment needed for the child or adolescent's admission.

5.17.2 The ICP should be developed collaboratively between the child or adolescent, their parent(s) and key worker.

5.17.3 All children and adolescents within CAMHS inpatient settings must have a written ICP which is completed within 7 days of admission in accordance with the *Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements towards Continuous Quality Improvement, 2017*.

[2] Regulation 15: Integrated Care Plan. Mental Health Commission, 2018. Judgement Support Framework (JSF).

5.17.4 The ICP should be reviewed on a weekly basis by the multi-disciplinary team. When changes are made, a revised copy should be provided to the child or adolescent and their parent(s).

5.17.5 An ICP should include a summary of the following:

- A clinical formulation
- A diagnosis if available
- Agreed goals between the CAMHS team, the child or adolescent and the parent(s)
- Medical and psychiatric history
- Physical health needs including history and current medications
- Risk assessment and management plan including strengths and protective factors
- Psychosocial history including family and social supports
- Communication abilities and needs
- Educational, occupational and vocational requirements
- A discharge/transition plan which includes a provisional discharge date

5.18 Risk Assessment and Risk Management

5.18.1 The range and nature of risk behaviours in a CAMHS inpatient unit can be complex. These can include risks to children themselves, risk to others, and risk from others. Staff within CAMHS Inpatient Units therefore have a broad understanding of risk assessment and management planning, and have a range of risk management strategies available which can be tailored to the needs of an individual child or adolescent.

5.18.2 Staff within the CAMHS Inpatient Unit should ensure that there are controls in place to identify, assess, measure and manage risks, including clinical and non-clinical risks. (See Appendix 3.5).

5.18.3 Risk assessment and management planning must involve a consideration of the individual child or adolescent's risk and environmental factors.

5.18.4 Positive risk-taking should be considered to allow children and adolescents to engage in activities that are meaningful to them and will help promote their recovery; where there is a clear clinical benefit to the child or adolescent; and where the identified risks can be managed.

5.19 Multi-disciplinary Team Review Meetings

5.19.1 Clinical MDT review meetings should be held weekly throughout the inpatient admission or at a frequency determined by the child or adolescent's clinical needs, especially if their stay is likely to be short.

5.19.2 People attending such reviews may include the child or adolescent, their parent(s) and the responsible inpatient CAMHS team representatives (consultant psychiatrist, key worker and CAMHS Unit staff).

5.19.3 It is essential that a senior clinician from the referring community CAMHS team or adult mental health service team attends reviews during the period of inpatient care. The Consultant Psychiatrist should join this meeting at a minimum by telephone. This is particularly important if transition of care or discharge to the community, or a move to adult mental health services is being considered.

5.20 Discharge Planning

5.20.1 Discharge from a CAMHS Inpatient Unit occurs when a child or adolescent no longer requires inpatient care. This may mean that they have achieved their goals or their care can be managed in a community setting.

5.20.2 Discussions about discharge planning should begin early on in the admission, when the Individual Care Plan is drawn up. This should be done in collaboration with the child or adolescent and their parent(s).

5.20.3 Discharge planning should focus on the child or adolescent's recovery and should include a follow-up plan with the GP and other community services.

5.20.4 A discharge meeting should occur with the child or adolescent, and the parent(s) and any community supports who are involved, prior to formal discharge from the service.

5.20.5 Discharge may need to be considered when it is deemed that the continued admission is counter-productive and appears to worsen the child or adolescent's mental state or compromises the safety of others on the Unit.

5.20.6 Children and adolescents admitted under Section 25 of the *Mental Health Act* will be discharged by a court order.

5.20.7 The discharge plan must ensure that there are clear processes in place for follow-up including outpatient appointments. The discharge plan should clearly indicate who is responsible for each process within the inpatient and community teams. This must be put in place in advance of discharge. (See Appendix 3.7).

5.20.8 At the completion of treatment, the GP, referral agent and parent(s) should receive a written discharge summary outlining the outcomes of the inpatient interventions and ongoing recommendations. (See Appendix 3.6).

5.20.9 Where indicated, there will be multi-agency involvement in discharge planning. These may include but are not limited to:

- Tusla – the Child and Family Agency, including aftercare programmes for 16/17 year olds moving out of care
- Specialist Autism Spectrum Disorder services (ASD)
- Specialist Intellectual Disability services including Mental Health of Intellectual Disability
- Local paediatric hospital/unit
- Primary/post-primary/Youth Reach and third level colleges
- Adult Mental Health Services
- Residential care services if the child or adolescent is in the care of Tusla – the Child and Family Agency
- Private providers of inpatient treatment or residential placement
- Voluntary agencies supporting the child or adolescent's recovery

5.21 Transition to Adult Services

5.21.1 If an adolescent of 17 years and above requires referral to general adult mental health services, a transition plan within their ICP will be required. This should ideally begin at least 6 months before their 18th birthday.

5.21.2 Not all adolescents require transition to another service, but it is essential that all are assessed for it and the outcome of the assessment of future need is recorded clearly.

5.21.3 Joint working between CAMHS and adult mental health services should be considered in the initial weeks of handover to aid a smooth transition from one service to the other. These services operate in a different way to each other and this can be a significant change for adolescents and their parent(s).

5.21.4 The adolescent's Consultant Psychiatrist and key worker will be responsible for initiating a handover to the adult mental health service and ensuring appropriate information is shared in accordance with the *General Data Protection Regulation, 2016/679* and the *Data Protection Act, 2018* and with the consent of the parent(s).

5.21.5 The information required for a transition includes as a minimum, a detailed referral letter or a copy of the ICP, a risk assessment, a record of all medication, and a formal handover of all MDT interventions including physical health needs. (See Appendix 3.8)

5.21.6 Any challenges during the transition should be escalated to the Area Mental Health Management Team in the relevant CHO area.

5.21.7 Joint care review/handover meetings must be organised by the CAMHS Inpatient team with the key agencies/services who will be taking on the care of the adolescent once they move on from the Inpatient Unit.

5.21.8 CAMHS should offer support for at least 3 months following transition to ensure continuity of care.

6

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7

Glossary

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.

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.

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.

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

Custody: As a result of parental separation or divorce proceedings, one parent may be granted sole custody. A copy of the order granting custody or the separation agreement could be sought to verify that only one parent is entitled.

Evidence-Based Practice: This requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources.

Guardianship: This is the collection of rights and duties that a parent (or non-parent) has for a child. Guardians make decisions for a child and are responsible for their welfare. A child's parents are most commonly their guardians, however guardians can be appointed by

a parent or by a court order. Further information is available from the Courts Service of Ireland. http://www.courts.ie/Courts.ie/Library3.nsf/0/208FE8290DDDD0A080257FB500413B16?opendocument&l=en. Guardianship rules post 2016 (Children and Family Relationships Act 2015): an unmarried father will automatically be a guardian if he has lived with the child's mother for 12 consecutive months after 18 January 2016, including at least 3 months with the mother and child following the child's birth. If there is disagreement as to whether they have been cohabiting for the required length of time, an application for the necessary declaration can be made to the court.

Key worker: A key worker is a point of contact on the CAMHS teams who coordinates care, not only within the mental health service but also across systems (e.g. education, social welfare, etc.) for the service user. 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*)

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.

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 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: 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 service user. The team members independently treat various issues a service user 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.

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: http://www.courts.ie/Courts.ie/Library3.nsfPageCurrent/208FE8290DDDD0A080257FB500413B16?opendocument&l=en

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 (see definition of tiered services below and Figure 2 on page xi). (*Source: Mental Health Services Directory*)

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

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.

