Deep End Ireland Submission: CAMHS
5th Feb 2018

Drs Anna Beug, Edel McGinnity, Patrick O'Donnell, Anne O'Brien, Mary O'Brien, Sarah Fitzgibbon and Susan Smith for Deep End Ireland.

Perspective

We are a group of GPs who practice in disadvantaged areas (www.deepend.ie), many of us for over 15 years. This is an area of healthcare that GPs in our areas have a particular interest in given the higher prevalence of mental health issues in our patient population, particularly in children and adolescents. We are extremely concerned about the current state of services. The neglect of children suffering mental distress leads to untold damage in terms of education, employment prospects, criminality and future mental health. There is a totally unacceptable level of services and our experience is that CAMHS has deteriorated significantly in recent years. These are a few core issues that we wish to highlight:

- **Available services and waiting lists**
  Even on the rare occasion when a referral is accepted the waiting lists can be extremely long. While this may be a resource issue, we strongly recommend *the distribution of resources within CAMHS to match need within the population served.* In other words, in disadvantaged areas where there is a higher prevalence of mental health problems in children and adolescents, there should be proportionately more services available to address these needs. The current SOP states that "The care and treatment offered reflects the identified clinical needs of the child." But there is no recognition of the need for resources to match the needs of local populations, leading to marked health inequalities, which can have a profound life long impact.

- **Barriers to Assessment**
  A GP referral of a child to CAMHS is usually a carefully considered decision in the context of significant distress. Our experience is that the referral criteria are inconsistently enforced and needlessly restrictive.
  Despite the clear SOPs around Autistic Spectrum Disorders (ASD), learning problems or behavioural problems and the role of CAMHS in supporting management of these patients, in our experience this has not been developed and the referrals for these patients seem to be automatically refused. It also discriminates particularly against children from lower socioeconomic groups whose parents have limited means to access private supports and services. A child with ASD may well be suffering from co-morbid mental health symptoms such as anxiety, and the refusal to engage with these issues gives an impression that the referral guidelines are simply being used as a tool to limit numbers because of lack of CAMHs capacity, rather than on clinical grounds. The waiting times for assessment of need (often suggested by CAMHS when rejecting a referral) are very lengthy, and community services are almost non-existent. Our experience now is that the majority of referrals are turned down in the first instance. In some cases GPs

in our group have had to write 3 or 4 referral letters just to get a patient assessed. This causes massive delays. As CAMHS will only accept patients with severe mental illness, GPs are given the responsibility to determine whether this is the case when this should be the purpose of assessment.

It is important to note that over 90% of all mental health problems are dealt with in primary care, and GPs are therefore very skilled at determining when a specialist service is required – this is our job and we are well trained for it. We would support a return to the model where referred children and families in distress are triaged by a multi disciplinary team and organized into appropriate referral pathways. This is currently provided in the HSE adult psychology services, who offer early assessment, and decide if they are the appropriate service, offering pointers to other services if appropriate.

- **Early discharge:**
  Many GPs in our group have experienced situations where adequate time is not being taken for therapeutic intervention. This likely reflects poor resourcing and we would strongly support resourcing based on population need.

- **Referral to community services, which don't exist.**
  Many of us have had referrals refused on the basis that a child should be referred to community psychology services. In many disadvantaged areas the waiting time for child psychology is excessive. For example in the South Inner City area, the waiting time is currently about 1 year and in Dublin 15 it is 18 months, and is the only service available for children under 12. In the case of an acutely distressed child this is completely unsafe/unacceptable. In the context of limited CAMHS, community services need to be vastly improved and easily accessible. In the meantime, CAMHS need to be aware of what services actually exist in the community and share the challenge of assessing and managing these children within this context.

- **Automatic discharge when appointments are missed**
  Although we understand the reason for this policy, we are very concerned that children in a deprived populations are particularly vulnerable as their parents may be dealing with multiple other social stressors and chronic physical and mental health problems where children are most vulnerable. There are often changes of address and mobile phone numbers that mean patients do not receive appointments. A child who does not attend (or more accurately, was not brought) should be regarded as a "red flag" situation where efforts are intensified, rather than being discharged, which is what usually happens. Accessibility needs to be considered and addressed by CAMHS if it is to reach those most at risk.

- **Communication between CAMHS and GPs**
  This is a very challenging area, which is compounded by the fact that for many of us, our practice population is split geographically between two

CAMHS services. This is not specific to CAMHS but complicates effective working between primary and specialty care about these vulnerable patients. SOP 10.1.5, which relates to links between general practice and CAMHS is not being operationalized effectively.

- **GP Training**
  SOP 12.3 outlines a service aim to "provide training and consultation for primary care professionals in order to maximise their ability to promote mental health within primary care settings." This aspiration is unrealized and initial training should focus on GPs practicing in disadvantaged areas, who are most in need of these supports.