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

List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ARI	Advancing Recovery Ireland
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Team
CHO	Community Healthcare Organisation
CMHT	Community Mental Health Team
ED	Emergency Department
GDPR	General Data Protection Regulation
GP	General Practitioner
HSE	Health Service Executive
ICP	Individual Care Plan
MDT	Multi-disciplinary team
MHID	Mental Health Intellectual Disability
MHS	Mental Health Services
NEPS	National Educational Psychology Services
NGO	Non-Governmental Agency
PPPG	Policies, Procedures, Protocols and Guidelines

8

Appendices

Appendix 1: Membership of the CAMHS SOP Review Project Group

Name	Title
Paul Braham	Project Lead, Senior Operations Manager, Mental Health Division
Sarah Hennessy	Project Manager, Mental Health Division
Dr Ann Marie Robertson	CAMHS Consultant Psychiatrist
Bernie Walsh	Senior Clinical Psychologist, CAMHS
Isobel Duffy	Occupational Therapy Manager, CAMHS
Professor Brendan Doody	Clinical Director, CAMHS Inpatient
Marie Duffy	Youth Representative/Advocate
Dr Mark Beirne	CAMHS Consultant Psychiatrist
Dr Eamon Raji	CAMHS Consultant Psychiatrist, Inpatient
Eoin Barry	Social Worker, CAMHS
Andrew Sheridan	Assistant Director of Nursing, CAMHS
Colman Noctor	Advanced Nurse Practitioner, CAMHS
Brian O'Malley	Area Director of Nursing, CAMHS
Dr Maeve Doyle	CAMHS Consultant Psychiatrist
Mark Smyth	Senior Clinical Psychologist
Jen Kane Mason	Parents Representative
Brendan Tuite	Parents Representative
Fiona Murray	Social Care Leader
Vivienne Foley	Speech and Language Therapy Manager
Linda Moore	Quality Officer, QSUS
Laura Molloy	Service Improvement Lead

Appendix 2: Forms and Templates

These forms have been collected from CAMHS teams throughout the country and sample templates are available to download and complete on the HSE CAMHS page https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/

All CAMHS teams need to satisfy themselves that they comply with local policies and procedures and that legislative and HSE PPPG Guidance is adhered to.

Appendix 3: List of Forms

3.1 Community Referral Form

COMMUNITY REFERRAL FORM

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

Details of which CAMHS Team Referral is being sent to:	
CAMHS Consultant:	**Address:**
Contact No(s).:	**Fax No.:**
Email:	

Name of child:	**DOB:**	**Gender:**
Parents/Carer Contact No.:		
Name of child's GP:	**Date GP Informed:**	
Practice Address:		

Please tick	Yes	No
G.P informed of Referral		
In Writing		
By Telephone		

School/ Occupation:	**Family Composition:**
How long have you known the child/young person?	
Describe the presenting problems, symptoms, when did they start and other problems identified:	

continued

What is the child/young person's current mental state?

What risk and/or resilience factors are currently present?

Is the child/ young person currently suffering from any medical problems?
If so describe:

Has the child/young person been previously referred to:

Please tick	Yes	No
Social Services		
Another Mental Health Service		
Psychology Service		
This Service		

If yes to any, please provide details:

Have you obtained consent for this referral: Yes/No *(it is advisable that consent is sought from both parents if practicable, however one is sufficient)*

Please tick	Yes	No
Both Parents		
Mother only		
Father only		
Neither parent		
Other *(Please specify)*		

If, 'Other', please specify:

Are there other agencies currently involved with the child/ young person?

Please tick	Yes	No
Community Care Social Work		
Paediatrician		
Community Care Psychology		
Speech & Language		
Autism Services		
Tusla - Child and Family Agency		
Other *(Please specify)*		

If yes to any, please provide details:

continued

Referrer's Name:	Referrer's Address:
Referrer's Clinical Discipline:	Date of Referral:
Contact No.:	Fax No.:
E-mail:	

3.2 CAMHS Inpatient Referral Form

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Child and Adolescent Mental Health Service (CAMHS) Inpatient Referral Form

Child and Adolescent Mental Health Services

ALL sections must be completed **Private & Confidential**

- Determining the 'seriousness' of a child or young person's mental health, its severity, complexity and risk is always a clinical judgement. Every case referred will be assessed on a case by case basis. The final decision regarding admission rests with the inpatient Consultant Psychiatrist who assumes clinical responsibility for the child/young person once they have been admitted.
- Failure to provide requested information may result in a delay in triaging the referral and/or offering an access assessment.
- Please attach any other clinical reports.
- The referring Consultant Psychiatrist must ensure that they are contactable by phone to discuss the referral.
- When a referring Consultant considers that an order under Section 25 of the Mental Health Act (2001) may be required or where a child is under a Care Order (Child Care Act, 1991), contact must be made with the relevant inpatient Consultant Psychiatrist in advance. It is the responsibility of the referring Consultant Psychiatrist to ensure that a bed is available prior to going to court.

Referrals are accepted from Consultant Psychiatrists only.
Forms must be signed by the referring Consultant Psychiatrist.

Referral form sent to the following Inpatient Units: Date form completed: _____

Yes, please x or ✓	Name of Unit	Address/Primary Catchment	Contact Details
☐	**Eist Linn CAMHS Approved Centre**	Eist Linn Child & Adolescent Mental Health Inpatient Unit, Bessbourough, Blackrock, Co Cork. **Primary catchment area; CHO 4 & 5**	Tel: 021 452 1100 Fax: 021 452 1164
☐	**Linn Dara CAMHS Approved Centre**	Linn Dara Child & Adolescent Mental Health Inpatient Unit, Cherry Orchard Campus, Ballyfermot, Dublin 10. **Primary catchment area; CHO 6, 7 & 8 [partial] (Laois/Offaly/Longford/Westmeath)**	Tel: 076 695 6500 Fax: 076 695 6636 E-mail: ac.linndaracamhs@hse.ie
☐	**Galway CAMHS Approved Centre**	Galway CAMHS Approved Centre, Merlin Park University Hospital, Dublin Road, Galway. **Primary catchment area; CHO 1 [partial], 2 & 3, (Sligo/Leitrim/Donegal)**	Tel: 091 731 401 Fax: 091 731 456 E-mail: ac.galwaycamhsinpatient@hse.ie
☐	**St Joseph's Adolescent Unit Approved Centre**	St Joseph's Adolescent Inpatient Unit, St Vincent's Hospital Convent Avenue, Richmond Road, Fairview, Dublin 3. **Primary catchment area; CHO 1 [partial], 8 [partial], 9, (Cavan/Monaghan/Louth/Meath)**	Tel: 01 884 2460 Fax: 01 884 2461
☐	Any other unit (e.g. private/abroad)	Details:	

NB: All Emergency referrals must be accompanied by a telephone call to the inpatient clinical team

Please specify the level of concern for this young person based on your mental health assessment (Place x or ✓)

☐ **Emergency** ☐ **Urgent** ☐ **Routine**

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

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

Routine: Where there are clear and present levels of acute mental ill health symptoms which have been ongoing and can be managed in the short-term by the child/young person's support network (i.e. Family, Community CAMHS). (HSE SOP, 2015)

CAMHS office use | Date and Time Received: Initials:

continued

Child/Young Person Details:			
Name:	Date of Birth:	Age:	Gender:
Preferred Name:	Preferred Pronouns:		
Current Address:	Nationality:	Ethnicity:	
	Religion:	Most spoken Language:	
Any known Allergies/Drug Allergies:	Special consideration for communications:		
Any particular needs/requirements:			

Person with Parental Responsibility: (if more than 2 parents please document in Family Composition)			
Name of Parent 1:		Name of Parent 2:	
Level of Contact with Child/YP:		Level of contact with Child/YP:	
Address:		Address (If different):	
Contact Numbers (Home, Mobile & Work):		Contact Numbers (Home, Mobile & Work):	
Occupation:		Occupation:	
Ethnicity:	Gender:	Ethnicity:	Gender:
Relationship to Child/YP:		Relationship to Child/YP:	
Does the Child/Young Person reside with this parent? YES ☐ NO ☐		Does the Child/Young Person reside with this parent? YES ☐ NO ☐	

continued

Status of Parental Relationship (if applicable)

Please Tick ✓	YES	NO
Married		
Divorced / Separated		
Cohabitating		
Single Parent		
Widowed		
No Contact		

Who has Parental Responsibility of the Child/YP (Detail any court order)?

Is the Child/YP subject to a Care Order?

YES: ☐ NO: ☐

Type:

Voluntary ☐

Interim ☐

Care (Full Care Order) ☐

Are TUSLA currently involved with the family? YES ☐ ***(Provide details on Page 12)*** **NO** ☐

Other Relevant Family Members (if known):

Name:	Relationship:	Age (If known):	Gender:

Loco Parentis Details (if applicable):

Name:	Contact Number:	Address:	Relationship to C/YP?

Family Composition / Situation / Needs (i.e. Interpreter etc.) / Genogram:

Details:

Primary Care Contact / General Practitioner:

GP Name:	GP Practice Name & Address:	Contact Number:

continued

Access Assessment / Admission Discussion:			
Please x or ✓	Yes	No	Unknown
Is the child or young person agreeable to a potential access assessment?			
Is the child or young person agreeable to a potential admission?			
Are both parents/Loco Parentis consenting to a potential access assessment?			
Are both parents/Loco Parentis consenting to a potential admission?			
Parent 1 Consent – Discuss:	Parent 2 Consent – Discuss:		

Referrer (Consultant Psychiatrist) Details: (Must be contactable by telephone to discuss referral)	
Name:	
Team Name:	
Address:	
Contact mobile number(s):	
Email Address:	

CAMHS Keyworker Details:	
Name:	
Team Name:	
Address:	
Contact mobile number(s):	
Email Address:	

Other Important CAMHS Contacts: (Please include all professionals and contacts that should be involved in the child/young person's care / discharge planning)	
Name:	
Profession:	
Address:	
Contact number: (Please include mobile number)	
Email Address:	

continued

Health Insurance Cover:			
Please x or ✓	Yes	No	Unknown
Private/Group Insurance			
Medical Card			
Details/Comments:			

School/Education/Employment: (Please include School Reports)	
Name of School/Education/Employment:	
Address/Contact Details:	
Details: (Level of functioning/year /any additional requirements in School [NEPS/Resource]/SNA required etc.)	
Goal of Referral / Reason for Access Assessment: (Discuss rationale for level of urgency)	

Child / Young Person's current Mental State:
Current Presentation: (include duration, frequency and severity of triggers, maintaining factors, coping mechanisms, current resources)
Appearance and behaviour:

continued

Speech: (rate, intonation; volume; pitch; use of language; disorders of speech)

Mood and Affect: (subjective & objective)

Thought processes and content: (Formal thought disorder; delusions; preoccupations; obsessions; self-image)

Perceptions: (Hallucinations; derealisation/dissociation, Pseudo-hallucinations)

Cognitions: (Orientation to time; place; person; age; attention; concentration)

Insight: (Understanding of difficulties and motivation for change /Judgement)

Outcome measures: (HoNOSCA/CGAS/SDQ etc.)

Child/Young Person's views and expectations/aim for access assessment/admission:

Parent's/Carer's views and expectations/aim for access assessment/admission:

continued

History of presenting complaint(s) (To include details of onset, duration, severity, ameliorating and exacerbating factors, chronology of symptoms)

Psychiatric History: (to include diagnoses, details of previous episodes of illness, services attended, inpatient admissions, any history of trauma)

Medication: Please provide details of current medication including dosage and/or details of medications previously prescribed and rationale for why they might have been discontinued

continued

Therapeutic Interventions: Please provide details on all therapeutic interventions employed for child/young person and family. What works well? What has not worked to date?

Child/Young Person's Medical-Physical Health History: (Please include all/any reports available)

Physical Intervention (Please X or ✓)	Yes (Attach reports)	No	Date
GP/Consultant Physician assessment			
Blood Test(s)			
ECG			
EEG			
MRI			
CT			
Neurological Assessment			

Details of Child/Young Person's Medical – Physical Health History & Interventions:

Relevant Family Medical / Psychiatric History: Please include engagement with services and any safeguarding issues:

continued

Developmental History:	
Is there a neurodevelopmental disorder/history of difficulties? (e.g. ASD/Other)	YES ☐ NO ☐
Details: (History of Service Involvement - Include who undertook the assessment and results)	
Difficulties during pregnancy/birth?	
Key developmental milestones/Any Trauma History?: (Please detail)	

Eating Disorder Specific Information: (Please see Appendix for MaRSiPAN)	
Diagnosis:	
Date of Diagnosis:	
Child/Young Person's understanding of the Eating Disorder? *Please specify if the young person is in agreement with the Eating Disorder diagnosis*	
Families' understanding of the Eating Disorder? *Please specify if the family is in agreement with the Eating Disorder diagnosis*	

continued

Adapted MaRSiPAN Risk Assessment Framework (Guides Clinical/Physical State of the Child/Young Person) Appendix 1			
Risk Indicator	**Result/Details**		**Risk Category**
BMI & Weight			
Heart rate Blood Pressure			
Hypovolaemia			
ECG			
Hydration Status			
Temperature			
Biochemistry			
Behaviours			
Engagement			
Activity & Exercise			
Self-Harm Suicidality			
Other Mental Health Diagnosis			
Muscular – SUSS Test Stand – Squat			
Muscular – SUSS Test Sit – Up			
Other			
Most recent weight:		Date weight recorded:	
Most recent height (cm)		Date height recorded:	
Most recent BMI		% Median BMI	
Weight/Height history and date record: (Attach records)			

continued

Dietary intake over the previous two weeks: (Food diary can be attached)	
Please specify interventions to rule out an organic cause:	**Most recent bloods/date:** Please specify LFT's, FBC, U&E, Mg, PO4 & K
Vital Signs Sitting: (Pulse/BP/SpO2/Temp)	**Vital Signs Standing:** (Pulse/BP)

Compensatory behaviours:	**Specify frequency:**
Excess exercise	
Binging	
Self-Induced Vomiting	
Laxative misuse	
Other	
Interventions to date:	**Details:**
Individual Work	
Family Based Treatment	
Systemic Family Therapy	
Dietitian	
CBT (CBT-E)	
Other	

continued

Name & Details of other Agencies Involved: (e.g. Primary Care Psychology, NEPS, Social Work, TUSLA, JLO, SLT. Include reports if available)	Contact Details

NB – *Please provide available reports from other agencies*

Drug / Alcohol:
Drugs: Past & Current use (include amount; frequency; motivation to use/change; effects)
Alcohol: Past & Current use (include amount; frequency; motivation to use/change; effects)

Forensic History:
Forensic History: (Include involvement with diversion programmes / JLO etc.)
Criminal Charges:
Court Orders:
Court Dates:

continued

Relevant Social Circumstances: (Family dynamics, position of child in the family, precipitating/perpetuating/ protective factors; bullying; abuse history, hobbies/skills, strengths)

Risk Indicator Checklist (Please complete and provide additional information/explanation in the space provided)			
Please ✓ risk indicators as appropriate	Yes	No	Unknown
Does the child/young person have a history of suicide attempts?			
Is the child/young person experiencing suicidal ideation?			
Is there a family history of suicide?			
Within the child/young person's social network has there been instances of suicide or suicide attempts?			
Has/Is the child/young person currently experiencing an event which may be perceived as traumatic (e.g. Bullying, Physical/Sexual Abuse, Diagnosis of a Physical/Mental Illness?)			
Does the child/young person engage in self-harming behaviours?			
Has the child/young person experienced a significant loss either recently or in the past?			
Has the child/young person exhibited or is the child/young person exhibiting signs of inappropriate sexual behaviour?			
Has the child/young person in the past or currently presenting with behavioural difficulties?			
Has the child/young person a history of absconding/leaving without informing adults?			
Is the child/young person compliant with current care plan?			
Does the child/young person have a history of self-neglect?			

continued

Does the child/young person have a history of an eating disorder body image difficulties?			
Does the child/young person have low self-esteem?			
Does the child/young person have difficulty communicating their needs?			
Are there significant financial constraints that may affect the child/young person's ability to self-care?			
Child/young persons or family drug/alcohol misuse-dependence?			
Does the child/young person have a history of violence or aggression towards adults/children/peers/animals?			
Has the child/young person ever made specific threats to harm others?			
Does the child/young person often talk about death, killing or weapons?			
Do TV shows/Movies/Games of a violent nature fascinate the child/young person?			
Does the child/young person have access to, or carry weapons?			
Is the child/young person experiencing thought/perceptual disturbance that consists of violence or harm?			
Please provide details of all YES risks and any other risk issues:			
List Protective Factors (Example: Resilience, Support Networks, Interests, Activities, Community Involvement, Functioning/IQ)			

continued

Any other relevant information

Summary of Referral

Summary of Clinical Impression at the time of referral:			
ICD 11 Diagnosis:			
Axis 1 (Clinical Psychiatric Syndromes)	1. 2. 3.	**Axis 4** (Medical diagnosis)	
Axis 2 (Specific developmental disorder e.g. autism)		**Axis 5** (Psychosocial adversity)	
Axis 3 (Intellectual)		**Axis 6** (Level of functioning)	

Please indicate the time and date that the Consultant Psychiatrist last reviewed the Child/YP			
Date:		**Time:**	

***Any child / young person referred must be seen by the referring Consultant Psychiatrist within the previous 48 hours**

In the event that this referral for an access assessment results in an accepted admission and the identified child/young person is admitted to an Approved Centre, I the Consultant Psychiatrist will accept back the care and treatment of this child/young person upon their discharge from the Approved Centre.

In the case of Adult/Liaison/Private Consultant Psychiatrists', I have discussed and agreed with the relevant CAMHS community service (Name of CAMHS Consultant Psychiatrist: _____) that the care and treatment of this child/young person upon their discharge from the Approved Centre will revert to the named CAMHS service/Consultant Psychiatrist.

Consultant Psychiatrist Making the Referral Name:	
Signature: (Must be electronic signature or hand signed)	
Date:	

continued

Appendix 1 – Adapted MaRSiPAN Risk Assessment Framework

MaRSiPAN Risk Assessment Framework (2012 & 2015)	RED High Risk	AMBER Alert to High Concern	GREEN Moderate Risk	BLUE Low Risk
BMI & Weight	<70% percentage median BMI	70-80% percentage median BMI	80-85% percentage median BMI	>85% percentage median BMI
	Recent loss of weight of ≥ 1 kg a week x 2 weeks	500 – 999 grams a week x 2 weeks	Up to 500 grams a week x 2 weeks	No weight loss in past 2 weeks
Heart rate Blood Pressure[a]	HR (awake) <40 bpm[a] Irregular heart rhythm (excluding sinus arrhythmia) Recurrent Syncope Marked Orthostatic changes in systolic BP ≥ 20 mmHg or increase in HR of > 30 bpm	HR (awake) 40 – 50 bpm Occasional Syncope Moderate Orthostatic changes in systolic BP of 15mmHg or more or fall in diastolic BP of 10mmHg or more within 3 minutes of standing or increase in HR of up to 30 bpm	HR (awake) 50 – 60 bpm Pre-Syncope symptoms Normal Orthostatic changes	HR (awake) >60 bpm Normal BP for age Normal Orthostatic changes Normal Heart Rhythm
Hypovolaemia	Tachycardia or inappropriate normal HR for degree of underweight Hypotension and prolonged capillary refill time			
ECG	<15yrs QTc >460 ms F >15yrs QTc >460 ms M >15yrs QTc >450 ms ***And evidence of*** – bradyarrhythmia or tachyarrhythmia (excludes sinus brady / sinus arrhythmia) ECG evidence of biochemical abnormality	<15yrs QTc >460 ms F >15yrs QTc >460 ms M >15yrs QTc >450 ms	<15yrs QTc 440-460ms F >15yrs QTc 450-460ms M >15yrs QTc 430-450ms ***And*** taking medication known to prolong QTc interval, family history of prolonged QTc or sensorineural deafness	<15yrs QTc <440 ms F >15yrs QTc <450 ms M >15yrs QTc <430 ms
Hydration Status	Complete Refusal / Minimal Fluid Severe Dehydration (>10%) reduced urine output, dry mouth, decreased skin turgor, sunken eyes, tachypnoea, tachycardia.	Severe fluid restriction / Moderate dehydration (5-10%) decreased urine output, dry mouth, normal skin turgor, some tachypnoea, some tachycardia[b]. Peripheral oedema.	Fluid restriction / Mild dehydration (<5%): may have dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance	Not clinically dehydrated
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C		
Biochemistry	↓K,↓PO4,↓Na,↓Ca,↓AL,↓glucose	↓K, ↓PO4, ↓Na, ↓Ca		
Behaviours	Acute food refusal or estimated calorie intake 400–600kcal per day	Severe restriction (≤50% of required intake) Vomiting / Purging laxatives	Moderate restriction Bingeing	

continued

Engagement	Violent when parents try to limit behaviour or encourage food/fluid intake Parental violence in relation to feeding (striking, force-feeding)	Poor insight into eating difficulties, lacks motivation to tackle eating difficulties, resistance to changes required for weight gain Parents unable to implement meal-plan advice	Some insight into eating problems, some motivation to tackle eating problems, ambivalent towards changes required to gain weight but not actively resisting	Some insight into eating problems, motivated to tackle eating problems, ambivalence towards changes required to gain weight not apparent in behaviours
Activity & Exercise	High levels of uncontrolled exercise in the context of malnutrition (>2hr / day)	Moderate levels of uncontrolled exercise in the context of malnutrition (>1hr / day)	Mild levels of uncontrolled exercise in the context of malnutrition (<1hr / day)	No uncontrolled exercise
Self-Harm Suicidality	Self –poisoning Suicidal ideals with moderate to high risk	Self-injury or similar Suicidal ideas with low risk		
Other Mental Health Diagnosis		Other major psychiatric co-diagnosis (e.g. OCD / Psychosis / Depression)		
SUSS Test Stand – Squat	Unable to get up at all from squatting (Score 0)	Unable to get up without using upper limbs (Score 1)	Unable to get up without noticeable difficulty (Score 2)	Gets up without any difficulty (Score 3)
SUSS Test Sit – Up	Unable to sit up at all from lying flat (score 0)	Unable to sit up from lying flat without using upper limbs (Score 1)	Unable to sit up from lying flat without noticeable difficulty (Score 2)	Sits up from lying flat without any difficulty (Score 3)
Other	Confusion / Delirium / Acute pancreatitis / Gastric or Oesophageal Rupture	Mallory-Weiss Tear / Gastroesophageal reflux or Gastritis / Pressure Sores	Poor attention and concentration	

a. Inappropriately high HR for degree of underweight are at even higher risk (hypovolaemia). HR may be increased through the consumption purposefully of excess caffeine.

b. Or inappropriate normal heart rate in an underweight young person.

continued

3.3 Initial Assessment Form

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INITIAL ASSESSMENT FORM

Child and Adolescent Mental Health Services

This intake form is to be used by CAMHS clinicians as a guide to collecting relevant information from parents/young person at the initial intake appointment(s).

Child/Young Person's Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Parents Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Consultant Psychiatrist	
Name: Dr.	**Contact No.:**
Address:	

CAMHS Key Worker	
Name(s):	**Job Title(s):**
Address:	**Phone Number:**

Referral Information:	
Referral Agent:	**Date of Referral:**
Reason:	

continued

Family Composition:		
Detail	**Age**	**Occupation/School**
Father		
Mother		
Children		

Intake Details:
Team Members Present
Family Members Present
Format of Intake

continued

Presenting Concerns (Parents/Young person's view of difficulty/concern)
What is your understanding of the reason for referral?:
What are your concerns? Who noticed first there was a problem? Whose idea was it to get help? How long has this been a concern?:
Context of difficulties/concerns e.g. frequency, intensity (1-10) durations etc….. Are these difficulties evident across settings? Are there situations in which the difficulties are not happening?:
How are difficulties managed? What works/helps? What methods of discipline are used with your child?:

continued

Can you describe a typical day?:

continued

Family Composition, Family History and Genogram
Current living arrangements: *Are parents married/living together/separated/access arrangements? (if relevant):*
Who is the child/young person close to? Significant others in his/her life:
Family support systems (opportunity for breaks etc.):
Family history of developmental/communication/mental and physical health difficulties:

continued

Current stressors:

Parents own experience growing up (if relevant):

Developmental History

- *Include details re: pregnancy, birth, postnatal period, motor milestones, gross and fine motor skills, feeding, sleeping, self-care, sensory sensitivities, any ritualistic behaviour, speech/ language and communication development, social skills, mixing/friendships:*
- *Other important life events (e.g. separations, traumas and losses):*

continued

Include Adolescent History *(if relevant)*

Drug and alcohol history include history of cigarette, alcohol or illicit substance use. Check frequency of use, history of intoxication, symptoms of addiction and negative sequelae from use. Psychosexual History.

School Information

Schools attended, including pre-school/Montessori/play school. Academic progress made and/or any concerns raised. Any behaviour difficulties, suspensions/expulsions and the reasons for the same. SNA/Resource teaching/special class/special school. History of bullying or being bullied.

Social History

Separation difficulties, mixing with peers.

continued

Medical History

Any illnesses, hospitalisations, operations, allergies or medication(s) prescribed.

Presentation/Observation/Mental State

Observations from Initial assessment (include appearance, engagement with therapist and parent, affect, mood, suicidality, and presence/absence of psychotic symptoms, behaviour, insight and motivation).

Parental Hopes/Expectations

continued

Protective Factors
What are the strengths and supports in the family? What things do different people in the family do well?

Child's Strengths
Hobbies and Interests, Sports/Clubs, Friendships:

Professional help/Intervention received to date		
Name:	**Telephone No.:**	**Profession:**

Other Relevant Information

continued

Formulation/Clinical Summary
The presenting difficulty, the context, possible preceding, precipitating and maintaining factors and strengths of the young person and the family.

Summary of Team Discussion and Plan/Recommendations		
Key worker assigned	Consent obtained from young person/parents for assessment/ intervention as appropriate	Limitations of confidentiality discussed with young person/parent
Formulation and plan discussed with young person/parents	Report Written	Copy given to YP/ Parent
Discussed at Team Meeting	Letter to Referral Agent	Referral to another agency
Liaison with other services		
Further Formal Assessment (e.g. SLT, Psychology, OT, Psychiatry or outside agency e.g. audiology etc):		

continued

Agreed Plan:	
Intervention/ treatment: (Individual, Group, Parents Plus, Family):	
Name:	**Signature:**
Discipline	**Date:**

3.4 Individual Care Plan

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INDIVIDUAL CARE PLAN (ICP)

Child and Adolescent Mental Health Services

Child/Young Person's Details	
Name:	Address:
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Parents Details	
Name:	Address:
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Consultant Psychiatrist	
Name: Dr.	Contact No.:
Address:	

CAMHS Key Worker	
Name(s):	Job Title(s):
Address:	Phone Number:

ICP No.	Date ICP completed	Next ICP review date

continued

Formulation *(including strengths):*

Goals				
	Goals	Child/Young Person/ Parent/Guardian	Rate 1-10 (Now)	Rate 1-10 (Goal)
1.				
2.				
3.				
4.				
5.				

Actions/ Plan

continued

Other agencies involved:

Additional information/comments:

ICP discussed/agreed with child/young person:	Yes/No	Date:	
ICP discussed/agreed with both parent(s)/guardian(s):	Yes/No	Date:	
Copy of ICP given to child/ young person and parents:	Yes/No	Date:	
Database updated:	Yes/No		
Projected Discharge Date:			
ICP completed by: (Print Name/Title)		Signature:	
Child/Young Person:		Signature:	
Parent(s):		Signature:	

3.5 Risk Assessment Tool

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

RISK ASSESSMENT TOOL

Child and Adolescent Mental Health Services

Child/Young Person's Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Parents Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Consultant Psychiatrist	
Name: Dr.	**Contact No.:**
Address:	

CAMHS Key Worker	
Name(s):	**Job Title(s):**
Address:	**Phone Number:**

Concerns/Incidents
(Please tick and provide further explanation of any relevant concerns/incidents in the spaces provided below)

Suicide and Safety	Yes	No
Does the child have a history of suicide attempts? *(If so provide details below)*		
Is the child currently experiencing suicidal ideation?		
Is there a family history of suicide?		
Within the child's social network have there been instances of suicide or suicide attempts. If so when? *(Provide details below)*		

continued

Has the child experienced or is the child currently experiencing an event, which may be perceived as traumatic *(e.g. Bullying, Physical/Sexual Abuse, Diagnosis of a Physical/mental illness etc.)*		
Has the child experienced a significant loss either recently or in the past? *(Family member, Relationship, Pet etc.)*		
Has the child exhibited or is the child currently exhibiting signs of inappropriate sexual behaviour?		
Has the child in the past or is the child currently presenting with behavioural problems?		
Has the child a history of absconding?		
Is the child compliant with his/her current treatment plan?		
Additional Comments:		

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

continued

Violence and Aggression	Yes	No
Does the child have a history of violence or aggression towards adults, children, peers or animals?		
Has the child ever made specific threats of harm towards others?		
Does the child have access to, or carry weapons?		
Is the child experiencing a psychotic episode with thoughts of violence?		
Additional Comments:		

Any other relevant information:

3.6 Discharge Summary

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DISCHARGE SUMMARY

Child and Adolescent Mental Health Services

The Parents/Carers and Young Person has agreed to have this document sent to GP [ ] and/or if relevant, Referring Agent/Adult Mental Health Service (AMHS)/Other Named Service [ ]
Further information can be provided if required, by contacting our service directly.

To: General Practitioner	To: Referring Agent / AMHS / Other Agency
Name: Address:	Name: Address:

CC. to:

Child/Young Person's Details	
Name:	Address:
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Parents Details	
Name:	Address:
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Consultant Psychiatrist	
Name: Dr.	
Address:	Phone Number:

CAMHS Key Worker	
Name(s):	Job Title(s):
Address:	Phone Number:

continued

Original reason for referral

Discharge Information

Discharge Plan discussed with young person & family/carer? Yes ☐ No ☐

Notification of discharge/service transfer given to young person and family? Yes ☐ No ☐

Any other relevant information given to young person or parent/guardian:

Brief Service Summary

Formulation:

Description of presentation, including diagnosis, onset, frequency, duration, features, consequences, precipitating and maintain factors and stressors:

continued

Outcome
Discharged to the care of:

Treating Consultant Psychiatrist (Print name):		Consultant Child & Adolescent Psychiatrist	
Signed:		Date:	

Key Worker (Print name):		Discipline:	
Signed:		Date:	

3.7 Discharge Checklist

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DISCHARGE CHECKLIST

Child and Adolescent Mental Health Services

Child/Young Person's Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Parents Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Consultant Psychiatrist	
Name: Dr.	**Address:**
Contact No.:	

CAMHS Key Worker	
Name(s):	**Job Title(s):**
Address:	**Phone Number:**

continued

Checklist for discharge	
Closure completed on Chart	
Closure completed on system	
HONOSCA completed	
Young person and parent/carer advised to attend GP in 2 weeks for review	
Relapse and protective factors discussed with young person & parent/carer	
Closing Discharge Summary Form completed	
Planned Case Closure recorded at weekly MDT meeting	
Signatures on Closing Discharge Summary Form and dates	
Copy of Closing Discharge Form forwarded to GP	
Copy of Closing Discharge Form forwarded to Referrer, if not GP	
Closed files to be filed in designated storage	

Key Worker:		**Discipline:**	
Signed:		**Date:**	

3.8 CAMHS Transition Plan Checklist

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CAMHS
TRANSITION PLAN CHECKLIST

Child and Adolescent Mental Health Services

Child/Young Person's Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Parents Details	
Name:	**Address:**
Gender:	
Date of Birth:	
Contact No.:	
Nationality:	

Consultant Psychiatrist	
Name: Dr.	**Address:**
Contact No.:	

CAMHS Key Worker	
Name(s):	**Job Title(s):**
Address:	**Phone Number:**

Teams details
CAMHS Team being referred from:
Team being referred to:

CONFIDENTIAL
This report is strictly confidential and has been prepared solely for circulation among the recipients named herein. It is not intended for release to third parties or to the patient themselves. The recipients are deemed to be aware of their obligations pursuant to the Data Protection Acts 1988-2003 and any regulations or enactments there under.

continued

Checklist	Tick as appropriate
Parental Consent obtained to transfer/transition and to provide relevant information to team being referred to?	Yes ☐ No ☐
Detailed Referral letter sent to Team being referred to?	Yes ☐ No ☐
Copy of ICP enclosed?	Yes ☐ No ☐
Risk assessment enclosed?	Yes ☐ No ☐
Medication Record enclosed?	Yes ☐ No ☐
Physical health record enclosed?	Yes ☐ No ☐
Summary of MDT interventions enclosed?	Yes ☐ No ☐

Additional Information provided

Completed by	
Name(s):	**Signature:**
Discipline:	**Date:**

3.9 Consent Form

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

CONSENT FORM

Child and Adolescent Mental Health Services

Informed Consent

A discussion has taken place with parent(s) to ensure they understand:

- The purpose of the assessment
- Who will carry it out
- What will be done with the information collected
- The purpose for which information is being collected
- That advice/consent can be withdrawn at any time

"I/ we consent to our child/young person being assessed at:

.....

(CAMHS Team Address)

Consent Details:	
Young Person's Name:	**Date of Birth:**
Signature *(mother)*:	
Guardian (Please tick)	Yes ☐ No ☐
Address:	**Contact No.:**
Signature *(father)*:	
Guardian *(please tick)*	Yes ☐ No ☐
Address:	**Contact No.:**
Does the other parent consent to the referral? Yes ☐ No ☐	**If "NO" please provide more details:**
Additional comments:	

3.10 Self-Assessment Tool - Community CAMHS

COMMUNITY CAMHS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

SELF-ASSESSMENT TOOL

Child and Adolescent Mental Health Services

The following self-assessment document should be completed in line with the Best Practice Guidance for Mental Health Services where appropriate (see ref.)

Self-Assessment Details					
Name of Service/Team:		**Date of Self-Assessment:**			
Name of all person(s) carrying out the Self-Assessment:					
Signature(s) of Lead person(s) carrying out the Self-Assessment:					
Theme: Guideline Structure and Purpose	**Evidence that indicator is being met** *(Ref Section 1.0 – 1.4 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are aware of the purpose and scope of the CAMHS Operational Guideline.				
2	All staff members have familiarised themselves with the legislation and other related HSE policies, procedures, processes and guidelines that should be read in conjunction with the CAMHS Operational Guideline.				
Theme: Roles and Responsibilities	**Evidence that indicator is being met** *(Ref Section 1.5 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are clear on their roles and responsibilities in relation to the CAMHS Operational Guideline.				
2	All staff members are clear on the national reporting structure as outlined.				

continued

COMMUNITY CAMHS

Theme: Implementation	Evidence that indicator is being met *(Ref Section 1.6 COG)*	Yes	No	Comment	Degree of achievement
1	All staff members are familiar with the Implementation Plan as outlined in the CAMHS Operational Guideline.				
2	All staff members have availed of the training supports offered to support Implementation of the CAMHS Operational Guideline.				
Theme: Revision	**Evidence that indicator is being met** *(Ref Section 1.7 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	The CAMHS team keeps a log of important revisions which can be used in the review of the Operational Guideline in 3 years' time.				
Theme: Self-Assessment	**Evidence that indicator is being met** *(Ref Section 1.8 COG and pages 16-21 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are aware of the purpose of the self-assessment process and their roles in relation to this.				
Theme: Recovery	**Evidence that indicator is being met** *(Ref Section 2.1 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
Cross reference with GAIT Tool recovery measures					
1	All staff members are familiar with the HSE National Framework for Recovery 2018-2020.				
2	All staff members have embedded the 4 principles of recovery into their interactions with children/adolescents and their families.				
3	All staff members provide a recovery- oriented service working in partnership with service users and families in the design and delivery of services.				

continued

COMMUNITY CAMHS

Theme: Involving Children and Adolescents	Evidence that indicator is being met *(Ref Section 2.2 COG and Page 30 BPG)*	Yes	No	Comment	Degree of achievement
1	All staff members involve children and adolescents in all matters and decisions that affect them, taking into account their age and understanding and issues of consent.				
2	Children and adolescents are involved in the design, implementation, delivery and evaluation of CAMHS. This can be done through: • Actively seeking feedback from children and adolescents • Ensuring communications are in plain English • Placing suggestion boxes in the waiting areas • Producing satisfaction surveys • Conducting focus groups on specific topics • Referral to advocacy services				
Theme: Involving Parent(s)	**Evidence that indicator is being met** ***(Ref Section 2.3 COG and page 31 BPG)***	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members maintain collaborative relationships with parent(s) and involve them in their children's care planning, treatments and interventions.				
2	All staff members provide advice to parent(s) on diagnoses, coping strategies and support to help them manage their child at home.				
3	All staff members connect parent(s) with local support structures such as those organised through the office of Mental Health Engagement.				
4	All staff members provide culturally sensitive and responsive services taking into account how this may affect attendance at services and treatment adherence.				

COMMUNITY CAMHS

Theme: Clinical Governance	Evidence that indicator is being met *(Ref Section 3.1-3.2 COG and page 114 BPG)*	Yes	No	Comment	Degree of achievement
1	All staff members are familiar with clinical governance structures in their local CHO area, which assist them in delivering high quality, safe services.				
2	All staff members are clear on the lines of accountability, authority and responsibility in relation to the smooth running of the CAMHS team.				
3	All staff members are clear on their clinical and professional reporting relationships.				
Theme: Children First	**Evidence that indicator is being met** *(Ref Section 3.3 COG and page 115 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are familiar with the Children First Guidance and legislation.				
2	All staff members have completed all mandatory training related to Children First.				
3	All staff members are aware of the roles and responsibilities of members and of mandated persons.				
Theme: Referral Process	**Evidence that indicator is being met** *(Ref Section 4.2 – 4.11 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	The CAMHS team accept referrals for all children in need of a specialist mental health service up to 18 years old.				
2	All open cases have moderate to severe mental disorders that require the input of a multi-disciplinary mental health team.				
3	**A service is offered to children with moderate to severe mental disorders including:**				
	• Moderate to severe Anxiety Disorders				

continued

COMMUNITY CAMHS

	• Moderate to severe Attention Deficit Hyperactive Disorder (ADHD/ADD)				
	• Moderate to severe Depression				
	• Bipolar Affective Disorder				
	• Psychosis				
	• Moderate/Severe Eating Disorder				
4	**Our exclusion criteria includes the following where there is no evidence of a moderate to severe mental disorder:**				
	• Children with mild intellectual disability				
	• Children with a moderate or severe intellectual disability				
	• Children with a developmental disorder				
	• Children who need assessments or interventions that relate to educational needs				
	• Children who present with child protection or welfare concerns				
	• A diagnosis of autism, where there is no co-morbid moderate to severe mental disorder				
	Joint working and shared care				
5	The CAMHS team provides appropriate multidisciplinary mental health assessment and treatment for the mental disorder.				
6	Consultation takes place with the other service to determine which is the most appropriate or whether a joint approach to assessment and intervention is indicated.				
7	The CAMHS team obtains consent and comply with local and national policies prior to sharing information and communicating with other services.				
8	The CAMHS team is clear on which HSE service has lead responsibility for coordination of care.				

continued

COMMUNITY CAMHS

9	**Our service accepts referrals from only the following professionals:**				
	a) The GP				
	b) Paediatricians (informing the child or adolescent's GP).				
	c) Consultant Psychiatrists (informing the child or adolescent's GP).				
	d) Emergency Department (ED) doctors in conjunction with ED Consultant (informing the child or adolescent's GP).				
	e) Community based clinicians (at senior/team leader level or above, in collaboration with GP).				
	f) Tusla – Child or adolescent and Family Agency (Team leader level or above in collaboration with the GP).				
	g) Assessment officers (as defined under the Disability Act, 2005).				
	h) Jigsaw – senior clinician (in collaboration with GP).				
	i) Community medical doctors (informing the child or adolescent's GP).				
	j) National educational psychologists – senior (in collaboration with GP).				
10	The Service uses the standardised CAMHS Referral Form with at least the minimum data set as outlined in the CAMHS Operational Guideline.				
11	Referrals received are screened daily by the nominated CAMHS Team member, consulting with the clinical lead.				
	Referral Response Times				
12	Routine referrals are seen within 12 weeks or sooner if possible.				
13	Urgent referrals are responded to within 3 working days and seen as soon as possible based on clinical risk				
14	CAMHS team provides advice and consultation regarding emergency referrals during working hours 9.00am – 5.00pm				

continued

COMMUNITY CAMHS

15	Where available, on-call Consultant Child and Adolescent Psychiatrists can be contacted by A&E services if required				
16	For referrals that do not require CAMHS, the CAMHS team informs the GP/referral agent in writing as soon as possible				
	Communication and sharing of information				
17	The CAMHS team obtains consent from the parent(s) and comply with relevant legislation				
18	The team communicates with the referrer within four weeks of the initial assessment and a summary assessment report is sent.				
19	The team communicates with the parent(s) throughout the assessment process to keep them informed.				
20	The service communicates at a minimum of six monthly intervals thereafter with the referrer.				
21	On discharge from the CAMHS service the child or adolescent's GP receives a written discharge summary.				
Individual Care Plan	**Evidence that indicator is being met** *(Section 4.15 COG and pages 73 – 75 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	• The ICP is developed in collaboration with the child or adolescent and their parent(s) and a copy provided to them. • The ICP is signed off by all parties.				
2	• The ICP is outcomes focused and recovery focused.				
3	• ICP is designed to meet the communication needs of the child or adolescent.				
4	• The ICP is in line with HSE policies on privacy and consent.				
5	• The key worker is responsible for the maintenance and regular review of the ICP.				

continued

COMMUNITY CAMHS

	An ICP includes the following:				
6	• A clinical formulation				
	• A diagnosis if available				
	• Agreed goals between the CAMHS team, the child or adolescent and the parent(s)				
	• A list of other agencies involved with the child or adolescent				
	• An individual risk and safety management plan				
	• A discharge/transition plan which includes a provisional discharge date				
MDT Team Reviews	**Evidence that indicator is being met** *(Ref Section 4.17 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	A weekly team meeting is held to discuss: • new referrals • open cases requiring review • cases being considered for discharge from the team.				
2	Each open case is formally reviewed by the CAMHS MDT every 6 months at a minimum.				
Attendance/Non-Attendance at Appointments	**Evidence that indicator is being met** *(Ref Section 4.18 – 4.20 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
	Management of Attendance at Initial Appointments				
1	All initial appointments are communicated to the parent/carer in writing with a copy to the child's GP and original referral agent.				
2	The parent/carer is asked to confirm attendance at least two weeks prior to the date of appointment.				
3	In the event that a child does not attend, the GP and other referral agent (if applicable) are informed				
4	A new appointment is offered or the referral agent is asked to re-refer if still clinically indicated and the parent/carer agrees.				

continued

COMMUNITY CAMHS

5	If clinical information in the referral form suggests the child may be very unwell or at risk, the GP/referrer is contacted so that they can initiate any further intervention that may be required. A follow up letter should be sent.				
	Management of Non-attendance at subsequent appointments				
6	Parent(s) are contacted to understand reason for non-attendance. If unable to make contact with parent(s), referral agent is informed.				
7	Decisions to close cases who do not attend for subsequent appointments are discussed and recorded at the multi-disciplinary team meeting.				
8	The GP/referral agent is notified in writing that the child has been formally discharged following non-attendance of subsequent appointments.				
Out-of-hours Arrangements	**Evidence that indicator is being met** *(Ref Section 4.21 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	Children and adolescents, and their parent(s) are provided with details of local out-of-hours arrangements while waiting for first appointment and again at first appointment in person				
Transition Planning	**Evidence that indicator is being met** *(Ref Section 4.23 and 4.24 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
	Transition to Adult Mental Health Services				
1	Every young person of 17 years who requires ongoing input from adult mental health services has a 'transition' plan within their ICP.				
2	All young people who are 17 years of age are assessed to determine whether they require a transition plan out of the service.				
3	There is a joint working plan between CAMHS and Adult Mental Health when a case is transferring over.				

continued

COMMUNITY CAMHS

4	Appropriate documentation has been shared with Adult Mental Health Services in accordance with GDPR and Data Protection and with the consent of parent(s), if relevant.				
	Transition to other CAMHS				
5	There is clear communication and planning between both CAMHS teams to facilitate a smooth transition of care.				
6	No child who is actively engaged with a particular CAMHS team goes on a waiting list with a new CAMHS team if they move from one area to another in Ireland.				
7	The clinical care remains with the referring team until formal handover and acceptance by new CAMHS team.				
Discharge from Community CAMHS	**Evidence that indicator is being met** *(Ref Section 4.25 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	Discussions about discharge planning takes place at initial assessment or when ICP is drawn up in collaboration with child or adolescent and parent(s).				
2	It will focus on child or adolescent recovery, and include a follow up plan with GP and other community services. It will also include advice and information and the re-referral process into CAMSH in the event of a relapse.				
3	A discharge summary will be shared with parents and referral agents subject to consent.				
4	A discharge meeting with child or adolescent, parent(s) and any community support will occur prior to formal discharge.				

3.11 Self-Assessment Tool - Inpatient CAMHS

INPATIENT CAMHS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

SELF-ASSESSMENT TOOL

Child and Adolescent Mental Health Services

The following self-assessment document should be completed in line with the Best Practice Guidance for Mental Health Services where appropriate (see ref.)

Self-Assessment Details:	
Name of Service/Unit:	**Date of Self-Assessment:**
Name of all person(s) carrying out the Self-Assessment:	
Signature(s) of Lead person(s) carrying out the Self-Assessment:	

Theme: Guideline Structure and Purpose	Evidence that indicator is being met *(Ref Section 1.0 – 1.4 COG)*	Yes	No	Comment	Degree of achievement
1	All staff members are aware of the purpose and scope of the CAMHS Operational Guideline.				
2	All staff members have familiarised themselves with the legislation and other related HSE policies, procedures, processes and guidelines that should be read in conjunction with the CAMHS Operational Guideline.				
Theme: Roles and Responsibilities	**Evidence that indicator is being met** *(Ref Section 1.5 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are clear on their roles and responsibilities in relation to the CAMHS Operational Guideline.				
2	All staff members are clear on the national reporting structure as outlined.				

continued

INPATIENT CAMHS

Theme: Implementation	Evidence that indicator is being met *(Ref Section 1.6 COG)*	Yes	No	Comment	Degree of achievement
1	All staff members are familiar with the Implementation Plan as outlined in the CAMHS Operational Guideline.				
2	All staff members have availed of the training supports offered to support Implementation of the CAMHS Operational Guideline.				
Theme: Revision	**Evidence that indicator is being met** *(Ref Section 1.7 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	The CAMHS team keeps a log of important revisions which can be used in the review of the Operational Guideline in 3 years' time.				
Theme: Self-Assessment	**Evidence that indicator is being met** *(Ref Section 1.8 COG and pages 16-21 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are aware of the purpose of the self-assessment process and their roles in relation to this.				
Theme: Recovery	**Evidence that indicator is being met** *(Ref Section 2.1 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
Cross reference with GAIT Tool recovery measures					
1	All staff members are familiar with the HSE National Framework for Recovery 2018-2020.				
2	All staff members have embedded the 4 principles of recovery into their interactions with children/adolescents and their families.				
3	All staff members provide a recovery-oriented service working in partnership with service users and families in the design and delivery of services.				

continued

INPATIENT CAMHS

Theme: Involving Children and Adolescents	Evidence that indicator is being met *(Ref Section 2.2 COG and Page 30 BPG)*	Yes	No	Comment	Degree of achievement
1	All staff members involve children and adolescents in all matters and decisions that affect them, taking into account their age and understanding and issues of consent.				
2	Children and adolescents are involved in the design, implementation, delivery and evaluation of CAMHS. This can be done through: • Actively seeking feedback from children and adolescents • Ensuring communications are in plain English • Placing suggestion boxes in the waiting areas • Producing satisfaction surveys • Conducting focus groups on specific topics • Referral to advocacy services				
Theme: Involving Parent(s)	**Evidence that indicator is being met** *(Ref Section 2.3 COG and page 31 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members maintain collaborative relationships with parent(s) and involve them in their children's care planning, treatments and interventions.				
2	All staff members provide advice to parents on diagnoses, coping strategies and support to help them manage their child at home.				
3	All staff members connect families with local support structures such as those organised through the office of Mental Health Engagement and Recovery.				
4	All staff members provide culturally-sensitive and responsive services taking into account how this may affect attendance at services and treatment adherence.				
5	There is dedicated visiting space for families on the unit.				

continued

INPATIENT CAMHS

Theme: Clinical Governance	Evidence that indicator is being met *(Ref Section 3.1-3.2 COG and page 114 BPG)*	Yes	No	Comment	Degree of achievement
1	All staff members are familiar with clinical governance structures in their local CHO area, which assist them in delivering high quality, safe services.				
2	All staff members are clear on the lines of accountability, authority and responsibility in relation to the smooth running of the CAMHS team.				
3	All staff members are clear on their clinical and professional reporting relationships.				
Theme: Children First	**Evidence that indicator is being met** *(Ref Section 3.3 COG and page 115 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	All staff members are familiar with the Children First Guidance and legislation.				
2	All staff members have completed all mandatory training related to Children First.				
3	All staff members are aware of the roles and responsibilities of members and of mandated persons.				
Theme: Referral Process	**Evidence that indicator is being met** *(Ref Section 5.3 – 5.9 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	The Team accepts referrals for all children in need of inpatient CAMHS services up to 18 years old.				
2	Children and adolescents requiring admission will have a severe and complex mental disorder with clear evidence that: • Intensive treatment is required within an inpatient setting • There is a level of risk due to their mental disorder that is more appropriately managed in an inpatient setting.				

continued

INPATIENT CAMHS

3	**Our exclusion criteria include the following children and adolescents, where there is no evidence of a moderate to severe mental disorder.**				
	• Those deemed to need treatment in appropriate medical settings in the first instance				
	• Those with substance misuse issues				
	• Those with a behavioural or conduct disorder				
	• Those with a diagnosis of Autistic Spectrum Disorder				
	• Those with a moderate or severe intellectual disability				
	• Those whose clinical presentation may be further exacerbated or compounded by removing them from their home environment				
	• Those who present with extreme behavioural disturbance and emotional instability that cannot be managed safely by the inpatient service				
4	The Service uses the standardised Inpatient CAMHS Referral Form (Appendix 3.2) with at least the minimum data set as outlined in the CAMHS Operational Guideline.				
5	Referrals are triaged immediately by a senior clinician in the CAMHS Unit and categorised into emergency, urgent and routine. A response is communicated on the same day to the referral agent notifying them of the status of their referral.				
Theme: Admission to Inpatient Units	**Evidence that indicator is being met** *(Ref Section 5.10 – 5.13 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
	Admission Process				
1	**Admission Process –Voluntary:** • Consent has been obtained from the parent(s)				

continued

INPATIENT CAMHS

2	**Admission Process – Involuntary:** • The HSE has received a Court Order authorising detention and treatment.				
	• The inpatient team has adhered to the HSE Section 25 Policy.				
3	An Initial Care Plan is completed by the admitting clinician. (This is not a replacement for the MDT ICP.)				
	Admission to Adult Psychiatric Units (in exceptional circumstances)				
3	The Mental Health Commission has recommended the following guidance for admission to an adult unit:				
	• the child or adolescent has access to a CAMHS team and consultant				
	• there is 1:1 nursing				
	• the child or adolescent has a single room and segregated bathroom facilities				
	• the MHC is notified within 72 hours of the admission				
Theme: Home Leave	**Evidence that indicator is being met** *(Ref Section 5.16 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	Parents should be provided with support, advice and emergency contact numbers should a crisis arise while a child or adolescent is on leave at home.				
2	If the child or adolescent has been admitted under S25 the consultant psychiatrist responsible for their care or treatment will grant permission in writing for the absence from the approved centre.				
Theme: Individual Care Plan	**Evidence that indicator is being met** *(Ref Section 5.17 - 5.18 COG, and Pages 73 – 75 BPG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
1	The ICP is developed in collaboration with the child or adolescent and their parent(s) and the key worker.				

continued

INPATIENT CAMHS

3	All children and adolescents on the Unit have a written multidisciplinary ICP which has been completed within 7 days of admission.				
4	The ICP is reviewed on a weekly basis by the Multidisciplinary Team. If changes are made, a revised copy is provided to the Child or Adolescent and their parent(s).				
5	An ICP includes a summary of the following:				
	• A clinical formulation				
	• A diagnosis if available				
	• Agreed goals between the CAMHS team, the child or adolescent and the parent(s)				
	• Medical and psychiatric history				
	• Physical health needs including history and current medications				
	• Risk assessment and management plan including strengths and protective factors				
	• Psychosocial history including family and social supports				
	• Communication abilities and needs				
	• Educational, occupational and vocational requirements				
	• A discharge/transition plan which includes a provisional discharge date				
Theme: Clinical MDT Review Meetings	**Evidence that indicator is being met** ***(Ref Section 5.19 COG)***	**Yes**	**No**	**Comment**	**Degree of achievement**
1	Clinical MDT meetings are held weekly as a minimum throughout admission.				
2	Community teams and other agencies and parents are invited to attend as required.				
3	Senior clinicians from the community CAMHS/adult services should attend reviews particularly when discharge is being considered.				

continued

INPATIENT CAMHS

Theme: Discharge Planning	Evidence that indicator is being met (Ref Section 5.20 COG)	Yes	No	Comment	Degree of achievement
1	Discharge planning takes place early on in the admission and is done in collaboration with the child or adolescent and their parent(s).				
2	It will focus on the child or adolescent's recovery and will include a follow up plan with the GP and other community services.				
3	The discharge plan ensures clear processes in place for follow up, including OPD appointments, and clearly indicates who is responsible for each process within the inpatient and community teams.				
4	The GP, referral agent and parent(s) receive a written discharge summary outlining the outcomes of the inpatient interventions and ongoing recommendations.				
Theme: Transition to Adult Services	**Evidence that indicator is being met** *(Section 5.21 COG)*	**Yes**	**No**	**Comment**	**Degree of achievement**
	Transition to Adult Mental Health Services				
1	An adolescent of 17 years and above who requires referral to general adult mental health services has a 'transition' plan within their ICP.				
2	All young people who are 17 years of age and over are assessed to determine whether they require a transition plan out of the service.				
3	There is a joint working plan between CAMHS and Adult Mental Health when a case is transferring over.				

continued

INPATIENT CAMHS

4	Appropriate documentation has been shared with Adult Mental Health Services in accordance with the GDPR and Data Protection and with the consent of parent(s), if relevant.				
5	Joint care review/handover meetings are organised by the CAMHS Inpatient Team with the key agencies/services who will be taking on the care of the adolescent once they move on from the Inpatient Unit.				
6	CAMHS offer support for at least 3 months following transition to ensure continuity of care.				

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The guideline can be found online at
www.hse.ie/eng/services/list/4/mental-health-services/camhs/publications/

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